

Application for a §1915 (c) HCBS Waiver

HCBS Waiver Application Version 3.3

Submitted by:

New York State Department of Health

Submission Date:

CMS Receipt Date (CMS Use)

Provide a brief one-two sentence description of the request (e.g., renewal of waiver, request for new waiver, amendment):

Brief Description:

This is a request for a new waiver. The intent of the waiver is to provide community based support and health care services to children in foster care and to those who have been discharged from foster care while in the waiver. These home and community-based services are supplementary to services available through the State Plan and other programs and are specifically tailored to address unmet health and other needs related to a child's severe emotional disturbances, developmental disabilities and/or physical health issues. These severe emotional disturbances, developmental disabilities and/or physical health issues are sufficiently severe to result in the children's being eligible for institutional care. These services will be provided to improve the health and welfare of children in foster care in the least restrictive, most integrated setting appropriate to their needs.

Because of the unique circumstances of children who have special needs and are also in foster care, Attachment 1 contains a number of key terms which will assist in understanding certain segments of the waiver application.

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Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

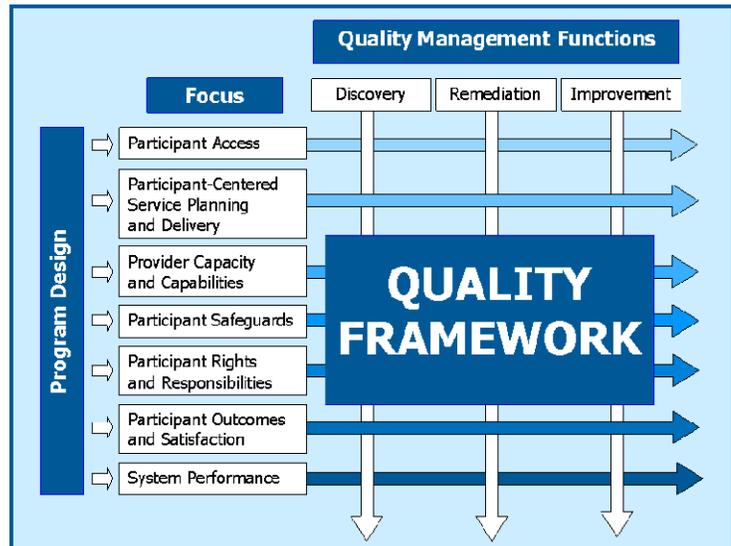
The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

The waiver application is based on the HCBS Quality Framework. The Framework focuses on seven broad, participant-centered desired outcomes for the delivery of waiver services, including assuring participant health and welfare:

- ◆ **Participant Access:** *Individuals have access to home and community-based services and supports in their communities.*
- ◆ **Participant-Centered Service Planning and Delivery:** *Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her life in the community.*
- ◆ **Provider Capacity and Capabilities:** *There are sufficient HCBS providers and they possess and demonstrate the capability to effectively serve participants.*
- ◆ **Participant Safeguards:** *Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.*
- ◆ **Participant Rights and Responsibilities:** *Participants receive support to exercise their rights and in accepting personal responsibilities.*
- ◆ **Participant Outcomes and Satisfaction:** *Participants are satisfied with their services and achieve desired outcomes.*
- ◆ **System Performance:** *The system supports participants efficiently and effectively and constantly strives to improve quality.*

The Framework also stresses the importance of respecting the preferences and autonomy of waiver participants.

The Framework embodies the essential elements for assuring and improving the quality of waiver services: design, discovery, remediation and improvement. The State has flexibility in developing and implementing a Quality Management Strategy to promote the achievement of the desired outcomes expressed in the Quality Framework.



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1. Request Information

A. The **State** of requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. **Waiver Title** (optional):

C. **Type of Request** (select only one):

<input checked="" type="radio"/>	New Waiver (3 Years)	CMS-Assigned Waiver Number (CMS Use):	<input type="text"/>
<input type="radio"/>	New Waiver (3 Years) to Replace Waiver #	<input type="text"/>	<input type="text"/>
	CMS-Assigned Waiver Number (CMS Use):	<input type="text"/>	
	<i>Attachment #1 contains the transition plan to the new waiver.</i>		
<input type="radio"/>	Renewal (5 Years) of Waiver #	<input type="text"/>	<input type="text"/>
<input type="radio"/>	Amendment to Waiver #	<input type="text"/>	<input type="text"/>

D. **Type of Waiver** (select only one):

<input type="radio"/>	Model Waiver. In accordance with 42 CFR §441.305(b), the State assures that no more than 200 individuals will be served in this waiver at any one time.
<input checked="" type="radio"/>	Regular Waiver, as provided in 42 CFR §441.305(a)

E.1 **Proposed Effective Date:**

E.2 **Approved Effective Date (CMS Use):**

F. **Level(s) of Care.** This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (check each that applies):

<input checked="" type="radio"/>	Hospital (select applicable level of care)
<input type="radio"/>	Hospital as defined in 42 CFR §440.10. If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care: <input type="text"/>
<input checked="" type="radio"/>	Inpatient psychiatric facility for individuals under age 21 as provided in 42 CFR § 440.160
<input checked="" type="radio"/>	Nursing Facility (select applicable level of care)
<input checked="" type="radio"/>	As defined in 42 CFR §440.40 and 42 CFR §440.155. If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care: <input type="text"/>
<input type="radio"/>	Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140
<input checked="" type="radio"/>	Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150). If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR facility level of care: <input type="text"/>

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G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities (*check the applicable authority or authorities*):

<input type="checkbox"/>	Services furnished under the provisions of §1915(a) of the Act and described in Appendix I	
<input type="checkbox"/>	Waiver(s) authorized under §1915(b) of the Act. <i>Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:</i>	
	Specify the §1915(b) authorities under which this program operates (<i>check each that applies</i>):	
<input type="checkbox"/>	§1915(b)(1) (mandated enrollment to managed care)	<input type="checkbox"/>
<input type="checkbox"/>	§1915(b)(2) (central broker)	<input type="checkbox"/>
<input type="checkbox"/>	A program authorized under §1115 of the Act. <i>Specify the program:</i>	
X	Not applicable	

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2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The Bridges to Health (B2H) Medicaid Waiver will address the multiple and severe medical, severe emotional disturbance, and developmental needs of a subset of children and youth in foster care, with the services following the child upon discharge from foster care. The B2H Waiver will allow the State to supplement the Medicaid State Plan and other supports by providing an array of services tailored to address the unmet health care needs of this complex population in the least restrictive, most home-like setting possible. These children are at risk of and eligible for institutional placement because of these unmet needs.

Research indicates that children who have been removed from their families and placed in foster care have significantly higher rates of unmet health care needs compared to the general population. Findings from the Northwest Foster Care Alumni Study revealed that a disproportionate number of children formerly in foster care suffered from mental health disorders. For instance, 25 percent have been diagnosed with post-traumatic stress disorder. This is five times that of the general population and double the rate of U.S. war veterans. A troubling 54 percent had one or more mental health disorders. Additionally, 60 percent of children in foster care exhibit developmental delays and at least one chronic medical condition, with 25 percent having three or more chronic conditions.

B2H is designed specifically with this vulnerable population in mind. B2H will provide services not otherwise available to children with these complex medical conditions within the context of their complicated family/caregiver circumstances to improve their overall health and welfare. By the end of the first three years, this application proposes thirty-three hundred and three (3,303) waiver opportunities. The enrolled children and youth will be eligible to receive a variety of comprehensive, community-based support services targeted to each child's specific needs that will complement, not duplicate, services provided to these children through other programs.

B2H's organizational structure, service-delivery methods and service package have been designed with the input of clinicians, child welfare providers, government experts, children and families. The New York State Office of Children and Family Services (OCFS) and Department of Health (DOH) are responsible for the operation and oversight of the B2H waiver. Under OCFS oversight, local departments of social services (LDSSs) and OCFS with regard to children in OCFS' custody and care will make enrollment, re-authorization and disenrollment decisions for waiver-eligible children. Since the majority of children will not be in OCFS' care, the application will use LDSSs to refer to those children in OCFS care, as well. LDSSs are also responsible for determining financial eligibility for Medicaid. Virtually all children in foster care are categorically eligible for the Medicaid program. While in the B2H program, LDSSs will retain program responsibilities, including after a child's discharge from foster care.

To promote efficiency and allow for regional flexibility, OCFS will enter into provider agreements with Health Care Integration Agencies (HCIAs) across the State to complete related administrative activities prior to DOH's enrolling the provider in eMedNY. The HCIAs will be not-for-profit voluntary agencies (VAAs as defined in attachment #1). But, in addition they must demonstrate experience in providing community-based services to individuals with disabilities. These agencies will recruit providers, and prepare enrollment applications for LDSS approval, propose individualized health plans (IHPs) to the LDSSs, arrange for waiver services and assist in waiver administration. The health care integrators (HCIs) they employ will be responsible for the child's health care coordination. If an HCIA also chooses to provide direct services beyond health care integration and is involved in preparing the enrollment package, strict guidelines and appropriate safeguards will be in place under the Medicaid provider agreement to prevent inappropriate influence over the service planning and delivery process.

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3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

- A. Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. Participant-Centered Service Planning and Delivery.** Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).
- E. Participant-Direction of Services.** When the State provides for participant direction of services, Appendix E specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

<input type="radio"/>	The waiver provides for participant direction of services. <i>Appendix E is required.</i>
<input checked="" type="radio"/>	Not applicable. The waiver does not provide for participant direction of services. <i>Appendix E is not completed.</i>

- F. Participant Rights.** Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.
- G. Participant Safeguards.** Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.
- H. Quality Management Strategy.** Appendix H contains the Quality Management Strategy for this waiver.
- I. Financial Accountability.** Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.
- J. Cost-Neutrality Demonstration.** Appendix J contains the State's demonstration that the waiver is cost-neutral.

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4. Waiver(s) Requested

- A. Comparability.** The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.
- B. Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):

<input checked="" type="radio"/>	Yes
<input type="radio"/>	No
<input type="radio"/>	Not applicable

- C. Statewideness.** Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act (*select one*):

<input checked="" type="radio"/>	Yes (<i>complete remainder of item</i>)
<input type="radio"/>	No

If yes, specify the waiver of statewideness that is requested (*check each that applies*):

<input checked="" type="checkbox"/>	<p>Geographic Limitation. A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State. <i>Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:</i></p> <p>B2H will be phased-in over a three (3) year period in every county in the State. This phase-in approach is a result of New York’s mix of population density as well as the difference between supporting and implementing the waiver. Furthermore, this design is intended to balance the need for HCIA’s to cover great distances to deliver care in some areas and minor distances in others. OCFS used as a base the existing New York State OCFS regions – whose staff will be key to successful implementation – but modified those regions to accommodate the design-driven roll-out plan.</p> <p>Counties/New York City participating Years 1 – 3: New York City; Albany; Chemung; Clinton; Columbia; Delaware; Essex; Franklin; Fulton; Greene; Livingston; Monroe; Montgomery; Ontario; Otsego; Rensselaer; Saratoga; Schenectady; Schoharie; Schuyler; Seneca; Steuben; Warren; Washington; Wayne; and Yates.</p> <p>Counties/New York City participating Years 2 & 3 only: Broome; Cayuga; Chenango; Cortland; Dutchess; Hamilton; Herkimer; Jefferson; Madison; Oneida; Onondaga; Orange; Oswego; Putnam; Rockland; Sullivan; St. Lawrence; St. Regis Tribal Nation; Tioga; Tompkins; Ulster; Westchester.</p>
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	<p>Counties/New York City participating Year 3 only: Allegany; Cattaraugus; Chautauqua; Erie; Genesee; Lewis; Nassau; Niagara; Orleans; Suffolk; and Wyoming.</p> <p>A detailed description of the phase-in plan and county/NYC slot allocation is included in Appendix B. Children who are in OCFS care immediately prior to Waiver entry will be assigned to their home counties following the roll-out plan.</p>
<input type="checkbox"/>	<p>Limited Implementation of Participant-Direction. A waiver of statewideness is requested in order to make <i>participant direction of services</i> as specified in Appendix E available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State. <i>Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:</i></p>

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5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

- A. Health & Welfare:** The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
 2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
 3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
- D. Choice of Alternatives:** The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
 2. Given the choice of either institutional or home and community-based waiver services.
- Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.
- G. Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan

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and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

- I. Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- J. Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) under age 21 when the State has not included the optional Medicaid benefit cited in 42 CFR §440.160.

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6. Additional Requirements

Note: Item 6-I must be completed.

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected amount, frequency and duration and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.
- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/MR.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.51, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid) and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- H. Quality Management.** The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity

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and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Management Strategy specified in **Appendix H**.

I. Public Input. Describe how the State secures public input into the development of the waiver:

The development of B2H was authorized by legislation directing the New York DOH to apply for a Waiver to serve children in the care and custody of local departments of social services and OCFS.

Throughout the waiver development process, multiple meetings were conducted with a variety of stakeholders to permit creation of a program design appropriate to the needs of children in foster care and their family/caregivers. These meetings were held with stakeholders that included children in foster care, parents of children in foster care, adoptive parents, clinicians, Local Departments of Social Services, foster care providers and representatives from New York’s DOH, Office of Mental Health (OMH), Office of Mental Retardation/Developmental Disabilities (OMR/DD), and Office of Alcoholism and Substance Abuse Services (OASAS).

Children and Families

- Child Welfare Organizing Project (biological parents of children in foster care)
- Post-Adoption Support Group (voluntary agency foster and adoptive parent group)
- Youth in Progress (children currently or formerly in foster care)

Children’s Advocates

- Citizen’s Committee for Children
- New York State Coalition for Children’s Mental Hygiene Services
- Schuyler Center for Analysis and Advocacy

Providers and Clinicians

- American Academy of Pediatrics New York Foster Care Workgroup
- Coalition of Voluntary Mental Hygiene Providers
- Council of Family and Child Caring Agencies (121-member child welfare provider group)
- House of the Good Shepherd (multi-service provider)
- Kids Oneida (a mental health demonstration initiative)
- New York City consortium of six agencies specializing in the medically fragile
- Parsons Child and Family Center (multi-service provider)
- Sick Kids Need Involved People (SKIP) of New York (developmental disability service coordination agency)
- 10-15 individual provider agencies are represented at most stakeholder meetings

Local and other Government Participants

- New York City - Administration for Children’s Services
- OMR/DD – New York City Regional Office
- New York Public Welfare Association 58-member consortia(local social services commissioners)
- New York State Conference of Local Mental Hygiene Directors
- Region II Joint Planning Team (a Rochester-area government and provider group working on children’s services across systems)
- Region IV LDSS Directors of Services
- Single Point of Access – Albany and Onondaga county sites (multi-system service coordination entity)
- Statewide Permanency Planning Team (cross-system group focusing on adoption of children in foster care)

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The Systems Engineering Group (SEG) was established to provide feedback on and assist in the design and implementation of B2H. This group consists of over 40 programmatically knowledgeable representatives from non-governmental stakeholders (e.g., private child welfare agencies and private agency associations) and governmental stakeholders (e.g., New York City Agency for Children’s Services; New York Local Departments of Social Services; OCFS regional, policy and fiscal offices). This group convened regularly and frequently to assist in developing waiver design elements.

An inter-agency advisory group (IAG) was convened to advise on overall strategy, develop agency contributions to the project and to support program integration across State agencies. This group consisted of members of various State agencies including OCFS, DOH, the Office of Mental Health, the Office of Mental Retardation and Developmental Disabilities, the Office of Alcoholism and Substance Abuse Services, and the Division of the Budget.

A stakeholder Advisory Group was also convened to provide input and policy guidance on various issues as they relate to the development of the B2H waiver. This Stakeholder Advisory Group was formed in February 2006 and comprises representatives from various entities that include, but are not limited to children’s advocates, community based service providers, the NYS Public Welfare Association (NYPWA), the Council of Family and Child Caring Agencies (COFCCA), state agencies and local governments from across New York State.

The stakeholder groups continue to meet and to discuss the development and implementation of B2H. Summaries of these meetings are available from OCFS upon request.

- J. Notice to Tribal Governments.** The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State’s intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date as provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.
- K. Limited English Proficient Persons.** The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services “Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons” (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

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7. Contact Person(s)

- A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

First Name:	Julie
Last Name	Elson
Title:	Director, Bureau of Maternal and Child Health, Office of Medicaid Management
Agency:	New York State Department of Health
Address 1:	One Commerce Plaza
Address 2:	
City	Albany
State	NY
Zip Code	12210
Telephone:	518-486-6562
E-mail	jxe04@health.state.ny.us
Fax Number	518-473-8250

- B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

First Name:	Nancy
Last Name	Martinez
Title:	Director, Office of Strategic Planning and Policy Development
Agency:	New York State Office of Children and Family Services
Address 1:	52 Washington Street
Address 2	Room 313 South
City	Rensselaer
State	New York
Zip Code	12144
Telephone:	518-473-1776
E-mail	Nancy.Martinez@ocfs.state.ny.us
Fax Number	518-473-2410

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8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are *readily* available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature:  **Date:**
10/20/06
State Medicaid Director or Designee

First Name:	Brian
Last Name	Wing
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Attachment #1: Transition Plan

Specify the transition plan for the waiver:

Not applicable.

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Appendix A: Waiver Administration and Operation

1. State Line of Authority for Waiver Operation. Specify the state line of authority for the operation of the waiver (*select one*):

<input type="radio"/>	The waiver is operated by the State Medicaid agency. Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (<i>select one; do not complete Item A-2</i>):
<input type="radio"/>	The Medical Assistance Unit (<i>name of unit</i>):
<input type="radio"/>	Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit (<i>name of division/unit</i>):
<input checked="" type="radio"/>	The waiver is operated by Office of Children and Family Services a separate agency of the State that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. <i>Complete item A-2.</i>

2. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

DOH and OCFS are developing a Memorandum of Understanding for the operation of the waiver. The MOU available upon request.

3. Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the waiver operating agency (if applicable) (*select one*):

<input checked="" type="radio"/>	Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable). Specify the types of contracted entities and briefly describe the functions that they perform. <i>Complete Items A-5 and A-6.</i>
	OCFS will enter into agreements with HCIAs for the development and selected quality management activities related to HCBS service providers in their communities. These agencies will identify potential waiver providers then recruit, develop, maintain, manage and train the providers. HCIAs will also provide utilization management services to OCFS. These services will include processes to support proper utilization of waiver services in conformance with the IHP. The HCIAs will also assist in the preparation of the enrollment package and be responsible for identifying instances when enrollees are not receiving services described in the IHP or when the services are far below levels determined in the IHP. They are also responsible for monitoring waiver expenditures against approved levels identified in the IHP.

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	<p>In addition to these administrative activities, the HCIA's will work on behalf of the waiver enrollees to assist during enrollment in the waiver by conducting level of care evaluations, disseminate information to the potential enrollee and manage enrollment in the waiver against approved limits.</p> <p>Health Care Integration Agencies will be not-for-profit voluntary agencies (VAAs as defined in Attachment #1) that meet the provider qualifications established by OCFS including having appropriate license or certification from OMH, OMR/DD or DOH; sufficient administrative and fiscal viability to conduct and sustain the B2H program; sufficient community standing; and the capacity and willingness to comply with Medicaid waiver provider agreement requirements. OCFS will use a multi-tiered review of established criteria, including an evaluation of the applicant agency's existing foster care and medical assistance programs and submission of letters of support from the majority of social services districts in the geographical area to be served by the HCIA. OCFS will advise applicants as to the completeness of the application and may provide an opportunity for discussion of the application and the submittal of an amended application, as necessary, followed by a final decision issued in writing by OCFS. The process will permit open-ended enrollment of approved applicants. There will not be an administrative appeal and unsuccessful applicants will be limited to pursuing their rights under Article 78 of the Civil Practice Law and Rules. Unsuccessful applicants will be permitted to reapply one year from the date of the initial application submittal.</p>
○	<p>No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).</p>

4. Role of Local/Regional Non-State Entities. Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*check each that applies*):

X	<p>Local/Regional non-state public agencies conduct waiver operational and administrative functions at the local or regional level. There is an interagency agreement or memorandum of understanding between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state agency that sets forth the responsibilities and performance requirements of the local/regional agency. The interagency agreement or memorandum of understanding is available through the Medicaid agency or the operating agency (if applicable). <i>Specify the nature of these agencies and complete items A-5 and A-6:</i></p> <p>OCFS (the waiver operating agency) will issue administrative directive memoranda (ADMS), as it routinely does to provide policy direction and program guidance on children in LDSS custody and those children in the waiver program who have been discharged from custody. Included in the ADMs will be direction for LDSSs to work with HCIA's on the dissemination of information regarding B2H. Enrollments, level of care determinations, reauthorizations and referrals will be conducted by the LDSSs for children in the care and custody of the LDSS. However, LDSSs retain authority for enrollment/disenrollment decisions for all children enrolled in the waiver through their own LDSS. A detailed listing of the administrative activities provided by LDSSs is provided in Section 7 of this Appendix. For those children related to ICF eligibility, OMR/DD will be conducting level of care determinations.</p>
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	Children who are in the care and custody of OCFS will have their enrollments, level of care determinations, reauthorizations and HCIA referrals performed by OCFS.
<input type="checkbox"/>	Local/Regional non-governmental non-state entities conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The contract(s) under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). <i>Specify the nature of these entities and complete items A-5 and A-6:</i>
<input type="checkbox"/>	Not applicable – Local/regional non-state agencies do not perform waiver operational and administrative functions.

5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities. Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

OCFS will be granted this responsibility through the Memorandum of Understanding with DOH.

6. Assessment Methods and Frequency. Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

OCFS, in conjunction with DOH, will enter into agreements with VAAs across the State with demonstrated experience in providing operational and administrative functions expected within this waiver to serve as HCIAs. OCFS, in conjunction with DOH, will oversee and monitor these HCIAs for their performance of the waiver functions for which they are responsible on an ongoing, regular basis.

OCFS will conduct regional HCIA meetings on a quarterly basis. HCIAs will be required to submit quarterly reports to OCFS. OCFS will conduct annual on-site reviews that will examine programmatic, operational and administrative performance of the HCIAs. Additionally, OCFS will conduct retrospective reviews of a random sample of IHPs to support quality performance. OCFS and DOH will conduct targeted reviews of IHPs as stipulated in the MOU between the two State agencies.

OCFS is committed to ongoing technical assessment and assistance with these contracted agencies on a regular basis to continually improve the quality of care provided to all waiver enrollees. The information gathered through OCFS' monitoring of the HCIAs will be used to create targeted technical assistance and training. Additionally, OCFS will monitor feedback from the HCIAs to review appropriate policy and operational guidance.

OCFS, as the waiver operating agency, will provide annual reports to DOH as the Medicaid agency to report the performance assessments of HCIAs and the activities of OCFS in conducting these reviews. OCFS will also utilize the staff of the Bureau of Waiver Management (BWM) to monitor the actions of each LDSS and HCIA. This monitoring will provide OCFS with comprehensive reviews of the HCIAs and their performance of the waiver's administrative functions. Information gathered through these

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reviews will also be used to identify policy areas that need revision or redirection.

In addition, OCFS will establish a Quality Advisory Board with participation from DOH and other State agencies and stakeholders, as appropriate. OCFS will solicit feedback on the operation of the HCIAs by convening annual regional forums. This will provide an opportunity for OCFS to meet with waiver participants, families, advocates and providers to gather stakeholders' perspectives. OCFS will provide a toll-free number to the B2H waiver for participants, their families and advocates for registering complaints and concerns. This will include a regular reporting and tracking process to describe types of calls received, the providers and the regions involved and actions taken. A waiver participant survey process will also be implemented as another means to track and assess the HCIAs' and B2H service providers' performance of waiver functions and activities.

7. Distribution of Waiver Operational and Administrative Functions. In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function.

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
Disseminate information concerning the waiver to potential enrollees	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Assist individuals in waiver enrollment	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Manage waiver enrollment against approved limits	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Monitor waiver expenditures against approved levels	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Conduct level of care evaluation activities	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Review participant service plans to ensure that waiver requirements are met	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Perform prior authorization of waiver services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Conduct utilization management functions	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Recruit providers	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Execute the Medicaid provider agreement	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Determine waiver payment amounts or rates	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Conduct training and technical assistance concerning waiver requirements	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

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Appendix B: Participant Access and Eligibility

Appendix B-1: Specification of the Waiver Target Group(s)

- a. **Target Group(s).** Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to a group or subgroups of individuals. *In accordance with 42 CFR §441.301(b)(6), select one waiver target group, check each subgroup in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

INCLUDED	TARGET GROUP/SUBGROUP	MINIMUM AGE	MAXIMUM AGE	
			MAXIMUM AGE LIMIT: THROUGH AGE –	
<input checked="" type="checkbox"/>	Aged or Disabled, or Both			
<input type="checkbox"/>	Aged (age 65 and older)			<input type="checkbox"/>
<input checked="" type="checkbox"/>	Disabled (Physical) (under age 65)	0	20	
<input checked="" type="checkbox"/>	Disabled (Other) (under age 65)	0	20	
Specific Aged/Disabled Subgroup				
<input checked="" type="checkbox"/>	Brain Injury	0	20	<input checked="" type="checkbox"/>
<input checked="" type="checkbox"/>	HIV/AIDS	0	20	<input checked="" type="checkbox"/>
<input checked="" type="checkbox"/>	Medically Fragile	0	20	<input checked="" type="checkbox"/>
<input checked="" type="checkbox"/>	Technology Dependent	0	20	<input checked="" type="checkbox"/>
<input checked="" type="checkbox"/>	Mental Retardation or Developmental Disability, or Both			
<input checked="" type="checkbox"/>	Autism	0	20	<input checked="" type="checkbox"/>
<input checked="" type="checkbox"/>	Developmental Disability	0	20	<input checked="" type="checkbox"/>
<input checked="" type="checkbox"/>	Mental Retardation	0	20	<input checked="" type="checkbox"/>
<input checked="" type="checkbox"/>	Mental Illness			
<input checked="" type="checkbox"/>	Mental Illness (age 18 and older)	19	20	<input type="checkbox"/>
<input checked="" type="checkbox"/>	Serious Emotional Disturbance (under age 18)	0	18	

- b. **Additional Criteria.** The State further specifies its target group(s) as follows:

Children in the care and custody of LDSSs and children in the custody of OCFS are the target population for children initially entering the waiver program. Once enrolled, eligibility can continue once the child is discharged from LDSS/OCFS custody.

- c. **Transition of Individuals Affected by Maximum Age Limitation.** When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit (*select one*):

<input type="radio"/>	Not applicable – There is no maximum age limit
<input checked="" type="radio"/>	The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit (<i>specify</i>):
	Eighteen months prior to reaching the enrolled child's 21 st birthday, the HCIA will generate a

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transition plan that identifies the action steps needed to connect with services each child needs in adulthood and the party responsible for conducting the action steps. This transition plan will outline the ongoing Medicaid State Plan and waiver services that may need to be accessed from another HCBS waiver that offers appropriate services. This transition plan will require evaluation of the B2H participant for adult services. An essential component of transition planning will be verifying that all necessary eligibility and/or assessment information is current and accurate to facilitate the child's transition from the B2H waiver to appropriate adult services. It should be noted that although the target population for enrollment of children with severe emotional disturbance is children from birth through age 18, the B2H waiver allows these children to continue receiving waiver services until their 21st birthday, if needed.

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Appendix B-2: Individual Cost Limit

- a. Individual Cost Limit.** The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual (*select one*):

<input checked="" type="radio"/>	No Cost Limit. The State does not apply an individual cost limit. <i>Do not complete Item B-2-b or Item B-2-c.</i>		
<input type="radio"/>	Cost Limit in Excess of Institutional Costs. The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. <i>Complete Items B-2-b and B-2-c.</i> The limit specified by the State is (<i>select one</i>):		
<input type="radio"/>		%, a level higher than 100% of the institutional average	
<input type="radio"/>	Other (<i>specify</i>):		
<input type="radio"/>			
<input type="radio"/>	Institutional Cost Limit. Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. <i>Complete Items B-2-b and B-2-c.</i>		
<input type="radio"/>	Cost Limit Lower Than Institutional Costs. The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver. <i>Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.</i>		
<input type="radio"/>			
<input type="radio"/>	The cost limit specified by the State is (<i>select one</i>):		
<input type="radio"/>	The following dollar amount: \$		
<input type="radio"/>	The dollar amount (<i>select one</i>):		
<input type="radio"/>	Is adjusted each year that the waiver is in effect by applying the following formula:		
<input type="radio"/>			
<input type="radio"/>	May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.		
<input type="radio"/>	The following percentage that is less than 100% of the institutional average:		%
<input type="radio"/>	Other – <i>Specify</i> :		
<input type="radio"/>			

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- b. Method of Implementation of the Individual Cost Limit.** When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

--

- c. Participant Safeguards.** When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant (*check each that applies*):

<input type="checkbox"/>	The participant is referred to another waiver that can accommodate the individual's needs.
<input type="checkbox"/>	Additional services in excess of the individual cost limit may be authorized. Specify the procedures for authorizing additional services, including the amount that may be authorized:
<input type="checkbox"/>	Other safeguard(s) (<i>specify</i>):

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Appendix B-3: Number of Individuals Served

- a. Unduplicated Number of Participants.** The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a	
Waiver Year	Unduplicated Number of Participants
Year 1	547
Year 2	1,467
Year 3	3,481
Year 4 (renewal only)	
Year 5 (renewal only)	

- b. Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

<input type="radio"/>	The State does not limit the number of participants that it serves at any point in time during a waiver year.
<input checked="" type="radio"/>	The State limits the number of participants that it serves at any point in time during a waiver year. The limit that applies to each year of the waiver period is specified in the following table:

Table B-3-b	
Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	536
Year 2	1,396
Year 3	3,303
Year 4 (renewal only)	
Year 5 (renewal only)	

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- c. **Reserved Waiver Capacity.** The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State (*select one*):

<input type="radio"/>	Not applicable. The state does not reserve capacity.	
<input checked="" type="radio"/>	The State reserves capacity for the following purpose(s). For each purpose, describe how the amount of reserved capacity was determined:	
	The OCFS Division of Rehabilitation Services (OCFS/DRS) regularly evaluates children in OCFS' custody in its facilities for entry into community placements. The children considered for such placements consistently include children who have health care issues that are significant enough that they are at risk of placement in a Medicaid facility and would be eligible for and benefit from the services available from the B2H waiver. Review of current caseloads and past placement experience suggests that three hundred (300) of the children in the care and custody of OCFS will qualify and benefit from enrollment in the B2H waiver during its initial three-year period. OCFS will reserve a certain amount of waiver openings each year for these children. The detailed number of openings appears below.	
	The capacity that the State reserves in each waiver year is specified in the following table:	
	Table B-3-c	
	Purpose:	Purpose:
	Children in the Custody of OCFS	
Waiver Year	Capacity Reserved	Capacity Reserved
Year 1	50	
Year 2	150	
Year 3	300	
Year 4 (renewal only)		
Year 5 (renewal only)		

- d. **Scheduled Phase-In or Phase-Out.** Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule (*select one*):

<input type="radio"/>	The waiver is not subject to a phase-in or a phase-out schedule.
<input checked="" type="radio"/>	The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an <i>intra-year</i> limitation on the number of participants who are served in the waiver.

- e. **Allocation of Waiver Capacity.** *Select one:*

<input type="radio"/>	Waiver capacity is allocated/managed on a statewide basis.
<input checked="" type="radio"/>	Waiver capacity is allocated to local/regional non-state entities. Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among

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local/regional non-state entities:

Waiver capacity will be allocated to counties/New York City but managed at the state level. This means that waiver capacity will be sub-allocated to each county/New York City and the St. Regis Mohawk Tribe. The allocations are calculated using the protocol outlined below.

The number of children in foster care in each county/New York City in proportion to the total number of children in foster care in the State was used to determine the percentage of enrollment opportunities each county/New York City is allocated for the waiver over the three years.

With key design elements in mind and knowledge of the current child welfare system, the roll-out plan has been developed to draw upon existing services while needed B2H capacity is under development. Additionally, it was deemed critical that OCFS would be able to determine that sufficient resources exist for a high-quality roll-out by focusing on regions of the State sequentially rather than attempting to provide the needed technical support in every part of the State.

Each county's/New York City's percentage of the State's foster care population was calculated using the total number of children in foster care as the denominator. This percentage was applied to the number of statewide waiver enrollment opportunities to estimate each county's/New York City's enrollment numbers. Using the number of enrollments in a given county/New York City for a given year, the new waiver enrollments per quarter are calculated using the following percentages by quarters:

- Quarter 1: 10% of new enrollments
- Quarter 2: 10% of new enrollments
- Quarter 3: 30% of new enrollments
- Quarter 4: 50% of new enrollments

OCFS will undergo a process of review and reallocation each year to manage enrollments as efficiently as possible on a statewide basis. During the 3rd and 4th quarter of each calendar year, OCFS will evaluate the utilization of each county/New York City in comparison to the number of enrollments allocated. If any county/New York City is unable to use a waiver enrollment for 12 months that enrollment will be reallocated by OCFS to the county/New York City with the greatest proportional need. OCFS will use the number of children on a waitlist and the LDSS proportion of the foster care population as the metrics for determining a district's need. During this process it will be necessary for OCFS to review the number of enrollments reserved for children in their care and custody. Unused enrollments held for this population are subject to the same rules as enrollments for each county/New York City.

- f. **Selection of Entrants to the Waiver.** Specify the policies that apply to the selection of individuals for entrance to the waiver:

Selection within an allocation will be on a "first come-first served" basis for all eligible children in foster care. The date and time of their request for enrollment in the B2H waiver will be used to determine order of applications. Once the total authorized enrollment level in any LDSS or in OCFS Custody has been reached, the names of additional qualifying children seeking enrollment will be forwarded to the LDSS for entry on a waitlist. Because virtually all children in foster care are enrolled in Medicaid, when a waiver enrollment opportunity is not available, the potential enrollee's access to State Plan services remains unchanged.

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Attachment #1 to Appendix B-3

Waiver Phase-In/Phase Out Schedule

a. The waiver is being (*select one*):

<input checked="" type="checkbox"/>	Phased-in
<input type="checkbox"/>	Phased-out

b. **Waiver Years Subject to Phase-In/Phase-Out Schedule** (*check each that applies*):

Year One	Year Two	Year Three	Year Four	Your Five
X	X	X	<input type="checkbox"/>	<input type="checkbox"/>

c. **Phase-In/Phase-Out Time Period.** Complete the following table:

	Month	Waiver Year
Waiver Year: First Calendar Month	JULY	
Phase-in/Phase out begins	1 JULY	2007
Phase-in/Phase out ends	30 JUN	2010

d. **Phase-In or Phase-Out Schedule.** Complete the following table:

Phase-In or Phase-Out Schedule			
Waiver Year:		1 (1 JULY 2007 – 30 JUN 2008)	
Month	Base Number of Participants	Change in Number of Participants	Participant Limit
JULY	0	16	16
AUG	16	16	32
SEPT	32	17	49
OCT	49	16	65
NOV	65	17	82
DEC	82	17	99
JAN	99	53	152
FEB	152	54	206
MAR	206	54	260
APR	260	89	349
MAY	349	90	439
JUN	439	90	529

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Phase-In or Phase-Out Schedule			
Waiver Year:		2 (1 JULY 2008 – 30 JUN 2009)	
Month	Base Number of Participants	Change in Number of Participants	Participant Limit
JULY	529	27	556
AUG	556	27	583
SEPT	583	28	611
OCT	611	27	638
NOV	638	28	666
DEC	666	28	694
JAN	694	84	778
FEB	778	85	863
MAR	863	85	948
APR	948	141	1,089
MAY	1,089	141	1,230
JUN	1,230	142	1,372

Waiver Year:		3 (1 JULY 2009 – 30 JUN 2010)	
Month	Base Number of Participants	Change in Number of Participants	Participant Limit
JULY	1,372	64	1,436
AUG	1,436	64	1,500
SEPT	1,500	65	1,565
OCT	1,565	64	1,629
NOV	1,629	65	1,694
DEC	1,694	65	1,759
JAN	1,759	192	1,951
FEB	1,951	193	2,144
MAR	2,144	193	2,337
APR	2,337	322	2,659
MAY	2,659	322	2,981
JUN	2,981	322	3,303

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Appendix B-4: Medicaid Eligibility Groups Served in the Waiver

a. **State Classification.** The State is a (*select one*):

<input checked="" type="checkbox"/>	§1634 State
<input type="checkbox"/>	SSI Criteria State
<input type="checkbox"/>	209(b) State

b. **Medicaid Eligibility Groups Served in the Waiver.** Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply:*

<i>Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)</i>	
<input checked="" type="checkbox"/>	Low income families with children as provided in §1931 of the Act
<input checked="" type="checkbox"/>	SSI recipients
<input type="checkbox"/>	Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121
<input checked="" type="checkbox"/>	Optional State supplement recipients
<input type="checkbox"/>	Optional categorically needy aged and/or disabled individuals who have income at: (<i>select one</i>)
<input type="checkbox"/>	100% of the Federal poverty level (FPL)
<input type="checkbox"/>	% of FPL, which is lower than 100% of FPL
<input type="checkbox"/>	Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(i)(XIII) of the Act)
<input checked="" type="checkbox"/>	Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)
<input checked="" type="checkbox"/>	Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)
<input type="checkbox"/>	Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)
<input checked="" type="checkbox"/>	Medically needy
<input checked="" type="checkbox"/>	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) <i>specify:</i>
	1902(a)(10)(i)(I) 1902(I)(1)(A) 1902(I)(1)(B) 1902(I)(1)(C) 1902(I)(1)(D) 1902(a)(10)(A)(VIII)
<i>Special home and community-based waiver group under 42 CFR §435.217) Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed</i>	
<input checked="" type="checkbox"/>	No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.

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<input type="radio"/>	Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. <i>Select one and complete Appendix B-5.</i>	
<input type="radio"/>	All individuals in the special home and community-based waiver group under 42 CFR §435.217	
<input type="radio"/>	Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217 (<i>check each that applies</i>):	
<input type="checkbox"/>	A special income level equal to (select one):	
<input type="radio"/>	300%	of the SSI Federal Benefit Rate (FBR)
<input type="radio"/>	%	Of FBR, which is lower than 300% (42 CFR §435.236)
<input type="radio"/>	\$	which is lower than 300%
<input type="checkbox"/>	Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)	
<input type="checkbox"/>	Medically needy without spend down in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)	
<input type="checkbox"/>	Medically needy without spend down in 209(b) States (42 CFR §435.330)	
<input type="checkbox"/>	Aged and disabled individuals who have income at: (<i>select one</i>)	
<input type="radio"/>	100%	of FPL
<input type="radio"/>	%	of FPL, which is lower than 100%
<input type="checkbox"/>	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) <i>specify</i> :	

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Appendix B-5: Post-Eligibility Treatment of Income

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217 (select one):

<input type="radio"/>	Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State elects to (select one):	
	<input type="radio"/>	Use <i>spousal</i> post-eligibility rules under §1924 of the Act. Complete Items B-5-b-2 (SSI State) or B-5-c-2 (209b State) <u>and</u> Item B-5-d.
	<input type="radio"/>	Use <i>regular</i> post-eligibility rules under 42 CFR §435.726 (SSI State) (Complete Item B-5-b-1) or under §435.735 (209b State) (Complete Item B-5-c-1). Do not complete Item B-5-d.
<input type="radio"/>	Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse. Complete Item B-5-c-1 (SSI State) or Item B-5-d-1 (209b State) Do not complete Item B-5-d.	

NOTE: Items B-5-b-1 and B-5-c-1 are for use by states that do not use spousal eligibility rules or use spousal impoverishment eligibility rules but elect to use regular post-eligibility rules.

b-1. Regular Post-Eligibility Treatment of Income: SSI State. The State uses the post-eligibility rules at 42 CFR §435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (select one):		
<input type="radio"/>	The following standard included under the State plan (select one)	
	<input type="radio"/>	SSI standard
	<input type="radio"/>	Optional State supplement standard
	<input type="radio"/>	Medically needy income standard
	<input checked="" type="radio"/>	The special income level for institutionalized persons (select one):
	<input type="radio"/>	300% of the SSI Federal Benefit Rate (FBR)
	<input type="radio"/>	% of the FBR, which is less than 300%
	<input type="radio"/>	\$ which is less than 300%.
	<input type="radio"/>	% of the Federal poverty level
	<input type="radio"/>	Other (specify):
<input type="radio"/>	The following dollar amount:	\$ _____ If this amount changes, this item will be revised.

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<input type="radio"/>	The following formula is used to determine the needs allowance:	
ii. Allowance for the spouse only (<i>select one</i>):		
<input type="radio"/>	SSI standard	
<input type="radio"/>	Optional State supplement standard	
<input type="radio"/>	Medically needy income standard	
<input type="radio"/>	The following dollar amount: \$	If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula:	
<input type="radio"/>	Not applicable (<i>see instructions</i>)	
iii. Allowance for the family (<i>select one</i>):		
<input type="radio"/>	AFDC need standard	
<input type="radio"/>	Medically needy income standard	
<input type="radio"/>	The following dollar amount: \$	The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula:	
<input type="radio"/>	Other (specify):	
<input type="radio"/>	Not applicable (<i>see instructions</i>)	
iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:		
a. Health insurance premiums, deductibles and co-insurance charges		
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. <i>Select one:</i>		
<input type="radio"/>	The State does not establish reasonable limits.	
<input type="radio"/>	The State establishes the following reasonable limits (<i>specify</i>):	

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c-1. Regular Post-Eligibility: 209(b) State. The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (<i>select one</i>):			
<input type="radio"/>	The following standard included under the State plan (<i>select one</i>)		
<input type="radio"/>	The following standard under 42 CFR §435.121:		
<input type="radio"/>	Optional State supplement standard		
<input type="radio"/>	Medically needy income standard		
<input type="radio"/>	The special income level for institutionalized persons (<i>select one</i>):		
<input type="radio"/>	<input type="radio"/>	300% of the SSI Federal Benefit Rate (FBR)	
<input type="radio"/>	<input type="radio"/>	%	of the FBR, which is less than 300%
<input type="radio"/>	<input type="radio"/>	\$	which is less than 300% of the FBR
<input type="radio"/>	<input type="radio"/>	%	of the Federal poverty level
<input type="radio"/>	Other (specify):		
<input type="radio"/>	The following dollar amount:	\$	If this amount changes, this item will be revised.
<input type="radio"/>	The following formula is used to determine the needs allowance:		
ii. Allowance for the spouse only (<i>select one</i>):			
<input type="radio"/>	The following standard under 42 CFR §435.121		
<input type="radio"/>	Optional State supplement standard		
<input type="radio"/>	Medically needy income standard		
<input type="radio"/>	The following dollar amount:	\$	If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula:		
<input type="radio"/>	Not applicable (<i>see instructions</i>)		
iii. Allowance for the family (<i>select one</i>):			
<input type="radio"/>	AFDC need standard		
<input type="radio"/>	Medically needy income standard		

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<input type="radio"/>	The following dollar amount: \$ <input type="text"/> The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula: <input type="text"/>
<input type="radio"/>	Other (specify): <input type="text"/>
<input type="radio"/>	Not applicable (see instructions)
iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.735:	
a. Health insurance premiums, deductibles and co-insurance charges	
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. <i>Select one:</i>	
<input type="radio"/>	The State does not establish reasonable limits.
<input type="radio"/>	The State establishes the following reasonable limits (<i>specify</i>): <input type="text"/>

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NOTE: Items B-5-c-2 and B-5-d-2 are for use by states that use spousal impoverishment eligibility rules and elect to apply the spousal post eligibility rules.

b-2. Regular Post-Eligibility Treatment of Income: SSI State. The State uses the post-eligibility rules at 42 CFR §435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant’s income:

i. Allowance for the needs of the waiver participant (select one):		
<input type="radio"/>	The following standard included under the State plan (select one)	
<input type="radio"/>	SSI standard	
<input type="radio"/>	Optional State supplement standard	
<input type="radio"/>	Medically needy income standard	
<input type="radio"/>	The special income level for institutionalized persons (select one):	
<input type="radio"/>	300% of the SSI Federal Benefit Rate (FBR)	
<input type="radio"/>	%	of the FBR, which is less than 300%
<input type="radio"/>	\$	which is less than 300%.
<input type="radio"/>	%	of the Federal poverty level
<input type="radio"/>	Other (specify):	
<input type="radio"/>	The following dollar amount: \$ If this amount changes, this item will be revised.	
<input type="radio"/>	The following formula is used to determine the needs allowance:	
ii. Allowance for the spouse only (select one):		
<input type="radio"/>	The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:	
Specify the amount of the allowance:		
<input type="radio"/>	SSI standard	
<input type="radio"/>	Optional State supplement standard	
<input type="radio"/>	Medically needy income standard	
<input type="radio"/>	The following dollar amount:	\$ If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula:	
<input type="radio"/>	Not applicable	

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iii. Allowance for the family (select one):	
<input type="radio"/>	AFDC need standard
<input type="radio"/>	Medically needy income standard
<input type="radio"/>	The following dollar amount: \$ <input type="text"/> The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula: <input type="text"/>
<input type="radio"/>	Other (specify): <input type="text"/>
<input type="radio"/>	Not applicable (see instructions)
iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:	
a. Health insurance premiums, deductibles and co-insurance charges	
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. <i>Select one:</i>	
<input type="radio"/>	The State does not establish reasonable limits.
<input type="radio"/>	The State establishes the following reasonable limits (specify): <input type="text"/>

c-2. Regular Post-Eligibility: 209(b) State. The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (select one):	
<input type="radio"/>	The following standard included under the State plan (select one)
<input type="radio"/>	The following standard under 42 CFR §435.121: <input type="text"/>
<input type="radio"/>	Optional State supplement standard
<input type="radio"/>	Medically needy income standard
<input type="radio"/>	The special income level for institutionalized persons (select one)
<input type="radio"/>	300% of the SSI Federal Benefit Rate (FBR)
<input type="radio"/>	% of the FBR, which is less than 300%
<input type="radio"/>	\$ which is less than 300% of the FBR
<input type="radio"/>	% of the Federal poverty level

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<input type="radio"/>	Other (specify):	
<input type="radio"/>	The following dollar amount:	\$ _____ If this amount changes, this item will be revised.
<input type="radio"/>	The following formula is used to determine the needs allowance:	
ii. Allowance for the spouse only (select one):		
<input type="radio"/>	The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:	
	Specify the amount of the allowance:	
<input type="radio"/>	The following standard under 42 CFR §435.121:	
<input type="radio"/>	Optional State supplement standard	
<input type="radio"/>	Medically needy income standard	
<input type="radio"/>	The following dollar amount:	\$ _____ If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula:	
<input type="radio"/>	Not applicable	
iii. Allowance for the family (select one)		
<input type="radio"/>	AFDC need standard	
<input type="radio"/>	Medically needy income standard	
<input type="radio"/>	The following dollar amount:	\$ _____ The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula:	
<input type="radio"/>	Other (specify):	
<input type="radio"/>	Not applicable (see instructions)	

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iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR 435.735:	
a. Health insurance premiums, deductibles and co-insurance charges	
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. <i>Select one:</i>	
<input type="radio"/>	The State does not establish reasonable limits.
<input type="radio"/>	The State establishes the following reasonable limits (<i>specify</i>):

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d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care.

i. Allowance for the personal needs of the waiver participant (select one):		
<input type="radio"/>	SSI Standard	
<input type="radio"/>	Optional State Supplement standard	
<input type="radio"/>	Medically Needy Income Standard	
<input type="radio"/>	The special income level for institutionalized persons	
<input type="radio"/>	%	of the Federal Poverty Level
<input type="radio"/>	The following dollar amount: \$	If this amount changes, this item will be revised
<input type="radio"/>	The following formula is used to determine the needs allowance:	
<input type="radio"/>	Other (specify):	
ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community. Select one:		
<input type="radio"/>	Allowance is the same	
<input type="radio"/>	Allowance is different. Explanation of difference:	
iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified section 1902(r)(1) of the Act:		
a. Health insurance premiums, deductibles and co-insurance charges.		
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. <i>Select one:</i>		
<input type="radio"/>	The State does not establish reasonable limits.	
<input type="radio"/>	The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.	

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Appendix B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

- a. Reasonable Indication of Need for Services.** In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for waiver services:

i.	Minimum number of services.	The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is <i>(insert number)</i> :
	1	
ii.	Frequency of services.	The State requires <i>(select one)</i> :
<input checked="" type="checkbox"/>	X	The provision of waiver services at least monthly.
<input type="checkbox"/>	O	Monthly monitoring of the individual when services are furnished on a less than monthly basis. If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

- b. Responsibility for Performing Evaluations and Reevaluations.** Level of care evaluations and reevaluations are performed *(select one)*:

<input type="checkbox"/>	O	Directly by the Medicaid agency
<input type="checkbox"/>	O	By the operating agency specified in Appendix A
<input type="checkbox"/>	O	By an entity under contract with the Medicaid agency. <i>Specify the entity:</i>
<input checked="" type="checkbox"/>	X	Other <i>(specify)</i> :
		The New York State Office of Mental Retardation and Developmental Disabilities will perform evaluation and reevaluations of level of care for those children with a developmental disability and/or mental retardation. The LDSS may perform or delegate responsibility to the HCIA for performing level of care evaluation and reevaluation activities for the severe emotional disturbance and nursing levels of care.

- c. Qualifications of Individuals Performing Initial Evaluation:** Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Since the B2H waiver will be utilizing level of care criteria and instruments used for existing NYS waivers, the qualifications will follow appropriately.
--

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Children with Serious Emotional Disturbances (SED)

Initial evaluations must be conducted by a physician (MD or DO), registered nurse (licensed in State), licensed social worker, psychologist, licensed occupational therapist, licensed master's social worker (LMSW), licensed clinical social worker (LCSW) or nurse practitioner. Two signatures are required on the level of care (LOC) form for both initial waiver entry and annual recertification: one from an authorized State or LDSS individual with qualifications listed under OCFS waiver, and one from a non-state or non-county individual with qualifications listed under OCFS waiver unless specific request for exemption approved by State. Minimum qualifications for second signature considered for exception is a state or county authorized individual with a BA degree in human services field with minimum of five years experience serving children with SED.

Children with Developmental Disabilities and/or Mental Retardation

Individuals who are qualified to evaluate children and youth with developmental disabilities and/or mental retardation must have a minimum of one year of experience performing assessments and developing care plans for persons with DD. Their work must be done under direction of supervisory staff.

Children with Health-Related Disabilities

Individuals who are qualified to evaluate children and youth with health-related disabilities must be a Registered Nurse (RN) in the State of New York using the Pediatric Patient Review Instrument (PPRI).

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- d. **Level of Care Criteria.** Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

All children must meet the following five criteria.

1. Be Medicaid eligible;
2. Be eligible for admission to institutional care;
3. Be willing to enroll in the waiver and reside in an environment where family/caregivers are willing to cooperate and support the child as a waiver participant;
4. Be enrolled in foster care or discharged from foster care as a waiver enrollee but still under the age of 21. See exception for children with Serious Emotional Disturbances;
5. Be able to benefit from services offered in the B2H waiver; and

According to their diagnosis, a child must meet additional criteria below by diagnosis group.

Children with Serious Emotional Disturbances

1. Between birth and 18 years old, unless requesting readmission to the B2H waiver while still in foster care and while under the age of 21;
2. Children in foster care upon waiver entry and through the age of 20;
3. Meets definition for SED;
4. Has complex health or mental health needs;
5. Is capable of being cared for in community if provided access to waiver services;

Children with Developmental Disabilities and/or Mental Retardation

1. Verification of a developmental disability diagnosis;
2. Presence of a life skill deficit related to behavioral needs, healthcare needs, and/or the activities of daily living as determined using the eligibility determination form;

Children with Health Related Disabilities

1. Meet eligibility for nursing home care according to the PPRI.

- e. **Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care (*select one*):

X	The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan. (This waiver application integrates three disability groups. It will use existing Level of Care protocols and instruments for two of those disability groups. This is explained below.
X	A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan. Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.
<p><u>Children with Serious Emotional Disturbances</u> Instruments used to determine the level of care for children with serious emotional disturbances will be comparable to those used by OMH (HCBS waiver NY 0296.90.R1).</p>	

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Children with Developmental Disabilities and/or Mental Retardation

The intermediate care facilities for the mentally retarded (ICF/MR) Level of Care Eligibility Determination form will be utilized as is described in the State of New York Home and Community-Based Services Waiver (NY 0238.90.R2) and conducted by OMR/DD. The B2H waiver will follow the level of care instrument utilized by this above referenced waiver for children with developmental disabilities and/or mental retardation.

Children with Health Related Disabilities

The PPRI instrument is used to identify medical events including conditions and treatments, activities of daily living (ADLs), behavioral difficulties, and specialized services for children eligible for nursing home care.

- f. **Process for Level of Care Evaluation/Reevaluation.** Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences.

The OMRDD will use the same process they currently use in their MR/DD Home and Community Based Services Waiver for evaluation and reevaluation of the level of care for children who have developmental disabilities and/or mental retardation.

The LDSS will evaluate the clinical assessments to determine a potential waiver participant's initial level of care for those children in foster care and in their care and custody who have severe emotional disturbances or health related disabilities. LDSSs will utilize HCIA's to assist with the administrative aspects of developing enrollment applications and obtaining necessary assessments. Ultimately, it is the responsibility of the LDSS to make enrollment decisions. OCFS will oversee and monitor all aspects of waiver administration.

OCFS will evaluate the clinical assessments to determine a potential waiver participant's initial level of care for those children in their care and custody who have severe emotional disturbances or health related disabilities. OCFS staff outside of the BWM will complete the enrollment applications, including collecting the necessary assessments. The OCFS/DRS will have ultimate responsibility to make enrollment decisions for children in OCFS' care and custody. The OCFS BWM (which is part of the OCFS Division of Development and Prevention Services) will monitor all aspects of these activities.

Reevaluation of a waiver participant's level of care will occur on an annual basis, or when a waiver participant has experienced significant changes in physical, cognitive or behavioral status, using the same process described above. It is the ultimate responsibility of the LDSS to reevaluate the level of care annually for those children in its care and custody. OCFS/DRS has the same responsibility for annual reevaluations of children in the waiver who are in OCFS' care and custody. If the LDSS delegates this responsibility to the HCIA, the LDSS must still assure the State, the Federal government and consenters that the appropriate level of care is being designated. OCFS/DRS will not delegate this responsibility.

- g. **Reevaluation Schedule.** Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule (*select one*):

Every three months

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<input type="radio"/>	Every six months
<input checked="" type="radio"/>	Every twelve months
<input type="radio"/>	Other schedule (<i>specify</i>):

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations (*select one*):

<input checked="" type="radio"/>	The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.
<input type="radio"/>	The qualifications are different. The qualifications of individuals who perform reevaluations are (<i>specify</i>):

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care (*specify*):

<p>The LDSS, with the assistance of the HCIA, is responsible for tracking when the reevaluation of level of care is due for each child to continue eligibility for B2H, as well as providing for service continuity. The LDSS is responsible for this process, in accordance with policies established by OCFS.</p>

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §74.53. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

<p>The LDSS and HCIA are responsible for the safe retention of all records pursuant to State laws and regulations, but at minimum seven (7) years. The records will be maintained in their agency and will be readily retrievable if requested by CMS, OCFS or DOH.</p>

ASSURED

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Appendix B-7: Freedom of Choice

Freedom of Choice. As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:

- i. informed of any feasible alternatives under the waiver; and
 - ii. given the choice of either institutional or home and community-based services.
- a. **Procedures.** Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

OCFS recognizes its responsibility to inform potential waiver participants and consenters of their right to Freedom of Choice. The HCIA will inform the potential waiver participant and consenter in the initial meeting that the potential waiver participant has a choice between receiving needed services in a qualifying Medicaid institution (ICF/MR, SNF, Psychiatric Hospital) or receiving services in the community supported by available services and supports, including services available through the B2H waiver. Each potential waiver participant's consenter will sign a Freedom of Choice form, signifying his/her preference, once the potential waiver participant has been determined to be eligible for these Medicaid services. Parent, when available, will be notified of the plan of care decisions, unless the parental rights of the parent have been terminated. When the district is exercising its responsibilities as the custodian of a child placed as an abused or neglected child or taken into protective custody under Article 10 of the Family Court Act, the district's decision will be de facto, the final decision. However, for all children served by the Waiver, the plan of care will be part of the child's permanency plan. All permanency plans are subject to periodic review by the Family Court, on notice to the parties and law guardian.

- b. **Maintenance of Forms.** Per 45 CFR §74.53, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

For all waiver participants and consenters who have chosen waiver services and have been approved to participate in the waiver program, copies of the completed Freedom of Choice forms will be maintained pursuant to State laws and regulations but at minimum seven (7) years in the LDSS.

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Appendix B-8: Access to Services by Limited English Proficient Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services “Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons” (68 FR 47311 - August 8, 2003):

Potential or active waiver participants and consenters with limited proficiency in English must have access to services without undue hardship. HCIA's and service providers must have arrangements to provide interpretation or translation services for only potential and active waiver participants and consenters who require these services. Potential or active waiver participants and consenters who are of Limited English Proficiency may bring a translator of their choice with them to meetings with waiver providers and/or the HCI. However, a potential or active waiver participant or consenter who is of Limited English Proficiency may not be required to bring their own translator, and no potential or active waiver participant who is of Limited English Proficiency can be denied access to services or enrollment in the Waiver on the basis of a HCIA's or service provider's inability to provide adequate interpretation or translation services.

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Appendix C: Participant Services

Appendix C-1: Summary of Services Covered

- a. **Waiver Services Summary.** Appendix C-3 sets forth the specifications for each service that is offered under this waiver. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Statutory Services (check each that applies)

Service	Included	Alternate Service Title (if any)
Case Management	X	Health Care Integration
Homemaker	<input type="checkbox"/>	
Home Health Aide	<input type="checkbox"/>	
Personal Care	<input type="checkbox"/>	
Adult Day Health	<input type="checkbox"/>	
Habilitation	X	Hourly skill building
Residential Habilitation	<input type="checkbox"/>	
Day Habilitation	X	Day habilitation
Expanded Habilitation Services as provided in 42 CFR §440.180(c):		
Prevocational Services	X	Vocational services
Supported Employment	X	Vocational services
Education	X	Special needs schooling support
Respite	X	Planned respite services Crisis respite
Day Treatment	<input type="checkbox"/>	
Partial Hospitalization	<input type="checkbox"/>	
Psychosocial Rehabilitation	<input type="checkbox"/>	
Clinic Services	<input type="checkbox"/>	
Live-in Caregiver (42 CFR §441.303(f)(8))	<input type="checkbox"/>	

Other Services (select one)

<input type="radio"/>	Not applicable
X	As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional services not specified in statute (<i>list each service by title</i>):
a.	Family/caregiver supports and services
b.	Crisis Avoidance and management and training

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c.	Immediate crisis response services
d.	Intensive in-home supports and services
e.	Accessibility modifications
f.	Adaptive and assistive equipment
g.	Flex funds
h.	
i.	

Extended State Plan Services (select one)

<input checked="" type="radio"/>	Not applicable
<input type="radio"/>	The following extended State plan services are provided (<i>list each extended State plan service by service title</i>):
a.	
b.	
c.	

Supports for Participant Direction (select one)

<input type="radio"/>	The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.	
<input checked="" type="radio"/>	Not applicable	
	Support	Included
		Alternate Service Title (if any)
	Information and Assistance in Support of Participant Direction	<input type="checkbox"/>
	Financial Management Services	<input type="checkbox"/>
	Other Supports for Participant Direction (<i>list each support by service title</i>):	
a.		
b.		
c.		

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b. Alternate Provision of Case Management Services to Waiver Participants. When case management is not a covered waiver service, indicate how case management is furnished to waiver participants (*check each that applies*):

<input type="checkbox"/>	As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management). <i>Complete item C-1-c.</i>
<input type="checkbox"/>	As an administrative activity. <i>Complete item C-1-c.</i>
<input type="checkbox"/>	Not applicable – Case management is not furnished as a distinct activity to waiver participants. <i>Do not complete Item C-1-c.</i>

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

HCIIs who are employed by HCIAS.

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Appendix C-2: General Service Specifications

- a. Criminal History and/or Background Investigations.** Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services-(*select one*):

<input checked="" type="checkbox"/>	<p>Yes. Criminal history and/or background investigations are required. Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):</p> <p style="padding-left: 20px;">For respite providers, New York State regulations (18 NYCRR 435.2 b.) govern requirements for screening through the State Central Register and finger print clearances. In addition, Social Services Law Section 378-a establishes the access to conviction records by authorized agencies. Every foster and adoptive parent is required to permit disclosure of criminal history. This statute also creates the mechanism for criminal background checks of employees of agencies who will be engaged directly in the care and supervision of children. Employees of voluntary agencies will be checked including HCIs and B2H waiver service providers that are also subject to Social Services Law Section 378-a.</p>
<input type="checkbox"/>	<p>No. Criminal history and/or background investigations are not required.</p>

- b. Abuse Registry Screening.** Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (*select one*):

<input checked="" type="checkbox"/>	<p>Yes. The State maintains an abuse registry and requires the screening of individuals through this registry. Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):</p> <p style="padding-left: 20px;">New York State maintains the State Central Register of Child Abuse and Maltreatment (SCR) in OCFS and requires that database checks through the SCR be completed for persons who will have the potential for regular and substantial contact with children cared for by a provider agency, as that term is defined by statute. This requirement would apply to some agencies and individual employees providing waiver services, depending upon the applicability of the statutory standards. Social Services Law Section 424-a establishes the criteria and mechanism for this activity.</p>
<input type="checkbox"/>	<p>No. The State does not conduct abuse registry screening.</p>

- c. Services in Facilities Subject to §1616(e) of the Social Security Act.** *Select one:*

<input type="checkbox"/>	<p>No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act. <i>Do not complete Items C-2-c.i – c.iii.</i></p>
<input checked="" type="checkbox"/>	<p>Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). <i>Complete Items C-2-c.i –c.iii.</i></p>

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	While some B2H waiver services will be provided in these facilities, they will not be provided as part of the residential service of the facility. They will be provided as supplemental services by B2H waiver service providers.
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i. **Types of Facilities Subject to §1616(e).** Complete the following table for *each type* of facility subject to §1616(e) of the Act:

Type of Facility	Waiver Service(s) Provided in Facility	Facility Capacity Limit
Group Home	All waiver services	12
Agency Boarding Home, including Supervised Independent Living Settings	All waiver services	6
Family Boarding Home	All waiver services	6

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- ii. **Larger Facilities:** In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

Each of the facilities in the licensure class is a free standing home in the community. The homes have all the features one would find in a typical private home including kitchens with cooking facilities, dining areas, living space for leisure time activities and sleeping space. Since the homes are located within the community, there is ready access to activities and facilities available to the general population of the locale. The children will be able to access the community and the services fairly, freely and have the opportunity to build meaningful relationships with community members and community organizations.

- iii. **Scope of Facility Standards.** By type of facility listed in Item C-2-e-1, specify whether the State's standards address the following (*check each that applies*):

Standard	Facility Type	Facility Type	Facility Type	Facility Type
	Group Home	Agency Boarding Home	Family Boarding Home	
Admission policies	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Physical environment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Sanitation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Safety	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Staff : resident ratios	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Staff training and qualifications	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Staff supervision	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Resident rights	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Medication administration	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Use of restrictive interventions	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Incident reporting	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Provision of or arrangement for necessary health services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Private individuals are the providers of family boarding home care. They are private citizens and not employees of an agency. These individuals receive specialized training on the needs of foster care children prior to their and their homes being licensed by governmental agencies and prior to the placement of a child in their home. The care they provide is monitored by either a governmental body or a not-for profit agency under contract to a governmental agency

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- d. Provision of Personal Care or Similar Services by Legally Responsible Individuals.** A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

<input checked="" type="radio"/>	No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.
<input type="radio"/>	Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services. Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of <i>extraordinary care</i> by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. <i>Also, specify in Appendix C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.</i>

- e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.** Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

<input checked="" type="radio"/>	The State does not make payment to relatives/legal guardians for furnishing waiver services.
<input type="radio"/>	The State makes payment to relatives/legal guardians under <i>specific circumstances</i> and only when the relative/guardian is qualified to furnish services. Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. <i>Also, specify in Appendix C-3 each waiver service for which payment may be made to relatives/legal guardians.</i>
<input type="radio"/>	Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-3. Specify any limitations on the types of relatives/legal guardians who may furnish services. Specify the controls that are employed to ensure that payments are made only for services rendered. <i>Also, specify in Appendix C-3 each waiver service for which payment may be made to relatives/legal guardians.</i>
<input type="radio"/>	Other policy. <i>Specify:</i>

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- f. **Open Enrollment of Providers.** Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

OCFS, in conjunction with the HCIAs, will pursue an aggressive outreach and publicity program to result in opportunities for any and all providers who are willing and qualified to enroll as a waiver service Medicaid provider. HCIAs will be contracting with qualified providers choosing to participate.

OCFS, in conjunction with HCIAs and LDSSs, will conduct statewide regional meetings and open forums along with information sessions in order to educate the community at large about the B2H waiver. The HCIA will be directed by OCFS to facilitate meetings with potential providers to inform them of the opportunities to provide waiver services.

Outreach and publicity materials will be published to provide necessary information on the B2H waiver. Public outreach will continue with the utilization of press releases, articles and other media as approved by OCFS, to support equity of opportunity.

Not-for-profit VAAs who meet State criteria for becoming an HCIA and apply to OCFS will be recommended to DOH for a provider agreement. OCFS will use a multi-tiered review of established criteria, including an evaluation of the applicant agency's existing foster care and medical assistance programs and submission of letters of support from the majority of social services districts in the geographical area to be served by the HCIA. OCFS will advise applicants as to the completeness of the application and may provide an opportunity for discussion of the application and the submittal of an amended application, as necessary, followed by a final decision issued in writing by OCFS. The process will permit open-ended enrollment of approved applicants. There will not be an administrative appeal and unsuccessful applicants will be limited to pursuing their rights under Article 78 of the Civil Practice Law and Rules. Unsuccessful applicants will be permitted to reapply one year from the date of the initial application submittal.

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Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	Health Care Integration
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>	
<input type="radio"/>	Service is included in approved waiver. There is no change in service specifications.
<input type="radio"/>	Service is included in approved waiver. The service specifications have been modified.
<input type="radio"/>	Service is not included in the approved waiver.
Service Definition (Scope):	
<p>HCI's who are employed by HCIA's oversee and manage the initial comprehensive assessment and reassessment processes, the results of which are used to identify the health care service needs of the participant and develop the IHP. It will manage and gain access for waiver participants to necessary medical, social, rehabilitation, vocational, educational and other services.</p> <p>Services:</p> <ul style="list-style-type: none"> • Assess the child's disability and healthcare-related needs and the family/caregiver's capacity to support those needs; includes assessment of needs for skill building and family/caregiver supports and services • Develop and update the child's IHP – <ul style="list-style-type: none"> - include the appropriate caregivers, professionals and people who know the child and the involved families/caregivers - include skill building plan to promote the child's successful functioning in and integration into the family/caregiver support plan - identify services, service providers and direction of IHPs, e.g., identify sentinel events that can be expected to trigger crises to assist in development of a crisis management plan - identify how new HCBS-related health care services are additive to existing foster care services • Link the child and/or family/caregiver with the health care-related supports and services identified in the IHP • Advocate for the child's health care needs and/or intercede on behalf of the child and/or family/caregiver to gain access to or facilitate needed services and supports in keeping with the child's presenting disability or health care needs • Monitor and observe the child and family/caregiver and the waiver services to verify that the needed health care services and supports are received and to observe their impact, including monitoring of progress towards goals. • Consult with service providers and the child and family/caregiver to establish that waiver services are delivered in accordance with the IHP • Stabilize the child and family/caregiver environment in response to the child's presenting disability and/or health care issues 	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
Provider Specifications	

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Provider Category(s) (check one or both):	<input type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
				Not-for-profit voluntary agencies (VAAs) (see attachment #1) that meet the waiver provider qualifications established by OCFS including having an appropriate license or certification from OMH, OMR/DD or DOH; sufficient administrative and fiscal viability; sufficient community standing; and the capacity and willingness to comply with Medicaid waiver provider agreement requirements.

Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input checked="" type="checkbox"/>	Relative/Legal Guardian
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Provider Qualifications (provide the following information for each type of provider):

Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
Health Care Integrators			<p>1. Preferred - Masters in social work, psychology or related human services field OR licensed qualified health care practitioner OR Registered Nurse or Special Education Teacher AND minimum one (1) year of experience providing service coordination and information, linkages and referral regarding community-based services for children with special needs, individuals with disabilities and/or seniors</p> <p>OR</p> <p>2. Minimum of Bachelors degree (preferred in human services field) + 4 years experience providing service coordination to children with special needs, individuals with disabilities and/or seniors and knowledge about community-based resources</p>

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
HCIAs	OCFS	Yearly

Service Delivery Method			
Service Delivery Method	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

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<i>(check each that applies):</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification				
Service Title:	Hourly skill building			
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>				
<input type="radio"/>	Service is included in approved waiver. There is no change in service specifications.			
<input type="radio"/>	Service is included in approved waiver. The service specifications have been modified.			
<input type="radio"/>	Service is not included in the approved waiver.			
Service Definition (Scope):				
<p>Hourly skill building services to support, guide, mentor, coach and/or train the child and/or family/caregiver in successful functioning in the home and community within the special context of both the child’s disability and their involvement in the foster care system .</p> <p>Services:</p> <ul style="list-style-type: none"> • Based on a skill building plan developed by the HCI, provide support, guidance, mentoring, coaching and/or training to assist the child and family/caregiver in acquiring, developing, and using functional skills and/or techniques that enable the child to function successfully in the home and community environments, including: <ul style="list-style-type: none"> - task completion; - communication; - socialization; - interpersonal skills; - sensory/motor skills; - participating in community activities; - activities of daily living; - - problem-solving; - money management; and - eliminating maladaptive behaviors. <p>These activities may take place at any time of the day as long as they do not supplant the child’s expected educational activities or program. These services may be delivered one-on-one or in small groups (not more than two waiver enrollees and their support networks).</p>				
Specify applicable (if any) limits on the amount, frequency, or duration of this service:				
Provider Specifications				
Provider	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; padding: 5px;">Individual. List types:</td> <td style="width: 5%; text-align: center; padding: 5px;">X</td> <td style="width: 45%; padding: 5px;">Agency. List the types of agencies:</td> </tr> </table>	Individual. List types:	X	Agency. List the types of agencies:
Individual. List types:	X	Agency. List the types of agencies:		

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Category(s) (check one or both):			Not-for-profit skill building agencies. HCIAs	
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative/Legal Guardian
Provider Qualifications (provide the following information for each type of provider):				
Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)	
Individuals approved to provide this service and employed by the provider agencies			Paraprofessional with a high school diploma or equivalent and appropriate skills and training	
Verification of Provider Qualifications				
Provider Type:	Entity Responsible for Verification:		Frequency of Verification	
Agencies approved to provide this service	Through a provider agreement with the HCIAs, OCFS will specify provider qualifications for B2H service providers. HCIAs are responsible for verifying qualifications of waiver service providers.		Yearly	
Service Delivery Method				
Service Delivery Method (check each that applies):	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed

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Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification				
Service Title:	Day habilitation			
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>				
<input type="radio"/>	Service is included in approved waiver. There is no change in service specifications.			
<input type="radio"/>	Service is included in approved waiver. The service specifications have been modified.			
<input type="radio"/>	Service is not included in the approved waiver.			
Service Definition (Scope):				
<p>Day habilitation services, in an established program model, assist individuals with developmental disabilities with the self-help, socialization and adaptive skills necessary to successful functioning in the home and community when other types of skill building services are not appropriate.</p> <p>Services:</p> <ul style="list-style-type: none"> • Assistance with acquisition, retention or improvement in skills related to: <ul style="list-style-type: none"> - Personal grooming and cleanliness - Bed making and household chores - Eating and/or preparing food - Social and adaptive skills - Transportation 				
Specify applicable (if any) limits on the amount, frequency, or duration of this service:				
Provider Specifications				
Provider Category(s) <i>(check one or both):</i>	<input type="checkbox"/> Individual. List types:	X	<input checked="" type="checkbox"/> Agency. List the types of agencies: OMR-certified, not-for-profit day habilitation provider agencies	
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative/Legal Guardian
Provider Qualifications <i>(provide the following information for each type of provider):</i>				
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>	
Individuals approved to		Certified day habilitation		

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provide this service and employed by a provider agency		provider	

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Agencies approved to provide this service	Through a provider agreement with the HCIAs, OCFS will specify provider qualifications for B2H service providers. HCIAs are responsible for verifying qualifications of waiver service providers.	Yearly

Service Delivery Method

Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed
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Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification																	
Service Title:	Vocational services																
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>																	
<input type="radio"/>	Service is included in approved waiver. There is no change in service specifications.																
<input type="radio"/>	Service is included in approved waiver. The service specifications have been modified.																
<input type="radio"/>	Service is not included in the approved waiver.																
Service Definition (Scope):																	
<p>Individually designed prevocational and supported employment services to prepare a youth with severe disabilities aged 14 or over to engage in paid work.</p> <ul style="list-style-type: none"> <i>Prevocational services</i> are not job-specific, but geared towards facilitating success in any work environment for children whose disabilities do not permit them to access other pre-vocational services. <i>Supported employment services</i> provide assistance to waiver participants with severe disabilities as they perform in a work setting. <p>Services:</p> <ul style="list-style-type: none"> <i>Prevocational services</i> include teaching concepts such as compliance, attendance, task completion, problem solving and safety based on a specific curriculum related to youth with disabilities. These include both individual and group activities. <i>Supported employment services</i> include supervision and training, intensive ongoing support, transportation, interface with employers regarding the child's disability(ies) and needs related to his or her health care issue(s), and other activities needed to sustain paid work (e.g., employment assessment and job placement.). This service includes job finding and development, assessing the interest and fit of a child for particular job opportunities, staff work with employers and job sites preparing them to be able to make necessary and reasonable accommodations, providing on-site support for the child as he or she learns specific job tasks, providing monitoring on-site and through communication with job supervisors and employers, and related staff and child travel. Supported employment services may be provided in a variety of settings, particularly work sites. 																	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:																	
Provider Specifications																	
Provider Category(s) <i>(check one or both):</i>	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; border: none;"></td> <td style="border: none; text-align: center;">Individual. List types:</td> <td style="width: 5%; text-align: center; border: none;">X</td> <td style="border: none; text-align: center;">Agency. List the types of agencies:</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"></td> <td style="border: none;"></td> <td style="border: none; text-align: center;">Not-for-profit vocational service providers</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"></td> <td style="border: none;"></td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"></td> <td style="border: none;"></td> <td style="border: none;"></td> </tr> </table>		Individual. List types:	X	Agency. List the types of agencies:				Not-for-profit vocational service providers								
	Individual. List types:	X	Agency. List the types of agencies:														
			Not-for-profit vocational service providers														

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Specify whether the service may be provided by (<i>check each that applies</i>):	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative/Legal Guardian
Provider Qualifications (<i>provide the following information for each type of provider</i>):				
Provider Type:	License (<i>specify</i>)	Certificate (<i>specify</i>)	Other Standard (<i>specify</i>)	
Individuals approved to provide this service and employed by provider agencies			Preferred – Bachelors + 2 years experience Minimum - Associates' degree plus 2 years experience	
Verification of Provider Qualifications				
Provider Type:	Entity Responsible for Verification:		Frequency of Verification	
Agencies approved to provide this service in compliance with applicable state laws	Through a provider agreement with the HCIAs, OCFS will specify provider qualifications for B2H service providers. HCIAs are responsible for verifying qualifications of waiver service providers.		Yearly	
Service Delivery Method				
Service Delivery Method (<i>check each that applies</i>):	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed

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Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification			
Service Title:	Special needs schooling support		
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>			
<input type="radio"/>	Service is included in approved waiver. There is no change in service specifications.		
<input type="radio"/>	Service is included in approved waiver. The service specifications have been modified.		
<input type="radio"/>	Service is not included in the approved waiver.		
Service Definition (Scope):			
<p>Special needs schooling support improves the child's ability to maximize the educational experience and enable the educational system to respond appropriately to the child's disability and/or health care issues without duplicating existing educational services. Special needs schooling support is intended to assist the child, family/caregiver and school in understanding and addressing the waiver participant's needs related to their disability(ies) in regard to their educational experience. Further, special needs schooling support is not intended to develop an IEP or provide special education.</p> <p>Services:</p> <ul style="list-style-type: none"> Training (one-on-one or group) for the child and/or the family/caregiver regarding methods and behaviors to enable success in the school Direct advocacy with the educational system or others regarding the child's disability(ies) and needs related to his or her health care issue(s) Advocacy training for the child and/or family/caregiver, including during transitions 			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
Provider Specifications			
Provider Category(s) <i>(check one or both):</i>	<input type="checkbox"/> Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies: A not-for-profit corporation whose corporate purposed include the provision of special needs schooling support services
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>
			Relative/Legal Guardian
Provider Qualifications <i>(provide the following information for each type of provider):</i>			
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>

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Individuals approved to provide this service			Preferred - Masters in education OR Masters in human services field + 1 year experience Minimum – Bachelors + 2 years related experience
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:	Frequency of Verification	
Agencies approved to provide this service	Through a provider agreement with the HCIAs, OCFS will specify provider qualifications for B2H service providers. HCIAs are responsible for verifying qualifications of waiver service providers.	Yearly	
Service Delivery Method			
Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

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Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification			
Service Title:	Planned respite services		
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>			
<input type="radio"/>	Service is included in approved waiver. There is no change in service specifications.		
<input type="radio"/>	Service is included in approved waiver. The service specifications have been modified.		
<input type="radio"/>	Service is not included in the approved waiver.		
Service Definition (Scope):			
<p>Planned respite services provide planned short term relief for family/caregivers (non-shift staff) needed to enable the family/caregiver's ability to contend with the child's disability or health care issues.</p> <p>Services: Direct care for child by staff trained to support the child's disability-related needs while providing relief from caregiver activities for the family/caregiver</p> <ul style="list-style-type: none"> Hourly (in-home or out of home by an approved respite care and services provider under Part 435 of OCFS regulations) Daily/Overnight (out of home by an approved respite care and services provider under Part 435 of OCFS regulations) Medical respite provided by LPNs or RNs will be available for children with significant physical health issues in the child's residence 			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
Provider Specifications			
Provider Category(s) <i>(check one or both):</i>	<input type="checkbox"/> Individual. List types:	<input checked="" type="checkbox"/> X	Agency. List the types of agencies: Out of home, non-medical respite agencies must be an approved respite care and services provider under Part 435 of OCFS regulations. For medical respite, not-for-profit agencies employing registered nurses and licensed practical nurses
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>
			Relative/Legal Guardian

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Provider Qualifications (provide the following information for each type of provider):				
Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)	
Individuals approved to provide this service			Paraprofessional with a high school diploma or equivalent and with appropriate skills and training For medical respite, individual must be a registered nurse or a licensed practical nurse	
Verification of Provider Qualifications				
Provider Type:	Entity Responsible for Verification:		Frequency of Verification	
Agencies approved to provide this service	Through a provider agreement with the HCIAs, OCFS will specify provider qualifications for B2H service providers. HCIAs are responsible for verifying qualifications of waiver service providers.		Yearly	
Service Delivery Method				
Service Delivery Method (check each that applies):	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed

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Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification			
Service Title:	Family/caregiver supports and services		
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>			
<input type="radio"/>	Service is included in approved waiver. There is no change in service specifications.		
<input type="radio"/>	Service is included in approved waiver. The service specifications have been modified.		
<input type="radio"/>	Service is not included in the approved waiver.		
Service Definition (Scope):			
<p>Family/caregiver supports and services enhance the ability of the child to function as part of a family/caregiver unit and to increase the family/caregiver's ability to care for the eligible child in the home and community.</p> <p>Services:</p> <ul style="list-style-type: none"> • Provide opportunities to: <ul style="list-style-type: none"> - Interact and engage with other children in appropriate developmental activities or appropriate community activities, including: health care appointments; vocational opportunities; or other community engagements included in an approved IHP - Maintain and encourage self-sufficiency of the family/caregiver to care for the child in the home and community - Address needs and issues of relevance to the family/caregiver unit as the child is supported in the home and community • Family/caregiver education and training on resource availability so that they might better support and advocate for the needs of the child and appropriately access needed services <p>This service may be provided as one-on-one support or interaction and training or in small groups (not more than two waiver enrollees and their support networks) where the child and/or family/caregivers participate with others who are in similar situations.</p>			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
Provider Specifications			
Provider Category(s) <i>(check one or both):</i>	Individual. List types:	X	Agency. List the types of agencies:
			Family/caregiver support provider agencies
Specify whether the service may be provided by <i>(check each that</i>		<input type="checkbox"/> Legally Responsible Person	<input type="checkbox"/> Relative/Legal Guardian

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<i>applies):</i>			
Provider Qualifications (provide the following information for each type of provider):			
Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
Individual practitioners employed by a not-for-profit agency approved to provide this service			Paraprofessional with a high school diploma or equivalent, preferably an individual with experience with the participant's B2H disability
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:	Frequency of Verification	
Not-for-profit agencies approved to provide this service	Through a provider agreement with the HCIAs, OCFS will specify provider qualifications for B2H service providers. HCIAs are responsible for verifying qualifications of waiver service providers.	Yearly	
Service Delivery Method			
Service Delivery Method (check each that applies):	<input type="checkbox"/>	Participant directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

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For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification													
Service Title:	Crisis avoidance and management and training												
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>													
<input type="radio"/>	Service is included in approved waiver. There is no change in service specifications.												
<input type="radio"/>	Service is included in approved waiver. The service specifications have been modified.												
<input type="radio"/>	Service is not included in the approved waiver.												
Service Definition (Scope):													
<p>Psycho-education and training to address specific issues that disrupt or jeopardize the child's successful functioning in the community. Special emphasis will be given to "anticipatory guidance", the capacity to proactively identify and plan for those sentinel events in the child's environment or community activities that are directly related to his or her disability and may trigger anxiety, frustration, and crisis with the potential for leading to the need for institutional care.</p> <p>Services:</p> <ul style="list-style-type: none"> Developing and updating a plan that identifies "sentinel events" and creates strategies to avoid predictable crises or interventions to use in the event of an impending crisis Coaching and/or mentoring to support the child's and/or family/caregiver efforts to avoid and/or manage crises Training on appropriate actions that may prevent or minimize crises Psycho-education (one-on-one or group) involving the child and/or the family/caregiver Conducting scheduled and unscheduled visits to the family/caregiver environment to monitor crisis management and/or behavior management activities 													
Specify applicable (if any) limits on the amount, frequency, or duration of this service:													
Provider Specifications													
Provider Category(s) <i>(check one or both):</i>	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; border: none;">Individual. List types:</td> <td style="width: 5%; text-align: center; border: none;">X</td> <td style="width: 45%; border: none;">Agency. List the types of agencies:</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"></td> <td style="border: none;">Not-for-profit crisis management provider agencies</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"></td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"></td> <td style="border: none;"></td> </tr> </table>	Individual. List types:	X	Agency. List the types of agencies:			Not-for-profit crisis management provider agencies						
Individual. List types:	X	Agency. List the types of agencies:											
		Not-for-profit crisis management provider agencies											
Specify whether the service may be provided by <i>(check each that applies):</i>	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%; text-align: center;"><input type="checkbox"/></td> <td style="width: 40%;">Legally Responsible Person</td> <td style="width: 30%; text-align: center;"><input type="checkbox"/></td> <td style="width: 10%;">Relative/Legal Guardian</td> </tr> </table>	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative/Legal Guardian								
<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative/Legal Guardian										
Provider Qualifications <i>(provide the following information for each type of provider):</i>													

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Provider Type:	License (<i>specify</i>)	Certificate (<i>specify</i>)	Other Standard (<i>specify</i>)
Individuals approved to provide this service			Preferred - Masters in social work, psychology or related human services field + 1 year experience Minimum - Bachelors degree + 2 years experience

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Not-for-profit agencies approved to provide this service	Through a provider agreement with the HCIAs, OCFS will specify provider qualifications for B2H service providers. HCIAs are responsible for verifying qualifications of waiver service providers.	Yearly

Service Delivery Method				
Service Delivery Method (<i>check each that applies</i>):	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed

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For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification			
Service Title:	Immediate crisis response services		
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>			
<input type="radio"/>	Service is included in approved waiver. There is no change in service specifications.		
<input type="radio"/>	Service is included in approved waiver. The service specifications have been modified.		
<input type="radio"/>	Service is not included in the approved waiver.		
Service Definition (Scope):			
<p>24-hour services designed to respond immediately to crises that threaten the stability of the child's placement and the child's ability to function in the community. This service is intended to be of a very short duration and primarily to engage/link to other services and resources, e.g., intensive in-home supports and services.</p> <p>Services:</p> <ul style="list-style-type: none"> Crisis de-escalation Crisis resolution support Development of a stabilization plan (in coordination with the HCI) for any additional crisis response services that are needed to resolve the immediate crisis. 			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
Provider Specifications			
Provider Category(s) <i>(check one or both):</i>	<input checked="" type="checkbox"/> Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies: Not-for-profit crisis management provider agencies
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>
			Relative/Legal Guardian
Provider Qualifications <i>(provide the following information for each type of provider):</i>			
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Individuals approved to provide this service			Preferred - Masters in social work, psychology or related human services field + 1 year experience

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			Minimum - Bachelors + 2 years experience
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:		Frequency of Verification
Agencies approved to provide this service	Through a provider agreement with the HCIAs, OCFS will specify provider qualifications for B2H service providers. HCIAs are responsible for verifying qualifications of waiver service providers.		Yearly
Service Delivery Method			
Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

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Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification			
Service Title:	Intensive in-home supports and services		
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>			
<input type="radio"/>	Service is included in approved waiver. There is no change in service specifications.		
<input type="radio"/>	Service is included in approved waiver. The service specifications have been modified.		
<input type="radio"/>	Service is not included in the approved waiver.		
Service Definition (Scope):			
<p>Intensive in-home services are delivered as specified in the crisis stabilization plan described in Immediate Crisis Response Services that are designed to provide interventions to secure child and family/caregiver's health and safety following a crisis.</p> <p>Services:</p> <ul style="list-style-type: none"> Psycho-education Crisis stabilization Crisis resolution support 			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
Provider Specifications			
Provider Category(s) <i>(check one or both)</i>	<input type="checkbox"/> Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
			Not-for-profit in home support provider agencies
Specify whether the service may be provided by <i>(check each that applies)</i> :	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/> Relative/Legal Guardian
Provider Qualifications <i>(provide the following information for each type of provider):</i>			
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Individuals approved to provide this service			<p>Preferred - Masters in social work, psychology or related human services field + 1 year experience</p> <p>Minimum - Bachelors + 2 years experience</p>

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Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:	Frequency of Verification	
Agencies approved to provide this service	Through a provider agreement with the HCIAs, OCFS will specify provider qualifications for B2H service providers. HCIAs are responsible for verifying qualifications of waiver service providers.	Yearly	
Service Delivery Method			
Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

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Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification			
Service Title:	Crisis Respite		
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>			
<input type="radio"/>	Service is included in approved waiver. There is no change in service specifications.		
<input type="radio"/>	Service is included in approved waiver. The service specifications have been modified.		
<input type="radio"/>	Service is not included in the approved waiver.		
Service Definition (Scope):			
<p>Crisis respite provides emergency short term relief for family/caregivers (non-shift staff) needed to resolve a crisis and segue back to the child's successful functioning and engagement in service plan activities. Crisis respite provides the family/caregivers with the ability to contend with the child's disability or health care issues.</p> <p>Services: Crisis respite will be provided by specially trained crisis respite providers. Direct care for child while providing relief from caregiver activities for the family/caregiver during a crisis.</p> <ul style="list-style-type: none"> Hourly (in or out of home by an authorized foster care provider) Daily/Overnight (out of home by an authorized foster care provider) Medical respite provided by LPNs or RNs will be available for children with significant physical health issues in the child's residence 			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
Provider Specifications			
Provider Category(s) <i>(check one or both):</i>	<input type="checkbox"/> Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
			Not-for-profit respite provider agencies. For out-of-home, non-medical respite, agencies must be authorized to provide foster care For medical respite, not-for-profit agencies employing registered nurses and licensed practical nurses
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>
			Relative/Legal Guardian

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Provider Qualifications (provide the following information for each type of provider):			
Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
Individuals approved to provide this service	Registered nurses and licensed practical nurses for medical respite		For non-medical respite: Preferred – Bachelors degree + 2 years experience Minimum - Paraprofessional with a high school diploma or equivalent with appropriate skills and training
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:		Frequency of Verification
Agencies approved to provide this service	Through a provider agreement with the HCIAs, OCFS will specify provider qualifications for B2H service providers. HCIAs are responsible for verifying qualifications of waiver service providers.		Yearly
Service Delivery Method			
Service Delivery Method (check each that applies):	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

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For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification			
Service Title:	Adaptive and assistive equipment		
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>			
<input type="radio"/>	Service is included in approved waiver. There is no change in service specifications.		
<input type="radio"/>	Service is included in approved waiver. The service specifications have been modified.		
<input type="radio"/>	Service is not included in the approved waiver.		
Service Definition (Scope):			
<ul style="list-style-type: none"> Includes aids, controls, appliances or supplies intended to supplement New York's approved Medicaid State Plan medical equipment and supplies coverage to enable the waiver participant to increase his or her ability to function in a home and community based setting with independence and safety. 			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
Provider Specifications			
Provider Category(s) <i>(check one or both):</i>	<input checked="" type="checkbox"/> Individual. List types:	X	Agency. List the types of agencies: Approved Medicaid providers
Specify whether the service may be provided by <i>(check each that applies)</i> :			
	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>
			Relative/Legal Guardian
Provider Qualifications <i>(provide the following information for each type of provider):</i>			
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Approved Medicaid provider			
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:		Frequency of Verification
Agencies approved to provide this service	Through a provider agreement with the HCIA's, OCFS will specify provider qualifications for		Yearly

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	B2H service providers. HCIAAs are responsible for verifying qualifications of waiver service providers.	
Service Delivery Method		
Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E
	<input checked="" type="checkbox"/>	Provider managed

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For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification			
Service Title:	Accessibility Modifications		
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>			
<input type="radio"/>	Service is included in approved waiver. There is no change in service specifications.		
<input type="radio"/>	Service is included in approved waiver. The service specifications have been modified.		
<input type="radio"/>	Service is not included in the approved waiver.		
Service Definition (Scope):			
Internal and external physical adaptations to the home or other residence of the foster child that are necessary to support the health and welfare of the waiver participant. These modifications are additive to services available through the Medicaid State Plan or Title IVE funds and enable the participant to function with greater independence related to the child's disability and/or health care issues. They may include: allergen controls, installation of ramps and grab bars, widening of doorways and hallways, modification of bathroom facilities, installation of specialized electrical or plumbing systems to accommodate necessary medical equipment, modifications necessary to support the participant's health and welfare.			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
Provider Specifications			
Provider Category(s) <i>(check one or both):</i>	<input type="checkbox"/> Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
			A corporation whose corporate purposes include the provision of accessibility modifications as defined under the waiver
Specify whether the service may be provided by <i>(check each that applies):</i>		<input type="checkbox"/>	Legally Responsible Person
		<input type="checkbox"/>	Relative/Legal Guardian
Provider Qualifications <i>(provide the following information for each type of provider):</i>			
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
HCIA's and/or qualified entities under subcontract to HCIA			An approved provider must demonstrate that subcontracted individuals or entities are appropriately qualified and/or licensed to comply with any State and local rules. All materials and products used must also meet any State or local construction requirements.

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			Providers must adhere to safety issues addressed in Article 18 of the New York State Uniform Fire Prevention and Building Code Act as well as all local building codes
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:		Frequency of Verification
Agencies approved to provide this service	Through a provider agreement with the HCIAs, OCFS will specify provider qualifications for B2H service providers. HCIAs are responsible for verifying qualifications of waiver service providers.		Yearly
Service Delivery Method			
Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

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Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification			
Service Title:	Flex funds		
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>			
<input type="radio"/>	Service is included in approved waiver. There is no change in service specifications.		
<input type="radio"/>	Service is included in approved waiver. The service specifications have been modified.		
<input type="radio"/>	Service is not included in the approved waiver.		
Service Definition (Scope):			
Financial resources to cover unanticipated, one-time needs of the waiver enrollee directly related to their disability and that are needed to support their successful integration in the community and/or successful functioning in the family/caregiver environment that are not covered by other sources.			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
Only available to waiver participants who are not covered by a foster care or adoption subsidy. Maximum total expenditures are limited to \$1,200 per year.			
Provider Specifications			
Provider Category(s) <i>(check one or both):</i>	<input checked="" type="checkbox"/> Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies: HCIA's will administer these funds
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/> Legally Responsible Person	<input type="checkbox"/>	Relative/Legal Guardian
Provider Qualifications <i>(provide the following information for each type of provider):</i>			
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:	Frequency of Verification	

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Service Delivery Method			
Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

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Appendix C-4: Additional Limits on Amount of Waiver Services

Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*check each that applies*).

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; and, (f) how participants are notified of the amount of the limit.

<input checked="" type="checkbox"/>	<p>Limit(s) on Set(s) of Services. There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver. <i>Furnish the information specified above.</i></p> <p style="margin-top: 10px;">Accessibility modifications and Adaptive and Assistive Equipment – There is a \$15,000 maximum per participant per five-year period for any combination of accessibility modifications and adaptive and assistive equipment. This applies to all waiver participants. Within the five-year maximum, there is also a \$5,000 maximum per address for permanent home modifications for rented homes. Individual service limits were combined to allow participants greater flexibility within the tangible item budget to meet their unique needs. Exceptions to these limits may be reviewed and authorized on a case-by-case basis by OCFS. Approvals will take into account Waiver requirements regarding fiscal neutrality.</p> <p style="margin-top: 10px;">Flex Funds – These funds are only available to waiver participants who are not covered by a foster care or adoption subsidy. Each child will have a maximum expenditure of \$1,200 per year.</p>
<input type="checkbox"/>	<p>Prospective Individual Budget Amount. There is a limit on the maximum dollar amount of waiver services authorized for each specific participant. <i>Furnish the information specified above.</i></p>
<input type="checkbox"/>	<p>Budget Limits by Level of Support. Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services. <i>Furnish the information specified above.</i></p>
<input type="checkbox"/>	<p>Other Type of Limit. The State employs another type of limit. <i>Describe the limit and furnish the information specified above.</i></p>
<input type="checkbox"/>	<p>Not applicable. The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.</p>

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Appendix D: Participant-Centered Planning and Service Delivery

Appendix D-1: Service Plan Development

State Participant-Centered Service Plan Title:	Individualized Health Plan (IHP)
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a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (*check each that applies*):

<input type="checkbox"/>	Registered nurse, licensed to practice in the State
<input type="checkbox"/>	Licensed practical or vocational nurse, acting within the scope of practice under State law
<input type="checkbox"/>	Licensed physician (M.D. or D.O)
<input checked="" type="checkbox"/>	Case Manager (qualifications specified in Appendix C-3)
<input type="checkbox"/>	Case Manager (qualifications not specified in Appendix C-3) <i>Specify qualifications:</i>
<input type="checkbox"/>	Social Worker. <i>Specify qualifications:</i>
<input type="checkbox"/>	Other (<i>specify the individuals and their qualifications</i>):

b. Service Plan Development Safeguards. *Select one:*

<input type="radio"/>	Entities and/or individuals that have responsibility for service plan development <i>may not provide</i> other direct waiver services to the participant.
<input checked="" type="radio"/>	Entities and/or individuals that have responsibility for service plan development <i>may provide</i> other direct waiver services to the participant. The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. <i>Specify:</i>
	<p>HCIAs may be authorized to provide other B2H waiver services. This reflects OCFS' recognition of the valued services that such qualified, multi-service agencies offer children in foster care who are at risk of institutionalization. It also reflects OCFS' recognition that the number of qualified providers is limited in many areas of New York. To safeguard the best interests of the waiver participant the following are expected:</p> <p>(1) The Health Care Integration function (case management) will have reporting lines to a cabinet or executive level manager who does not have responsibility for other B2H waiver programs and services;</p> <p>(2) The Health Care Integration function cannot be provided by staff who also deliver or manage other B2H waiver services;</p>

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(3) The HCI will be responsible for providing unbiased and comprehensive information to the waiver participant and consenter about available services and service providers;
 (4) The consenter must sign a document that contains the names of the approved waiver service providers in the region. By signing the document, the consenter is affirming that he/she was given a choice of approved waiver providers and recognizes that he/she has the right to change providers. The consenter's signature is required on the Initial IHP, the Revised IHP and Addendums to the IHP.;

(5) The waiver participant and consenter have the right to change waiver service providers at any time during the period covered by an approved IHP. With the assistance of their HCI, the consenter completes a Change of Provider Form, which is then sent to the HCIA. The HCIA sends a Verification of Provider Change Form to the consenter, the HCI and the current and new waiver service providers. If the consenter wishes to change HCIs, the consenter contacts the HCIA directly. The HCIA will provide information to the waiver participant and consenter about HCIs and assist the consenter with completing the Change of Provider Form; and

(6) The B2H monitoring activities related to service plan development will include review of all above items.

- c. **Supporting the Participant in Service Plan Development.** Specify (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

The HCIA provides detailed written information to the waiver participant and consenter regarding the purpose and design of the B2H waiver, available services, application and IHP development process and the role of the HCI. The waiver participant and consenter may include any person of his/her choosing to assist in the development of the IHP.

- d. **Service Plan Development Process.** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The HCI develops the IHP jointly with the waiver participant and consenter, and directs the gathering of appropriate information and guides the participation of those individuals chosen by the waiver participant and consenter to also participate in that process. The goal of the IHP is to increase the waiver participant's health and welfare, in support of successful integration into the community and successful functioning in their family/caregiver environment. The HCIA will develop a preliminary IHP and budget as part of the package of information for the LDSS to review when making enrollment decisions. The final IHP will be submitted to the LDSS within 30 days of the enrollment decision to allow for further refinement of the IHP.

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After an evaluation of the participant’s support under existing Medicaid State Plan services, such as through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program, the next step is identifying the waiver participant’s strengths, abilities, and preferences as the starting point for developing the IHP. Each IHP will include an assessment of the individual to determine the services needed to successfully handle sentinel events that may be expected to precipitate a worsening of the child’s condition. The assessment process is completed utilizing a multi-faceted approach which may include self-assessment, speaking with biological, adoptive or foster family members, school personnel and other professionals and/or service providers involved with the child.

The process to develop the initial IHP includes obtaining pertinent information from relevant parties to fully understand and document the strengths and needs of the waiver participant. The HCI needs to have a complete and accurate picture of the waiver participant or consenter’s preferences including such areas as family/caregiver, living situation, recreation or leisure time, physical and mental health, spiritual, vocation or job and community service. The assessment will include the following: demographic information; description of the individual in person centered terms including personal or valued outcomes and goals; psycho-social history; a needs assessment and an assessment of risk factors.

The potential waiver participant and consenter will be afforded the opportunity to have family/caregiver; friends and/or advocates participate in the development of the IHP. However, the request by a capable potential waiver participant and consenter that a specific individual not participate in the planning process will be respected unless otherwise required by the court.

Upon gathering all relevant information and assessments, the HCI will meet with the waiver participant and consenter. Over one or two face-to-face meetings, the HCI will summarize the child’s current health care services, foster care-related services and the disability-related personal outcomes and needs that are to be addressed and outline the waiver and non-waiver services that are appropriate. The HCI will present options for meeting the needs and preferences that the waiver participant and consenter have deemed to be important. The IHP is based primarily on the potential waiver participant and consenter’s choice of services and reflects the potential waiver participant’s dignity, tolerance to risk and right to fail. At the same time the HCI will identify the providers in the community who are authorized to deliver such services. This dialogue will lead to decisions by the HCI in collaboration with the child or youth and involved decision-maker regarding the services and providers to be included in the IHP. This will include the expected disability-related impacts and outcomes that are expected from each service provider.

The IHP will itemize the waiver services, Medicaid State Plan and/or other services to be furnished, the amount, frequency and duration of each service, and the provider who will furnish each service. This part of the assessment of services will include the waiver service providers who will provide a Detailed Plan to the HCI. The IHP specifies supports to be provided to the waiver participant, including but not limited to: Medicaid State Plan services and waiver services. Waiver services are those that are provided when informal or formal supports are not available to meet the participant’s needs.

The IHP is the essential tool that clearly states responsibility for each of the services and supports that the waiver participant’s needs based on a comprehensive, person centered assessment. The HCI will arrange and coordinate the services that have been jointly developed for the IHP. The IHP must reflect coordination among providers involved with the waiver participant. The HCI will have ultimate responsibility for the completion of the IHP and monitoring that the waiver participants are receiving the specified services. The IHP must be updated at least annually using

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updated information from all appropriate sources and a similar series of face-to-face meetings with the waiver participant and consentor. If a waiver participant should experience significant life changing events, or at the discretion of the HCI, the IHP may be updated more frequently as needed.

The IHP must reflect that the waiver participant and consentor were actively involved in the development of the IHP. By signing the IHP, the consentor acknowledges that he/she has contributed to the development of the IHP, and agrees with its contents.

- e. **Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

The B2H waiver recognizes the waiver participant's right to risk and the dignity to fail as it relates to his or her successful integration into the community and family/caregiver environment, within parameters of the foster care program, and balances this with responsibilities to support health and welfare of the participant and the waiver participant's and consentor's right to select their services and providers. It is critical to obtain an accurate picture of what services and supports might be needed to maintain the health and welfare of the waiver participant thereby providing the opportunity to mitigate the consequences of the problems that can be triggered by sentinel events. Through the development of the IHP, a comprehensive understanding of the waiver participant's needs, risks and setting is obtained. This provides the background to understand the areas which may cause a crisis in the life of the waiver participant. Every effort is made to assist the waiver participant and consentor to understand his/her risks that may be associated with his/her life. The consentor has the right to accept or reject any services offered.

There may come a point when the waiver participant and consentor's choices are such that the waiver program becomes concerned that it will not be able to support the waiver participant's health and welfare. This concern is clearly discussed with the waiver participant and consentor. If the waiver participant's health and welfare can be supported, then the waiver participant can remain in the waiver. If this is not possible, then the waiver participant and consentor are issued a Notice of Decision, indicating discontinuance from the waiver, with Fair Hearing rights attached. Parents will receive notice of decisions, unless the parental rights of the parent have been terminated. When the district is exercising its responsibilities as the custodian of a child placed as an abused or neglected child or taken into protective custody under Article 10 of the Family Court Act, the district's decision will be de facto, the final decision. However, decisions will be reflected in the child's permanency plan. All permanency plans are subject to periodic review by the Family Court.

The IHP explicitly states the individuals who are responsible for assisting the waiver participant with daily activities, medication management, and financial transactions. Fire, safety issues and backup plans are also included. The IHP may include a system to reduce risk and address safety issues. The IHP may address back-up issues for activities which are directly related to health and welfare. The HCI is responsible for monitoring that the activities outlined in the IHP are carried out and are sufficient.

Participant risk and safety considerations are identified and potential interventions considered that

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promote independence and safety with informed involvement of the waiver participant and consentor.

- f. Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Upon determination that a waiver participant is potentially eligible for the B2H waiver and after providing a list of the HCIAS serving the catchment area to the participant and consentor, the LDSS, refers the participant to the selected HCIA to assist in the waiver application process. As part of that responsibility the HCIA provides the waiver participant and consentor with a list of HCIs who will be available to assist in developing the final IHP once enrollment is completed and encourages them to select one based on a information provided by the HCIA regarding the availability, specific experiences and skills of individual HCI's, knowledge of the community where the child lives, cultural sensitivities of the HCI's and other criteria of relevance to the child and consentor. The selected HCIA is responsible for having consentors sign a Service Selection form during the application process, indicating that they have been informed of all approved providers within their region. Enrollees in B2H have an ability to choose among HCIAS, HCIs and waiver service providers. During the development and any subsequent reevaluations of the IHP, HCIs will continue to inform them of all authorized waiver service providers and work with the enrollee to find appropriate service providers.

In the Participant Rights Form, which is signed annually, there is a description of the right to choose and change waiver service providers, as requested by the consentor. The HCI is responsible for informing the waiver participant and consentor about their ability to choose or change waiver service providers and assist the waiver participant to do so. OCFS will develop a user friendly process for changing waiver service providers.

- g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The IHP is the service plan. It is reviewed and approved by the LDSS that is responsible for the child who is participating in the waiver. The LDSS administers the State plan on behalf of the State Agency, the DOH. The review of the IHP is part of the enrollment, authorization and reauthorization process. It should be noted that OCFS will review a statistically valid random sample of all IHPs as part of its quality management function

- h. Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. *Specify the minimum schedule for the review and update of the service plan:*

<input type="radio"/>	Every three months or more frequently when necessary
<input type="radio"/>	Every six months or more frequently when necessary
<input checked="" type="radio"/>	Every twelve months or more frequently when necessary
<input type="radio"/>	Other schedule (<i>specify</i>):

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- i. Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following (*check each that applies*):

<input type="checkbox"/>	Medicaid agency
<input type="checkbox"/>	Operating agency
<input checked="" type="checkbox"/>	Case manager
<input checked="" type="checkbox"/>	Other (<i>specify</i>):
	LDSS

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Appendix D-2: Service Plan Implementation and Monitoring

- a. Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

Once the IHP has been recommended by the HCIA and approved by the consentor the HCI is responsible for monitoring the implementation of the IHP and the waiver participant's health and welfare. The HCI has two contacts a month (at a minimum) with the waiver participant to determine that the services are meeting the waiver participant's needs and that the waiver participant and consentor are satisfied with the services being provided. Additionally, the HCI, on at least a quarterly basis, is required to meet face to face with the waiver participant, in the waiver participant's home. It is anticipated that the HCI will meet face to face with the waiver participant at least monthly and perhaps multiple times per month for many waiver enrollees. The standard of at least a quarterly meeting is the minimum threshold, recognizing that many participants could require more frequent meetings. A team meeting can be called at any time by the HCI and at the request of the waiver participant and consentor. The purpose of this meeting is an opportunity to allow for collaboration among the service providers and the waiver participant and consentor regarding the waiver participant's current needs and to support the health and welfare of the waiver participant. This would be essentially the same participants involved in revising an IHP at 12-month intervals.

In addition to this, the HCIAS are responsible for the review of every IHP, Revised IHP and Addendum to monitor that they are meeting the waiver participant's health and welfare and that they are cost-effective.

The methodology used to monitor the IHPs includes the HCI collaborating with the waiver participant, consentor, other interested parties and service providers. The HCI meets with the waiver participant at least twice every month and, at minimum, meets once every quarter in the waiver participant's residence. The IHP can be revised with an Addendum if needed, as a result of changes in the waiver participant's condition. The HCIA can also meet, as needed, with the team to discuss the provision of services and will monitor IHPs. Finally, OCFS and DOH retrospectively review a random sample of IHPs.

When a problem arises, the HCI will work with the waiver participant and consentor to find an agreeable resolution. If an agreeable solution is not found, then a team meeting may be called to further discuss the issue. Additionally, LDSS and OCFS QMS will be included as necessary. If the issue is not resolved, then a Fair Hearing may be requested. If a service needs to be added, modified or deleted then an Addendum must be made.

- b. Monitoring Safeguards.** *Select one:*

<input type="radio"/>	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare <i>may not provide</i> other direct waiver services to the participant.
<input checked="" type="radio"/>	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare <i>may provide</i> other direct waiver services to the participant. The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. <i>Specify:</i>
	HCIAS may be authorized to provide other B2H waiver services. This reflects OCFS' recognition of the valued services that such qualified, multi-service agencies offer children in

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foster care who are at risk of institutionalization. It also reflects OCFS' recognition that the number of qualified providers is limited in many of the more rural areas of New York. To safeguard the best interests of the waiver participant the following are expected:

- (1) The Health Care Integration monitoring function as part of its overall case management function will have reporting lines to a cabinet or executive level manager who does not have responsibility for other programs and services;
- (2) The Health Care Integration monitoring function cannot be provided by staff who also deliver or manage other B2H waiver services;
- (3) The HCIA will have a quality management function that expressly reviews the HCI monitoring activities, its impact on IHPs and its impact on the best interest of the waiver participant; and
- (4) The OCFS B2H monitoring activities related to service plan monitoring will include review of all above items.

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Appendix E: Participant Direction of Services

[NOTE: Complete Appendix E only when the waiver provides for one or both of the participant direction opportunities specified below.]

Applicability (select one):

<input type="radio"/>	Yes. This waiver provides participant direction opportunities. Complete the remainder of the Appendix.
<input checked="" type="radio"/>	No. This waiver does not provide participant direction opportunities. Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction. Indicate whether Independence Plus designation is requested (select one):

<input type="radio"/>	Yes. The State requests that this waiver be considered for Independence Plus designation.
<input type="radio"/>	No. Independence Plus designation is not requested.

Appendix E-1: Overview

- a. Description of Participant Direction.** In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver’s approach to participant direction.

- b. Participant Direction Opportunities.** Specify the participant direction opportunities that are available in the waiver. *Select one:*

<input type="radio"/>	Participant – Employer Authority. As specified in <i>Appendix E-2, Item a</i> , the participant (or the participant’s representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
<input type="radio"/>	Participant – Budget Authority. As specified in <i>Appendix E-2, Item b</i> , the participant (or the participant’s representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
<input type="radio"/>	Both Authorities. The waiver provides for both participant direction opportunities as specified in <i>Appendix E-2</i> . Supports and protections are available for participants who exercise these authorities.

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c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies:*

<input type="checkbox"/>	Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.
<input type="checkbox"/>	Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.
<input type="checkbox"/>	The participant direction opportunities are available to persons in the following other living arrangements (<i>specify</i>):

d. Election of Participant Direction. Election of participant direction is subject to the following policy (*select one*):

<input type="radio"/>	Waiver is designed to support only individuals who want to direct their services.
<input type="radio"/>	The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.
<input type="radio"/>	The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria. <i>Specify the criteria.</i>

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

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f. Participant Direction by a Representative. Specify the State's policy concerning the direction of waiver services by a representative (*select one*):

<input type="radio"/>	The State does not provide for the direction of waiver services by a representative.
<input type="radio"/>	The State provides for the direction of waiver services by a representative. Specify the representatives who may direct waiver services: (<i>check each that applies</i>):
<input type="checkbox"/>	Waiver services may be directed by a legal representative of the participant.
<input type="checkbox"/>	Waiver services may be directed by a non-legal representative freely chosen by an adult participant. Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

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g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-3. *(Check the opportunity or opportunities available for each service):*

Participant-Directed Waiver Service	Employer Authority	Budget Authority
	<input type="checkbox"/>	<input type="checkbox"/>

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one:*

<input type="radio"/>	Yes. Financial Management Services are furnished through a third party entity. <i>(Complete item E-1-i).</i> Specify whether governmental and/or private entities furnish these services. <i>Check each that applies:</i>
<input type="checkbox"/>	Governmental entities
<input type="checkbox"/>	Private entities
<input type="radio"/>	No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. <i>Do not complete Item E-1-i.</i>

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one:*

<input type="radio"/>	FMS are covered as the waiver service entitled _____ as specified in Appendix C-3.
<input type="radio"/>	FMS are provided as an administrative activity. <i>Provide the following information:</i>
i.	Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services: _____
ii.	Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform: _____
iii.	Scope of FMS. Specify the scope of the supports that FMS entities provide <i>(check each that applies):</i>
	<i>Supports furnished when the participant is the employer of direct support workers:</i>
<input type="checkbox"/>	Assist participant in verifying support worker citizenship status
<input type="checkbox"/>	Collect and process timesheets of support workers
<input type="checkbox"/>	Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance

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	<input type="checkbox"/>	Other (<i>specify</i>):
	<i>Supports furnished when the participant exercises budget authority:</i>	
	<input type="checkbox"/>	Maintain a separate account for each participant's participant-directed budget
	<input type="checkbox"/>	Track and report participant funds, disbursements and the balance-of participant funds
	<input type="checkbox"/>	Process and pay invoices for goods and services approved in the service plan
	<input type="checkbox"/>	Provide participant with periodic reports of expenditures and the status of the participant-directed budget
	<input type="checkbox"/>	Other services and supports (<i>specify</i>):
	<i>Additional functions/activities:</i>	
	<input type="checkbox"/>	Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency
	<input type="checkbox"/>	Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency
	<input type="checkbox"/>	Provide other entities specified by the State with periodic reports of expenditures and the status of the participant directed budget
	<input type="checkbox"/>	Other (<i>specify</i>):
iv.	Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.	

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j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (*check each that applies*):

<input type="checkbox"/>	Case Management Activity. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services. <i>Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:</i>
<input type="checkbox"/>	Waiver Service Coverage. Information and assistance in support of participant direction are provided through the waiver service coverage (s) specified in Appendix C-3 entitled: _____
<input type="checkbox"/>	Administrative Activity. Information and assistance in support of participant direction are furnished as an administrative activity. <i>Specify: (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:</i>

k. Independent Advocacy (*select one*).

<input type="radio"/>	Yes. Independent advocacy is available to participants who direct their services. <i>Describe the nature of this independent advocacy and how participants may access this advocacy:</i>
<input type="radio"/>	No. Arrangements have not been made for independent advocacy.

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

m. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

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- n. Goals for Participant Direction.** In the following table, provide the State’s goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n		
	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 1		
Year 2		
Year 3		
Year 4 (renewal only)		
Year 5 (renewal only)		

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Appendix E-2: Opportunities for Participant-Direction

a. Participant – Employer Authority (Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b)

i. Participant Employer Status. Specify the participant’s employer status under the waiver. Check each that applies:

<input type="checkbox"/>	Participant/Co-Employer. The participant (or the participant’s representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions. <i>Specify the types of agencies (a.k.a., “agencies with choice”) that serve as co-employers of participant-selected staff:</i>
<input type="checkbox"/>	Participant/Common Law Employer. The participant (or the participant’s representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant’s agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant’s representative) has decision making authority over workers who provide waiver services. Check the decision making authorities that participants exercise:

<input type="checkbox"/>	Recruit staff
<input type="checkbox"/>	Refer staff to agency for hiring (co-employer)
<input type="checkbox"/>	Select staff from worker registry
<input type="checkbox"/>	Hire staff (common law employer)
<input type="checkbox"/>	Verify staff qualifications
<input type="checkbox"/>	Obtain criminal history and/or background investigation of staff. Specify how the costs of such investigations are compensated:
<input type="checkbox"/>	Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-3.
<input type="checkbox"/>	Determine staff duties consistent with the service specifications in Appendix C-3.
<input type="checkbox"/>	Determine staff wages and benefits subject to applicable State limits
<input type="checkbox"/>	Schedule staff
<input type="checkbox"/>	Orient and instruct-staff in duties
<input type="checkbox"/>	Supervise staff
<input type="checkbox"/>	Evaluate staff performance
<input type="checkbox"/>	Verify time worked by staff and approve time sheets
<input type="checkbox"/>	Discharge staff (common law employer)
<input type="checkbox"/>	Discharge staff from providing services (co-employer)
<input type="checkbox"/>	Other (specify):

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b. Participant – Budget Authority (Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b)

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Check all that apply:*

<input type="checkbox"/>	Reallocate funds among services included in the budget
<input type="checkbox"/>	Determine the amount paid for services within the State’s established limits
<input type="checkbox"/>	Substitute service providers
<input type="checkbox"/>	Schedule the provision of services
<input type="checkbox"/>	Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-3
<input type="checkbox"/>	Specify how services are provided, consistent with the service specifications contained in Appendix C-3
<input type="checkbox"/>	Identify service providers and refer for provider enrollment
<input type="checkbox"/>	Authorize payment for waiver goods and services
<input type="checkbox"/>	Review and approve provider invoices for services rendered
<input type="checkbox"/>	Other (<i>specify</i>):

ii. Participant-Directed Budget. Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

iii. Informing Participant of Budget Amount. Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

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iv. Participant Exercise of Budget Flexibility. *Select one:*

<input type="radio"/>	The participant has the authority to modify the services included in the participant-directed budget without prior approval. Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:
<input type="radio"/>	Modifications to the participant-directed budget must be preceded by a change in the service plan.

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

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Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Transmittals to consenters include detailed, easy-to-read instructions about the right to a Fair Hearing, and the process for applying for one. (See Attachment #5 – Fair Hearing Request Form) This process conforms to the Federal and State statutory and regulatory provisions of a Fair Hearing program. In the State of New York, the Office of Temporary and Disability Assistance conducts and manages the Fair Hearings and the associated processes. This Office, which has an MOU with DOH, will conduct all fair hearings relating to the B2H Waiver. When a waiver enrollee receives any waiver transmittal, it will include the process to request a fair hearing. Upon contacting the OTDA Fair Hearing Office, the waiver enrollee will receive additional information and a description of their rights under 42 CFR Part 431.

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Appendix F-2: Additional Dispute Resolution Process

- a. Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

<input type="radio"/>	Yes. The State operates an additional dispute resolution process (<i>complete Item b</i>)
<input checked="" type="radio"/>	No. This Appendix does not apply (<i>do not complete Item b</i>)

- b. Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

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Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

<input checked="" type="radio"/>	Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver (<i>complete the remaining items</i>).
<input type="radio"/>	No. This Appendix does not apply (<i>do not complete the remaining items</i>).

b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

OCFS is responsible for verifying that a grievance complaint system is developed by each waiver service provider.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

OCFS requires that each waiver service provider develop and implement a policy for responding to grievances and complaints raised by the waiver participant and consenter. Each policy must be in compliance with the laws and regulations of the oversight agency as appropriate including OCFS, OMH, OMR, DOH. OCFS laws and regulations and those of any other oversight agency that might impact a specific service provider. The grievance process is limited to those areas that are outside the scope of, but not in lieu of, the existing right to request access to the fair hearing system.

A waiver participant or consenter may file a grievance/complaint through various mechanisms. These include providing a written or verbal complaint to any staff person associated with the waiver program. A waiver participant or consenter may file grievances/complaints including the type, delivery and frequency of services, problematic issues and general concerns about the waiver program. The HCIA's will be responsible for developing a process for addressing written and verbal complaints. When a complaint cannot be resolved by the HCIA, the LDSS and OCFS Quality Management Specialists (QMSs) will be notified.

A waiver participant or consenter may initiate a verbal or written complaint at any time to the HCI, HCIA, waiver service providers, Regional QMS and OCFS BWM. Within 72-hours, the waiver participant and consenter will be contacted and updated regarding the investigational process.

OCFS will offer a toll-free B2H waiver number. This will offer waiver participant and consenters an alternative means of communicating grievances/complaints. Calls received will be transmitted geographically to the OCFS Regional QMS. The QMSs will contact the appropriate HCIA. The HCIA will contact the provider allegedly involved, and the provider will investigate. If the HCIA is cited in the complaint, OCFS Quality Management Specialists will conduct the investigation. If the OCFS QMS staff and/or the HCIA deem the complaint to be at a significant level of concern, it may be turned into a Reportable Incident. The Regional QMS will inform the LDSS of complaints and grievances.

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All parts of any grievance and complaint investigation, regardless of the filing method, will be documented, from intake through resolution. For any grievance or complaint investigation the OCFS Regional QMS or OCFS BWM staff may meet with the waiver participant, consenter and anyone the waiver participant or consenter would like to have present, at the earliest and most convenient time for all interested parties. The investigation must be completed within a maximum of forty-five (45) business days from receipt of the complaint. Written notification will be provided to the waiver participant and consenter advising them that the investigation has been completed and of any resolution of the complaint.

Additionally, to affirm that the waiver participant and consenter has proper access to the grievance/complaint process, they will be provided with a list of telephone numbers of their waiver service providers, and their supervisors, and the OCFS Regional QMSs. Waiver participants and consenters will be informed through the process that filing a grievance or making a complaint is not a pre-requisite or substitute for a fair hearing.

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Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

- a. **State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents, and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

SERIOUS REPORTABLE INCIDENT is defined as any situation in which the waiver participant experiences a perceived or actual threat to his/her health and welfare. These incidents fall into three general categories:

- Allegations of physical, sexual, and psychological abuse or maltreatment, including all such allegation types contained in the child abuse or maltreatment reporting protocols;
- Serious Injury and/or Accident to the children that threatens their ability to maintain waiver services. This includes death of a waiver participant; hospitalization, and missing person;
- Significant disruption of the caregivers' capacity to care for the waiver participant.

Follow up and Time Frame of a Serious Reportable Incident:

1. The HCIA must be notified immediately by the reporting waiver provider of any Serious Reportable Incident and take initial responsibility for any inquiry or investigation.
2. The HCIA must notify the appropriate LDSS and the Regional Quality Management Specialist within 24 hours using the OCFS Incident Reporting Form. In the case of a waiver participants' death, OCFS BWM will also receive the OCFS Incident Reporting form within 24 hours. The HCIA and the Regional Quality Management Specialists will keep an Incident Report database to be reported to OCFS on a quarterly basis or as necessary, per severity of incident. The HCIA must inform the consentor and family/caregivers of a serious reportable incident that does not involve a report to the New York State Central Register of Child Abuse or Maltreatment (SCR). Also, the consentor and family/caregivers must be informed within 24 hours by the HCIA when the evidence of injury or incident may impact services of the agency.
3. The existing laws, regulations, and protocols regarding reports to the SCR will apply, including but not limited to mandated reporter expectations, training for staff and residents, timeframes for investigation, notifications of reports, determinations of reports and corrective action plans.
4. The involved waiver provider must immediately comply with any requests for supplemental information by the HCIA, the appropriate LDSS and/or OCFS Regional Quality Management Specialist as well as cooperate in all on-site inquiries and elements of any investigation.
5. Within 30 business days following the initial report, the HCIA must submit a status report to the appropriate LDSS and OCFS Regional Quality Management Specialist.
6. If the incident is determined to remain open at the time of the status report, the waiver provider shall submit written progress reports on a monthly basis to the HCIA, the appropriate LDSS or OCFS Regional Quality Management Specialist until the incident is

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determined to be closed.

7. If the incident is reported to the SCR, then all SCR-related investigation and reporting requirements and timeframes apply.

Who must report a Serious Reportable Incident:

Any employee of a waiver provider witnessing any action or lack of attention that constitutes a Serious Reportable Incident as described above. If no waiver provider employee witnessed the incident, the employee who first becomes aware of the incident must complete the OCFS Incident Reporting Form. If an HCIA employee becomes aware of an incident that has not been reported, the HCIA shall notify the appropriate LDSS and QMS within 24 hours using the incident reporting form. The involved waiver provider is responsible for investigating the incident and submitting requested reports. Any incident of suspected abuse or maltreatment will be reported to the SCR.

A RECORDABLE INCIDENT is defined as incidents that do not meet the level of severity as a Serious Reportable Incident but do impact the waiver participant's life in the community.

Each waiver provider will identify the agency's follow-up and time frame policy and procedures for reporting a Recordable Incident. As necessary, these policies and procedures will delineate when an incident should be reported beyond the HCIA.

- b. Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

The HCI will provide the waiver participant and consentor with information to identify actions described as abuse, neglect and exploitation. The HCI will provide the waiver participant and consentor with the Waiver Participant's Rights, in addition to all information on how to contact the HCIA, OCFS Waiver Management Staff, the toll-free B2H waiver number, the SCR and DOH.

The HCI will provide all of the above noted information to the waiver participant and consentor at the time of the development of the initial IHP and annually. If the waiver participant's health and welfare are noted as being of concern, additional education may be necessary.

- c. Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

The entities that receive reports of critical events or incidents specified in G-1a include the consentor, OCFS, the LDSSs, the HCI and the HCIA. OCFS will notify DOH immediately of a waiver participant's death or of any special circumstances that occur. In some instances, the SCR may also receive reports of critical events and incidents.

Within 24-hours of the incident, an OCFS Incident Reporting form is completed by the waiver

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provider and received and reviewed by the HCIA and OCFS. The HCIA provides a copy to the consentor within 24-hours of receipt of the report.

Within one (1) week of the reported incident, the investigating agency (OCFS' central office BWM) submits a preliminary investigative report to the HCIA, the appropriate local district of social services and the OCFS QMS. The investigating agency evaluates the report to determine if further follow-up is necessary based on the current status of the incident. If further follow-up is not necessary, the investigating agency must submit the final report to the HCIA, the appropriate local district of social services and the OCFS QMS.

If it is determined necessary to conduct additional follow-up, within thirty (30) days of the reported incident, the investigating agency must submit the final report to the HCIA, the appropriate local district of social services and the OCFS QMS and inform any involved waiver provider of its findings. Should the investigation remain open at this time, reasons will be articulated and a new timeframe for closure established and regular updates required.

A Serious Incident Review Committee, organized by the HCIA, will meet at least quarterly and always within one-month of a report of a Serious Reportable incident. The Committee will determine if its response and that of any involved waiver provider have been thorough and complete and whether final recommendations and actions taken are sufficient and in line with the best clinical practice and are in compliance with the guidelines of the waiver. This Committee will determine if there is a need for recommendations for changes that may prevent or minimize recurrence of the incident and identify trends in Serious Reportable Incidents. The Committee will submit a quarterly report to OCFS regarding Serious Reportable Incidents and the waiver providers' response to these incidents. OCFS will review the Committee's quarterly report regarding identified preventive and disciplinary actions.

OCFS will also receive an Annual Report from each HCIA and identify trends or best practices that will assist the HCIA with implementing training and other activities needed to address concerns.

OCFS will summarize these annual reports and submit this summary to DOH.

- d. **Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

OCFS, through a Memorandum of Understanding with the DOH, will have responsibility for oversight of critical incidents and events. The BWM will review and analyze all reports on a quarterly basis and determine if there are systemic issues involved that need redress. OCFS will prepare a yearly report for submittal to DOH. This report will include the number of critical incidents and events; the actions taken to resolve these events; the reporting mechanisms employed; and any other element deemed appropriate by DOH or OCFS. The BWM will utilize the data collected and included in these reports to prevent critical incidents and events from reoccurring.

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Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions

This Appendix must be completed when the use of restraints and/or restrictive interventions is permitted during the course of the provision of waiver services regardless of setting. When a state prohibits the use of restraints and/or restrictive interventions during the provision of waiver services, this Appendix does not need to be completed.

a. Applicability. Select one:

<input checked="" type="checkbox"/>	This Appendix is not applicable. The State does not permit or prohibits the use of restraints or restrictive interventions (<i>do not complete the remaining items</i>)
<input type="checkbox"/>	This Appendix applies. Check each that applies:
<input type="checkbox"/>	The use of personal restraints, drugs used as restraints, mechanical restraints and/or seclusion is permitted subject to State safeguards concerning their use. <i>Complete item G-2-b.</i>
<input type="checkbox"/>	Services furnished to waiver participants may include the use of restrictive interventions subject to State safeguards concerning their use. <i>Complete items G-2-c.</i>

b. Safeguards Concerning Use of Restraints or Seclusion

- i. Safeguards Concerning the Use of Restraints or Seclusion.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints or seclusion). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- ii. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints or seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

c. Safeguards Concerning the Use of Restrictive Interventions

- i. Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

B2H waiver service providers are not authorized to use restraints or restrictive interventions during the provision of B2H waiver services. OCFS has policies concerning the use restraints and restrictive interventions by foster care or other licensed providers. These policies do not apply to B2H waiver service providers. If a B2H service provider does use a restraint or restrictive intervention on a waiver enrollee during the provision of a waiver service, this event will be considered a reportable incident. Restraints and restrictive interventions not

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enacted by a waiver service provider (i.e., a foster care parent or other service provider) must adhere to established OCFS policies.

- ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Waiver service providers are not authorized to use a restraint or restrictive intervention on a waiver service enrollee during the course of provider a waiver service. The State oversight responsibility rests with the OCFS regional offices and the HCIA.

- Any use of restraints or restrictive interventions by a waiver service provider will be considered a reportable incident and follow the processes described in Appendix G-1.
- OCFS provides comprehensive training in a train the trainer format in crisis prevention, de-escalation and intervention at no cost for voluntary agency staff. This curriculum and delivery mechanism is reviewed annually.

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Appendix G-3: Medication Management and Administration

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

<input checked="" type="checkbox"/>	Yes. This Appendix applies (<i>complete the remaining items</i>).
<input type="checkbox"/>	No. This Appendix is not applicable (<i>do not complete the remaining items</i>).

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

Waiver participants living in homes (foster homes, kinship homes or their own homes) must be monitored regarding their ability to self-administer medications. Upon admission into the waiver, every six months and as necessary, the HCI gathers information regarding the child's ability to self-administer medications. If problems are identified, the child and family/caregiver are referred to an appropriate service provider for an assessment and/or training and assistance so that safe management of the child's medication will occur. An appropriate service provider may include providers of Medicaid State Plan services, other local, State or Federal program providers or a waiver services provider. In some instances, informal supports may be utilized. All waiver staff are responsible for reporting cognitive, physical and/or behavioral changes to the HCI which may require intervention. Children residing in foster boarding homes are under the supervision of trained foster parents. These parents act in 'loco parentis' and provide routine care to children, including medication administration.

Each child in an agency operated boarding home (AOBH) or group home setting must have an Individual Medication Plan (IMP) maintained in the child's medical record and accessible to staff who administer medication to that child. The IMP is developed at the initial comprehensive health assessment by a licensed medical practitioner and reviewed and updated annually and whenever there is a change. The IMP shall include the condition or diagnosis for which a prescribed or over-the-counter medication is to be used, medication name, dosage and route of administration, the frequency of administration, monitoring standards for each medication, the child's capability to self-administer medication, and specific instructions related to the medication. An individual Medication Administration Record (MAR) will also be maintained in the child's medical record and made accessible to staff who administer medication to that child. The MAR must include the date and time that each dose is administered and the initials of the individual who administered, assisted or supervised the self-administration of the medication. The MAR must also include documentation of medication errors, actions taken, and effects of the errors.

A determination must be made for each child receiving medication in an AOBH or group home as to the child's ability to self-administer medication. The determination of the child's ability to self-administer medication is made by the prescribing physician in conjunction with the child's treatment team. Any such determination must be documented in the child's medical record.

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All authorized agencies that provide AOBH or group home care for children in foster care must use the services of a licensed medical practitioner to oversee all aspects of medication administration in those settings. These include but are not limited to: Reviewing the prescribing practitioner's medication orders; Reviewing medications received from pharmacies for accuracy and compliance with orders; Reviewing medication administration records for accuracy, timeliness, and compliance with orders; Working with trained staff in the administration of medication to children; Directing the storage and handling of medication in accordance with applicable statutes; Reviewing the content and provision of medication training for agency staff; and Overseeing the maintenance of each child's IMP and MAR.

- ii. **Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

AOBHs and group homes are licensed and monitored by OCFS. OCFS has specific regulations to file regarding medication management and medication assistance for children in AOBHs and group homes. Child caring agencies must have written policies and procedures to address the safe and effective administration of medication. Policies must address: The communication, documentation, and staffing requirements for safe and effective medication management; Procedures for medication administration when the child is off-site, including home visits and school; Procedures and safeguards for the use of 'as needed' and over-the-counter medications; Procedures and safeguards to prevent medication errors; A plan for training staff involved in administering, assisting and supervising the self-administration of medication. Training includes written and skills competency tests, and annual updates. Quality management activities related to this oversight are described in Appendix H.

c. **Medication Administration by Waiver Providers**

- i. **Provider Administration of Medications.** *Select one:*

<input checked="" type="radio"/>	Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications. <i>(complete the remaining items)</i>
<input type="radio"/>	Not applicable <i>(do not complete the remaining items)</i>

- ii. **State Policy.** Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

B2H Waiver service providers and staff who are authorized to administer medication by the Nurse Practice Act (Article 139, Section 6900) or other statute or regulation and who have

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completed training may administer medication to waiver participants. No waiver participant will self-administer medication unless it is authorized in writing by the child's physician and agreement with this authorization is confirmed in writing by the consentor.

iii. Medication Error Reporting. *Select one of the following:*

<input type="radio"/>	Providers that are responsible for medication administration are required to <i>both</i> record and report medication errors to a State agency (or agencies). <i>Complete the following three items:</i>
	(a) Specify State agency (or agencies) to which errors are reported:
	(b) Specify the types of medication errors that providers are required to <i>record</i> :
	(c) Specify the types of medication errors that providers must <i>report</i> to the State:
<input checked="" type="radio"/>	Providers responsible for medication administration are required to <i>record</i> medication errors but make information about medication errors available only when requested by the State. Specify the types of medication errors that providers are required to record:
	Providers are required to record the following errors: waiver participant in receipt of prescribed medication, dosage, routing, dosage timing and frequency.

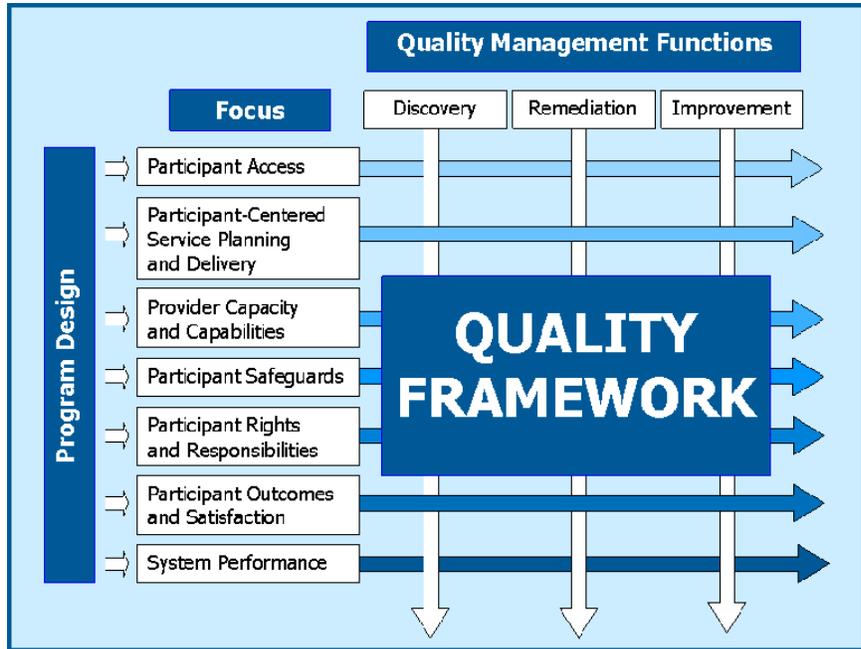
iv. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

The management of each waiver participant's medication is described in the IHP. The HCI is responsible for reviewing and validating that involved staff and caregivers are familiar with this plan. While the waiver participant is in foster care, HCI's will also review practice in the waiver participants' residences to verify compliance with OCFS policy with regard to who is authorized to conduct medication administration activities and how medication administration errors are reported.

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Appendix H: Quality Management Strategy

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver’s critical processes, structures and operational features in order to meet these assurances.



Quality Management is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement. A Quality Management Strategy is explicitly describes the processes of discovery, remediation and improvement; the frequency of those processes; the source and types of information gathered, analyzed and utilized to measure performance; and key roles and responsibilities for managing quality.

CMS recognizes that a state’s waiver Quality Management Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver’s relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Management Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Management Strategy.

Quality management is dynamic and the Quality Management Strategy may, and probably will, change over time. Modifications or updates to the Quality Management Strategy shall be submitted to CMS in conjunction with the annual report required under the provisions of 42 CFR §441.302(h) and at the time of waiver renewal.

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Quality Management Strategy: Minimum Components

The Quality Management Strategy that will be in effect during the period of the waiver is included as Attachment #1 to Appendix H. The Quality Management Strategy should be no more than ten-pages in length. It may reference other documents that provide additional supporting information about specific elements of the Quality Management Strategy. Other documents that are cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

1. The Quality Management Strategy must describe how the state will determine that each waiver assurance and requirement is met. The applicable assurances and requirements are: (a) level of care determination; (b) service plan; (c) qualified providers; (d) health and welfare; (e) administrative authority; and, (f) financial accountability. For each waiver assurance, this description must include:

- Activities or processes related to discovery, i.e. monitoring and recording the findings. Descriptions of monitoring/oversight activities that occur at the individual and provider level of service delivery are provided in the application in Appendices A, B, C, D, G, and I. These monitoring activities provide a foundation for Quality Management by generating information that can be aggregated and analyzed to measure the overall system performance. The description of the Quality Management Strategy should not repeat the descriptions that are addressed in other parts of the waiver application;
- The entities or individuals responsible for conducting the discovery/monitoring processes;
- The types of information used to measure performance; and,
- The frequency with which performance is measured.

2. The Quality Management Strategy must describe roles and responsibilities of the parties involved in measuring performance and making improvements. Such parties include (but are not limited to) the waiver administrative entities identified in Appendix A, waiver participants, advocates, and service providers.

Roles and responsibilities may be described comprehensively; it is not necessary to describe roles and responsibilities assurance by assurance. This description of roles and responsibilities may be combined with the description of the processes employed to review findings, establish priorities and develop strategies for remediation and improvement as specified in #3 below.

3. Quality Management Strategy must describe the processes employed to review findings from its discovery activities, to establish priorities and to develop strategies for remediation and improvement. *The description of these process(es) employed to review findings, establish priorities and develop strategies for remediation and improvement may be combined with the description of roles and responsibilities as specified in #2 above.*

4. The Quality Management Strategy must describe how the State compiles quality management information and the frequency with which the State communicates this information (in report or other forms) to waiver participants, families, waiver service providers, other interested parties, and the public. *Quality management reports may be designed to focus on specific areas of concern; may be related to a specific location, type of service or subgroup of participants; may be designed as administrative management reports; and/or may be developed to inform stakeholders and the public.*

5. The Quality Management Strategy must include periodic evaluation of and revision to the Quality Management Strategy. Include a description of the process and frequency for evaluating and updating the Quality Management Strategy.

If the State's Quality Management Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Management Strategy, including the specific tasks that the State plans to undertake during the period that the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

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When the Quality Management Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and identify the other long-term services that are addressed in the Quality Management Strategy.

Attachment #1 to Appendix H

The Quality Management Strategy for the waiver is:

Quality Management Program

Introduction

The primary measure of the Quality Management Plan (QMP) is whether the waiver participant has been able to achieve the outcomes outlined in the IHP, within the Federal and State guidelines, and avoid institutional placement. For the waiver participant these desired outcomes are tempered by the reality of the person's skills, resources and resource availability. The waiver's services, policies, and procedures have been developed to allow the greatest opportunity for waiver participants to be successful in the pursuit of their desired outcomes. There must be various methods for all involved to determine that the waiver participant has received the quality services, and care to support his/her success.

The QMP's structure has three necessary elements: discovery, remediation and continual improvement of the program. First, the QMP enables OCFS to collect the necessary data to adequately assess the waiver's implementation and service delivery to all enrollees. OCFS, through this QMP, proposes corrective actions that will be taken to remediate quality concerns whether involving a specific waiver participant's experience or a systemic issue. OCFS will utilize the data and knowledge gained through these steps to continuously improve the waiver from programmatic, policy and administrative infrastructure standpoints.

The QMP is supported through the collaborative efforts of the Department of Health (DOH); OCFS and, specifically, its Bureau of Waiver Management (BWM); the Local Department of Social Services (LDSS); and the HCIA. Below is a brief description of each of these entities:

New York State Department of Health

As the Single State Agency for Medicaid, DOH must oversee OCFS' implementation of the B2H waiver and its compliance with CMS assurances and guidelines. Although DOH will have ultimate responsibility for oversight, they will delegate activities to OCFS as appropriate. Generally, DOH oversees the B2H waiver performance of OCFS and, as appropriate, involved local governmental (LDSS) and non-governmental entities (HCIA).

The following lists DOH quality management responsibilities and/or activities to be delegated to OCFS.

- OCFS develops forms to assist waiver provider agencies with understanding the waiver participant's life situation and personal goals. These forms include the IHP and the Freedom of Choice Forms.
- OCFS provides evaluations, information collected and reports created to DOH that it uses to evaluate and monitor the performance of the waiver program and areas that need change or improvement.
- OCFS monitors the fiscal system as necessary to demonstrate that waiver expenditures are appropriate according to budgeted targets.
- OCFS develops information, technical assistance and training materials for the HCIA's, service providers, waiver participants and/or consenters.
- OCFS reports to DOH on dispute resolution activities.

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- DOH will receive reports from OCFS regarding the on site visits conducted by OCFS with a sample of HCIA's and QMSs.
- DOH receives reports from OCFS on administration of the toll-free telephone for B2H Waiver Telephone Consultant Line (warmline) for use by waiver participants, consenters and others.

In entering into the agreement with CMS to operate the waiver, DOH makes the following assurances which represent the basis for the activities in the QMP:

1. To support the health and welfare of the waiver participants;
2. That only qualified providers, as defined by the State, serve waiver participants;
3. That level of care need determinations are conducted at appropriate intervals;
4. That IHPs are responsive to the waiver participants' needs and goals; and
5. That the overall Medicaid costs for waiver and State Plan Medicaid services are less than or equal to the overall cost of providing institutional care to a similar population.

OCFS and its Bureau of Waiver Management

The OCFS Bureau of Waiver Management (BWM) has responsibility for the design, development, implementation and oversight of the B2H waiver (other than oversight of OCFS audit functions). Comprising a Bureau Director and professional staff, this bureau oversees program and administrative responsibilities of this waiver for OCFS. It also coordinates the activities of the Quality Management Specialists (see below) who are located in the OCFS central and regional offices. The BWM reports to the Deputy Commissioner for the Division of Development and Prevention Services and has the following responsibilities.

- BWM oversees the performance of involved LDSSs and HCIAS.
- BWM creates policy, forms and instructions related to the B2H waiver and/or reviews and approve all forms developed by other OCFS bureaus, the LDSS and/or the HCIA to assist waiver provider agencies with understanding the waiver participant's life situation and personal goals. These forms include the IHP, which supports the health and welfare of each waiver participant, and the Freedom of Choice Forms.
- BWM gathers, evaluates and monitors data and reports to determine the effectiveness of the waiver program and areas that need change or improvement. This includes monitoring of availability of waiver service providers and access services.
- BWM develops and monitors the processes necessary to oversee that the waiver's fiscal performance.
- BWM, in conjunction with OCFS senior management, defines the qualifications necessary to provide each waiver service.
- BWM forms a Quality Advisory Board and facilitate and/or direct regular meetings. This Board will act as an Implementation & Quality Advisory Board for the first three years of the waiver to provide BWM and OCFS will adequate advice to successfully operate the waiver.
- BWM may act as mediator for unresolved disputes presented by the waiver participants or consenters.
- BWM assesses waiver participant satisfaction and addresses trends that may require modifications of particular policies and procedures through the use of a tool similar to the Waiver Participant Experience Survey developed by Medstat or the Human Services Research Institute's National Core Indicators Survey. In some instances, this function includes assessing the satisfaction of the consenter.
- BWM conducts annual Regional Forums to meet with waiver participants, consenters, families, advocates and providers to gather information regarding how the waiver is functioning in each

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region. This meeting will provide BWM with information about how the HCIA and the QMS have been performing.

- BWM has annual on site visits at the HCIA and with the QMS.
- BWM provides for a toll-free B2H Waiver Telephone Consultation Line (warmline) for use by waiver participants, consenters and others.
- BWM trains HCIAS on waiver philosophy and mission.
- BWM communicates with DOH through OCFS senior management and the BWM Bureau Director.

OCFS Regional Offices - Quality Management Specialist

The QMS, who is an OCFS regional staff member, is a key resource for the successful implementation of the waiver program. QMS are managed on a regional basis by the OCFS BWM. The QMS:

- Monitors waiver functions of LDSSs and the HCIAS. This monitoring will be reported to the BWM on a quarterly basis or more frequently as required by the situation.
- Reviews IHPs over a monetary amount (yet to be determined) to evaluate the appropriateness and reasonableness of the service package cost.
- Monitors the HCIA's review of Incident Reporting Forms when there is an allegation of abuse, neglect, or when a waiver participant dies. The QMS will also review Incident Reports and other data for trends.
- Reviews a sample of the incident reports that have been closed by the HCIA to verify that these closures were appropriate. The QMS is a resource to the HCIA when the incidents remain open.
- Offers technical assistance, written guidance and training to HCIA's and Waiver Providers, as needed.
- Surveys a random sample of waiver participants regarding satisfaction of services received, through the use of the Waiver Participant Experience Survey, developed by Medstat, or a similar tool. In some instances, the QMS will also survey the satisfaction of consenters.
- Provides summary reports to the OCFS BWM on a quarterly basis.

OCFS Evaluation function

OCFS will undertake an audit function that is separate and distinct from the role of BWM and the QMS. The function will report to the Deputy Commissioner for Administration and will undertake the following tasks:

- Review HCIAS retrospectively to determine if providers and subcontractors meet qualifications and are complying with program requirements;
- Examine HCIA activities to determine whether HCIA oversight of subcontractors is being conducted as determined in the provider agreement;
- Review a statistically valid random retrospective sample of IHP's according to applicable State and Federal mandates, and verify B2H waiver eligibility and that these IHPs have been properly approved
- Conduct special studies to identify and analyze problems areas and identify trends, both independently and at the request of BWM

Local Department of Social Services (LDSS)

The LDSS is responsible for making the enrollment decisions in all cases. The LDSS may choose to delegate to the HCIAS the process of identifying children who may be eligible for the waiver and conducting the evaluations for enrollment. Additionally, the LDSS must always approve the IHP created by the HCIA. The LDSS will also perform a number of administrative tasks that include the following:

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- providing information to enrollees and potential enrollees;
- monitoring services against approved limits;
- managing slot utilization;
- assisting in resolving concerns/grievances/complaints.

Health Care Integration Agency (HCIA)

HCIA's are VAAs that meet the provider qualifications established by OCFS including having an appropriate license or certification from OMH, OMR/DD or DOH; sufficient administrative and fiscal viability; sufficient community standing; and the capacity and willingness to comply with Medicaid waiver provider agreement requirements. An HCIA may have a provider agreement that authorizes it to deliver any B2H waiver service for which it qualifies. The process by which it requests and is authorized are described in other sections of this application.

In addition, a HCIA may have two sets of administrative functions that are described in an agreement with OCFS. The first set of administrative functions supports the B2H waiver enrollment and reauthorization processes. It includes compiling a potential waiver enrollee's application packet and conducting reauthorization activities prior to LDSS approval. The HCIA is responsible for providing information to potential enrollees and their family/caregivers and consenters regarding the B2H waiver. It includes collecting and compiling all relevant assessments (including Level of Care) and preparing the information needed to make an initial enrollment or reauthorization decision. It includes reviewing the implementation of the IHP and any revisions required for a reauthorization decision that were completed by a waiver participant's HCI.

The second set of administrative function involves quality management activities related to B2H waiver service providers in its catchment area. These include providing public information and training regarding the B2H waiver to all stakeholder groups; training B2H service providers on OCFS and DOH policy related to providing authorized services, handling client information, managing quality, documentation, billing and payment, among other administrative and quality management responsibilities. HCIA's, through agreement with OCFS, also have responsibility for monitoring service delivery activities of B2H service providers.

In these administrative capacities, the HCIA:

- Conducts the preliminary interview with prospective waiver participants and consenters to evaluate potential eligibility. In some cases, this initial meeting will involve the consenter. The HCIA provides the individual with an explanation about the waiver's philosophy, goals and available services, and information regarding other alternatives, including institutional services.
- Prepares Application Packets for those potential waiver participants who are likely to meet waiver eligibility criteria to determine completeness, and gathers or provides written evaluations including the need for revisions.
- Maintains waiver budgets and submits quarterly reports to the LDSS and OCFS which include the average cost for all waiver participants as indicated by the eMedNY system through claims reports.
- Receives and reviews all reports of Serious Reportable Incidents, determines whether any further action is needed, and immediately reports the incident and action to OCFS.
- Provides technical assistance to waiver participants, consenters, their families, providers, and community agencies. Technical assistance is provided through trainings, Waiver provider meetings and consultation.
- Is responsible for developing, implementing, monitoring, and revising their IHP.
- Reviews IHP's – including revisions and addendums - to verify that waiver services are appropriately meeting the waiver participant's health and welfare and are cost-effective. This information is submitted to the LDSS for enrollment and reenrollment decisions.

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- May be contacted regarding a grievance or complaint by the waiver participant and/or consentor and facilitates the resolution process.
- Develops community resources to attract potential service providers. The HCIA conducts interviews of potential service providers.
- Provides training to Waiver Service Providers regarding the philosophy, policies and procedures of the B2H waiver.

HCIA's will structurally separate their service delivery responsibilities from their administrative responsibilities. (See Appendix D for a description of how HCIA's will structurally separate service planning responsibilities and decisions from other service delivery activities and responsibilities.) Waiver applicants who are helped as they prepare an enrollment application packet will be informed that, if enrollment is approved, they will have multiple opportunities and support that helps them select a HCIA agency and HCI. They will be informed of all HCIA's that are authorized in their communities and that they are under no obligation to remain with the HCIA that assisted in developing their B2H waiver application. This discussion and the consentor knowledge of such choices will be recorded and reviewed as part of OCFS' quality management plan.

HCIA quality management functions will be discharged by staff that have no role in B2H service delivery and no role in assisting in the development of a B2H waiver enrollment application. Further, HCIA quality management staff will report to a senior manager who has no service delivery responsibility and who does not report to an executive who oversees service delivery. This separation of administrative and supervisory responsibility will be described in the OCFS agreement and included as part of OCFS' quality management plan and monitoring activities.

Framework for a Quality Management Plan

The quality framework developed by CMS provides an excellent avenue for anyone wanting to construct a viable and practical approach to dealing with the quality aspects of a waiver. This Quality Framework contains three distinct functions: Discovery, Remediation and Improvement.

By evaluating the waiver through its ability to be aware of and respond to unwanted events, the waiver can meet its assurances to CMS. There is a need to segment the activities associated with the waiver into specific focus areas to understand the effectiveness of the waiver. Through ongoing data analysis, OCFS will make adjustments and changes to the waiver's policies and procedures to support the health and welfare of all waiver participants. These focus areas are:

Focus I: Waiver Participant Access

Desired Outcome: Individuals have ready access to home and community-based services and supports in their communities.

A. Information/Referral –

- Desired Outcome: Individuals and families can readily obtain information concerning the availability of the waiver and the application process. When necessary, additional referrals are made.
- Method: Each HCIA will be responsible for tracking information about referrals made to them and sending the reports to BWM on a quarterly basis. The reports include the following:
 - i. Number of referrals received;
 - ii. Appropriate vs. inappropriate referrals;
 - iii. Reasons for a referral being inappropriate;
 - iv. The time required to set up an appointment to meet the potential waiver participant

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and consenter if appropriate. It is expected that setting up this appointment will be accomplished within two weeks of receiving the referral; and

- v. Referrals to other community resources for individuals not eligible for the waiver.

B. Intake and Waiver Eligibility

- o *User Friendly Processes –*

- i. Desired Outcome: Intake and eligibility determination processes are understandable and user-friendly to individuals and families. Assistance is available when applying for the waiver.
- ii. Method: During the initial interview, the HCIA will offer the potential waiver participant and/or consenter the assistance of a translator to interpret the Understanding of the Waiver Process form, into the waiver participant’s primary language and/or the primary language of the participant and/or consenter. Signing this form indicates that the potential waiver participant and/or consenter understand the enrollment process, the philosophy of the waiver and the services and supports available through the waiver.

- o *Waiver Eligibility Determination*

- i. Desired Outcome: Each individual’s needs and eligibility for the waiver are assessed and determined promptly.
- ii. Method: The HCIA will monitor that the Application Packet is submitted within sixty (60) calendar days of the waiver participant’s HCI selection. The HCIA has fifteen (15) working days to review the application and determine if the request can be approved. If not, the HCI will be provided with written feedback regarding what must be changed in order to approve the application. It is expected that corrections required by the HCI will be submitted to the HCIA in fifteen (15) working days. The HCIA will provide the LDSS with the Application packet for final approval of enrollment. The HCIA will provide a final approved copy of the Application Packet to the QMS, if it is over a monetary amount, yet to be determined. The HCIA and LDSS are required to retain records referring to eligibility determinations and evaluations pursuant to State laws and regulations, but at minimum seven (7) years after submittal date or until seven (7) years after the child is no longer enrolled in the waiver, whichever shall come first.

- o *Referral to Community Resources*

- i. Desired Outcome: Individuals who need services but who are not eligible for this waiver are linked to other community resources.
- ii. Method: The LDSS is responsible for determining eligibility for the waiver and for referring ineligible individuals to other resources within the community. The LDSS must tabulate the number of individuals determined ineligible and, as a result, referred to other resources by each LDSS in accordance with the Waiver Information and Referral section

- o *Individual Choice of Provider*

- i. Desired Outcome: Each individual is given timely information about available services to exercise his or her choice in selecting between the waiver program and institutional services.
- ii. Method: HCI’s are responsible for including a signed Freedom of Choice form in each Application Packet. This form indicates that the individual has been notified of his/her right to reside in the community with waiver services. The individual has the option to decline participation in the waiver, which could result in the individual being admitted to an institution or continuing to reside in the community with other community-based alternative programs or services.

- o *Prompt Initiation*

- i. Desired Outcome: Services are initiated promptly when the individual is

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determined eligible and selects the waiver program.

- ii. Method: HCIA's are responsible for assuring that each waiver service begins on the date specified in the IHP, if the enrollment and IHP are approved by the LDSS, pending availability of waiver opportunities. As a quality assurance measure, BWM will track the prompt initiation of services by sampling the Notice of Approval date, the specific start date of services, and the date of the first payment to the Service Provider. Negotiations or other settlement discussions do not affect the time in which a fair hearing must be requested.

Focus II: Waiver Participant-Centered Service Planning

Desired Outcome: Services and supports are planned and effectively implemented in accordance with each waiver participant's unique needs, expressed preferences and decisions concerning his/her life in the community.

A. Waiver Participant-Centered Service Planning

- o *Assessment –*

- i. Desired Outcome: Comprehensive information concerning each waiver participant's and/or consenter's preferences, personal goals, needs, abilities, health status and other available supports are gathered and used in developing an individualized IHP.
- ii. Method: The HCI is responsible for working with the waiver participant and/or consenter to develop an IHP which is driven by the goals, needs and preferences of the waiver participant or consenter and based upon appropriate assessments. All IHP's include information related to health and welfare issues, and this information is fully considered in the development of the plan. The HCI is responsible for discussing relevant plan elements with the waiver participant and consenter each time they meet, and all waiver provider staff are responsible for providing input to the HCI regarding the plan on an ongoing basis. A more formal review will occur prior to the development of the next IHP. By signing the IHP each participant/consenter is acknowledging that these plans represent his/her desired outcomes. The HCI will arrange a meeting of the waiver participant and/or consenter, the HCI, all appropriate service providers and any additional person chosen by the waiver participant or consenter. That meeting will occur at least every twelve (12) months to revise the waiver participant's plan as necessary. Appropriate communication and reports from all involved service providers should be available at this review.

- o *Waiver Participant Decision Making*

- i. Desired Outcome: Information and support is available to help waiver participants and consenters make informed selections among service options.
- ii. Method: Initially, the HCIA provides the waiver participant and consenter with a list of approved HCIs employed by the HCIA. The selected HCI is responsible for providing the waiver participant and/or consenter with objective information regarding the type of waiver services available and the approved providers of each service. Team meetings must occur prior to developing a revised IHP to allow for waiver participant and consenter's input.

- o *Free Choice of Providers*

- i. Desired Outcome: Information and support is available to assist waiver participants and consenters in freely choosing among qualified providers.
- ii. Method: The HCI is responsible for requiring that consenters sign a Service Selection form during the application process, indicating that they have been informed of all approved providers within their region. In the Waiver Participant's

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Rights Form, which is signed annually by the waiver participant and/or consentor there is a description of the right to choose and change providers as requested by the waiver participant or consentor. The HCI is responsible for informing the waiver participant and consentor about his/her opportunity to choose and/or change providers and assisting the waiver participant to do so.

o *Service Plan*

- i. Desired Outcome: Each waiver participant’s IHP comprehensively addresses his/her identified need for waiver services, health care and other services in accordance with his/her expressed personal preferences and goals.
- ii. Method: Each IHP is signed by the waiver participant and/or consentor and anyone who participated in its development indicating approval of the contents. The LDSS must authorize the IHP. Team Meetings, including the waiver participant and/or consentor and anyone he/she chooses, must occur when a revised IHP is submitted. The HCIA reviews all IHPs for completeness, focusing on issues of health and welfare, the inclusion of the waiver participant’s goals, and the need for the waiver and each service requested.

B. *Service Delivery –*

o *Ongoing Service and Support Coordination*

- i. Desired Outcome: Waiver participants have continuous access to assistance as needed to obtain and coordinate services and promptly address issues encountered in community living.
- ii. Method: HCIs are responsible for the ongoing review of all IHPs to determine if the services described in the IHP are being delivered as stated. The HCI’s ongoing review of each IHP determines that these services assist the waiver participant in meeting his/her goals and supports the waiver participant’s health and welfare. A formal review occurs at the time of the development of an Addendum and Revised IHP. It is the responsibility of the HCI to act with the waiver participant and consentor to make needed changes in the type and/or amount of services received in a timely manner. The HCIA reviews all IHPs to verify that the frequency of health care integration matches the waiver participant’s needs.

o *Service Provision*

- i. Desired Outcome: Services are furnished in accordance with the waiver participant’s IHP.
- ii. Method: All service providers are responsible for monitoring service provision in the following areas: there is compliance with the IHP, in amount and type of service approved; staff are present and on time as stated in IHP; interaction with waiver participants, family/caregivers and other service providers is documented; and staff supervision is provided in accordance with best practices.

o *Ongoing Monitoring*

- i. Desired Outcome: Regular, systematic and objective methods – including obtaining the waiver participant’s feedback – are used to monitor the waiver participant’s well being, health status, and the effectiveness of the waiver in enabling the individual to achieve his/her personal goals.
- ii. Method: HCIs meet with waiver participants and, if appropriate, their consentors as stated in the IHP. These meetings occur in the waiver participant’s residence on a minimum quarterly basis. The HCIA reviews IHPs when they are submitted initially and every twelve (12) months thereafter. Waiver service providers are responsible for soliciting feedback from waiver participants on at least an annual basis, using standardized satisfaction survey tools and monitoring tools. In some instances, it will be appropriate for feedback to be solicited from the consentors. If the waiver participant and/or consentor require assistance with completing the

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survey, someone other than the waiver service provider soliciting the feedback is to provide this assistance. In addition, QMS will conduct annual waiver participant satisfaction surveys with results forwarded to BWM.

- *Responsiveness to Changing Needs*
 - i. Desired Outcomes: Significant changes in the waiver participant’s needs or circumstances promptly trigger consideration of modifications in his/her IHP.
 - ii. Method: Waiver Service Providers maintain documentation in the waiver participant’s records that indicate significant changes in needs have been addressed. When an Addendum is necessary, it is submitted in a timely manner to the HCI. The Revised IHPs are submitted in a timely manner by the HCI to the HCIA, describing the changes in the waiver participant’s life during that period of time. The request for waiver services reflects the waiver participant’s current and expected needs for the next six (6) months.

Focus III: Provider Capacity and Capabilities

Desired Outcome: There are sufficient waiver providers and they possess and demonstrate the capability to effectively serve waiver participants.

A. *Provider Networks and Availability*

- Desired Outcome: There are sufficient qualified providers to meet the needs of waiver participants in their communities.
- Method: The HCIA will gather data on whether there are sufficient numbers of providers and report to QMS and BWM quarterly. These reports provide the QMS with data regarding the sufficiency of available providers, any areas where additional providers would improve access to services and how this impacts the policy and procedures which directly affect service delivery. The QMS provides annotated summaries to the BWM on a quarterly basis so solutions may be pursued, identifying current or proposed action steps to be taken by the HCIA and/or initiated by the BWM.

B. *Provider Qualifications*

- Desired Outcome: All waiver service providers possess the requisite capacity, skills, competencies and qualifications to support waiver participants effectively.
- Method: Each waiver service provider will submit written documentation of the capacity, skills, competencies, and qualifications needed to effectively deliver service to the HCIA. The provider maintains the required documentation dealing with personnel records and training. HCIA or BWM will provide certificates of attendance to all waiver service providers who attend HCIA or BWM organized training sessions. Waiver service providers will use pre-and post-testing to monitor that the staff has acquired the information presented in any waiver service provider presented training. Supervision provides an opportunity for the supervisor to judge the staff members’ level of skill and competence, and need for additional training and support. Waiver service providers will maintain documentation in personnel files. Quality monitoring activities conducted by the operating agency will assess the appropriateness of such documentation and that services are delivered only by qualified personnel.

C. *Provider Performance*

- Desired Outcome: All waiver service providers demonstrate the ability to provide services and supports in an effective and efficient manner consistent with the individual’s IHP.
- Method: Waiver service providers formally offer comments through the Individual Service Report for the Revised IHP, tracking the extent to which waiver participants have met goals established in prior IHPs (effectiveness), and that these goals have been met within established timeframes (efficiency). An 80% achievement rate for each of these measures (% goals met: % timeframes met) will be considered as acceptable performance. In

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addition, waiver participant satisfaction surveys, administered by the waiver service providers, the QMS and BWM, annually, will provide data regarding the success of the waiver program.

Focus IV: Waiver Participant Safeguards

Desired Outcome: Waiver participants are safe and secure in their residences and communities, taking into account their informed and expressed choices

A. Risk and Safety Planning

- Desired Outcome: Waiver participant risk and safety considerations are identified and potential interventions considered that promote independence and safety with the informed involvement of the waiver participant and/or consenters.
- Method: This information is included each time an IHP, Revised IHP or Addendum is developed and authorized.

B. Critical Incident Management

- Desired Outcome: There are systematic safeguards in place to protect waiver participants from critical incidents and other life-endangering situations.
- Method: Safeguards are outlined in each IHP. The Incident Reporting Policy describes procedures for the reporting, investigation, and response to Serious Reportable Incidents and Recordable Incidents. Where incidents are the responsibility of the foster care/voluntary agency provider or LDSS the HCI will receive copies of all incident reports, evaluations and corrective actions involving a waiver participant. HCIA's complete an Annual Incident Trend Report, submitted to the QMS on a schedule that allows it to impact OCFS policy and fiscal decisions in a timely manner, if appropriate; and the QMS forwards this report to BWM.

C. Housing and Environment

- Desired Outcome: The safety and security of the waiver participant's living arrangement is assessed, risk factors are identified and modifications are offered to promote independence and safety in the residence.
- Method: The LDSS or the HCI, as applicable, will review the currency of all licenses and certificates related to housing and program sites as part of the information submitted in developing the IHP and related Addendums and/or Revisions. The HCI is required to meet with the waiver participant and, if appropriate, the consentor at least once quarterly in the waiver participant's residence and include case notes that identify any concerns and necessary action steps. The HCI is also a mandated reporter, so any incidents of abuse or neglect arising from the child's housing or other program environments are appropriately reported and appropriately investigated and resolved.

D. Restrictive Interventions

- Desired Outcome: Restrictive interventions – including chemical and physical restraints – are only used as a last resort and subject to oversight.
- Method: Regulations currently in place concerning the use of restraints or seclusions in foster care are found in 18NYCRR441.17. No agency may use any method of restraint unless it has submitted a policy to OCFS. The policy must be reviewed and approved in writing by the appropriate OCFS Regional Office prior to the implementation of such policy. Duration of approval is for two years. No changes or modifications of the agency's policy shall be made without prior written approval of OCFS.
- OCFS will monitor incident reports to identify any use of restrictive restraints that are outside an approved policy.
- OCFS completes a comprehensive voluntary agency review protocol at least once every three years. This protocol includes a review of the agency's restraint plan and use.
- A plan is under development for quarterly submission of restraint logs by each agency

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approved for the use of restraint.

- OCFS provides comprehensive training in a train the trainer format in crisis prevention, de-escalation and intervention at no cost for voluntary agency staff. This curriculum and delivery mechanism is reviewed annually.

E. Medication Management

- Desired Outcome: Medications are managed effectively and appropriately.
- Method: The management of each waiver participant's medication is described in the IHP. The HCI is responsible for reviewing and validating that involved staff and caregivers are familiar with this plan.
- While the waiver participant is in foster care, HCI's will also review practice in the waiver participant's residences to verify compliance with OCFS policy with regard to who is authorized to conduct medication administration activities and how medication administration errors are reported.
- OCFS/QMS will regularly review Serious Reportable Incidents reports to identify the need for additional training, technical assistance, intervention and/or policy changes.

F. Natural Disasters and Other Public Emergencies

- Desired Outcome: There are safeguards in place to protect and support waiver participants in the event of natural disasters or other public emergencies.
- Method: The safeguards in place to protect and support waiver participants in the event of natural disasters or other public emergencies are addressed in the IHP. In addition, each waiver service provider agency is responsible for creating and maintaining disaster plans and sharing these plans with the waiver participant and, if appropriate, their consentor.

Focus V: Waiver Participant Rights and Responsibilities

Desired Outcomes: Waiver participants receive support to exercise their rights and in accepting personal responsibilities.

A. Civil and Human Rights

- Desired Outcome: Waiver participants and consentor are informed of, and supported to freely exercise, their fundamental Constitutional and Federal and State statutory rights.
- Method: The HCI is responsible for having the waiver participant and/or consentor review and sign a copy of the Waiver Participant's Rights Form on an annual basis. A copy of this form must be maintained with each waiver provider agency. The HCI will retain the original copy of this form and a copy will be provided to the waiver participant and/or their consentor by the HCI. Waiver service provider agencies may have their own Bill of Rights which will be maintained in their own respective files.

B. Waiver Participant Decision Making Authority

- Desired Outcome: Waiver participants and/or consentors receive training and support to exercise and maintain their own decision-making authority.
- Method: The HCIA and HCI explain and support the waiver participant's right to be a primary decision maker regarding his/her life, goals, activities, services received, and providers of the services. Waiver provider staff is trained to assist the waiver participant/consentor to make key decisions about the goals for each waiver service. The waiver participant's or consentor's signature on the Freedom of Choice form, the Initial and Revised IHPs and Addendums demonstrate consistency between the waiver participant's stated goals, and the interventions provided by waiver provider and State Plan provider staff. Waiver participants' satisfaction, which is often a reflection of the level of control they have over their lives, is monitored through waiver participant satisfaction surveys.

C. Due Process

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- Desired Outcome: Waiver participant and/or consentor are informed of and supported to freely exercise their Medicaid due process rights.
- Method: Fair hearing documentation is issued to the waiver participant and consentor with each Notice of Decision. This waiver has a provision for negotiating any matter within the scope of the Notice of the Decision prior to moving to a more formal Fair Hearing.

D. Grievances

- Desired Outcome: Waiver participants and, if appropriate, their consentors may be informed are informed of how to register grievances and complaints and supported in seeking their resolution. Grievances and complaints are resolved in a timely fashion.
- Method: This is measured through the provider grievance process and information reported to the B2H toll-free warmline. In addition, waiver service provider agencies are responsible for informing waiver participants and consentors of the grievance policies and procedures. Grievances and complaints are also measured by Participant Satisfaction Surveys conducted as a part of the Quality Management Strategy.

Focus VI: Waiver Participant Outcomes and Satisfaction

Desired Outcome: Waiver participants are satisfied with their services and achieve desired outcomes.

A. Waiver Participant Satisfaction

- Desired Outcome: Waiver participants, consentors and family/caregiver, as appropriate, express satisfaction with their services and supports.
- Method: Waiver participant satisfaction surveys, part of the provider’s self monitoring process, are used by each provider on at least an annual basis for each waiver participant receiving services. The QMS will conduct a waiver participant satisfaction survey on an annual basis. BWM also has an annual process for assessing waiver participant satisfaction and tracking the outcomes. In some instances, feedback will be solicited from the consentors.

B. Waiver Participant Outcomes

- Desired Outcome: Services and supports lead to positive outcomes for each waiver participant.
- Method: Providers maintain documentation of waiver participant outcomes. Such documentation may be in the form of standardized outcome measurements (e.g. Community Integration Questionnaire, Child and Adolescent Needs and Strengths (CANS)), or documentation of success in goal attainment from one IHP period to the next.

Focus VII: System Performance

Desired Outcome: The system supports waiver participants efficiently and effectively and constantly strives to improve quality.

A. System Performance Appraisal

- a. Desired Outcome: The service system promotes the effective and efficient provision of services and supports by engaging in systematic data collection and analysis of program performance and impact.
- b. Method: The HCIA meets 2-4 times during the year with waiver provider groups to train the waiver service providers in the effective and efficient use of waiver services and to clarify policies. The HCIA reviews all IHPs for appropriate and effective use of all services. BWM coordinates a quarterly meeting with all HCIAS and QMS’ to review and discuss data concerning the effectiveness of services and service delivery. Waiver participant surveys, administered by each Service Provider, the QMS and BWM, provide data which is analyzed to the determine areas of intervention, training, and waiver participant satisfaction. BWM representatives, the QMS and the Quality Advisory Board

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will meet regularly to determine areas of the waiver in need of intervention, training and/or modification. Random sample and targeted retrospective reviews of either the waiver participant's complete file or latest IHP assist the program in evaluating the effectiveness of waiver services.

B. *Quality Improvement*

- a. Desired Outcome: There is a systematic approach to the continuous improvement of quality in the provision of HCBS.
- b. Method: The HCIA will provide feedback with each IHP as a primary vehicle for quality improvement. The HCIA will meet with Waiver Service Providers at least twice annually to provide a forum for discussion, training and technical support pertaining to the waiver program. On an ongoing basis, the HCIA will provide BWM, via email and telephone calls, with information about any barriers that may prevent the waiver from reaching its stated goals. BWM will coordinate a quarterly meeting with all HCIA and QMS, as an opportunity for discussion, training and technical support necessary for efficient service delivery and maximization of all available waiver services. QMS and BWM representatives will meet with the Quality Advisory Board on a regular basis to evaluate the effectiveness of the waiver Quality Management Program, as well as other quality issues. The Serious Reportable Incident Database will assist BWM waiver management staff in understanding the types of incidents that most regularly occur, which providers are involved and any trends that may adversely affect the delivery of the waiver program and require remediation.

C. *Cultural Competency*

- a. Desired Outcome: The HCBS system effectively supports waiver participants of diverse cultural and ethnic backgrounds.
- b. Method: The waiver serves all populations regardless of culture/ethnicity. The HCIA seeks to recruit waiver service providers who have needed cultural competencies.

D. *Waiver Participant and Stakeholder Involvement*

- a. Desired Outcome: Waiver participants, consenters and other stakeholders have an active role in program design, performance appraisal, and quality improvement activities.
- b. Method: HCIA receives feedback from providers, waiver participants and if appropriate their consenters. The HCIA informs BWM about concerns regarding waiver policies and procedures. BWM staff is accessible to waiver participants, consenters, advocates, providers and others stakeholders via telephone, email and annual visits to each region. Regional Forums, held throughout the State, bring together the HCIA and QMS' to discuss waiver related issues. The Quality Advisory Board is composed of representatives from key stakeholder groups including BWM waiver management staff, QMS', HCIA, waiver provider staff, representatives from State agencies, waiver participants, consenters and their family/caregivers. The toll-free B2H waiver toll-free line will provide an opportunity for waiver participants, consenters and advocates to voice concerns regarding the waiver program.

E. *Financial Integrity*

- a. Desired Outcome: Payments are made promptly in accordance with program requirements (see Appendix I-1 and Appendix J).
- b. Method: The MMIS (eMedNY) automated claims processing system is responsible for paying providers in a timely and accurate manner. BWM and eMedNY contract staff assists providers when they have concerns about payments. Providers are directed to examine their own Quality Programs in relation to this framework and to evaluate if they have the capacity to meet the assurances and desired outcomes for which they are responsible. This may not include adaptive and assistive equipment or accessibility modifications. To the extent feasible, these services will be billed through eMedNY.

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Quality Management Program Activities

The following are activities that make up the components of the QMP. Data is accumulated from a variety of activities to determine the effectiveness of this program. The Discovery process identifies the need for Provider or systems intervention, or both.

- **B2H Waiver Manual**

- The B2H Waiver Manual includes the definitions of each waiver service, provider qualifications, required training, and policy and procedure standards for quality assurance and incident reporting. Anytime revisions or additions are made to the waiver policies or procedures, a copy is forwarded to all waiver service providers, HCIAS and QMS'.

- **HCIA Interview with Potential Waiver Participants**

- The HCIA is responsible for meeting with individuals who are interested in receiving services through the waiver. During this interview the HCIA explains the philosophy of the waiver and the services available. An important part of the interview process includes a preliminary assessment of the potential waiver participant to determine if the individual meets the established eligibility criteria of the waiver. QMS receives quarterly reports from HCIA including: the number of referrals; the number approved ; the number denied; and suggested referral for those not appropriate for this waiver.

- **Waiver Participants' Choice of Waiver Services and Providers**

- Potential waiver participants and consenters are informed by the HCIA of their right to choose to participate in the waiver. Those selecting the waiver are provided with a list of approved HCIAS. Once selected, the HCIA will provide a list of HCIs and, to the extent possible, will indicate which HCI's background and experience best suit the participant's needs. It is the responsibility of the HCI to assist the individual in establishing goals and selecting service providers appropriate for accomplishing these goals. A list of selected services and providers is included in a detailed IHP as part of the Application Packet submitted to an HCIA for acceptance into the waiver. To support a waiver participant's and consenter's right to choose, a number of forms are signed and submitted to the HCIA, including voluntary participation of the waiver and selection of providers and services. Retrospective review of a random sample of all IHPs is conducted by QMS.

- **Waiver Participant Satisfaction Survey**

- All approved providers, QMS and BWM are required to conduct an annual survey of the waiver participant's satisfaction. The survey focuses on the satisfaction of the waiver participant with the waiver services provided. Providers are required to review all surveys and address recommendations and concerns expressed by the waiver participants and/or consenter. Providers maintain this data for review by BWM during survey process. QMS' conduct Waiver Participant Satisfaction Surveys annually with results submitted to BWM.

- **Provider Self-Monitoring Tools**

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- All providers are required to implement a self-monitoring process to assess the provision of waiver services. This assessment serves as a basis for identifying areas where revisions to provider's policies and procedures are indicated. Providers maintain this data for review by BWM during survey process.
- **Fair Hearing Rights**
 - Waiver participants and consenters are afforded the rights for a fair hearing in compliance with 42 CFR Part 431 Subpart E. They shall be informed of their right to a Fair Hearing upon denial of their application, denial of requested provider or services, or discontinuation of service and/or from the waiver. The number of Fair Hearings is reported by the HCIA in their quarterly reports to QMS. Parent, when available will receive notice, unless the parental rights of the parent have been terminated. When the district is exercising its responsibilities as the custodian of a child placed as abused or neglected child or taken into protective custody under Article 10 of the Family Court Act, the district's decision will be de facto, the final decision. However, for all children served by the Waiver, decisions will be reflected in the child's permanency plan. All permanency plans are subject to periodic review by the Family Court, on notice to the parties and law guardian.
- **Waiver participants' Rights Forms**
 - The HCI will inform each waiver participant and consenter of his/her rights under this waiver on an annual basis. The list of Waiver Participants' Rights will be provided to the waiver participant and consenter at each IHP review and can be referred to when there are questions or concerns. Both the consenter and HCI sign the form, and the consenter receives a copy.
- **Contact Sheets**
 - Each waiver participant and consenter is given a listing of names and phone numbers of waiver provider staff, their supervisors, the HCIA, the LDSS, QMS and BWM Waiver Management staff in case any concerns arise.
- **HCIA Interview with Potential Waiver Service Providers**
 - All potential waiver service providers are interviewed by the HCIA using a standardized process to evaluate the qualifications of the provider and their ability to meet the needs of the waiver participants. Each service to be provided is reviewed and approved separately. During the interview process, the HCIA provides information on the philosophy and services of the waiver. The HCIA makes recommendations to BWM. BWM makes a recommendation to DOH which is responsible for the final decision regarding approval of the potential provider. BWM will contact any State agency if the provider is already known to the other entities.
- **Surveillance of Providers**
 - Providers are surveyed on a regular basis by QMS and BWM. The survey focuses primarily on the providers' compliance with policies described in the Program Manual. A written report is provided to the provider, and if needed the provider submits a plan of correction.
 - DOH will regularly monitor OCFS' administrative oversight of B2H waiver service

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providers and may conduct on-site visits of providers as part of its oversight of the administration of this waiver.

- **Suspension and Termination of Providers**

- DOH has the right to suspend providers from providing waiver services to new waiver participants by terminating its Medicaid Provider Agreement if the provider is unable to fulfill its responsibilities and obligations.
- OCFS/BWM will identify providers that DOH should consider for suspension and/or termination.

- **Review of IHPs**

- HCIAAs review all IHPs to verify that adequate and appropriate services are provided to support the waiver participants' health and welfare. Any questionable IHPs are returned to the HCI for clarification. Plans must be submitted at least every twelve (12) months for review and approval by the HCIA. QMS will review IHPs over a cost amount, yet to be determined by BWM.
- OCFS will outline protocols and performance expectations for HCIA quality management activities that include the review of all IHPs as a first line of quality assurance.
- Each IHP will be reviewed by the involved LDSS as part of its enrollment, authorization and reauthorization process.
- OCFS will generate a statistically valid random sample of all IHPs for review as part of its internal quality management function.

- **Retrospective Review of IHPs**

- OCFS' Division of Administration and DOH are responsible for a statistically valid retrospective review of all active IHPs. The IHPs to be reviewed are selected either randomly or based on specific concerns regarding activities in a region, of a provider, or of a service. The percentage reviewed is based upon established agreements between OCFS and DOH.

- **Waiver participants' Signature On IHPs**

- Waiver participants or their consentor must sign all IHPs verifying that the signatory agrees with the information included in the IHP. This information includes the services requested, the amount and frequency of the services, and the providers of the services.

- **Assuring Timely Submission of IHPs**

- The HCIA maintain a system for tracking when IHPs are due and will report to BWM if not submitted timely. Continuous problems with the timely submission of IHPs may lead to suspension or termination of the HCI.

- **Addendum to IHP**

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- This process provides the HCI and the waiver participant and consentor an opportunity to request a change to an approved IHP, which reflects a need for a change in waiver services. The Addendum is used when a waiver service is to be increased, decreased, added or discontinued. Any changes or additions to a waiver enrollee’s IHP must be authorized by the LDSS.
- **Incident Reporting Policy**
 - This policy describes the definition of various types of incidents, procedures, timelines and standardized forms for reporting these events, and outlines the providers’ responsibilities for investigation and resolution of all incidents. The policy includes actions taken by the observer of the incident, the HCI, HCIA, Service Providers, QMS’, Serious Incident Review Committee and BWM.
- **Examination of Claim Detail Reports**
 - OCFS has the ability to examine the claim detail reports of a waiver participant. This report is an accounting of all Medicaid expenditures for services for a waiver participant. This report can be compared to the IHP to identify discrepancies between services approved, provided and billed to Medicaid. This report also verifies the health and welfare of the waiver participant through the delivery of the authorized services.
- **Coordination with Other State Agencies**
 - BWM has developed relationships with other State agencies and organizations that regulate or provide services and supports to waiver participants and other special needs populations in the community. Through communication with agencies such as the Office of Mental Health, Office of Mental Retardation and Developmental Disabilities, Vocational and Educational Services for Individuals with Disabilities, and Office of Alcohol and Substance Abuse Services, BWM is aware of available services and the quality of providers, and can facilitate coordination among these services to promote the most effective and efficient use of all available services
- **Accessibility to Statewide Monitoring Systems**
 - BWM will initiate the development of Quality Advisory Boards, Regional Forums and a B2H Toll-free Warmline. The Quality Advisory Board will consist of QMSs, HCIAS, HCIs, Service Providers, Patient Advocacy Groups and waiver participants. These monitoring systems will provide BWM with data needed for any policy and procedure changes.
- **BWM Technical Assistance to HCIA**
 - BWM Staff is available to the HCIA, service providers and QMS to address questions regarding the waiver, provision of services and management of waiver activities.
- **HCIA and QMS Quarterly Meetings with BWM**
 - All HCIA and QMS staff meet with BWM Waiver Management Staff on a quarterly basis. New policies or program changes are presented, training is provided, and

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common problems are discussed.

- **HCIA/QMS Technical Assistance to Providers, Waiver participants and Family/Caregivers**
 - All HCIAS schedule regular training sessions for providers, waiver participants, consenters and family/caregiver. This will be done on a regional basis, with at least one occurring in each region. This is an opportunity for training and for the introduction and clarification of waiver policies. In addition, HCIA/QMS are available to provide technical assistance to individual agencies to address any problems or concerns that may arise. The HCIA/QMS are also available to waiver participants, consenters and family/caregiver who have questions or concerns regarding the waiver and services.
- **Accessibility of BWM Waiver Management Staff**
 - The BWM Staff visit regions regularly (at least annually) and are accessible to waiver participants, advocates and providers via phone, e-mail or in person.
- **Policy Clarification Letters**
 - When there is a change in statewide policy or procedure, letters are sent to providers by BWM to describe these new policies. Letters clarifying existing policies are also sent when necessary.
- **Directives to LDSSs**
 - BWM regularly sends the LDSS directives regarding changes in policies related to the waiver.
- **Technical Amendment Requests to CMS**
 - Any policy changes related to the agreement between the State and CMS must be submitted to CMS in a letter requesting a technical amendment to the waiver. These include the development of a new waiver service, modifying the definition of a waiver service, or amending the qualifications of a provider.

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Appendix I: Financial Accountability

APPENDIX I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

DOH is the State agency responsible for monitoring payments made under the NYS Medicaid Program. As part of this responsibility, DOH, the Office of the Medicaid Inspector General, conducts audits and reviews of various providers of Medicaid reimbursable services, equipment and supplies. These audits and reviews are directed at monitoring provider compliance with applicable laws, regulations, rules and policies of the Medicaid program as set forth by the Departments of Health and Mental Hygiene [Titles 10, 14 and 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York] and the eMedNY provider manuals. The OCFS BWM will review all audit results and will keep DOH informed of any issues or concerns.

To support the integrity of provider claims for Medicaid payment of waiver services, OCFS, in conjunction with DOH, the Office of the Medicaid Inspector General, will conduct audits and reviews of a sample of waiver service providers. These providers will be targeted via Data Warehouse monitoring and provider profiling which will identify claiming patterns that appear suspicious or aberrant. The Quality Management Specialist and the HCIA may also recommend providers to be audited and reviewed. Specifically, a random sample of providers and waiver services will be selected from the total paid claims for the calendar year most recently completed. The purpose of the review is to determine if the records maintained by waiver providers adequately support Medicaid claims for waiver services and if program guidelines have been met.

B2H, in accordance with the Single Audit Act Amendments of 1996, will be audited on a yearly basis by an independent auditing agency. OCFS will utilize the state's single audit firm for the audits of B2H. It may be necessary to switch independent auditing firms if the State's contract should change in the future.

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APPENDIX I-2: Rates, Billing and Claims

- a. Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

For each of the proposed waiver services, the state agencies and a group of experts established a set of functions and duties required to perform a specific waiver service. The group then established provider qualification related to those functions and duties. Based on the provider qualifications and salary and fringe benefit assumptions that existed in comparable service systems in New York's health care system, salary and fringe benefit allowances were established. Salary and fringe benefit allowances, supervisory span of control, other than personal service and agency administration and overhead percentages that are typical of agencies providing comparable HCBS waiver services in New York were established in an Upstate and Downstate configuration to account for geographic differences within the state. Separate fee for service rates were established for each waiver service and the same fee for service rate will apply to all providers within the geographic section. The Downstate rate will apply to waiver service providers in the five boroughs of New York City, Nassau, Suffolk, Orange, Rockland and Westchester counties. All providers in the remaining counties in the State will be subject to the Upstate rate. These rates, once finalized will be published and available to all willing and qualified providers.

- b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

In the B2H waiver, all waiver service providers will have Medicaid provider agreements, B2H waiver service billing codes and their claims for services delivered will go directly to the state's claims processing system, eMedNY.

In the eMedNY system, the reimbursement claims for the services provided are tested against whether the waiver service was provided to a Medicaid recipient who has been approved for this waiver, whether it has the right rate code and whether the waiver provider has been approved to provide the billed service.

The Medicaid providers are responsible for verifying the accuracy of appropriate Medicaid data, such as the Medicaid provider ID, Medicaid recipient ID, that the service was provided to an approved waiver participant and the rate code for the services provided.

- c. Certifying Public Expenditures** (*select one*):

Yes. Public agencies directly expend funds for part or all of the cost of waiver services and certify their public expenditures (CPE) in lieu of billing that amount to Medicaid (*check each that applies*):

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<input type="checkbox"/>	<p>Certified Public Expenditures (CPE) of State Public Agencies. Specify: (a) the public agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). <i>(Indicate source of revenue for CPEs in Item I-4-a.)</i></p>
<input type="checkbox"/>	<p>Certified Public Expenditures (CPE) of Non-State Public Agencies. Specify: (a) the non-State public agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). <i>(Indicate source of revenue for CPEs in Item I-4-b.)</i></p>
<input checked="" type="checkbox"/>	<p>No. Public agencies do not certify expenditures for waiver services.</p>

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- d. Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant’s approved service plan; and, (c) the services were provided:

When the payment claim is submitted to eMedNY, there are a series of edits performed that examines data validity. Some of the edits include: whether the waiver participant is Medicaid eligible; whether the individual was enrolled in the waiver program; and, whether the service providers are enrolled waiver service providers in NYS. Edits also exist to determine if waiver services are being claimed for time periods when the waiver participant was receiving other Medicaid services. Retrospective reviews focus on whether the services provided were part of the approved IHP and whether the amount of services had proper authorization. In addition, validation of services provided will occur through provider survey and participant satisfaction process. A process will be developed to compare claims data to the IHPs.

- e. Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §74.53.

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APPENDIX I-3: Payment

a. Method of payments — MMIS (*select one*):

<input checked="" type="checkbox"/>	Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).
<input type="checkbox"/>	Payments for some, but not all, waiver services are made through an approved MMIS. Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64.
<input type="checkbox"/>	Payments for waiver services are not made through an approved MMIS. Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:
<input type="checkbox"/>	Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS. Describe how payments are made to the managed care entity or entities:

b. Direct payment. Payments for waiver services are made utilizing one or more of the following arrangements (*check each that applies*):

<input type="checkbox"/>	The Medicaid agency makes payments directly to providers of waiver services.
<input checked="" type="checkbox"/>	The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.
<input type="checkbox"/>	The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent. Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:
<input type="checkbox"/>	Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity. Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

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- c. **Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

<input checked="" type="radio"/>	No. The State does not make supplemental or enhanced payments for waiver services.
<input type="radio"/>	Yes. The State makes supplemental or enhanced payments for waiver services. Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made and (b) the types of providers to which such payments are made. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

- d. **Payments to Public Providers.** *Specify whether public providers receive payment for the provision of waiver services.*

<input checked="" type="radio"/>	Yes. Public providers receive payment for waiver services. Specify the types of public providers that receive payment for waiver services and the services that the public providers furnish. <i>Complete item I-3-e.</i>
County mental health agencies may choose to participate in the B2H waiver. These entities can provide any waiver service; providing they meet the qualifications established in Appendix C of this application.	
<input type="radio"/>	No. Public providers do not receive payment for waiver services. <i>Do not complete Item I-3-e.</i>

- e. **Amount of Payment to Public Providers.** Specify whether any public provider receives payments (including regular and any supplemental payments) that in the aggregate *exceed* its reasonable costs of providing waiver services and, if so, how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

<input type="radio"/>	The amount paid to public providers is the same as the amount paid to private providers of the same service.
<input type="radio"/>	The amount paid to public providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.
<input type="radio"/>	The amount paid to public providers differs from the amount paid to private providers of the same service. When a public provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report. Describe the recoupment process:

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- f. Provider Retention of Payments.** Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

<input checked="" type="radio"/>	Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.
<input type="radio"/>	Providers do not receive and retain 100 percent of the amount claimed to CMS for waiver services. Provide a full description of the billing, claims, or payment processes that result in less than 100% reimbursement of providers. Include: (a) the methodology for reduced or returned payments; (b) a complete listing of types of providers, the amount or percentage of payments that are reduced or returned; and, (c) the disposition and use of the funds retained or returned to the State (i.e., general fund, medical services account, etc.):
<input type="radio"/>	Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment. Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

g. Additional Payment Arrangements

- i. Voluntary Reassignment of Payments to a Governmental Agency.** *Select one:*

<input type="radio"/>	Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e). Specify the governmental agency (or agencies) to which reassignment may be made.
<input checked="" type="radio"/>	No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

- ii. Organized Health Care Delivery System.** *Select one:*

<input type="radio"/>	Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10. Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:
<input checked="" type="radio"/>	No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.

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iii. **Contracts with MCOs, PIHPs or PAHPs.** *Select one:*

<input type="radio"/>	The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may <i>voluntarily</i> elect to receive <i>waiver</i> and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.
<input type="radio"/>	This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain <i>waiver</i> and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.
<input checked="" type="checkbox"/>	The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

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APPENDIX I-4: Non-Federal Matching Funds

- a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Check each that applies:*

<input type="checkbox"/>	Appropriation of State Tax Revenues to the State Medicaid agency
<input checked="" type="checkbox"/>	<p>Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency. If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by public agencies as CPEs, as indicated in Item I-2-e.</p> <p>The General Fund (state tax revenue supported) state share for Medicaid is also appropriated in the NYS Office of Mental Health (OMH), Office of Mental Retardation and Developmental Disabilities (OMRDD), OCFS, Office of Alcoholism and Substance Abuse Services, and State Education Department budgets. Funds are transferred from these agencies, upon approval from the NYS Director of Budget, to the Department of Health using the certificate of approval process (funding control mechanism specified in the State Finance Law, or through journal transfers to DOH).</p>
<input checked="" type="checkbox"/>	<p>Other State Level Source(s) of Funds. Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by public agencies as CPEs, as indicated in Item I-2- c.</p> <p>Medicaid State share is also provided through appropriations in DOH for funds (net of any federal share) received from drug rebates, audit recoveries and refunds, and third party recoveries; assessments on nursing home and hospital gross revenue receipts; and Health Care Reform Act (HCRA) revenues. Appropriations in OMRDD for the Mental Hygiene Patient Income Account and in OMH for HCRA also fund the state share of Medicaid and are transferred to DOH.</p>

- b. Local or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Check each that applies:*

<input checked="" type="checkbox"/>	<p>Appropriation of Local Revenues. Specify: (a) the local entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by public agencies as CPEs, as specified in Item I-2- c:</p> <p>Counties in New York State and the City of New York have the authority to levy taxes and other revenues. These local entities may raise revenue in a variety of ways including taxes, surcharges and user fees. The State, through a state/county agreement, has an established system by which local entities are notified at regular intervals of the local share of Medicaid</p>
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	expenditures for those individuals for which they are fiscally responsible. In turn, the local entities remit payment of these expenditures directly to the State.
<input type="checkbox"/>	Other non-State Level Source(s) of Funds. Specify: (a) the source of funds; (b) the entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by public agencies as CPEs, as specified in Item I-2- c:
<input type="checkbox"/>	Not Applicable. There are no non-State level sources of funds for the non-federal share.

c. **Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources. *Check each that applies.*

<input checked="" type="checkbox"/>	Provider taxes or fees
<input type="checkbox"/>	Provider donations
<input type="checkbox"/>	Federal funds (other than FFP)
	For each source of funds indicated above, describe the source of the funds in detail: The State utilizes revenue from the following health provider tax programs to assist in financing its overall health care delivery system: <ul style="list-style-type: none"> • Surcharges on net patient services revenue for certain hospitals and comprehensive clinics • An assessment on general hospitals' gross inpatient hospital revenue • An assessment on certain hospitals' gross receipts for patient care services and other operating revenue • An assessment on certain nursing homes' gross receipts for patient care services and other operating revenue
<input type="checkbox"/>	None of the foregoing sources of funds contribute to the non-federal share of computable waiver costs.

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APPENDIX I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

<input type="radio"/>	No services under this waiver are furnished in residential settings other than the private residence of the individual. <i>(Do not complete Item I-5-b).</i>
<input checked="" type="radio"/>	As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual. <i>(Complete Item I-5-b)</i>

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

Room and Board costs, as defined by federal regulation, are included in only two (2) B2H waiver services, and then only for subsets of those services. They are: Daily/Overnight Out-of-home Planned Respite Services that are provided in a qualifying residence or facility and Daily/Overnight Crisis Respite services that are provided in a qualifying residence or facility. Those two sub-sets have rate methodologies that include room and board costs, in accordance with 42 CFR 441.310(a) (2).

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APPENDIX I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver.

Select one:

<input type="radio"/>	<p>Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services. <i>The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:</i></p> <div style="border: 1px solid black; height: 40px; width: 100%; background-color: #e0e0e0;"></div>
<input checked="" type="radio"/>	<p>No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.</p>

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APPENDIX I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing

- a. **Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services as provided in 42 CFR §447.50. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

<input checked="" type="checkbox"/>	No. The State does not impose a co-payment or similar charge upon participants for waiver services. <i>(Do not complete the remaining items; proceed to Item I-7-b).</i>
<input type="checkbox"/>	Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services. <i>(Complete the remaining items)</i>

- i. **Co-Pay Arrangement** Specify the types of co-pay arrangements that are imposed on waiver participants *(check each that applies):*

<i>Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):</i>	
<input type="checkbox"/>	Nominal deductible
<input type="checkbox"/>	Coinsurance
<input type="checkbox"/>	Co-Payment
<input type="checkbox"/>	Other charge <i>(specify):</i>

- ii **Participants Subject to Co-pay Charges for Waiver Services.** Specify the groups of waiver participants who are subject to charges for the waiver services specified in Item I-7-a-iii and the groups for whom such charges are excluded. The groups of participants who are excluded must comply with 42 CFR §447.53.

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- iii. **Amount of Co-Pay Charges for Waiver Services.** In the following table, list the waiver services for which a charge is made, the amount of the charge, and the basis for determining the charge. The amount of the charge must comply with the maximum amounts set forth in 42 CFR §447.54.

Waiver Service	Amount of Charge	Basis of the Charge

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iv. Cumulative Maximum Charges. Indicate whether there is a cumulative maximum amount for all co-payment charges to a waiver participant (*select one*):

<input type="radio"/>	There is no cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant.
<input type="radio"/>	There is a cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant. Specify the cumulative maximum and the time period to which the maximum applies:

v. Assurance. In accordance with 42 CFR §447.53(e), the State assures that no provider may deny waiver services to an individual who is eligible for the services on account of the individual's inability to pay a cost-sharing charge for a waiver service.

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants as provided in 42 CFR §447.50. *Select one*:

<input checked="" type="checkbox"/>	No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.
<input type="checkbox"/>	Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement. Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income as set forth in 42 CFR §447.52; (c) the groups of participants subject to cost-sharing and the groups who are excluded (groups of participants who are excluded must comply with 42 CFR §447.53); and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

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Appendix J: Cost Neutrality Demonstration

Appendix J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the following table for each year of the waiver.

Level(s) of Care (<i>specify</i>):							
Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Column 7 less Column 4)
1	17,545	10,513	28,058	126,684	44,421	171,105	143,047
2	30,018	10,944	40,963	131,878	46,242	178,120	137,158
3	32,431	11,393	43,824	137,285	48,138	185,423	141,600
4							
5							

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Appendix J-2 - Derivation of Estimates

- a. Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table J-2-a: Unduplicated Participants				
Waiver Year	Total Number Unduplicated Number of Participants (From Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)		
		Level of Care:		Level of Care:
		RTF	SNF	ICF
Year 1	540	431	14	95
Year 2	1,442	1,154	36	252
Year 3	3,479	2,783	87	609
Year 4 (renewal only)				
Year 5 (renewal only)				

- b. Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in Item J-2-d.

The calculation of average length of stay in the waiver assumes waiver participants continually flow into the waiver whenever an enrollment opportunity is available. A turnover rate of 10 percent per year and the phase-in assumptions provide the number of enrollment days, which was divided by the number of unduplicated enrollees to arrive at average length of stay by year.

- c. Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

- i. Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

OCFS examined the foster care population and met with providers and clinicians to assess the unmet needs of the children in foster care. OCFS coordinated with representatives from various New York State agencies (DOH, OMR-DD and OMH) and representatives of service providers, including those who participate in other HCBS waiver programs. For each of the proposed services, the workgroup reviewed other waiver programs and existing care requirements of similar populations to estimate the intensity of services (utilization). In developing the cost estimates, the workgroup established provider qualifications which were equitable with the provider qualifications in other approved waivers or which met the special needs of these waiver participants. For each of the proposed waiver services, either an hourly or monthly rate was established to fund the waiver service at the qualifications proposed by the workgroup and the anticipated use of service by the children participating in the waiver.

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- ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Attachment 2 contains Medicaid cost data for State Plan Medicaid services that are supplied to children in foster care. Medicaid expenditures, for other institutional care, are detailed by type of expenditure (i.e. physician, dental, eye care, etc.). To calculate Factor D', the Medical Consumer Price Index from the Bureau of Labor Statistics was applied to the average annual cost per member per year. Attachment 2 shows this calculation in detail.

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- iii. Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

OCFS obtained institutional cost data for the calendar year ending December 31, 2005 from DOH. These Medicaid expenditures, contained in Attachment 3 to this application, represent those made on behalf of children residing in Residential Treatment Facilities (“RTF”) which are a sub-set of Inpatient Psychiatric Hospital as defined in New York’s Mental Hygiene Law Title A Article 1 or Skilled Nursing Facilities (“SNF”). The average inpatient cost per person is calculated using items #91 (RTF) and #92(SNF) for each population respectively. The calculation for children in an RTF is based on RTF costs rather than inpatient psychiatric hospital costs since in New York State children under the age of 18 are admitted to an RTF rather than an inpatient psychiatric hospital for serious emotional disturbances. The Factor G for children admitted to a Intermediate Care Facility (“ICF) comes from the New York State Care at Home VI Waiver (Waiver # 40200.90.R1)

The sum of the three individual Factor Gs (RTF, SNF and ICF) is weighted by the anticipated level of care placement for foster care children absent their participation in the waiver to produce the Overall Factor G, which can be seen in Attachment 4. The Factor G for 2005 was adjusted by Medical Consumer Price Index.

- iv. Factor G’ Derivation.** The estimates of Factor G’ for each waiver year are included in Item J-1. The basis of these estimates is as follows:

OCFS secured level of care actual cost data for the calendar year ending December 31, 2005 from DOH. These Medicaid expenditures, contained in Attachment 3 to this application, represent those made on behalf of children residing in RTFs or SNFs. Costs excluding inpatient costs are used to calculate the average per person costs. The calculation for children in an RTF is based on RTF costs rather than inpatient psychiatric hospital costs since in New York State children under the age of 18 are admitted to an RTF rather than an inpatient psychiatric hospital for serious emotional disturbances. The Factor G’ for children admitted to a Intermediate Care Facility (“ICF) comes from the New York State Care at Home VI Waiver (Waiver # 40200.90.R1)

The sum of the three individual Factor G’s (RTF, SNF and ICF) is weighted by the anticipated level of care placement for foster care children absent their participation in the waiver to produce the Overall Factor G’, which can be seen in Attachment 4. The Factor G’ for 2005 was adjusted by Medical Consumer Price Index.

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d. **Estimate of Factor D.** *Select one:* Note: Selection below is new.

<input checked="" type="radio"/>	The waiver does not operate concurrently with a §1915(b) waiver. Complete Item J-2-d-i
<input type="radio"/>	The waiver operates concurrently with a §1915(b) waiver. Complete Item J-2-d-ii

i. **Estimate of Factor D – Non-Concurrent Waiver.** Complete the following table for each waiver year

Waiver Year: Year 1					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/Unit	Total Cost
Health Care Integration	per month	540	4	1,468.25	3,362,574
Family/Caregiver Supports and Services	per hour	372	102	38.92	1,482,923
Skill Building	per hour	372	102	38.92	1,482,923
Day Habilitation	per hour	14	307	38.92	170,531
Educational training and support	per hour	459	8	55.04	214,289
Vocational Services – Prevocational Services	per hour	32	106	43.99	151,118
Vocational Services – Supported Employment	per hour	32	106	43.99	151,188
Respite Services	per hour	448	102	39.10	1,784,363
Crisis Avoidance & Management and training	per hour	533	13	58.02	415,322
Immediate crisis response services	per hour	267	6	58.02	37,705
Intensive in-home supports and services	per hour	267	5	58.02	76,507
Crisis Respite	per hour	133	8	41.51	46,941
Flex Funds	per year	0	0	800.00	0
Adaptive and assistive equipment	per year	44	0	1338.00	20,830
Accessibility modifications	per year	65	0	1196.00	27,433
GRAND TOTAL:					9,474,310
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					540
FACTOR D (Divide grand total by number of participants)					17,545
AVERAGE LENGTH OF STAY ON THE WAIVER					129

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Waiver Year: Year 2					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Health Care Integration	per month	1,442	7	1,528.45	15,361,734
Family/Caregiver Supports and Services	per hour	993	168	40.52	6,777,842
Skill Building	per hour	993	168	40.52	6,777,842
Day Habilitation	per hour	38	505	40.52	774,962
Educational training and support	per hour	1,226	14	57.30	978,966
Vocational Services – Prevocational Services	per hour	87	174	45.79	690,376
Vocational Services – Supported Employment	per hour	87	174	45.79	690,376
Respite Services	per hour	1,197	167	40.70	8,149,038
Crisis Avoidance & Management and training	per hour	1,424	22	60.40	1,898,267
Immediate crisis response services	per hour	712	9	60.40	399,635
Intensive in-home supports and services	per hour	712	8	60.40	349,681
Crisis Respite	per hour	356	14	43.21	214,546
Flex Funds	per year	7	1	800.00	3,350
Adaptive and assistive equipment	per year	117	1	1392.86	94,785
Accessibility modifications	per year	173	1	1245.04	125,133
GRAND TOTAL:					43,286,532
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					1,442
FACTOR D (Divide grand total by number of participants)					30,018
AVERAGE LENGTH OF STAY ON THE WAIVER					212

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Waiver Year: Year 3					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Health Care Integration	per month	3,479	7	1591.11	40,037,501
Family/caregiver Supports and Services	per hour	2,396	175	42.18	17,665,183
Skill Building	per hour	2,396	175	42.18	17,665,183
Day Habilitation	per hour	91	524	42.18	2,019,794
Educational training and support	per hour	2,957	14	59.65	2,551,493
Vocational Services – Prevocational Services	per hour	209	181	47.67	1,799,336
Vocational Services – Supported Employment	per hour	209	181	47.67	1,799,336
Respite Services	per hour	2,888	174	42.37	21,238,950
Crisis Avoidance & Management and training	per hour	3,436	23	62.88	4,947,481
Immediate crisis response services	per hour	1,718	10	62.88	1,041,575
Intensive in-home supports and services	per hour	1,718	8	62.88	911,378
Crisis Respite	per hour	859	14	44.98	559,174
Flex Funds	per year	35	1	800.00	16,775
Adaptive and assistive equipment	per year	283	1	1449.97	247,039
Accessibility modifications	per year	417	1	1296.08	326,136
GRAND TOTAL:					112,826,332
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					3,479
FACTOR D (Divide grand total by number of participants)					32,431
AVERAGE LENGTH OF STAY ON THE WAIVER					220

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Attachment 1
Key Terms

Caregiver –	Any individual, such as a parent, foster parent, or head of a household, who attends to the needs of a child.
Consenter –	The person or governmental entity legally authorized to give medical consent
Family –	Individuals and members of households involved with the waiver enrollees life; this may include the foster family, biological family and/or adoptive family
Home –	A dwelling place together with the family or social unit that occupies it.
OCFS -	New York State Office of Children and Family Services
Not-for-Profit Voluntary Authorized Agency (VAA)	defined in social service law section 371(10) (a). “Authorized agency” means (a) Any agency, association, corporation, institution, society or other organization which is incorporated or organized under the laws of this state with corporate power or empowered by law to care for, to place out or to board out children, which actually has its place of business or plant in this state and which is approved, visited, inspected and supervised by the department (now OCFS) or which shall submit and consent to the approval, visitation, inspection and supervision of the department as to any and all acts in relation to the welfare of children performed or to be performed under this title. The use of the term voluntary eliminates a social services district.
Waiver Participant –	An individual participating in the waiver. This includes children who are currently enrolled in the foster care system as well as those who were enrolled in foster care but have since been discharged but continue to be enrolled in the waiver. Because waiver participants can range from infants to youth age 20, the waiver application assumes that the sharing of information and involvement in meetings will be appropriate to the child’s age and capacity. The B2H waiver is designed to maximize the child’s involvement where appropriate and possible.