NEW YORK STATE OF OPPORTUNITY

Office for People With Developmental Disabilities

Guidance for ICF Conversions with No Change in Capacity

April 2015

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I. Introduction – OPWDD's Residential Transformation

Supporting individuals moving out of institutional settings and into the community is a critical component of OPWDD's system transformation. In July 2013, OPWDD announced it would close four of its six developmental centers (DCs), and retain an institutional capacity at the remaining two facilities. Those two DCs will support individuals with intensive behavioral needs who require stabilization in a focused, intensive treatment setting prior to returning to a community setting.

In addition, OPWDD has received approval from the federal Centers for Medicare & Medicaid Services (CMS) for an ambitious ***ICF Transition Plan*** (http://www.opwdd.ny.gov/node/4971) which would over time shift the developmental disabilities service system's reliance on the Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IIDs) institutional model of care to more integrated, community-based supports. Through the ICF Transition Plan, OPWDD will decrease the number of individuals supported in ICF/IIDs each year through October 1, 2018, at which time the only ICF/IID capacity that will remain is that contained in the Children's Residential Programs. The only campus-based capacity remaining will be 150 opportunities for intensive assessment and treatment for individuals who require those services prior to community placement. The Plan also stipulates that OPWDD will increase its use of Supportive and Supervised Individualized Residential Alternatives (IRAs) over the same time period. Finally, OPWDD is committed to supporting more individuals to live in non-certified residential settings and is actively exploring ways to access these settings and support individuals with developmental disabilities who choose them.

In support of the DC closures and the ICF Transition Plan, OPWDD has joined the New York State Money Follows the Person (MFP) Demonstration and the Balancing Incentives Program (BIP), both of which bring additional resources to New York State in support of a more balanced system of long-term supports and services. Through these programs OPWDD will be actively assisting individuals with developmental disabilities in moving from campus and community-based ICFs and nursing homes into private homes, apartments, or other community residential settings. Some individuals will move out of ICFs and DCs, while others may remain living in their current location, but experience greater community integration as ICFs (an institutional program model) convert to IRAs. In addition, OPWDD recognizes that the Olmstead mandate applies to each and every individual we support, and to fulfill that mandate will mean that OPWDD also supports individuals living in community settings now to continue to experience greater community integration and independence in their living arrangements. OPWDD will be exploring ways to ensure that the individuals it supports ─ whether currently living in a group home, family care or in an institutional setting ─ have the opportunity to be supported in the most integrated setting appropriate for them.

A. Implementing the ICF Transition Plan

OPWDD has issued an ***ICF Transition Plan Implementation Strategy*** (http://www.opwdd.ny.gov/transformation-agreement/mfp/ICF_Transitions) which describes OPWDD's intent to prepare the developmental disabilities service system to dramatically reduce its reliance on institutional models of residential support over the next few years and the activities it will undertake to achieve its goals. It describes how achieving the kind of transformative change embodied in the ICF Transition Plan will require several strategies including ICF downsizing and closure as well as the conversion of some ICFs to community-integrated waiver service settings. The ICF Transition Plan Implementation Strategy lays out the kinds of analyses that OPWDD and its service providers must undertake to prepare for all of the ICF transitions. OPWDD is placing the highest attention and priority to supporting and assuring that the necessary person-centered planning occurs for each person affected by an ICF conversion, downsizing and closure. These changes must result in individualized plans of service that truly reflect the person's informed choice of where to live and his or her unique goals and ambitions. The concurrent promulgation of new Home and Community Based Services (HCBS) settings and Person-Centered Planning (PCP) regulations by CMS means that as OPWDD and its providers undertake this shift from institutional services to community-based services, we will do so ensuring the greatest degree of community integration, choice and autonomy possible for each transitioning individual.

B. Overview of Conversion Processes

This guidance document is intended to summarize in one place the many tracks of activity that providers must initiate when they seek to convert an ICF operation to a community-based HCBS waiver residential opportunity with no change in capacity. **The first step in the process is to submit an ICF Conversion Proposal using the ICF Transition Proposal Template (**http://www.opwdd.ny.gov/transformation-agreement/mfp/ICF_Transitions) **to your respective Developmental Disabilities Regional Office (DDRO) and to Community.Transitions@opwdd.ny.gov** (See Section VII. ICF Conversion Contact Information). The Division of Person Centered Supports (DPCS) and the Division of Quality Improvement (DQI) will review Sections F and G of the proposal, respectively, and follow up with any outstanding questions or concerns directly with the provider. Once the provider has submitted the conversion proposal, the provider may initiate the processes for obtaining all necessary approvals to convert the ICF. The graphics below summarize the processes required, many of which can begin simultaneously.

Conversion Proposal Review Process	Responsible Party
Submit conversion proposal to DDRO and Community.Transitions@opwdd.ny.gov and begin the processes described on p. 6 to convert ICF to an IRA.	ICF Provider
DDRO indicates support of the project.	DDRO
Review Proposal for Compliance with HCBS Settings Standards Rule.	Division of Quality Improvement
Review Proposal for Person-Centered Planning for Improved Community Integration and Autonomy for Individuals.	Division of Person Centered Supports
After all other required processes are complete, the Operating Certificate for the IRA is issued.	Division of Quality Improvement

ICF Conversion Processes

Certification of Need	•Obtaining approval for program change from local planning body	***Start immediately***
Notification	•Notifying individuals and their families/advocates of the program changes	***Start immediately***
Obtain Correct Provider Agreement/ Billing Codes	•Obtaining correct provider agreement and billing codes for new services	***Start immediately***
Quality Assurance Review	•Pass Site Certification & obtain Operating ***and*** Certificate for new program from OPWDD	***Start after CON is approved provider has received CPPC Form***
Money Follows the Person Requirements	•Confirm individuals' MFP eligibility and report to OPWDD	***Start immediately***
Person-Centered Planning	•Plan for successful transition to community services and supports	***Start immediately***
MSC and Waiver Enrollment	•Obtain Medicaid Service Coordination, Conduct Person-Centered Planning for Community Services, Waiver enrollment	***Start immediately***
Benefits Enrollment for Individuals	•Ensure individuals are enrolled in all available benefits programs	***Start immediately***

II. Processes Required for Conversion of the Site

A. Certification of Need (CON)

Pursuant to Mental Hygiene Law §16.09, an agency must get approval from the Commissioner of OPWDD before commencing with a change to any public or private facility which requires an Operating Certificate (OC). Pursuant to 14 NYCRR 620, the Certification of Need (CON) process requires an individual, association, corporation, or public or private agency to submit an application to OPWDD for authorization to proceed with projects described in the regulation, and the process of converting an ICF to an IRA requires the provider to complete the CON application process. The CON process ensures that all program development projects requiring an OPWDD OC are included in the plans of statewide, regional and county authorities. It also provides the Commissioner with the opportunity to modify the parameters of the proposed program, including type, capacity, or even continued inclusion in the statewide plan. The process expedites the review of projects that are in conformance with the statewide plan to allow for the development and operation of needed and appropriate programs without delay.

Different types of projects require different types of CON review. A project will be classified as an Administrative Review Project or a Substantial Review Project, as defined in regulation and further described in OPWDD's Guidance on the Certification of Need Process http://www.opwdd.ny.gov/opwdd_resources/opwdd_forms/ CONGuidanceDoc). Each type of CON review has distinct review activities and timelines for the review. Providers should consult these guidelines to determine the category of their ICF conversion proposal.

Certification of Need

- Provider agency contacts OPWDD Regional Office (DDRO) to initiate CON Process.
- Provider agency submits CON application to DDRO.
- DDRO staff review CON application.
- DDRO staff send CON application to county for approval.
- County reviews CON application.
- County decision received by DDRO.
- DDRO sends conditional approval letter to provider agency and OPWDD's Division of Quality Improvement to start certified site survey process.
- Development Process continues.
- DQI issues Operating Certificate.

Only one CON application will be required for converting one ICF to an IRA. A separate CON application will be required for each ICF operating certificate that will change.

Prior to formal submission of a CON application, and as early as possible, the applicant must consult with applicable local authorities, local governmental units (LGUs) and the appropriate local health systems agency (HSA) to ensure that the proposed project is needed and appropriate. If a project should, at the time it moves forward to completion, result in an increase in cost or in individual program capacity or a change in the class of OC approved at the time of original CON application, it is necessary to submit an amended application for the CON to address the change(s).

B. Notification to Individuals and their Correspondents/Advocates

Providers converting their ICF residences to Individualized Residential Alternatives (IRAs) must notify the individuals residing in the ICF of the planned changes. If, after meeting with the individuals and their advocates to discuss the conversion of the ICF, an individual plans to remain in the home when it converts to an IRA, the provider should notify the individual and his or her correspondent of the planned changes in writing, at least 30 days prior to the conversion. A template letter is provided for such notifications (See Section VI. Forms and Related Helpful Resources/Guidance).

To ensure that individuals, families, advocates and correspondents (including the Consumer Advisory Board [CAB] for Willowbrook class members) understand the proposed changes, the timeline for such changes, and how each person's needs will continue to be met when the facility converts to an IRA, providers are advised to involve the individual, his or her family members, advocates and the CAB in the planning discussions *well ahead* of any formal notification. This document describes best practices and resources for effective communications practices. As planning continues for the individuals who reside in the ICF, the provider should provide each person and his/her advocates:

- written notice of the conversion; and
- the opportunity to ask questions and request changes to his or her existing service plan, or to request a transfer to another ICF; and
- the opportunity to meet with appropriate staff to discuss any objections or concerns with the proposed conversion.

At a minimum, the notified parties must include the individual and the individual's correspondent, Mental Hygiene Legal Service (MHLS), and for the Willowbrook Class members only, the plaintiffs' attorney and others designated by the Willowbrook Permanent Injunction. Written notice must be provided in plain language and in the preferred language of the individual and his correspondent, who could be the individual's guardian, family member, or other close friend. Documentation of all notifications sent and received, including dates, should be kept in the individual's record. An example of an acceptable notification letter is provided in the appendices to this guidance.

If the provider proposes to discharge an individual from the residence, written notification must be provided to the individual and their correspondent, as well as MHLS and for Willowbrook Class members, the plaintiff's attorneys. If any such person objects to a proposed discharge, the provider is required to comply with the requirements of 14 NYCRR 633.12.

Alternatively, if the provider proposes to discharge an individual from the residence and offer a placement in another location, the provider must notify, in writing, the individual, his/her correspondent, MHLS and for Willowbrook Class members, the plaintiff's attorneys *and* comply with the due process requirements of 42 CFR 483.440, 14 NYCRR 633.12 and the Community Placement Policy (the "Greenbook"). If any such person objects to a proposed discharge, the provider is required to comply with the requirements of 14 NYCRR 633.12.

C. Fiscal Approval

Beyond the CON application process, no fiscal information or application is required from ICF providers proposing to convert to IRA operations. OPWDD Central Office staff will review and approve reimbursement for each proposal based on the provider's July 1, 2014 ICF funding (net of day services and tax assessment reimbursement) and IRA reimbursement rates, to arrive at a funding plan that is revenue neutral to the provider.

Fiscal Reimbursement

Once support of the project has been obtained from the DDRO, and the Division of Person-Centered Supports and the Division of Quality Improvement have reviewed and approved the proposal, the OPWDD Budget Office completes a fiscal analysis.

The Budget Office shares the analysis with the DDRO. The DDRO shares it with the provider for approval.

The provider indicates approval of the proposed reimbursement for the new IRA by sign off on the ICF conversion fiscal template.

DDRO notifies OPWDD Budget Office of provider sign-off and initiates an Assistive Support Price to ensure the revised reimbursement is revenue neutral to the provider.

Specifically, the Central Budget Office will calculate the supplemental payment (if necessary) that will be made to ensure revenue neutrality to the provider and notify the DDRO, which in turn, will notify the provider of the calculated reimbursement for the proposal. The provider must indicate its agreement to the reimbursement offered by returning a PDF version of the ICF Revenue Neutral Conversion Template with the agency signature block completed to the DDRO (bottom right hand corner of template). The DDRO will then inform the OPWDD Budget Office of the provider's sign-off and initiate an Assistive Support Price to implement the agreed upon level of reimbursement.

For additional detail regarding such conversions, please see OPWDD's Fiscal Policy for ICF Conversions. (See Section VI. Forms and Related Helpful Resources/Guidance.)

D. HCBS Waiver Provider Agreement/Provider Billing Code Requirements

1. Waiver Provider Agreement

When a provider wishes to convert an ICF to an IRA, the provider must ensure that it has an appropriate Provider Agreement in place with OPWDD, authorizing it to provide HCBS Waiver services. If it does not have the appropriate agreement, it must work with the Regional Office of OPWDD to obtain the agreement. The provider should notify the DDRO in writing of their need for either a Provider Agreement (if one does not currently exist for that provider) or an amendment to the Provider Agreement is required. Upon this request, the DDRO will initiate a new HCBS Waiver Provider Agreement or amendment as needed and will submit required documents to the DDRO Director and Associate Deputy Commissioner for signatures.

Once the necessary dates/signatures are completed, the DDRO forwards the Waiver Provider Agreement documents (including a copy of the agency Board of Directors with names, positions held on the Board and contact information) to the DQI for review. DQI's review consists of agency compliance in the areas of survey, incident management, fiscal reporting and viability, and audit services. Once approved, DQI will issue an authorization letter to the agency listing all approved services with an effective date of service. At this time DQI will also inform the Central Operations unit of the authorization in order for them to begin the Medicaid Provider ID process if needed (See Section 2. Provider Billing Code below).

In the event that an agency is not authorized to receive a Provider Agreement, DQI will notify the DDRO of the reason and will request that the DDRO inform the agency of the reason for denial. Once the needed corrections have been made, the DDRO will resubmit the waiver Provider Agreement packet.

2. Provider Billing Code

In order to bill Medicaid for IRA services, a provider must have a provider ID (also called a MMIS Number or Medicaid Provider ID) specific to IRA residential habilitation services (Supervised or Supportive). When a new IRA is being developed or when an ICF is proposed for conversion to an IRA, DDRO staff must send an email to OPWDD’s Central Operations unit’s shared email account Central.Operations@opwdd.ny.gov (subject line must say “New IRA Res Hab”) identifying:

- the provider agency,
- the target open date, and
- the designation of the new IRA as Supervised or Supportive.

Central Operations will verify whether the provider has the necessary MMIS Provider ID to bill the Residential Habilitation services once the site is certified, and link the provider’s ID to the site. Central Operations will send a Medicaid application

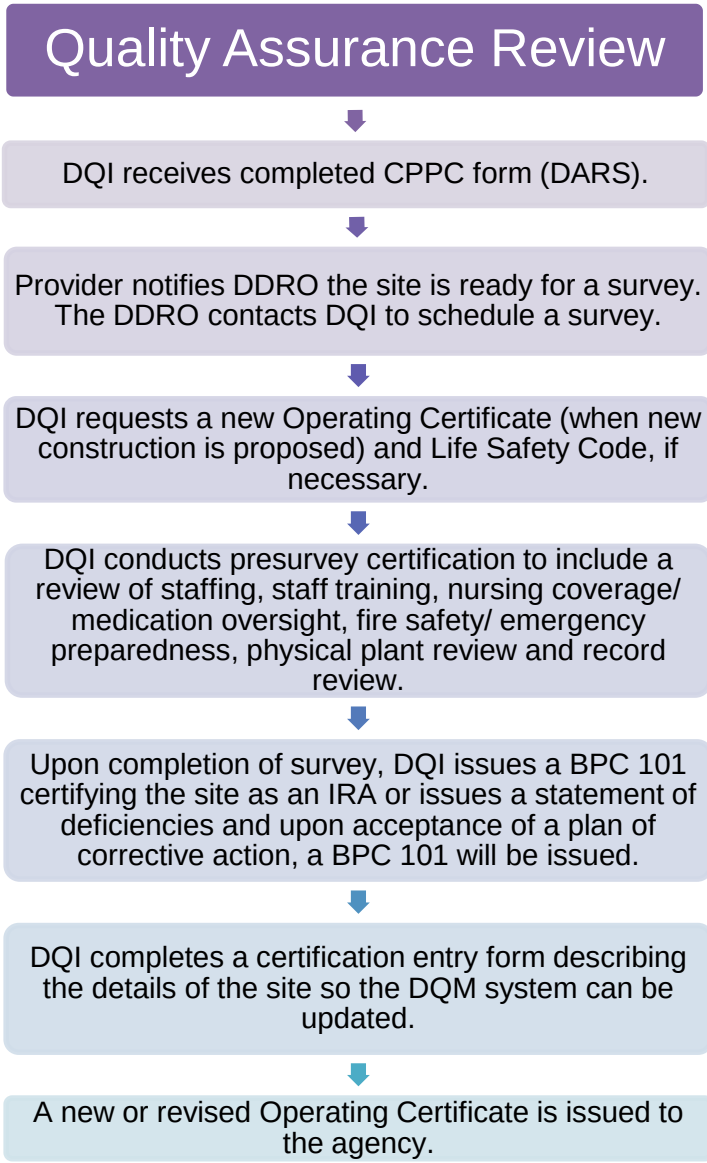
to the provider to complete, with a copy of the approved authorization to provide services. The provider must then complete the Medicaid application and submit it directly to the NYS Department of Health (DOH) per instructions included with the application. DOH has 90 days to process the application, assuming there are no errors that need to be addressed.

E. Quality Assurance Review

To open a new certified setting such as a new IRA, a provider must pass a site survey by OPWDD's Division of Quality Improvement (DQI) in order to receive an Operating Certificate (OC) for the new program. While it does complete a site survey for ICF conversions, DQI does not issue a new OC when a provider is proposing a change to an existing certified site. Instead, it reissues a modified OC for the changed program site.

Once the CON is approved and DQI receives the Confirmation to Proceed with Program Certification (CPPC) Form (also known as the DARS form) from OPWDD's Budget Office, survey staff will conduct a pre-opening survey to ensure:

- The provider has completed all required documents in accordance with established timelines and meets all regulatory requirements.
- The physical plant of the facility is in move-in, operational condition on the date of the pre-opening DQI visit with all health and safety features operational.
- The program's staffing adequate to meet individuals' needs (i.e. sufficient staff are hired and trained).



1. Prior to the Site Survey

Prior to the survey, the provider must receive an approved Certificate of Need (CON) and the DDRO must initiate a CPPC for circulation and sign-off by OPWDD Central Office staff. After the appropriate signatures are on the CPPC, the DDRO sends the completed form to DQI. Once the CON is approved, the CPPC is complete, and the site is ready for certification, the provider should contact the local DDRO and request a site survey. The ICF provider must also submit an “opt out” letter to the regional DQI office that documents the agency’s request to voluntarily withdraw from the ICF program and the desired date for the conversion. (See Appendix B for a sample opt out letter and the elements it should contain.) The DDRO will arrange a survey with the DQI. Or alternatively, in lieu of a site visit, DQI can request records information be provided to survey staff for review at the DQI office. During this process, the facility will continue to provide services to the individuals as an Intermediate Care Facility. There can be no breaks in certification. As part of the ICF conversion process,

2. Life Safety Code Survey

Some sites will also require a Life Safety Code (LSC) survey. DQI management will determine if a LSC survey is required based on the size of the house and the ability of the provider to evacuate all the residents within 3 minutes. If a house is certified for 9 or more individuals, or individuals cannot completely evacuate within three minutes, a LSC is required. In addition, if the proposed site is already LSC certified, and has had a LSC survey in the past year, no LSC survey is required. Finally, if the proposed IRA is “new construction” and the agency is choosing to be LSC certified, an OFPC survey will be conducted. If a LSC visit is to occur, DQI will contact the NYS Office of Fire Prevention and Control (OFPC) to conduct the LSC survey. It usually takes approximately 1 to 2 weeks to schedule this visit. If a LSC review is not needed, DQI can complete a paper review at the provider agency’s main office.

Scenario	**Life Safety Code Required (Y/N)**
Proposed IRA is certified for 9 or more individuals	Yes
Proposed IRA individuals cannot evacuate completely in 3 minutes	Yes
Site already LSC certified, but LSC survey is more than 1 year old	Yes
Agency chooses to meet LSC survey for new construction	Yes
Proposed new construction is for fewer than 9 individuals, individuals can completely evacuate in 3 minutes, and the agency does not choose to meet LSC survey	No
Proposed IRA is for fewer than 9 individuals and can evacuate completely in 3 minutes or less	No

3. The Records/Site Survey

On the date of the site survey, or through a review of requested records, DQI will be surveying to ensure that the needs of the individuals can be met by the provider agency. DQI staff will conduct a pre-survey certification, a physical plant review and a records review. Providers should reference the pre-survey activity task list noted in the resources section of this guidance. The areas that are evaluated include the following:

- **Staffing** – Are there sufficient number of staff to meet the needs of the individuals who will be residing in the IRA? DQI staff review personnel files to ensure staff meet criteria and have received the appropriate background clearances (Staff Exclusion List (SEL) check, Mental Hygiene Law checks and criminal background checks).
- **Staff training** – Are there an appropriate number of SCIP trained staff, if necessary, CPR trained staff, Approved Medication Administration Professional (AMAP) staff; have the staff been trained on the ISPs, Individual Protective Oversight Plans (IPOPs), Residential Habilitation Plans and Behavior Plans?
- **Nursing Coverage/ Medication Oversight** – Is there adequate nursing coverage to meet the medical needs of the individuals? Does the facility have a policy for when staff are to contact the Registered Nurse? Is there appropriate medication storage?
- **Fire Safety/ Emergency Preparedness** – DQI staff review the fire evacuation plan (see components for an acceptable fire evacuation plan in resources section of this document). Does the agency have an effective emergency plan? Have staff been trained on the fire plan and the operation of the fire alarm system?
- **Physical Plant review** – Does the facility meet the LSC, if necessary? DQI completes a physical plant inspection to ensure the facility is in compliance with the requirements detailed in ADM 2012-02 Standardization of Fire Safety Practices.
- **Record Review** – DQI staff conducts a thorough review of all documentation, ISPs, IPOPs, Residential Habilitation Plans and Behavior Plans.

4. After the Survey

Upon completion of the DQI survey, if no deficiencies are identified, DQI can authorize the conversion and issue a Bureau of Program Certification 101 (BPC-101) which documents that the facility has met all requirements and can proceed with the conversion. If deficiencies are identified, DQI issues a Statement of Deficiencies and the agency is required to provide an Acceptable Plan of Correction and implement the needed corrections. DQI must approve the Plan of Correction and the completion of the corrections before the BPC-101 can be issued.

Upon return to the office, DQI survey staff will update the Quality Assurance (QA) data system by completing a certification entry form which documents what changes have occurred with the program (e.g. program type change, LSC category change, capacity change, location change etc.) and provides an effective date for the new program. Once the certification entry form is signed and the QA system is updated, DQI will issue the provider a revised operating certificate.

III. Processes Required for Individuals

A. Money Follows the Person (MFP) Participation Requirements

Individuals who are changing their residential services from an ICF residential placement to a community placement (IRA, private home or Family Care) in which they will receive HCBS waiver services may be eligible to participate in New York State's Money Follows the Person (MFP) Demonstration. This demonstration provides an opportunity for New York State to capture enhanced funding for improvements in long-term supports and services. **It does not bring additional funding to the individual.**

As ICF staff begin planning for ICF conversions, the ICF provider should confirm the ICF residents' eligibility to participate in the MFP Demonstration and if a person is eligible, the provider should email OPWDD at community.transitions@opwdd.ny.gov to inform the agency of the planned dates of discharge and enrollment in the HCBS waiver for each transitioning individual. Thereafter, the New York Association on Independent Living (NYAIL), the statewide MFP contractor, will contact the provider to arrange to visit the individual and offer transition assistance, peer support, obtain a signed MFP Informed Consent Form and conduct a baseline Quality of Life (QoL) Survey. OPWDD will provide an MFP Participant Tracking spreadsheet for the residential provider to use for recording and regularly reporting information about the individual, his/her planned transition (date of conversion) and his/her continued participation in MFP after the transition.

MFP Demonstration Reporting

- Individual must have resided in a **qualified institution** (hospital, nursing home, ICF) for a minimum of 90 consecutive days.
- Individual must have been in receipt of Medicaid for at least one day prior to transition.
- Individual must continue to meet the ICF/IID level of care requirement and must enroll in the HCBS Waiver.
- Individual must transition into a **qualified residence**: home owned/leased by individual or his/her family; apartment with individual lease; community-based residential setting in which no more than four unrelated individuals live (IRA, Family Care).
- NYAIL will visit the individual, offer transition assistance, peer support and obtain signatures on the MFP Informed Consent form.
- NYAIL will conduct three Quality of Life surveys: Baseline Survey prior to transition, 11-month follow-up and 24-month follow-up.
- Provider must report MFP participant data to OPWDD via MF Participant Tracking Spreadsheet on a monthly basis.

Eligibility for MFP depends upon the length of time an individual has resided in an institutional setting (for MFP purposes all ICFs are defined as institutional settings), his/her Medicaid status, his/her enrollment in the HCBS waiver upon discharge from the ICF, and the size and type of community placement the individual moves into. In planning

with individuals, and their advocates, families, and the CAB, for an ICF conversion, ICF staff should discuss their participation in MFP. If the individual will be moving into a qualified residence (see sidebar on previous page), ICF staff should notify OPWDD. NYAIL will then obtain a signature on the MFP Informed Consent form and, just prior to the conversion of the ICF to IRA operations, conduct an initial (baseline) QoL survey with the individual. The survey must be completed at least two weeks, but no more than 30 days, prior to the individual's move.

OPWDD will use the **MFP Participant Tracking Spreadsheet** to obtain and verify additional information from residential service providers and Medicaid Service Coordination agencies via monthly email. OPWDD uses some of the information in this tracking spreadsheet for reporting to the federal government, but the tracking spreadsheet is also reviewed by OPWDD staff to ensure that individuals' needs are being met in the community and that barriers to an individual's success are promptly and appropriately addressed. Since MFP Unit staff may need to follow up with an agency on information contained in this spreadsheet, it is vital that every agency that supports individuals who participate in MFP designate an MFP contact person and provide contact information on the tracking spreadsheet.

Resource materials can be found at http://www.opwdd.ny.gov/transformation-agreement/mfp/home. Questions about MFP, the reporting requirements or materials should be emailed to community.transitions@opwdd.ny.gov.

B. Person-Centered Planning, Discharge Planning and Enrollment in MSC and the HCBS Waiver

There are many activities that must occur to plan for an individual who is residing in an ICF that will convert to an IRA, including person-centered planning that reflects compliance with regulations and rules published by CMS on March 17, 2014 [42 CFR 441.301(c) (1-3)], enrollment in Medicaid Service Coordination (MSC), and enrollment in the HCBS Waiver. In addition, individuals who are asked to, or who choose to, move to a new setting will participate in discharge planning (described below).

Individuals who, after a person centered planning process that includes education on available Home and Community Based Services (HCBS) Waiver options, have decided they will remain in the same setting that is converting to an IRA or to relocate to another community-based setting (not an ICF), will have their waiver enrollment processed through an expedited Front Door process as depicted on page 22 of this document.

Many of the steps involved in person-centered planning for discharge or enrollment in the HCBS Waiver do not have to be linear, and can be worked on simultaneously. Please note, for individuals who are under the age of 18 and independently not eligible for Medicaid, the waiver enrollment process is different. In these instances, providers should seek guidance from their DDRO.

1. Discharge Planning (Required for individuals who choose to leave the converting ICF and relocate)

ICF discharge planning is governed by federal regulation 42 CFR 483.440 (b) (4) & (5). These regulations require admission and discharge planning for all individuals admitted to an ICF residential facility, and OPWDD quality assurance guidelines for these regulations reaffirm, that no admission to an ICF should be regarded as permanent. Rather, ongoing planning for each person's discharge to an alternate placement is expected. Each individual's treatment team (ITT) assesses the person's interest in and appropriateness for being supported in a community setting at the 30-day review following admission into the ICF and thereafter at each 90 day review, or more frequently as status changes occur

Pursuant to 42 CFR 483.440, if an individual is to be discharged from the ICF, the facility must:

- have documentation in the individual's record that the individual was transferred or discharged for good cause (any reason that is in the best interest of the individual); and
- Provide a reasonable time to prepare the individual and his or her parents, guardian, or the CAB for the transfer or discharge (except in emergencies).

Further, at the time of discharge from the home, the facility must:

- develop a final summary of the individual's developmental, behavioral, social, health and nutritional status and, with the consent of the individual, parents (if the individual is a minor), legal guardian, family members or the CAB, provide a copy to authorized persons and agencies; and
- provide a post-discharge/transition plan of care that will assist the individual to adjust to the new living environment.

Additional activities, beyond those specified above in 42 CFR Part 483.440, which must occur as part of discharge planning are described in the Community Placement Procedures (CPP) (http://www.opwdd.ny.gov/opwdd_resources/willowbrook_class/community_placement_procedures). The CPP outlines those elements that must be considered as part of the discharge planning process. Providers should use the IPP-70 and IPP-71 forms (found in the CPP) or their equivalent in this process. In addition, as OPWDD has downsized and closed its developmental centers (DCs), the agency has developed numerous recommendations related to the discharge planning for each individual. Specifically, providers should review the information and resources contained on OPWDD's Person Centered Planning webpage (http://www.opwdd.ny.gov/opwdd_services_supports/person_centered_planning).

The ICF provider should assist individuals who choose to relocate and receive community-based supports to work with OPWDD's Front Door staff to obtain a Medicaid Service Coordinator, identify service needs, and request the desired community supports and services. The ICF provider must prepare and submit to the DDRO a **Discharge Packet** for each individual who will be relocating. The packet should contain:

- Comprehensive Functional Assessment (CFA) [There is no prescribed form for the CFA, but it must include the requirements described in 42 CFR 483.440(c)(3)(i)-(iv)];
- Documentation from the individual's record of program planning meetings that family and advocates were involved in the decision making process to move the individual and were provided reasonable time to prepare for the transition to HCBS waiver services or a physical move to the community;
- Consent form signed by the individual or his/her guardian, advocate or the CAB that documents consent to be supported in the new residential site;
- Recommendations regarding services and supports to assist the individual to adjust to his/her new living environment to be in effect on the date of discharge. The DDRO will use this information to develop a Preliminary ISP (PISP); and
- Documentation of specific follow-up actions related to service planning that must be completed soon after discharge, in the form of a letter, a recorded note or an email.

2. Medicaid Service Coordination Enrollment

Planning for someone to transition from an ICF to HCBS waiver services may begin at least 60 days in advance of the person's actual transition to ensure that all appropriate documentation can be completed. Because the Medicaid Service Coordinator plays such a vital role in the service planning and waiver enrollment processes, it is essential that Medicaid Service Coordination (MSC) is pursued prior to the individual's discharge from an institution or transition to waiver services. The Front Door staff will provide a list of available MSC providers to the individual and family for use in selecting an MSC. The MSC agency will be reimbursed for their work to assist transition planning through a single transition MSC billing once the individual is discharged from the institution and as long as all other billing requirements are met. MSC agencies that provide MSC to Willowbrook class members are required to not exceed case load ratios of 1:20 for class members and will continue to receive an enhanced rate of funding for the MSC services provided to the class members. For Willowbrook class members, service coordination must be provided by an agency other than the provider of residential services. A 2014 Memorandum from OPWDD to MSC providers explaining the requirements for this transition payment for individuals leaving ICFs can be found at http://www.opwdd.ny.gov/node/5766. (See also the link to the MSC Vendor Manual in Section VI. Forms and Related Helpful Resources/Guidance.)

To enroll an individual in MSC, an MSC agency or a discharge planner must complete an MSC enrollment application and the MSC Assessment of the Need for Ongoing and Comprehensive Service Coordination (a worksheet demonstrating the need for ongoing and comprehensive service coordination) and submit both forms to the DDRO Front Door staff.

Medicaid Service Coordination (MSC) assists persons with developmental disabilities and their families in gaining access to services and supports appropriate to their needs. MSC is provided by qualified service coordinators and uses a person-centered planning process in developing, implementing, and maintaining an ISP.

Plan of Care Support Services (PCSS) is a form of service coordination and can be delivered when an individual does not require ongoing and comprehensive service coordination. PCSS providers assist individuals to review and update their ISP. PCSS is delivered by a qualified Medicaid Service Coordinator.

Willowbrook Service Coordination (WSC) is service coordination provided to Willowbrook class members who are not Medicaid eligible. It is paid with state funding at an enhanced monthly rate.

3. Person-Centered Planning for HCBS Waiver Enrollment and Service Enrollment (Required for individuals who will remain at the converted ICF)

Like discharge planning, planning for waiver enrollment must be person-centered, completed by an interdisciplinary team and support the individual and his or her family, guardian, advocates or the CAB to direct the planning process. This kind of planning is a multi-step process that requires coordinated efforts of the clinical, administrative and direct support staff from the ICF and, if the person is relocating, the team that will oversee and deliver the individual's new residential services, and the individual's family members, advocates and the CAB, if appropriate. When an ICF is converting to an IRA, individuals who will continue to reside at the converted IRA will be receiving more individualized services and supports in a new way, and it is important that the planning for each individual consider the same elements described in the CPP. For further guidance, providers should consult the information and resources contained on OPWDD's Person Centered Planning webpage (http://www.opwdd.ny.gov/opwdd_services_supports/person_centered_planning).

ICF providers are advised to notify the DDRO Front Door staff of each person who will be transitioning to HCBS Waiver services. Selection of an MSC by the individual/family should occur early in the planning process so the MSC provider can assist in discharge planning and identifying needed community supports and services. Person-centered planning for individuals whose ICF is converting to an IRA should be documented and well underway for each resident of a converting ICF prior to the provider preparing its conversion proposal. It is not uncommon for 60 days or more of lead time to be needed to ensure that all required elements are completed in advance of a person's move.

On March 17, 2014, new CMS regulations regarding Home and Community Based Waiver settings and person-centered planning requirements went into effect [42 CFR 441.301 (c)]. This new rule provides a consistent definition of community settings across all HCBS Medicaid authorities and defines person centered planning requirements. These requirements align with OPWDD's current expectations regarding the person centered planning process. More information on the regulation can be found at the Electronic Code of Federal Regulations at: www.ecfr.gov. OPWDD has posted on its website both Administrative Memorandum #2014-04 (http://www.opwdd.ny.gov/node/5760) and federal guidance on implementing the new person-centered planning rule (http://www.opwdd.ny.gov/node/5772). In addition, OPWDD has developed a Person-Centered Planning Review Form (http://www.opwdd.ny.gov/transformation-agreement/mfp/ICF_Transitions) that can assist providers as they undertake the person-centered planning that is needed to meet these new requirements.

In line with this regulation, for individuals who choose to remain in the converting ICF, service providers must document in the individual's record that the individual or his/her involved advocate or guardian, was informed of options available through HCBS waiver services and made an informed choice of available waiver service options. The provider must ensure, and document in their conversion proposal, that the individual and his or her advocates engage in a person-centered process of determining and selecting individualized, community-based services that will support their needs and achievement of their personal goals. The individual and his/her advocates must drive this process.

Using the ICF Conversion/Transition Proposal Template, provider agencies should also describe in their conversion proposal:

- How the conversion to an IRA will result in enhanced community integration and/or autonomy for each affected individual;
- How the routines, supports and services that are being planned for each individual will be based on his or her interests, preferences, strengths, capacities and service needs, noting specific interests that will be pursued or strengths further developed;
- How activities, supports and services that are being planned for each individual will foster skills to achieve personal relationships, community inclusion, dignity and respect, noting specific possible outcomes envisioned for each individual;
- How each individual will use natural and community supports, noting specific possibilities for each individual; and
- How each individual will have meaningful choice over his or her experiences.

OPWDD staff will review this information to ensure that the conversion process involves individualized planning for meaningful enhancements in these areas for each individual, that each individual has the opportunity to exercise informed choice regarding where he/she will live, and that the provider's planning process meets the requirements of the federal regulations (42 CFR 441.301(c)). Specifically, OPWDD will review each proposal for conversion against a PCP checklist, the PCP review form (http://www.opwdd.ny.gov/transformation-agreement/mfp/ICF_Transitions).

The ICF provider may pursue HCBS Waiver service enrollment and MSC enrollment for an individual simultaneously, and HCBS Waiver enrollment may be completed even if an MSC has not been selected by an individual. There are several steps to waiver enrollment and service enrollment:

a. **The Level of Care/Eligibility Determination** - The MSC (or the ICF provider or in some cases, the DDRO) must complete the Level of Care/Eligibility Determination (LCED) with the required 3 pre-enrollment assessments for each individual leaving the ICF. The three assessments are an annual physical, the most recent psychological assessment, and the most recent social history assessment. These documents and the completed LCED form must be approved and signed by a physician. The forms are then uploaded into CHOICES by the MSC (or the ICF provider or the DDRO).

b. If an MSC has been selected, the MSC is also responsible for completing the **application for participation in the HCBS Waiver** and the **Documentation of Choices** form, and uploading them into Choices.

c. The MSC or the ICF provider (if an MSC has not yet been selected) must facilitate and document the person-centered planning process that is required and develop and submit to the DDRO Front Door staff a **Service Planning Packet** that contains:

- Comprehensive Functional Assessment (CFA) [There is no prescribed form for the CFA, but it must include the requirements described in 42 CFR 483.440(c)(3)(i)-(iv)];
- Documentation from the individual's record of program planning meetings that family and advocates were involved in the decision making process to move the individual and were provided reasonable time to prepare for the transition to HCBS waiver services or a physical move to the community; and
- Recommendations regarding services and supports to assist the individual to adjust to his/her new living environment to be in effect on the date of discharge. The DDRO will use this information to develop a Preliminary ISP (PISP).

  NOTE: For individuals who are choosing to move to a new setting and enroll in the HCBS waiver, the discharge packet may be combined with the service planning packet as long as all required elements are included. Providers should label the packet "Combined Discharge Planning/Service Planning Packet".

d. **PISP Review** – The DDRO Front Door staff will prepare a Preliminary Individualized Service Plan (PISP) for the individual and send it to the MSC to review with the individual and his/her advocates, family members or the CAB.

e. **Service Enrollment Request** -The MSC must request the required services with a service authorization request form sent to the DDRO Front Door.

f. For any individuals in the converting ICF who were receiving day services outside of the ICF and whose day services will continue, the Day Habilitation provider must **submit a DDP1** to enroll the individual in its service program code *(if it hasn't already done so*). In addition, the Day Habilitation provider should wait to bill for Day Habilitation services until the IRA program certification is complete and the individual's HCBS Waiver enrollment status is finalized so that the correct Rate Codes and Locator Code will be used. Residential providers must take responsibility for communicating to other service providers who are impacted by the conversion. Day Habilitation providers can verify IRA program certification status and waiver enrollment via CHOICES or by contacting their DDRO.

Person-Centered Planning for HCBS Waiver Services

The ICF provider informs DDRO Front Door that the individual is being discharged/transitioned to waiver services and provides information on his/her eligibility status. The DDRO Front Door provides a list of MSC agencies to the individual and the ICF.

The ICF provider invites advocates, residential and day service providers, MSC, clinicans, obmudsman, MHLS, direct support staff to the Person-Centered Planning meeting(s) to review and discuss all current Behavior Support Plans, Safeguards/IPOP and all Human Rights Committee approvals and identify needed community supports and services.

The MSC or ICF provider sends the Service Planning Packet to DDRO Front Door along with attestation that family and advocates were involved in the decision for the individual to transition to community supports and all were provided reasonable time to prepare for the transition to HCBS waiver services.

The Front Door staff reviews the service recommendations and ensures they reflect personal choice and community integration for each individual and that they align with the individual's DDP2. If the DDP2 and service planning recommendations do not align, Front Door staff notify the ICF Provider, who then makes needed updates and resubmits the information.

Front Door staff develop the Preliminary ISP (PISP).

The MSC receives the PISP and a Service Authorization Request Form from the Front Door staff. The MSC reviews the PISP with the individual and his/her family and advocates. Service providers are identified. Together these parties finalize a request for services and return the Service Authorization request to DDRO Front Door, along with the LCED and Waiver application.

MSC Enrollment

Using the list provided by the DDRO Front Door, the indivdual and his/her advocates select an MSC provider. For WB class members who are fully represented by the CAB, the CAB will select the MSC provider.*

The MSC completes the MSC application and the MSC Assessment of the Need for Ongoing and Comprehensive Service CoordinationWorksheet and sends them to the DDRO Front Door staff.

DDRO Front Door staff verify Medicaid eligibility and notify the MSC that the individual is authorized for MSC or PCSS.

The DDRO Front Door staff enroll the individual into MSC (or PCSS) upon discharge from the ICF.

**WB* MSC providers that agree to provide services to WB class members must be able to maintain the case load ratios (e.g. 1:20) required by law. For more specific requirements, please review the MSC Vendor Manual.

Waiver Application and Service Enrollment

The MSC or ICF provider completes the LCED with the required 3 pre-enrollment assessments prior to discharge/transition and sends to physician. If LCED was updated in the past 12 months, no update is needed for ICF conversion.

With the individual and his/her advocates, the MSC or ICF provider completes an HCBS Waiver application.

The MSC or ICF provider or DDRO receives the completed LCED and accompanying documents signed by physician and uploads the documents into Choices.

With the individual and his/her advocates, the MSC or ICF provider completes a Documentation of Choices Form (this must be signed by the MSC).

The MSC or ICF provider uploads the HCBS Waiver application and the Documentation of Choices form into Choices.

The DDRO Director or Designee reviews and signs the Waiver Notice of Decision (NOD), and the DDRO Front Door staff upload the NOD into Choices.

The DDRO Director or designee reviews and approves the Service Authorization request and sends a service authorization letter and Waiver Notice of Decision to the individual, family and the MSC.

The MSC notifies the selected provider agencies of service authorization.

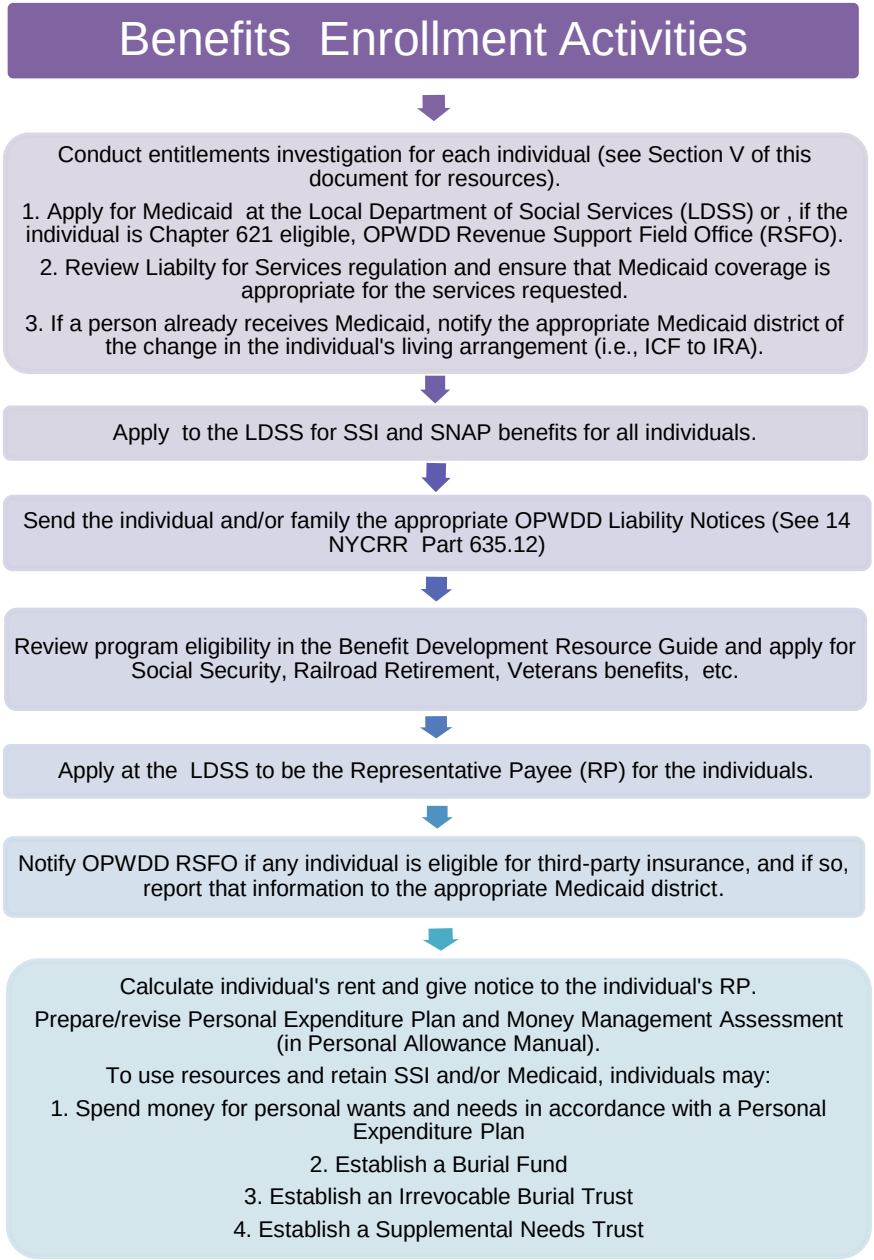
When no individuals move, no DDP1 is needed for residential services. If an individual was receiving day services outside the ICF and these services will continue, and the Day Hab (DH) provider had not already submitted a DDP1 to have the individual enrolled in its service program code, the DH provider must submit a DDP1 to add person to DH services.

C. Benefits Enrollment Activities

When an ICF is converting to an IRA, it is important for the provider to ensure that each individual who will be supported in the new IRA is enrolled in and receiving all of the benefits to which he/she is entitled, including Social Security, Supplemental Security Income (SSI) and Medicaid and other available benefits. The benefits can be applied to the cost of the individual's supports and services in the community setting, and they may change when the setting changes.

The requirements and provisions of benefit programs are extremely complex. Providers are encouraged to refer to the OPWDD Benefit Development Resource Guide, the Personal Allowance Manual, and OPWDD's benefits information webpage (http://www.opwdd.ny.gov/opwdd_resources/benefits_information) and to seek related training and information when it is offered through the OPWDD training catalog (http://www3.opwdd.ny.gov/wp/index.jsp).

Providers can access individuals' SSI [administered by the Social Security Administration (SSA)] to support the costs of the residence and the federal Supplemental Nutrition Assistance Program (SNAP) to support food costs. Providers should apply for these benefits on behalf of individuals at SSA and the Local Department of Social Services (LDSS), respectively. Alternatively, an individual may be eligible for other benefits which may replace SSI (such as Social Security, Veterans benefits, etc.) and be used to support that individual as well. However, it is important to note that if an individual is not receiving SSI, but his or her income exceeds the SSI benefit level, the Medicaid District will require a spend down, meaning the individual must incur or pay a certain level of medical expenses in order to qualify for Medicaid. Providers are reminded that if an individual has "Chapter 621"



eligibility (per the Resource Guide), the OPWDD Revenue Support Field Office (RSFO) serves as the Medicaid district for that individual.

In addition, 14 NYCRR 635.15 requires that a residential agency Executive Director file to be Representative Payee (RP) if the individual is not capable of managing his or her own funds and there is no family member or friend willing to serve. If an individual has an outside RP, the provider must notify the RP of the rent they will be expected to pay for the IRA residence.

Any time a provider is offering an individual a new service, 14 NYCRR 635.12 requires them to notify individuals and families of their liability for payment for specified OPWDD services (including residential habilitation) through Medicaid or private pay before providing the services. Under this regulation, individuals who wish to receive any of the specified services (see Liability for Services at http://www.opwdd.ny.gov/opwdd_resources/benefits_information/liability_for_services/overview) must take all steps necessary to apply for and obtain the appropriate type of Medicaid coverage needed to pay for the service, and if the individual will receive HCBS Waiver services, take all necessary steps to enroll in the HCBS Waiver (See Section III. B. Obtaining HCBS Waiver Services). Except for very specific, extenuating circumstances, which are outlined in the regulation, state funding is not available for people who do not have Medicaid coverage and HCBS Waiver enrollment.

To ensure that all available benefit programs and Medicaid are in effect for each individual, it is important that whenever an ICF is converting to an IRA the provider conducts a full benefit eligibility investigation, looking at each person's income and resources, gathering all the information needed to obtain and maintain benefits for each person, assisting him/her and/or his or her family in applying for any additional benefits to which the person may be entitled, and notifying appropriate benefit-paying agencies of changes in the person's financial situation (e.g. the individual begins working or receiving an additional benefit) or address. The timing of benefit-related actions, including applications and change reporting, is critical to an agency's operations because Supplemental Security Income (SSI) eligibility is not retroactive, and the maximum retroactivity for Medicaid is three months. **It is imperative that the agency work with SSA and the LDSS to ensure that SSI and Medicaid enrollment occur in a timely fashion. Not doing so could result in the loss of benefits for the individual and loss of revenue for the agency.** Actions listed on the right sidebar are the responsibility of the IRA provider.

Providers should refer to OPWDD's Benefit Development Resource Guide (http://www.opwdd.ny.gov/opwdd_resources/benefits_information/benefit_development_resource_guide) for more detailed information about the benefit programs.

IV. Demonstrating Compliance with HCBS Settings Standards

In January 2014, CMS promulgated final regulations describing standards for all HCBS waiver service settings. Those regulations became effective March 17, 2014 (http://www.opwdd.ny.gov/opwdd_services_supports/HCBS/home). OPWDD has

submitted a transition plan to CMS, which proposes a phased approach to achieving and demonstrating compliance with the standards over the next five years. In the first phase, OPWDD is preparing to undertake a statewide assessment of a sample of certified residential settings to determine the current readiness of New York's developmental disabilities service system to achieve full compliance with the new settings standards. That assessment will not be complete until late 2015, at which time OPWDD will work toward the development of regulations that integrate these federal requirements fully into certification standards.

At the same time that this baseline assessment is underway, providers are preparing to assist individuals to transition from institutional settings (ICFs) to community settings and waiver services, in fulfillment of the ICF Transition Plan (http://www.opwdd.ny.gov/node/4971). It is important that OPWDD assure that all ICF conversions in which individuals remain in their current location will constitute a true change in the way each person is supported to be a member of his/her community, and it is therefore essential that providers understand the expectations that will be placed on any ICF conversions and any new IRA development that they seek to achieve prior to completion of the baseline settings assessment. For these reasons, OPWDD has developed a Pre-Opening Checklist for HCBS Settings that will guide providers to determine how well their proposals for conversions and development will meet the new standards (See Section V. Forms and Related Helpful Resources/Guidance). **OPWDD will request that providers complete a checklist for each site being converted and document their answers to the checklist items in their conversion/downsizing/development proposals.**

This Pre-opening checklist is a reference tool for the providers to utilize to self-assess compliance with the new HCBS settings rules prior to converting the ICF to an IRA. ICF conversion providers can use this checklist to develop an action plan to work towards full compliance with the HCBS settings rules no later than October 2018.

OPWDD has also developed and posted on its website the following Administrative Memorandum - #2014-04 Home and Community Based Settings Preliminary Transition Plan Implementation (http://www.opwdd.ny.gov/node/5760) which provides further guidance on the expectations for residential service providers.

V. Cultural Competency and Language Access – Requirements and Best Practices

Cultural Competence is "the process by which individuals and systems respond respectively and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, religions, and other diversity factors in a manner that recognizes, affirms, and values the worth of individuals, families, and communities, and protects and preserves the dignity of each."

While assuring cultural competence and language access during ICF conversion does not require an administrative process between the provider and OPWDD, it is a reflection and response activity that providers must apply to every interaction with the

individuals they serve and their families and advocates. The CMS HCBS Settings Rule, which became effective March 17, 2014, defines person-centered planning requirements and includes specifications for cultural considerations, plain language, and accessibility for individuals and persons who are limited-English speaking. Providers need to ask the question, “Who are the people getting services, and are we responsive to their needs.” They must actively strive to meet people “where they are.” This involves considering and understanding cultural background, what influence it has on people and how they see the world. The concern should be for people who are left out of full participation in the community due to disabilities, due to color, due to culture. We need to work to develop systems that reach out and take differences into account so that we are able to meet individual and family needs across the broad range of whom we support.

Guiding principles for providers planning to convert Intermediate Care Facilities (ICFs) should include the recognition, respect, and accommodation of differences related to disability, culture, race, religion, gender, gender identity, and sexual orientation. This section on cultural and linguistic competence addresses not only the laws, rules, and regulations that cultural competence is governed under, but addresses best practices to provide the best possible, high quality, most respectful and dignified supports and services to people with developmental disabilities and their families that we possibly can.

There are many laws, rules, and regulations that dictate what providers are required to do for individuals surrounding cultural and linguistic competence.

A. Requirements

Title VI of the Civil Rights Act of 1964; Language Access for LEP Persons
Title VI is a civil rights law in the Civil Rights Act of 1964, prohibiting discrimination in a variety of situations and circumstances. It ensures that federal money does not support programs or activities that discriminate on the basis of race, color, or national origin. The U.S. Department of Justice has interpreted “national origin” to include people who are limited English proficient. This means that any program in receipt of federal Medicaid dollars must address language access, or risk the loss of funding.

NYS Mental Hygiene Law 13.09 (e)
MHL §13.09(e), Person’s Rights and Responsibilities, states that any individuals seeking services in **facilities owned, operated, or licensed** by OPWDD must address the communication needs of non-English speaking individuals so they can have “equal access” to services. MHL §13.09(e) states that these facilities must take into consideration the language capabilities (literacy level) and preferences of non-English speaking individuals in those facilities, and that information must be provided in appropriate languages. The law also stipulates that the overall quality and level of services must be equal to that made available to all other persons without disabilities.

14 NYCRR 633.4

14 NYCRR 633.4 dictates that **no facility owned, operated, or licensed** by OPWDD shall deny care and treatment to, or otherwise discriminate against, non-English speaking people. This regulation also requires access to services be facilitated by providing information in appropriate languages and through competent interpreters; it discourages the use of family members as interpreters.

14 NYCRR 633.99 – Consent, Informed

For individuals receiving services in **facilities owned, operated, or certified** by OPWDD, "informed consent" means that information must be presented in a manner "permitting a knowledgeable evaluation and decision to be made," and must be presented in whatever language the party giving informed consent reads or understands most easily and clearly.

14 NYCRR 671.6 Service Planning and Service Delivery

The provider of community residential habilitation services – both during the service planning and service delivery process – must respect the person's cultural and language needs and has attempted to ensure that the person's primary language or means of communication has been used to facilitate learning and understanding.

CMS Home and Community-Based Waiver Services (HCBS) Final Rule – Issued January 10, 2014

42 CFR 441.301(C)(1)(iv)

The person-centered planning process: Reflects cultural considerations of the individual and is conducted by providing information in plain English and in a manner that is accessible to individuals with disabilities and with persons who are limited English proficient.

42 CFR 441.301(C)(2)(vii)

The written plan must be understandable to the individual receiving services and supports, and the individuals important in supporting him or her. At minimum, for the written plan to be understandable, it must be written in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with 435.905 (b) of this chapter.

42 CFR 441.301(C)(2)(x)

The written plan must: be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation.

42 CFR 441.301(C)(2)(xi)

The written plan must be distributed to the individual and other people involved in the plan.

42 CFR 441.301(C)(4)
Home and Community based settings must have all of the following qualities and such other qualities as the Secretary of Health and Human Services determines to be appropriate, based on the needs of the individual as indicated in their person-centered service plan.

42 CFR 441.301(C)(4)(i)
The setting is integrated in, and facilitates the individual's full access to the greater community including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

B. Helpful Definitions

Activities of Daily Living: Activities that a person ordinarily performs during the course of a day such as: mobility, personal hygiene, dressing, sleeping, eating, and skills required for community living. A person's ability to perform these activities is indicative of his or her physical ability to function independently.

Americans with Disabilities Act (ADA): A civil rights law administered by the United States Department of Justice, and other federal agencies. The ADA was enacted to establish a clear and comprehensive prohibition of discrimination based on disability in employment, accessing public services, transportation, private business, and telecommunications.

Culture: Culture is "the integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious or social group." Culture may include, but is not limited to, race, ethnicity, national origin, and migration backgrounds, sex, gender, gender identity or gender expression, sexual orientation, and marital or partner status, age and socioeconomic class, religious or political belief or affiliation, and physical, mental, or cognitive disability. It is important to remember that no two individuals are identical in every aspect of cultural identity and expression.

Cultural Competence: Cultural competence is "the process by which individuals and systems respond respectively and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, religions, and other diversity factors in a manner that recognizes, affirms, and values the worth of individuals, families, and communities, and protects and preserves the dignity of each."

Developmental Disability: A severe, chronic disability of an individual who has a physical and/or mental impairment that substantially limits one or more major life activities;

- Is attributable to a mental or physical impairment, or combination of mental and physical impairments;
- Is manifested before age 22;

- Is likely to continue indefinitely; or
- Results in substantial functional limitation in three or more of the following areas of major life activities: self-care; receptive and expressive language; learning mobility; self-direction; capacity for independent living; and economic self-sufficiency.

Health Literacy: People's ability to obtain, understand, communicate about, and act upon information in health-related settings and situations. Basic health literacy is at a 4th to 6th-grade level, per the federal Centers for Medicare & Medicaid Services (CMS).

Institution: Defined by CMS as an establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor.

Linguistic Competence: Linguistic competence is a key component of cultural competence. On an operational level, it entails "providing readily available, culturally appropriate, oral and written language services to limited English proficient (LEP) people through such means as bilingual/bicultural staff, trained medical interpreters, and qualified translators, among other practices."

Most Integrated Setting: This is defined by the ADA as a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible.

C. Best Practices

Cultural competence is a journey that begins and ends with respect. ICF transitions should be approached in a manner that takes the time to understand others with the ultimate goal of everyone participating in the best, most meaningful lives possible. Best practices for success in cultural and linguistic competence include the following:

1. Outreach and Education

Education — of both individuals and families and the community — is a critical component of community integration and crucial to the successful transition from institutional care to community-based settings. By and large, local communities have limited knowledge of the Olmstead ruling and the critical role local infrastructure plays in its implementation and in meeting the needs of their community members with disabilities to live and thrive in community settings. This lack of knowledge can be a major roadblock to strong support of people with developmental disabilities.

2. Offering Communication and Language Assistance

Language assistance services are mechanisms used to facilitate communication with individuals who do not speak English, those who have limited English proficiency, and those who are deaf and/or hard of hearing. Language assistance services facilitate the effective and accurate exchange of information between a person with language and communication needs and his/her provider. By facilitating conversations regarding prevention, symptoms, diagnosis, treatment, and other issues, language assistance improves the quality of services and safety.

These services include:

- In-person interpreters
- Bilingual staff
- Remote interpreting systems such as telephone or video interpreting
- Translation of written materials or signage
- Sign language
- Braille materials.

Limited English proficiency refers to a level of English proficiency that is insufficient to ensure equal access to public services without language assistance. Individuals may have communication needs not related to a language barrier, such as those who are deaf or hard of hearing, visually impaired, or disabled or those with low literacy skills. It is important to remember that family members or caregivers may be involved in the provision of support or care to an individual. If family member or caregivers have limited English proficiency and/or other communication needs, their linguistic needs should also be met to ensure the best outcomes for the person receiving care.

To ensure that they are appropriately supporting language access and communication, service providers should:

- Ensure that staff is fully aware of, and trained in, the use of language assistance services, policies, and procedures. If your agency does not have a policy or procedure for interpretation or translation services, you should consider implementing one. Resources are available www.lep.gov.
- Develop processes for identifying the language(s) a person speaks (e.g., language identification flash cards or “I Speak” cards) and for adding this information to that person’s health record or service plan.
- Develop a process for informing individuals and their family members of the availability of language assistance services and that they are provided to them free of cost, and upon request.

In **discharge planning, waiver enrollment and service authorization** it is important that the provider remembers that language access services are *required by law,* and may be necessary. This means in each of these steps, the provider must consider what is needed to communicate with each person and his/her family members and advocates, taking into consideration their language access needs, literacy levels, need for plain language and their cultural needs.

In **quality assurance review**, providers must be sure to assess their own success at meeting communication, language and cultural needs. Best practices include:

- The person-centered planning process reflects cultural considerations of the individual and family members, and is conducted by providing information in plain language and in a manner that is accessible to individuals with developmental disabilities and persons who are limited English proficient;
- Service settings reflect the cultural preference of the individual. Cultural or ethnic celebrations, traditions, or rituals that are important to the person are reflected in the person's needs and preferences;
- Staff has reached out to ethno-cultural and religious communities to engage people who understand the cultural background of individuals to enlist their assistance with facilitating appropriate activities;
- Any materials listing activities occurring outside of the setting are provided in a language the individual or his/her representative understands;
- Staff is trained in how to provide supports and services to individuals with diverse backgrounds and ethnicities;
- Individuals and their representatives know the right questions to ask regarding services offered, resources that are available to them, and how to engage these resources. The resources are provided in plain language and in the preferred language of both the individual and his/her representative;
- The provider has a meaningful process for community representation and feedback, such as an advocate from each person's ethnic community, who can serve as a bridge to providing culturally competent supports and services;
- Individuals and their representative are assessed for health literacy level and language needs;
- Individuals and their representative are aware of their right to receive interpretation or translation services at no charge to them;
- Individuals are made aware of their rights per NYS Mental Hygiene Law 33.02;
- Staff is provided with diversity and cultural competence training on a regular basis; and
- Cultural décor and signage are allowed and encouraged in sleeping areas or in personal spaces.

VI. Forms and Related Helpful Resources/Guidance

Resource Title	Where to find the Form/Resource
ICF Conversion Proposal Template	http://www.opwdd.ny.gov/transformation-agreement/mfp/ICF_Transitions
CON Approval	
14 NYCRR 620	https://govt.westlaw.com/nycrr/Browse/Home/NewYork/NewYorkCodesRulesandRegulations?guid=Icc6e04b0b7ec11dd9120824eac0ffcce&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)
CON Application	http://www.opwdd.ny.gov/opwdd_resources/opwdd_forms/certificate_of_need
CON Application Instructions	http://www.opwdd.ny.gov/opwdd_resources/opwdd_forms/CONApplicationInstructions
CON Process Guidance Document	http://www.opwdd.ny.gov/opwdd_resources/opwdd_forms/CONGuidanceDoc
Notification of Individuals and Advocates	
14 NYCRR 633.12	https://govt.westlaw.com/nycrr/Document/I5039098acd1711dda432a117e6e0f345?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default)
Community Placement Policy (the "Greenbook")	http://www.opwdd.ny.gov/opwdd_resources/willowbrook_class/community_placement_procedures
Notice of Rights of Willowbrook Class Members	http://www.opwdd.ny.gov/opwdd_resources/willowbrook_class/notice_of_rights
Fiscal Approval	
Fiscal Policy for ICF Conversions	http://www.opwdd.ny.gov/transformation-agreement/mfp/ICF_Transitions
Money Follows the Person	
MFP Informed Consent Form	http://www.opwdd.ny.gov/transformation-agreement/mfp/informed-consent-form
MFP Quality of Life Survey & Proxy Guidance	http://www.opwdd.ny.gov/transformation-agreement/mfp/MFP_Quality_ofLifeSurveyInformation
MFP Overview Fact Sheet	http://www.opwdd.ny.gov/transformation-agreement/mfp/overview
MFP Provider Reporting Guidance	http://www.opwdd.ny.gov/transformation-agreement/mfp/mfp-reporting-guidance
Other MFP Information	http://www.opwdd.ny.gov/transformation-agreement/mfp/home

Resource Title	Where to find the Form/Resource
Conversion to Waiver Services: Discharge Planning, Person-Centered Planning, Medicaid Service Coordination/ HCBS Waiver Enrollment	
42 CFR 483.440	http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&sid=eb6851d98cc86c7d09313b0c4cb08fa1&rgn=div8&view=text&node=42:5.0.1.1.2.9.7.6&idno=42
Community Placement Procedures	(http://www.opwdd.ny.gov/opwdd_resources/willowbrook_class/community_placement_procedures
Guidance to HHS Agencies for Implementing Principles of Section 2402(a) of the Affordable Care Act: Standards for Person-Centered Planning and Self-Direction in Home and Community-Based Services Programs	http://www.opwdd.ny.gov/node/5772
OPWDD's Person Centered Planning Review Form	http://www.opwdd.ny.gov/transformation-agreement/mfp/ICF_Transitions
ICF/MR Level of Care Eligibility Determination (LCED) Form	http://www.opwdd.ny.gov/node/870
Annual physical form with the year	Located in the individual's record at the ICF or in the individual's MSC record.
Most recent psychological assessment	Located in the individual's record at the ICF or in the individual's MSC record.
Most recent social history assessment	Located in the individual's record at the ICF or in the individual's MSC record.
Application for Participation in the OPWDD Home and Community Based Services Waiver	http://www.opwdd.ny.gov/opwdd_regulations_guidance/adm_memoranda/documents/application_hcbs_microsoft_word_fillable
Documentation of Choices	http://www.opwdd.ny.gov/opwdd_regulations_guidance/adm_memoranda/documents/documentation_choices_hcbs_microsoft_word_fillable
Notice of Decision (for waiver enrollment)	Sent to the MSC by the DDRO Front Door, must be part of the individual's service record.
Eligibility Determination of OPWDD Services Letter	Located in the individual's record at the ICF or in the individual's MSC record.
Preliminary Individualized Service Plan (PISP)	Located in individual's record at the ICF or in the individual's MSC record.
Medicaid Service Coordination Vendor Manual	http://www.opwdd.ny.gov/opwdd_services_supports/service_coordination/medicaid_service_coordination_vendor_manual

Resource Title	Where to find the Form/Resource
Individual Application for Participation in Medicaid Service Coordination.	http://www.opwdd.ny.gov/opwdd_services_supports/service_coordination/medicaid_service_coordination/documents/msc_forms/msc1
MSC Assessment of the Need for Ongoing and Comprehensive Service Coordination	http://www.opwdd.ny.gov/opwdd_services_supports/service_coordination/medicaid_service_coordination/documents/ongoing_and_comprehensive_service_coordination_guidance_and_msc_assessment
Notice of Decision (for MSC)	Sent to the MSC by the DDRO Front Door, must be part of the individual's service record.
Notice of Decision (for waiver enrollment)	Sent to the MSC by the DDRO, must be part of the individual's service record
DDP1-Registration/Movement Form	Instructions for uploading through Choices at: http://www.opwdd.ny.gov/node/1661
Benefits Enrollment	
OPWDD Benefit Information Webpage	http://www.opwdd.ny.gov/opwdd_resources/benefits_information
OPWDD's Benefit Development Resource Guide	http://www.opwdd.ny.gov/opwdd_resources/benefits_information/benefit_development_resource_guide
Liability for Service regulations (14 NYCRR 635.12)	http://www.opwdd.ny.gov/opwdd_resources/benefits_information/liability_for_services/liability_notices
Instructions for applying for Supplemental Security Income (SSI)	http://www.socialsecurity.gov/disabilityssi/ssi.html
SNAP Benefits Application Form (LDSS-4826) and "How to Complete the SNAP Benefits Application/Recertification"	www.otda.ny.gov - select forms/applications
Social Security Administration	www.ssa.gov or 1-800-772-1213
OPWDD Training Catalog	http://www3.opwdd.ny.gov/wp/index.jsp
Quality Assurance Review	
ADM 2012-02 Standardization of Fire Safety Practices and related forms	http://www.opwdd.ny.gov/node/1979 http://www.opwdd.ny.gov/node/1980
Pre-Survey Activity Check List	http://www.opwdd.ny.gov/node/5690
Personnel records (applications for employment, letters of hire, staff training records, etc.)	https://govt.westlaw.com/nycrr/Document/I50390975cd1711dda432a117e6e0f345?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default)

Program policies and procedures (14 NYCRR 624, 633, 635)	624: https://govt.westlaw.com/nycrr/Browse/Home/NewYork/NewYorkCodesRulesandRegulations?guid=Iccf276f0b7ec11dd9120824eac0ffcce&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default) 633: https://govt.westlaw.com/nycrr/Browse/Home/NewYork/NewYorkCodesRulesandRegulations?guid=Icd306a50b7ec11dd9120824eac0ffcce&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default) 635: https://govt.westlaw.com/nycrr/Browse/Home/NewYork/NewYorkCodesRulesandRegulations?guid=Ice812d40b7ec11dd9120824eac0ffcce&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)
Site-specific policies/procedures (emergency plans, site-specific protective oversight plan, space utilization plan, etc.)	https://govt.westlaw.com/nycrr/Document/I5039f3bfcd1711dda432a117e6e0f345?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default)
Criteria for an Acceptable Plan of Corrective Action (POCA) (if applicable)	http://www.opwdd.ny.gov/transformation-agreement/mfp/criteria-plan-corrective-action
BPC-101 (Request for IRA Authorization)	http://www.opwdd.ny.gov/opwdd_resources/opwdd_forms/request-ira-auth
HCBS Settings Standards	
HCBS Settings Checklist for Conversions of ICFs to IRAs	http://www.opwdd.ny.gov/node/5744
Resources for Cultural and Linguistic Competence	
Language Access Resources: • Translated Forms • "I Speak" cards • Desk Reference Guides • Telephonic Interpretation Services	http://www.opwdd.ny.gov/resources/language-access/Language_Access_Resources_for_Providers
Draft Guidelines for Cultural and Linguistic Competence	http://www.opwdd.ny.gov/node/5697
Guidelines for Clear and Simple Communications- *guidance on developing publications and Web sites for people with limited English proficiency.*	http://www.opwdd.ny.gov/node/5673
Guidelines for Developing Low-Literacy Print Materials	http://www.opwdd.ny.gov/resources/cultural_competence/cultural-and-linguistic-competence

OPWDD's Characteristics of a Well-Designed Web Site	http://www.opwdd.ny.gov/node/5672
Plainlanguage.Gov - *This federal Website offers extensive information on transforming documents into plain language. It also provides an extensive thesaurus for health communications*.	www.Plainlanguage.gov
Centers for Medicaid and Medicare Services (CMS) TOOLKIT for Making Written Material Clear and Effective	www.cms.gov - select Outreach & Education.
One Size Does Not Fit All: Meeting the Health Care Needs of Diverse Populations Self Assessment Tool – Complete Joint Commission	http://www.jointcommission.org/assets/1/6/One_Size_Report_One_Pager.pdf
The Centers for Disease Control and Prevention (CDC) Plain Language Thesaurus for Health Communications (2009 version) by the CDC's National Center for Health Marketing	http://www.mmc.org/cepthesaurus

VII. ICF Conversion Contact Information

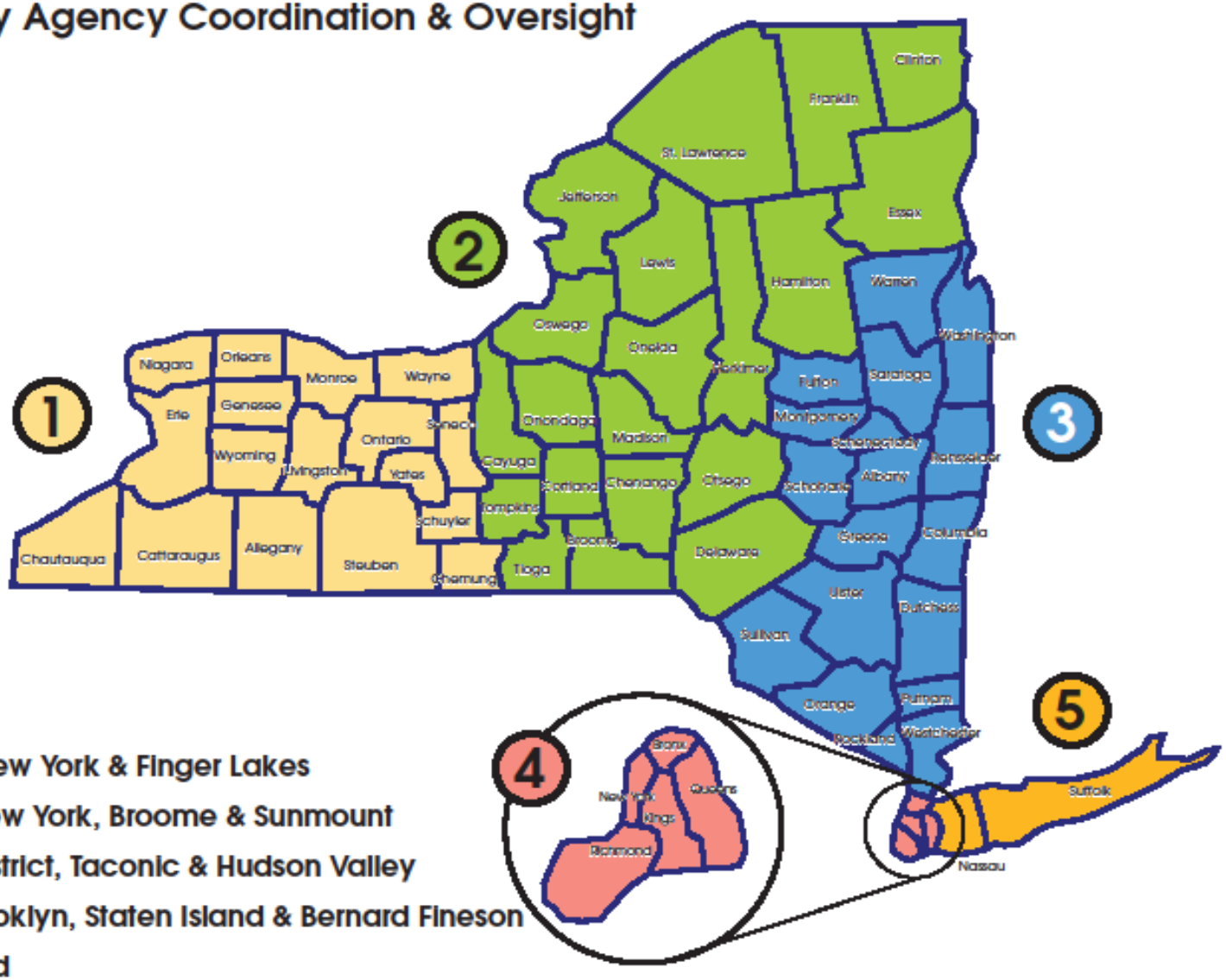
A. DDRO Contacts

Contacts for Submitting ICF Conversion Proposals

Agencies should submit their proposals for ICF conversions to their Developmental Disabilities Regional Office (DDRO) and to Community.Transitions@opwdd.ny.gov. A map of the catchment areas for each DDRO is provided below. For contact information for each DDRO, visit http://www.opwdd..ny.gov/opwdd_contacts/ddro.

5 Developmental Disabilities Regional Offices

Voluntary Agency Coordination & Oversight



1 - Western New York & Finger Lakes

2 - Central New York, Broome & Sunmount

3 - Capital District, Taconic & Hudson Valley

4 - Metro, Brooklyn, Staten Island & Bernard Fineson

5 - Long Island

B. Contacts for Submitting Requests for Site Surveys

Upstate Area: Regional Director - Michael Savery
Michael.Savery@opwdd.ny.gov
518-474-3625

North Area
Dennis Coker - Area Director
Phone: (518) 377-5204
Counties served: Albany, Broome, Clinton, Delaware, Essex, Franklin, Fulton, Herkimer (VO), Montgomery, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, St. Lawrence, Warren, Washington

South Area
Angela Crell – Area Director
Phone: (518) 377-5418
Counties served: Broome, Chenango, Columbia, Delaware, Dutchess, Greene, Orange, Otsego, Putnam, Rockland, Sullivan, Ulster

Central Area
Jean Avery - Area Director
Phone: (315) 331-8646
Counties served: Cayuga, Chemung, Cortland, Herkimer (SO), Jefferson (VO), Lewis, Livingston (SO), Madison, Oneida, Onondaga, Ontario, Oswego, Seneca, Schuyler, Steuben (SO & some VO), Tioga (SO), Tompkins, Wayne, Yates

West Area
Daniel Caryl - Area Director
Phone: (315) 331-8646
Counties served: Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Livingston (VO), Monroe, Niagara, Orleans, Steuben (some VO), Wyoming

Downstate Area: Regional Director – Brian ODonnell
Brian.ODonnell@opwdd.ny.gov
646-766-3467

Area A
Jonathan Pease - Area Director
Phone: (212) 229-3350
Counties served: Nassau, Suffolk

Area B

Winfred Ernest - Area Director
Phone: (212) 229-3350
Counties served: Bronx, New York (Manhattan), Queens, Westchester

Area X
Carole Bartoli, Area Director – **effective 10/1/14**
Phone: (212) 229-3350
Counties served: Kings (Brooklyn), Richmond (Staten Island)

C. Central Office Contacts

The following central office contacts may also be useful when proposing ICF conversions.

Division of Quality Management
518-474-3625

Division of Enterprise Solutions
518-474-8214

Office of Diversity Management
518-408-2146
diversity.management@opwdd.ny.gov

Money Follows the Person Demonstration
Community.transitions@opwdd.ny.gov

VIII. Appendices

A. ICF TO IRA CONVERSION NOTIFICATON TEMPLATE LETTER [PLAIN LANGUAGE VERSION] - 1/5/2015

Dear Individual:

I am writing to tell you about a change that will take place in your home located at _____. Your home will change from an intermediate care facility (ICF) to a community home known as an "individualized residential alternative" or IRA. The change will take place on [or after] _____ (date). Please understand that you will still be able to live in this home when the change takes place.

The reason [the Agency] is changing your home from an ICF to an IRA, is to make it easier to offer more personal services to you and to the other people who live there. [Name of Agency] will still take care of your home. Across the state, other people with developmental disabilities are also moving living in homes that are changing to IRAs.

A major difference between the IRA and the ICF is how your services will be offered to you. ICF rules tell us what types of services must be offered. In the IRA, the main focus is on you and your needs and the things you want to do. In an IRA, you will get services that are thought of as separate from housing. Such services, known as Home and Community Based Services, are usually billed to Medicaid.

You will be asked to sign up for the Home and Community Based Services waiver program. If you sign up, someone will help you choose a Medicaid Service Coordinator (MSC) who will work with you. The MSC will help you choose the services you want and create an Individualized Service Program (ISP.) A MSC can be chosen from any agency that offers service coordination. You have the right to change service coordinators at any time.

Your day and clinical services will stay the same, unless you agree to make changes. [You will continue to attend/participate in the ABC day program, located at [street address.] or [we will work with you to identify new day services…]

No one will be forced to move in or out of the home because of this change unless he or she asks to move to a different home. You will be asked to meet with staff to create a preliminary individualized service plan (PISP). The plan will be updated, with your input, 60 days after the home becomes an IRA. If you ask to move to another ICF or choose another living option, you will be helped to choose a new home and to create a new service plan.

[FOR CLASS MEMBERS: You are a member of the Willowbrook Class and enjoy certain entitlements that accompany the status. Please be advised that the conversion of your home to an IRA will neither exclude nor minimize your receipt of services mandated by the "Willowbrook Permanent Injunction."

We will work with you to fix any concerns you have before your home becomes an IRA. If you have any questions about the changes, or would like more information, please call me [or staff] at [phone.]

Sincerely,

Executive Director

cc: Correspondent/Advocate

Service Coordinator

Mental Hygiene Legal Service (MHLS)

Residential Staff Contact

Day Staff Contact

Individual File

[FOR CLASS MEMBERS:

Enc.: Summary of Rights of Willowbrook Class Members

ALSO cc: Antonia Ferguson, Executive Director, Consumer Advisory Board

Roberta Mueller, Plaintiff's Counsel, NYLPI

Beth Haroules, Plaintiff's Counsel, NYCLU

Lori Lehmkuhl, Willowbrook Liaison, OPWDD

DDSOO Willowbrook Liaison]

B. Sample Opt-Out Letter

Date

OPWDD Upstate/Downstate DQI Regional Office Director
Address

Re: ICF address

Dear: Applicable Upstate Regional Director or Downstate Regional Director

This letter is to confirm our intention to convert the ICF program referenced above at 11:59 pm on (example: 4/30/15), thus withdrawing from the ICF program.

Effective 12:00 am on (example: 5/1/15) the residence will commence operation as an IRA.

If you need any additional information, please do not hesitate to contact (Agency representative name and contact information)

Sincerely,

Agency representative