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 waivers 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.

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The **State** of **New York** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. Program Title:
NYS OPWDD Comprehensive Renewal Waiver

C. Waiver Number:NY.0238
Original Base Waiver Number: NY.0238.

D. Amendment Number:NY.0238.R05.05

E. Proposed Effective Date: (mm/dd/yy)

07/01/19

Approved Effective Date: 07/01/19
Approved Effective Date of Waiver being Amended: 03/31/16

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

The purpose of this amendment is to make technical changes related to the currently approved New York State Plan Community First Choice Option (CFCO) service option. These changes will align service definitions and limit/reimbursement categories related to Community Habilitation and Community Transition Services (CTS). In addition, the timelines are extended for the use of the CAS for use in rate-setting methodologies and technical changes and clarifying language changes have been made to reflect the OPWDD care management transition to Care Coordination Organizations/Health Homes (CCO/HHs) effective 7/1/2018. Due to the delay of the CFCO State Plan and the higher-than anticipated results of the 2013 Transformation Agreement, Factor C and D figures for waiver years 3, 4, and 5 are being adjusted. The 2013 Transformation agreement included commitments to decrease rates of institutionalization and support community-based living in the most independent setting possible, increase access to self-direction and increase access to employment. As a result of higher than anticipated growth in Transformation-related services, this amendment reflects the higher/lower utilization of the following services: Prevocational Services, Residential Habilitation, Supported Employment (SEMP), Community Transition Services, Fiscal Intermediary, Individual Directed Goods and Services (IDGS), Support Brokerage, Assistive Technology, Community Habilitation, Environmental Modifications, Family Education and Training, Intensive Behavioral Services and Pathway to Employment.

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

Component of the Approved Waiver	Subsection(s)
☒ **Waiver Application**	Main
☒ **Appendix A Waiver Administration and Operation**	A.2, QI
☒ **Appendix B Participant Access and Eligibility**	B-3,B-6, QI, B-7
☒ **Appendix C Participant Services**	C-1/C-3, C-1
☒ **Appendix D Participant Centered Service Planning and Delivery**	D-1, D-2, QI
☒ **Appendix E Participant Direction of Services**	E-1, E-2
☐ **Appendix F Participant Rights**	
☐ **Appendix G Participant Safeguards**	
☒ **Appendix H**	H-1
☒ **Appendix I Financial Accountability**	I-1, QI, I-2
☒ **Appendix J Cost-Neutrality Demonstration**	J-2

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment *(check each that applies):*

- ☐ **Modify target group(s)**
- ☐ **Modify Medicaid eligibility**
- ☐ **Add/delete services**
- ☐ **Revise service specifications**
- ☐ **Revise provider qualifications**
- ☒ **Increase/decrease number of participants**
- ☒ **Revise cost neutrality demonstration**
- ☐ **Add participant-direction of services**
- ☒ **Other**

Specify:

The nature of this amendment is to make technical changes related to the currently approved New York State Plan Community First Choice Option (CFCO) service option. These changes will align service definitions and limit/reimbursement categories related to Community Habilitation and Community Transition Services (CTS). In addition, the timelines are extended for the use of the CAS for use in rate-setting methodologies and technical changes and clarifying language changes have been made to reflect the OPWDD care management transition to Care Coordination Organizations/Health Homes (CCO/HHs) effective 7/1/2018. Due to the delay of the CFCO State Plan and the higher-than anticipated results of the 2013 Transformation Agreement, Factor C and D figures for waiver years 3, 4, and 5 are being adjusted. The 2013 Transformation agreement included commitments to decrease rates of institutionalization and support community-based living in the most independent setting possible, increase access to self-direction and increase access to employment. As a result of higher than anticipated growth in Transformation-related services, this amendment reflects the higher/lower utilization of the following services: Prevocational Services, Residential Habilitation, Supported Employment (SEMP), Community Transition Services, Fiscal Intermediary, Individual Directed Goods and Services (IDGS), Support Brokerage, Assistive Technology, Community Habilitation, Environmental Modifications, Family Education and Training, Intensive Behavioral Services and Pathway to Employment.

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

1. Request Information (1 of 3)

A. The **State** of **New York** 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. Program Title (*optional - this title will be used to locate this waiver in the finder*):

NYS OPWDD Comprehensive Renewal Waiver

C. Type of Request: amendment

Requested Approval Period:*(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **3 years** ◉ **5 years**

Original Base Waiver Number: NY.0238
Waiver Number:NY.0238.R05.05
Draft ID: NY.021.05.05

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 10/01/14
Approved Effective Date of Waiver being Amended: 03/31/16

1. Request Information (2 of 3)

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*):

☐ **Hospital**

Select applicable level of care

○ **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:

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☐ **Nursing Facility**
Select applicable level of care

○ **Nursing Facility 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:

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☒ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**
If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities
Select one:

○ **Not applicable**

◉ **Applicable**
Check the applicable authority or authorities:

☒ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**

☐ **Waiver(s) authorized under §1915(b) of the Act.**
Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

Specify the §1915(b) authorities under which this program operates *(check each that applies):*

☐ **§1915(b)(1) (mandated enrollment to managed care)**

☐ **§1915(b)(2) (central broker)**

☐ **§1915(b)(3) (employ cost savings to furnish additional services)**

☐ **§1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under §1932(a) of the Act.**
Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

☐ **A program authorized under §1915(i) of the Act.**

☐ **A program authorized under §1915(j) of the Act.**

☐ **A program authorized under §1115 of the Act.**
Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

☒ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

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.

Purpose, Goals, and Objectives:

The New York State Office for People with Developmental Disabilities (NYS-OPWDD) HCBS Waiver was initiated in 1991 creating a new service provision model that encouraged increased use of community resources to meet the needs and enrich the lives of persons with developmental disabilities. The initial goal of the waiver was to serve more people with a wider range of community-based services that were more individualized and less expensive than institutional care. This goal continues to be a central focus of OPWDD's waiver which today continues to provide the framework within which individualization and "putting people first" have been put into practice.

Waiver participants, their families, the non-profit provider community and state authorities continue to collaborate to create a person-centered service environment that is innovative and focused on community resources and self-direction principles.

OPWDD's customers have made it clear that they want a "life, not a program" and a real life is based on four primary person-centered outcomes that support OPWDD's mission of "helping people lead richer lives". An important goal of OPWDD's HCBS waiver is to facilitate these outcomes for participants:

a) to live in the home of their choice;
b) to work or engage in activities that contribute to the community;
c) to have meaningful relationships; and
d) to have good health.

OPWDD's 2014 HCBS waiver renewal continued to build on this foundation to provide participants with a life that offers person-centered and individualized alternatives and to enable people to lead more typical lives in their communities. The HCBS waiver renewal continued to offer more choice, control and community membership through currently approved waiver services and service modifications.

Waiver Organizational Structure:

OPWDD is the waiver’s operating agency and works with the New York State Department of Health (DOH), the single state Medicaid agency. As the single state Medicaid agency, DOH maintains oversight responsibility as expressly identified in a memorandum of understanding (MOU) between OPWDD and DOH described in Appendix A, Waiver Administration and Operation. OPWDD has a central office in Albany, and Regional Offices (formerly known as Developmental Disability Services Offices-DDSOs) which are geographically dispersed throughout New York State. OPWDD Regional Offices play a central role in the HCBS waiver by continuing to provide direct waiver residential and day services where needed and to oversee and provide assistance to non-profit organizations that serve waiver enrollees in their geographic catchment areas.

OPWDD is supported by more than 500 non-profit organizations. Non-profit organizations include: non-profit corporations formed under New York State Law or authorized to do business in New York, local government units, and organizations created by an act of the New York State Legislature for charitable purposes which include providing services to persons with developmental disabilities.
Providers range from relatively small organizations that provide one or two services to large agencies that are authorized to provide every waiver service and support hundreds of people.

Services are delivered in various ways in accordance with the needs of the waiver participants. Approximately 50 percent of waiver enrollees live in their own home or family home where they receive services that enable them to live as independently as possible and work or engage in meaningful activities in their communities. Many of the participants have intermittent waiver supports such as staff that come to their residence a few days or hours per week. Other participants have greater needs. They may have 24/7 staffing in a certified residence and use an intensive day service such as day habilitation five days per week.

Wherever a person lives, works or interacts with the community, OPWDD uses the waiver with natural supports and community-based resources to allow the participant to be as independent, and when possible as self-directing, as he or she can possibly be.

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*):

- (●) **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ( ) **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

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 Improvement Strategy. Appendix H contains the Quality Improvement 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.

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)*:

- ( ) **Not Applicable**
- ( ) **No**
- (●) **Yes**

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

- (●) **No**
- ( ) **Yes**

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

☐ **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. *Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:*

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make

participant-direction of services 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.
Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

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 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 Act (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) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

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 frequency 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/IID.

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 §431.151, 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 Improvement**. 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 and nature of the problem. During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified in **Appendix H**.

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

OPWDD is committed to ensure that waiver participants, their families, the non-profit provider community and State authorities continue to collaborate to create a person-centered service environment that "helps people lead richer lives". Central to this collaboration is ensuring that public input is secured and factored into service design. As a result, OPWDD continuously engages in public outreach with persons receiving services, their families and other stakeholders to provide ample opportunity for these stakeholders to engage in meaningful dialogue regarding OPWDD's services. The following outlines OPWDD's public outreach related to the 2014 waiver renewal:

In addition to two rounds of public comment (May 2014 and February-April 2015) surrounding The HCBS Transition Plan, as described more fulfilling in those sections of this waiver application, OPWDD has the following standing committees for stakeholder outreach on changes to the waiver.

- The Commissioner's Developmental Disabilities Advisory Council (DDAC) established by New York Mental Hygiene Law 13.05 and comprised of self-advocates, family members, provider representatives, and other stakeholders; the Self-Advocacy Association of New York State; provider associations and provider councils, the Statewide Family Support Services Committee; the County and Local Mental Hygiene Directors; and the Real Choice Systems Committee. The DDAC which began in this iteration in Spring of 2012, is a workgroup that meets quarterly and is designed to oversee and guide the development of the new waiver and assist OPWDD and its stakeholders define the system reforms the waiver will achieve. The DDAC has specific subcommittees that have responsibility for particular areas, including self-direction and managed care implementation.
- The Joint Advisory Council (JAC), effective in April 2013, is a quarterly workgroup that focuses on ensuring care improvement for individuals and their families with a thoughtful transition to the new path for receiving services. OPWDD and DOH Commissioner, individuals, and their families are informed on the design of MC models that will provide services to IDD individuals.
- The Transformation Panel, which began in February 2015, is a group chaired by the OPWDD Commissioner that meets monthly with individuals, families, and professionals in the field to discuss shared goals identified by CMS and NYS that will improve opportunities for IDD individuals in areas of employment, integrated living, and self-direction of services.

Additionally, information is available to the public through the following formats:

- Guidance Documents regarding waiver services that are available on the website
- Information Line (866-946-9733) is available 24/7 for inquiries, complaints, and general information.
- People First News Newsletter which is also available on the website, is updated quarterly since July of 2014 to share news, programs, events, and stories from the field to the OPWDD community.
- Regular presentations by OPWDD Senior Management and Waiver Unit staff regarding changes to the waiver and service updates affected by the waiver changes to various stakeholders throughout the year.

Public outreach specific to this substantive amendment of the OPWDD Comprehensive Waiver mirrored the process utilized during the work on the Renewal and previous Amendment applications. OPWDD published the full version of “Amendment 05” to the OPWDD Comprehensive Waiver Renewal application effective October 1, 2014 (approved March 31, 2016) on its website from March 27, 2019 to May 24, 2019 to comply with the formal 30-day public comment period prior to submission. The proposed and approved “Amendment 05 ” applications are available at: http://www.opwdd.ny.gov/opwdd_services_supports/people_first_waiver/HCBS_waiver_services. On March 27, 2019, NYS published public notice in the NYS Register regarding the availability of public comment on “Amendment 05” from March 27, 2019 to May 24, 2019. The public notice also included a summary of the actions included in the “Amendment 05” Waiver application. In addition, hard copies of the proposed “Amendment 05” were made available at all fourteen OPWDD Regional Office locations from March 27, 2019 to May 24, 2019 at the following addresses:

- Finger Lakes DDRO, 620 Westfall Rd, Rochester, NY 14620
- Western NY DDRO, 1200 East and West Rd, West Seneca 14224
- Central NY DDRO, 187 Northern Concourse, North Syracuse, NY 13212
- Broome DDRO, 229-231 State St, Binghamton, N.Y. 13901
- Sunmount DDRO, 2445 State Rt. 30, Tupper Lake, NY 12986
- Capital District DDRO, 500 Balltown Rd, Schenectady, NY 12304
- Hudson Valley DDRO, 9 Wilbur Rd, Thiells, NY 10984
- Taconic DDRO, 38 Firemens Way, Poughkeepsie, NY 12603
- Metro NY/Bronx DDRO, 2400 Halsey St, Bronx, NY 10461
- Metro NY/Manhattan DDRO, 25 Beaver St, New York, NY 10004
- Brooklyn DDRO, 888 Fountain Ave, Brooklyn, NY 11208
- Staten Island DDRO, 1150 Forest Hill Rd, Staten Island, NY 10314

- Bernard Fineson DDRO, 80-45 Winchester Blvd, Queens Village, NY 11427
- Long Island DDRO, 415-A Oser Ave, Hauppauge, NY 11788.

OPWDD received questions on various HCBS Waiver topics from individuals and organizations. The majority of feedback was received on the Community First Choice Option (CFCO) State Plan and rate setting methodologies.

Following the public comment period, OPWDD published a questions and answers document to provide clarification on questions received available at:
http://www.opwdd.ny.gov/opwdd_services_supports/people_first_waiver/HCBS_waiver_services.

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 is 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.

7. Contact Person(s)

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

Last Name: Zachary-Elkind

First Name: Janet

Title: Deputy Director, Office of Health Insurance Programs

Agency: NYS Department of Health

Address: 99 Washington Avenue

Address 2: Suite 720

City: Albany

State: **New York**

Zip: 12210

Phone: (518) 473-0919 **Ext:** ☐ **TTY**

Fax: (518) 486-2495

E-mail: janet.zachary-elkind@health.ny.gov

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

Last Name: Marlay

First Name: Kate

Title: Deputy Commissioner, Division of Policy and Program Development/People First Waiver

Agency: Office for People with Developmental Disabilities (OPWDD)

Address: 44 Holland Ave.

Address 2:

City: Albany

State: **New York**

Zip: 12229

Phone: (518) 486-6466 **Ext:** ☐ **TTY**

Fax: (518) 402-4325

E-mail: katherine.marlay@opwdd.ny.gov

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the state's request to amend its approved waiver under §1915(c) of the Social Security Act. The state affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The state further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The state certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature: Donna Frescatore

State Medicaid Director or Designee

Submission Date: Jun 28, 2019

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name: Frescatore

First Name: Donna

Title: State Medicaid Director

Agency: New York State Department of Health

Address: 99 Washington Avenue

Address 2: Suite 1211

City: Albany

State: **New York**

Zip: 12210

Phone: (518) 474-3018 **Ext:** ☐ **TTY**

Fax: (518) 486-1346

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Attachments

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- ☐ **Replacing an approved waiver with this waiver.**
- ☐ **Combining waivers.**
- ☐ **Splitting one waiver into two waivers.**
- ☐ **Eliminating a service.**
- ☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**
- ☒ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- ☐ **Reducing the unduplicated count of participants (Factor C).**
- ☐ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**
- ☐ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**
- ☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

Through this amendment, OPWDD is aligning service limits for Environmental Modifications, Assistive Technology, and Vehicle Modifications in conjunction with the currently approved CFCO State Plan. With the alignment of the currently approved CFCO State Plan, the service limit for Environmental Modifications, Assistive Technology and Vehicle Modifications will be modified to a limit of $15,000 which may be exceeded due to medical necessity. The medical necessity criteria developed by the NYS Department of Health (DOH) will be utilized for the authorization of any modification or device that exceeds the $15,000 limit to ensure there is consistency in service authorization statewide.

On June 30, 2018, PCSS was terminated. Effective July 1, 2018, OPWDD implemented Health Home Services (SPA# NY-17-0025) for individuals with I/DD and terminated MSC State Plan Services (SPA# NY-12-30). OPWDD HCBS Waiver Care management is fully compliant with the federal regulatory requirement for conflict of interest (COI) following a one-year transition period through a managed care option or a fee-for-service reimbursement system using the Health Home State Plan for comprehensive Care Coordination Organizations/Health Homes (CCO/HHs). For individuals who do not elect to receive CCO/HH Care Management, he or she will be provided Basic HCBS Plan Support (SPA# NY-18-0058) services that will include the coordination of all services with a focus on their OPWDD services. This basic service will be provided by a CCO of their choice that meets the COI rules following a one-year transition period.

To ensure a smooth transition, during the first year of operations CCOs, with appropriate firewalls and supervisory structures in place, may provide Health Home Care Management services through a contract or may directly employ Care Managers. After one year of operation, all Care Managers (including former Medicaid Service Coordination (MSC) Service Coordinators) providing care management (Health Home Care Management or Basic HCBS Plan Support) under a designated CCO must be directly employed by the CCO and may not provide Home and Community-Based Services (HCBS), with the exception of Care Managers who are affiliated with an MSC agency that is operated by a federally recognized Tribe.

Attachment #2: Home and Community-Based Settings Waiver Transition Plan
Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.
Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.
To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.
Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.
Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

The State assures that this Waiver amendment or renewal will be subject to any provisions or requirements included in the State's most recent and/or approved Home and Community-Based Settings Statewide Transition Plan. The State will implement any CMS required changes by the end of the transition period as outlined in the Home and Community-Based Settings Statewide Transition Plan.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Not applicable.

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*):

○ **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 *(select one)*:

○ **The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

○ **Another division/unit within the state Medicaid agency that is separate from the Medical Assistance Unit.**

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

(Complete item A-2-a).

◉ **The waiver is operated by a separate agency of the state that is not a division/unit of the Medicaid agency.**

Specify the division/unit name:

New York State Office for People With Developmental Disabilities (OPWDD)

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. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. 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:

The New York State (NYS) Department of Health (DOH) is the Single State Medicaid Agency (SMA) and as such has oversight for the supervision of the Medical Assistance Program under Title XIX of the Social Security Act. Appointed by Governor A. Cuomo, Donna Frescatore is the Director of the Office of Health Insurance Programs (OHIP) and the State Medicaid Director. In this capacity she is the signatory for all 1915(c) HCBS Waiver programs for NYS, including the Office For People With Developmental Disabilities (OPWDD) HCBS Waiver. The State Medicaid Director has final authority for the oversight of all aspects of the Medicaid (MA) program in NYS.

In addition, DOH Administrative Directives and General Information System messages have been issued to provide ongoing guidance regarding the MA Program administration, including eligibility determination, system management provider reimbursement, monitoring, and corrective actions to LDSSs. DOH also issues the monthly newsletter, MA Update, to announce major policy changes and other important MA related information. The MA Update is available on the DOH website:
http://www.health.ny.gov/health_care/medicaid/program/update/main.htm.

Administration and operation of the OPWDD HCBS Waiver is delegated to OPWDD through a Memorandum of Understanding (MOU) that states the respective roles and responsibilities of each agency. This interagency MOU is reviewed/revised as needed and available to CMS upon request. The current MOU was signed on 8/6/2013 and strengthens the Single State Medicaid Agency (SMA)'s oversight.

DOH responsibilities include:
-Submit all reports including the CMS 372 Annual Report and technical amendments to CMS;
-Provide information and directives regarding MA policies and procedures concerning the waiver to the local departments of social services (LDSS);
-Review applications of voluntary waiver service providers recommended by OPWDD. If qualified, issue Medicaid Provider numbers and enroll providers in Medicaid/eMedNY;
-Maintain, upgrade, and monitor systems/processes for qualified providers to bill MA for authorized waiver services and design system edits to assure and accommodate appropriate coding/ billing practices;
-Pay qualified providers of waiver services for those services authorized by OPWDD;
-Assure financial accountability for funds expended for waiver services, provide for an independent fiscal audit of the waiver program, maintain and make available to CMS, the Office of the State Comptroller or other designees, the appropriate financial records documenting the cost of services provided under the waiver, including independent audits;
-Oversee OPWDD's annual review of Individual Service Plans (ISP)/Life Plans (LPs) in accordance with the assurances set forth by CMS; perform annual fiscal review of a statistically valid sample of ISPs/LPs according to established procedure;
-Perform ISP/LP Inter-rater Reliability Review by selecting a subset of ISPs/LPs to validate that the OPWDD review process was performed as required and that the CMS assurances have been met.

OPWDD responsibilities include:
•Timely determinations regarding applicant HCBS Waiver enrollment requests in accordance with its procedures;
•Issuance of Notice of Decisions (NODs), on a form approved by DOH, to individuals whose enrollment has been approved, denied, suspended or terminated; and include notices of the right to a local conference with OPWDD and/or a fair hearing as required by State and Federal regulations;
•Establish standards for providers of waiver services, approve these providers for participation in the waiver, and forward to DOH agency specific recommendations for MA provider agreements;
•Determine payment levels for waiver services, as approved by the NYS Division of Budget;
•Submit to DOH data and reports on a statistically valid sample of ISPs/Life Plans for individuals enrolled in the HCBS Waiver;
•Provide reports and updates to DOH as requested, i.e. established Critical Incident Management Notification Process.

OPWDD maintains the successful day-to-day operation of the HCBS Waiver, while DOH, as the oversight agency, is responsible for evaluating OPWDD’s performance in accomplishing its operational and administrative functions.
Multiple divisions within DOH, especially within OHIP, work together to maintain and to monitor the complex intra-agency operating systems that support operation of the OPWDD HCBS Waiver, as described in Table A.7.

These include:

•Waiver Expenditures Managed Against Approved Levels/Waiver Enrollment Managed Against Approved Limits: DOH's Division of Administration, Fiscal Management Group (FMG) is primarily responsible for the fiscal accountability and integrity of payments for waiver services (See Appendix I). FMG monitors OPWDD's expenditures by querying data stored in systems maintained by the OHIP Division of Systems. eMedNY provides detailed breakouts of waiver expenditures by category of service, based on a claims date of payment and as such, payments are calculated and made on an ongoing basis through this system. FMG is responsible for the submission of quarterly expenditure projection reports to CMS, along with the submission of actual expenditure reports following the end of each fiscal quarter. In addition, FMG performs monthly tracking of OPWDD HCBS Waiver expenditures. Monthly and quarterly reports are a part of the public record and are accessible to OPWDD, Division of Budget and the LDSS or local department of social services (county government).
Specific MA inquiries which are beyond the scope of prefabricated MARS reports are addressed via ad-hoc queries run against OHIP Data Mart and/or eMedNY Medicaid Data Warehouse. In the event fiscal inconsistencies or concerns are identified, FMG contacts OPWDD to clarify and resolve issues. Ultimately, the DOH’s aggregate reporting infrastructure is reviewed and audited by State, federal and independent auditors for accuracy and fiscal integrity.

Participant Waiver Enrollment: OHIP Division of Eligibility and Marketplace Integration (formerly the Division of Coverage and Enrollment) serves as a liaison to the LDSS with respect to MA eligibility policies. The Division of Eligibility and Marketplace Integration responds to questions raised by LDSS in relation to MA applicants/recipients who are either seeking MA enrollment or are currently enrolled in the OPWDD HCBS Waiver. This division also monitors the specific coverage codes on file for MA enrolled Waiver participants that permit MA payment of Waiver services through periodic case record reviews of local districts’ Medicaid population. In cases where waiver services are not being paid due to lack of proper coding, this division communicates the need for corrective actions to the LDSS so that coding errors may be corrected.

•Prior Authorization of Waiver Services/Utilization Management/Establishment of a Statewide Methodology: OHIP Division of Systems (DOS) DOH has a long established and well-defined process of review and oversight of changes to HCBS waiver services by OPWDD or similar stakeholders for considered implementation within eMedNY. This process, which leverages industry-standard Software Development Life Cycle (SDLC) methodologies, is known as the Evolution Project (EP) process. Before becoming an EP, a change request is first carefully reviewed by DOH policy staff in conjunction with other appropriate DOH staff (i.e. relevant program and fiscal areas). After the preliminary review and approval has been completed and a prioritization ranking assigned, a communique is transmitted by DOS to the State’s Fiscal Agent requesting that an EP be initiated. This initiation process includes the development of a Functional Requirements Document (FRD) in collaboration with applicable stakeholders, subsequently followed by a Project Design Document (PDD). Extensive design, testing, and revision continue until it is demonstrated that the programmatic and edit logic achieves the desired functionality. The OHIP DOS includes the eMedNY system and the Welfare Management System (WMS) system which coordinate the continued system support to effect the necessary computer changes to insure that eligible individuals are receiving the correct services and that the appropriate Medicaid providers bill correctly for the correct Medicaid services. eMedNY handles the computer process for the Medicaid billing aspects of the Waiver and WMS maintains the MA recipient eligibility system. One component of the system is the WMS Restriction/Exception (R/E) subsystem which restricts client abusers and supports system exceptions. (One of its main functions is to develop, test, and implement the necessary system programming via specifications or edit restrictions to ensure that eligible OPWDD HCBS Waiver recipients receive appropriate services from a qualified Medicaid provider).

•Qualified Provider Enrollment/Execution of Medicaid Provider Agreements/Numbers: Division of Health Plan Contracting and Oversight uploads qualified providers into eMedNY, the Medicaid Management Information System. OPWDD establishes standards for providers of waiver services, reviews completed provider applications and for qualified providers, issues waiver provider agreements that allow participation in the waiver program and provide the application for eMedNY. Division of Health Plan Contracting and Oversight then reviews the completed eMedNY application and recommendations made by OPWDD, completes an in depth review that incorporates four different sanction searches: eMedNY Sanction, NYS OMIG, HHS-OIG, and System For Award Management (SAM) on the providers board members and managing employees. If found to be appropriate, the Division of Health Plan Contracting and Oversight then issues a provider number to enroll the voluntary provider

in the NYS Medicaid program. In addition to provider enrollment, the Division of Health Plan Contracting and Oversight updates and performs maintenance on all qualified waiver provider files. The Division of Finance and Rate Setting add rates which are approved by the Division of Budget and activate or terminate provider numbers based on provider specific review findings and interacts with the waiver provider community concerning file discrepancies. Billing and reimbursement issues are handled by Computer Science Corporate.

Rules, Policies, Procedures, and Information Development Governing the Waiver Program: DOH reviews MA regulatory and operational functions for the OPWDD HCBS waiver in consultation with other DOH Divisions including the Division of Legal Affairs as needed.

•Quality Assurance and Quality Improvement Activities/Review of Participant Service Plans/Level of Care Evaluations: OHIP Division of Program Development and Management (DPDM), Waiver Management Unit (WMU) serves as the clearinghouse for many of OPWDD HCBS Waiver activities involving Medicaid (MA). The WMU coordinates all Waiver oversight functions, including the development and update of MA policies that impact the Waiver; oversight of the annual ISP/Life Plan Review of a statistically valid sample generated by DOH and conducted by OPWDD; completion of the ISP/Life Plan Inter Rater Reliability Review, limited ISP/LP fiscal review, and targeted ISP/LP reviews as required; submission of the annual
CMS 372 reports; monitoring of potential computer system changes through the Evolution Project Process.

In cooperation with CMS and OPWDD, the WMU continues to improve its collection of relevant quality assurance data and comprehensive trend analyses. Additionally, the WMU uses the Medicaid Update when required to communicate critical MA policy and coverage information to all MA providers. This document is published monthly on the DOH website.

Finally, the WMU shares all HCBS Waiver oversight activities and quality improvement strategies with the State Medicaid Director.

Appendix A: Waiver Administration and Operation

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

○ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

◉ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

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 (*Select One*):

◉ **Not applicable**

○ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.
Check each that applies:

☐ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

☐ **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).

Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

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:

Appendix A: Waiver Administration and Operation

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:

Appendix A: Waiver Administration and Operation

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. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Other State Operating Agency
Participant waiver enrollment	☒	☒
Waiver enrollment managed against approved limits	☒	☒
Waiver expenditures managed against approved levels	☒	☒
Level of care evaluation	☒	☒

Function	Medicaid Agency	Other State Operating Agency
Review of Participant service plans	☒	☒
Prior authorization of waiver services	☒	☒
Utilization management	☒	☒
Qualified provider enrollment	☒	☒
Execution of Medicaid provider agreements	☒	☒
Establishment of a statewide rate methodology	☒	☒
Rules, policies, procedures and information development governing the waiver program	☒	☒
Quality assurance and quality improvement activities	☒	☒

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority
The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. *As necessary and applicable, performance measures should focus on:*

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
A.i.1:Number and percent of required OPWDD Individualized Service Plans(ISPs)/Life Plans(LPs) reviewed for the annual DOH ISP/LP Review sample that was completed annually by OPWDD.(Percent = Number of ISPs/LPs reviewed by OPWDD from the statistically valid random sample provided by DOH for annual review /Total number of the statistically random sample of OPWDD beneficiaries reviewed.)

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 5%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
A.i.2: The percentage of serious reportable incidents (SRI) where appropriate corrective actions/safeguards were taken by the provider as verified by OPWDD. (Percent = number of SRIs reported to DOH by OPWDD where appropriate action was taken by providers as verified by OPWDD/Total number of SRIs reported to DOH by OPWDD).

Data Source (Select one):
Other
If 'Other' is selected, specify:
IRMA and DQI Survey

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
A.i.3: Number and percent of ISPs/LPs reviewed by OPWDD DQI that were validated by the DOH Inter rater reliability review (IRR= 10% of the statistically valid random sample DOH provided to OPWDD).(Percent = number of ISP/LPs reviewed during the DOH IRR annual review/Total number of ISPs/LPs requested/received by DOH from OPWDD for the annual IRR review).

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence

		Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: Annually, DOH selects & reviews a subset of ISPs/LPs from the corresponding larger, annual DOH ISP/LP sample. The IRR sample is representative of the entire population.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	Specify:

Performance Measure:
A.i.4: Number and percent of deficiencies identified in the DOH ISPs/LPs review that were remediated by OPWDD. (Percent = number of deficiencies remediated as verified by OPWDD/Total number of deficiencies identified during OPWDD DQI review of the statistically valid random sample provided from DOH).

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = +/-5%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
A.i.5: Number and percent of discrepancies identified during DOH ISP/LP Fiscal review that were remediated by OPWDD within a 12 month calendar year. (Percent: number of fiscal discrepancies found during DOH fiscal review that were remediated by waiver service providers as verified by OPWDD/Total number of fiscal discrepancies found during the DOH fiscal review.)

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = +/-5%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
A.i.6:Number and percent of potential waiver providers who were recommended by OPWDD for enrollment in NYS Medicaid that are subsequently enrolled in the Medicaid Program.(Percent = number of new HCBS waiver providers enrolled in the Medicaid program that were recommended by OPWDD for enrollment/Total number of new HCBS waiver providers that were recommended for enrollment into Medicaid by OPWDD).

Data Source (Select one):
Provider performance monitoring
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
A.i.7: Number and percent of OPWDD waiver providers on Early Alert where decision to sanction, terminate and/or take other appropriate corrective action was implemented appropriately and timely by OPWDD.(Percent= # of OPWDD waiver providers where the decision to sanction/terminate was implemented & DOH was notified/Total # of OPWDD waiver providers that were sanctioned/terminated by OPWDD).

Data Source (Select one):
On-site observations, interviews, monitoring
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Changes to Administrative Authority functions have been implemented to strengthen and broaden the scope of DOH oversight of the OPWDD HCBS Waiver, especially in the areas of health/welfare, qualified providers, and service plans to assure that SMA oversight is current, timely, and reflects OPWDD's present reform initiatives.

As part of its oversight responsibility, DOH provides assurances to CMS as outlined in the HCBS Waiver agreement. At a minimum, the monitoring responsibilities and activities include verifying that:
- Necessary safeguards have been taken to assure the health and welfare of waiver participants;
-Evaluations and periodic re- evaluations of individual waiver service plans have been provided as needed and required;
-Choice of HCBS Waiver or institutional care has been offered to all waiver participants;
-A formal quality assurance system is provided and accurately reflects the waiver status of individuals and providers; - Average per capita expenditures have been appropriately recorded and billed as waiver services and do not exceed the amount that would have been incurred without the waiver;
-Annual waiver reports and technical amendment(s), where applicable, are submitted to CMS with information about program costs and services. Oversight discovery activities include the following:

1. DOH oversight of OPWDD's annual review of a statistically valid sample of ISPs/Life Plans: The annual review of a statistically valid, representative sample of ISPs/Life Plans, previously completed by DOH, is conducted by OPWDD DQI. The ISP/Life Plan review time frame has been adjusted to align with the current waiver year. DOH oversight activities will ensure that OPWDD is correctly using the agreed upon review tool and that OPWDD DQI surveyor ISP/Life Plan reviews are accurate, complete, and executed as per the agreed upon process. OPWDD tracks individual deficiencies identified in this ISP/Life Plan review, monitors both individual and systemic remediation activities related to these deficiencies, and reports these finding to DOH semi- annually and more frequently as requested by DOH. DOH will continue to select a statistically valid representative sample annually of individuals enrolled in the HCBS waiver using established Raosoft formula. The selected sample will be forwarded to OPWDD DQI at the beginning of the waiver year (i.e. by October 1). DQI will complete the review, using the established review tool and timeline agreed upon both agencies. OPWDD DQI will develop and provide a semiannual report for DOH that summarizes: 1. the ISP/LP Review results, 2.OPWDD Performance metrics related to the ISP/Life Plan review and 3. Identified trends observed by each assurance category. (See Appendix D 2 a&b). Findings are reported in the 372 under performance measure FAa1 as described in Appendix I.

2. Annual DOH ISP/Life Plan Medicaid Claims review (Fiscal review) of waiver services documented in the ISP/Life Plan: DOH will continue to perform the Medicaid billing validation review for a subset of the DOH statistically valid sample. Deficiencies identified by DOH will be monitored to assure that appropriate remediation is completed by OPWDD within an established time frame.

3. Annual DOH ISP/Life Plan inter rater reliability (IRR) review: DOH will annually select a percentage of ISPs/Life Plans from the larger DOH statistically valid sample to conduct the IRR review. ISPs/Life Plans in the IRR will be reviewed independently by both DOH and OPWDD DQI. DOH will use the applicable portions of the DQI MSC Review Tool used by DQI so that the results can be compared and validated. In addition, deficiencies identified by DQI and/or DOH will be monitored to assure that appropriate remediation is completed.

4. Timely CMS 372 Report submission: The fiscal portion of the CMS 372 report, which includes data regarding waiver services and cost neutrality, is prepared, reviewed, and approved for fiscal accountability by various units within the DOH, including the Bureau of Budget Management (Fiscal Management Group or FMG). Results from both the quality portion(ISP/LP review) and fiscal portion review are combined to complete the CMS 372 report which is then submitted to DOH executive staff for final approval prior to submission to CMS.

5. Establishment of a process and time frame for the interagency Critical and Significant Event (CSE) Notification
system. The Director of the Incident Management Unit (or designee) provides notification to the DOH WMU within 24 hours of receipt of the CSE or on the next business day for individuals enrolled in the HCBS Waiver. DOH logs and tracks all incidents reported in the Critical and Significant Events Tracking Log. DOH meets internally every month, and as needed, to monitor, analyze and trend reported incidents. As part of the interagency quarterly meeting standing agenda, DOH discusses incident related issues with OPWDD.

6. DOH reviews the OPWDD Monthly Report for status of plans of correction and trending adverse actions especially for those HCBS Waiver providers placed on the OPWDD Early Alert system.

7. DOH and OPWDD adhere to an interagency process for monitoring OPWDD Waiver providers. OPWDD informs DOH when: 1.Voluntary waiver provider is recommended by OPWDD for enrollment in NYS Medicaid; 2.Voluntary waiver provider who is currently enrolled in NYS Medicaid has been approved to amend waiver service provision;3.When OPWDD terminates a voluntary waiver service provider, the DOH Bureau of Provider Enrollment notifies the DOH WMU in writing when providers are denied MA enrollment or are disenrolled from MA.

8. DOH coordinates, monitors, tracks, approves and evaluates all OPWDD evolution projects related to OPWDD's HCBS Waiver.

continued in section App A-QIS b.i below

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

A.i.1-A.i.2: Quality Assurance & Improvement Administrative Integrity: DOH monitors timelines to assure the integrity of the joint OPWDD/DOH quality management process by monitoring that ISPs/Life Plans are reviewed for accuracy and timeliness and the annual CMS 372 report is complete, contains all required elements, and submitted as required. DOH will work with OPWDD in the event that critical elements of the ISP/Life Plan review and/or completion/submission of the CMS 372 report requires revision.

The DOH WMU has an established Policy & Process in place for OPWDD Notification to DOH of Critical Significant Events and Incidents. The Policy assures that DOH remains vigilant of emerging issues that pertain to the safety, health and welfare of persons enrolled in the HCBS waiver.

DOH is responsible for:
- review and monitor of all incident reports received from OPWDD
- tracking, analyzing, and evaluation of all identified incident investigations reported to DOH
- fostering effective communication between OPWDD and DOH

The DOH WMU has designated staff that review and track all reports received and as needed, monitor investigations through outcome. The DOH WMU team meets monthly (or as needed) to review, analyze and trend reports received and if necessary request supporting information from OPWDD. The DOH WMU team provides incident related feed-back to OPWDD during the quarterly inter-agency meeting (or as needed).

If a situation arises that DOH is not satisfied with OPWDD remediation activity or timeliness of corrective actions regarding a specific incident, DOH will:
- Advise OPWDD in writing that documentation of completion of corrective action is required within 2 weeks (10 business days).
- Inform OPWDD that they are granted one additional week (5 business days) if OPWDD fails to respond or meet the designated (2 week completion date) deadline.
- Apprise key OHIP management for further recommendation if OPWDD fails to meet the final deadline.

A.i.2: Quality Assurance & Improvement, Health and Welfare: DOH will review aggregate reports compiled by OPWDD DQI regarding health and welfare performance measure outcomes. DOH will analyze these reports and require that OPWDD verify that remediation and follow-up activities have been completed in the agreed upon timeframe.

A.i.3 - A.i.4: Service Planning and Level of Care - Oversight of ISP/Life Plan Review: DOH's Strategy for Remediation for the annual ISP/Life Plan reviews: OPWDD's DQI is required to report performance measure outcomes to DOH semi- annually. The report findings and individual remediation activities are discussed at the quarterly meetings. Additionally, all deficiencies identified in the DOH IRR review are shared with OPWDD along with recommendations for improvements to the review process or protocols. OPWDD's response to these reports will occur within the timeframe agreed upon by both agencies. DOH may also periodically request additional operational and Quality Improvement Strategy reports to augment the review process.

A.i.5.: Financial Integrity: Following each DOH annual fiscal review, identified deficiencies, trends, and recommendation for improvements will be provided to OPWDD in a Statement of Discovery (SOD) report. OPWDD will respond to the SOD report and provide evidence of remediation of identified deficiencies in the timeframe agreed upon by both agencies. DOH will also provide CMS with both the SOD report and OPWDD's responses. DOH may also periodically request additional operational and Quality Improvement Strategy reports as a result of the review process. Additional fiscal oversight is performed by outside agencies, such as the Office of the Medicaid Inspector General (OMIG), the Office of the State Comptroller (OSC), and by the State's Single Independent Auditors, KPMG LLP.

A.i.6 - A.i.7: Qualified Provider Integrity: DOH will require OPWDD to verify that individual remediation of provider specific deficiencies that emerge from DOH tracking activities described in the previous section, have been addressed and completed within an appropriate timeframe. In addition, DOH reviews aggregate reports of provider specific performance measure outcomes compiled semi annually by OPWDD DQI. DOH will analyze these reports, obtain additional information from OPWDD DQI as needed, and verify that remediation has been addressed by OPWDD.

********** Continued from section App A-QIS.a.ii above

9. DOH and OPWDD maintain a standing interagency quarterly meeting that includes a comprehensive quality monitoring agenda that addresses reports and trends in the areas of health and welfare, incident management, qualified providers, service plans, fiscal accountability, level of care assurances, as well as any follow up to required remediation and QI strategies.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☒ **Other** Specify: Semi-annually

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

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 one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ Aged or Disabled, or Both - General					
	☐	Aged			☐
	☐	Disabled (Physical)			
	☐	Disabled (Other)			
☐ Aged or Disabled, or Both - Specific Recognized Subgroups					
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
☒ Intellectual Disability or Developmental Disability, or Both					
	☒	Autism	0		☒
	☒	Developmental Disability	0		☒
	☒	Intellectual Disability	0		☒
☐ Mental Illness					
	☐	Mental Illness			☐
	☐	Serious Emotional Disturbance			

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

Not applicable. Note: There is no minimum or maximum age requirement for participation in OPWDD's comprehensive waiver.

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):*

◉ **Not applicable. There is no maximum age limit**

○ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

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)*. Please note that a state may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

◉ **No Cost Limit.** The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

○ **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. *Complete Items B-2-b and B-2-c*.

The limit specified by the state is *(select one)*

○ **A level higher than 100% of the institutional average.**

Specify the percentage:

○ **Other**

Specify:

○ **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. *Complete Items B-2-b and B-2-c*.

○ **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.

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.

The cost limit specified by the state is *(select one)*:

○ **The following dollar amount:**

Specify dollar amount:

The dollar amount *(select one)*

○ **Is adjusted each year that the waiver is in effect by applying the following formula:**

Specify the formula:

○ **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.**

○ **The following percentage that is less than 100% of the institutional average:**

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

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)*:

☐ **The participant is referred to another waiver that can accommodate the individual's needs.**

☐ **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:

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

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	75483
Year 2	79972
Year 3	

Waiver Year	Unduplicated Number of Participants
	82203
Year 4	84811
Year 5	91000

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)* :

- ◉ **The state does not limit the number of participants that it serves at any point in time during a waiver year.**
- ○ **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	
Year 2	
Year 3	
Year 4	
Year 5	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

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)*:

- ○ **Not applicable. The state does not reserve capacity.**
- ◉ **The state reserves capacity for the following purpose(s).**

Purpose(s) the state reserves capacity for:

Purposes	
Individuals moving from Developmental Centers and Intermediate Care Facilities	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Individuals moving from Developmental Centers and Intermediate Care Facilities

Purpose *(describe):*

Reserved capacity for individuals moving from Development Centers (DCs) and Intermediate Care Facilities for Individuals with Developmental Disabilities (ICF/IDD) into HCBS waiver settings.

Describe how the amount of reserved capacity was determined:

The reserve capacity was based on the State's plan for ICF and Developmental Center closures.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	0
Year 2	1294
Year 3	1435
Year 4	1851
Year 5	944

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

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)*:

- (●) **The waiver is not subject to a phase-in or a phase-out schedule.**
- ( ) **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 intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

- (●) **Waiver capacity is allocated/managed on a statewide basis.**
- ( ) **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 local/regional non-state entities:

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

OPWDD's waiver capacity is allocated and managed on a statewide basis. OPWDD receives funding through legislative appropriation, which includes resources for existing services and for new or expanded services. OPWDD's HCBS waiver is constructed to ensure a sufficient number of HCBS opportunities to maximize the number of individuals served through available state appropriation during each funding cycle. HCBS enrollment levels are calculated to approximate the number of new HCBS enrollments that could be afforded by anticipated legislative appropriation.

Individuals seeking supports and services from OPWDD may request entry in OPWDD's system from many points including approaching the local Regional Office directly or a provider agency. The Regional Offices assists individuals who indicate a need for services by utilizing OPWDD's tools for assessing individual needs and service planning. This process includes the determination of developmental disability and Level of Care evaluation process outlined in Appendix B-6 (f) as well as the development of a Preliminary Individualized Service Plan (see Appendix D for more information). Once eligibility for OPWDD services is established, individuals are provided with opportunities for supports and services that meet the individual’s needs and valued outcomes (as a first step) and then resources (including HCBS waiver services) are identified and offered thereafter to meet those needs.

This individualized planning and delivery process maintains each person’s access to local, state, and federal programs, while subordinating eligibility and funding decisions to choices determined through the person-centered planning process. These efforts ensure the provision of sustainable supports and services for individuals across the full continuum of needs and challenges.

If, through this person-centered planning process, an individual chooses to apply for HCBS waiver services, the individual must first meet the following criteria for enrollment:

1. Have an intellectual disability or a developmental disability in accordance with the definition found at New York State Mental Hygiene Law Section 1.03 (22),

2. Be Medicaid eligible,

3. Be eligible for ICF/DD level of care. Please see the section describing the Level of Care evaluation process.

4. Reside in an appropriate living arrangement (and/or be residing in an appropriate living arrangement once enrolled in the HCBS waiver) as per OPWDD's waiver regulations.

The process for waiver enrollment is then coordinated and facilitated through the individual's local regional office.

In accordance with OPWDD's CMS approved waiver (2009-2014), OPWDD continues to prioritize participant needs on a statewide basis as follows:

Priority 1: Any of the following (i.e., emergencies):

--Abusive or neglectful situation constituting imminent risk of harm
--Imminent danger to self
--Imminent danger to others
--Homeless or in imminent danger of becoming homeless

Priority II: Any of the following (i.e., urgency/emergency prevention)

--Aging or failing health of caregiver/no alternate caregiver available
--Living situation presents a significant risk of neglect or abuse
--Medical/physical condition requires care not available in present situation
--Presents an increasing risk to self or others
--Affected by court or legislative mandate requiring residential placement

Priority III: This priority group includes all who present a need but there is no danger to the health and safety of the individual or his/her caregiver (i.e. considered not urgent). Factors to consider include:

--Compatibility of the individual with available services

--Compatibility with the other individuals in a shared living arrangement
--Relative need for supports for daily living

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a. **1. State Classification.** The state is a *(select one)*:

- (●) **§1634 State**
- ( ) **SSI Criteria State**
- ( ) **209(b) State**

2. Miller Trust State.
Indicate whether the state is a Miller Trust State *(select one)*:

- (●) **No**
- ( ) **Yes**

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*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- [ ] **Low income families with children as provided in §1931 of the Act**
- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- [x] **Optional state supplement recipients**
- [ ] **Optional categorically needy aged and/or disabled individuals who have income at:**

  Select one:

  - ( ) **100% of the Federal poverty level (FPL)**
  - ( ) **% of FPL, which is lower than 100% of FPL.**

  Specify percentage: [ ]

- [ ] **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- [x] **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- [x] **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)**
- [ ] **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)**
- [ ] **Medically needy in 209(b) States (42 CFR §435.330)**
- [x] **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- [x] **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state**

plan that may receive services under this waiver)

Specify:

Infants and Children under Age 19 (42 CFR 435.118);

Mandatory Coverage of Parents and other Caretaker Relatives (42 CFR 435.110); Optional Coverage of Parents and other Caretaker Relatives (42 CFR 435.220);

Adult Group (covers non-pregnant individuals age 19 – 64, not enrolled in Medicare) (42 CFR 435.119);

Children who qualify for State adoption assistance (42 CFR 435.227);

Children for whom an adoption agreement is in effect or foster care maintenance payments are being made under Title IV-E (42 CFR 435.145);

Individuals who qualify under 1902(a)(10)(A)(i)(II)(bb)(Qualified Severely Impaired); and

Disabled Adult Children (DAC) beneficiaries who are eligible under 1634(c) of the Social Security Act.

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*

- (●) **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.*
- ( ) **Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

- ( ) **All individuals in the special home and community-based waiver group under 42 CFR §435.217**
- ( ) **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

Check each that applies:

- [ ] **A special income level equal to:**

Select one:

- ( ) **300% of the SSI Federal Benefit Rate (FBR)**
- ( ) **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage: [ ]

- ( ) **A dollar amount which is lower than 300%.**

Specify dollar amount: [ ]

- [ ] **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**
- [ ] **Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
- [ ] **Medically needy without spend down in 209(b) States (42 CFR §435.330)**
- [ ] **Aged and disabled individuals who have income at:**

Select one:

○ **100% of FPL**

○ **% of FPL, which is lower than 100%.**

Specify percentage amount:

☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

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. 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:

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

b. Regular Post-Eligibility Treatment of Income: SSI State.

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

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 and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: §1634 State - 2014 through 2018.

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

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. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

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 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: 1

ii. Frequency of services. The state requires (select one):

- ○ **The provision of waiver services at least monthly**
- ◉ **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:

Not applicable.

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

- ○ **Directly by the Medicaid agency**
- ○ **By the operating agency specified in Appendix A**
- ○ **By a government agency under contract with the Medicaid agency.**

Specify the entity:

- ◉ **Other**

Specify:

The Initial LOC is the responsibility of the Operating Agency's regional offices, although a family or individual may be assisted by a voluntary agency to gather the necessary information (see C below for qualifications of individuals performing initial evaluations).

The individual's Care Manager is responsible for assuring that the annual LOC re-evaluations occur. The person's Care Manager may complete the annual LOC redetermination if that person is also a Qualified Intellectual Disabilities Professional (QIDP). If the Care Manager does not have the QIDP credentials, the Care Manager must assure that a QIDP familiar with the person would complete the annual redetermination. Credentials for a QIDP are described below in B-6-h.

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:

The initial LOC must be completed by a professional with at least one year of experience in conducting assessments or developing plans of care for people with developmental disabilities. Initial LOCs are reviewed by a physician and include the assessments conducted by "qualified practitioners" who may administer and interpret standardized measures of intelligence and adaptive behavior. A qualified professional is a person with a directly relevant master's degree or doctoral level education in psychology, who has training and supervised experience in the use and interpretation of such measures consistent with the recommendations contained in the respective test manuals for measures and with the requirements of ERA /APA/NCME (1999) standards for test administration and use and interpretation of individual test results.

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.

The OPWDD level of care instrument for the HCBS Waiver is identical to the level of care instrument used for ICF/DD. The same instrument is used for both initial evaluations and re-evaluations. A paper copy of the level of care instrument has been submitted in previous renewals and is available from OPWDD for CMS' review upon request. The level of care instrument and instructions are available on the OPWDD website at the following location: http://www.opwdd.ny.gov/opwdd_resources/opwdd_forms/home. The level of care instrument does not limit participation by individuals with certain conditions or diagnoses.

The criteria appearing in the level of care instrument are:

1. Evidence of a developmental disability,
2. Disability manifested before age 22,
3. Evidence of a severe behavior problem (not required),
4. Health care need (not required),
5. Adaptive behavior deficit in one or more of the following areas: communication, learning, mobility, independent living or self- direction.

The applicant must have functional limitations that demonstrate a substantial handicap. For most applicants over the age of eight, the substantial handicap must be determined using a nationally normed and validated, comprehensive measure of adaptive behavior, administered by a qualified professional. For applicants over the age of eight who have an IQ of 60 or lower, the presence of a substantial handicap may be assessed and confirmed through clinical observation or interview rather than standardized testing.

For children (birth through eight) with a developmental delay, but no specific diagnosis, provisional eligibility may be confirmed based on clinical judgement by use of criteria based on 20 CFR, Appendix 1 to Subpart P of Part 404 regarding SSI eligibility, and determination of functional limitations in motor development, cognition and communication or social function. Consistent with Section 200.1 (mm)(1) of NYS Education Department regulations, substantial handicap associated with delay can be documented by the results of an evaluation that indicates:
- A 12-month delay in one or more functional areas, or
- A 33% delay in one functional area, or a 25% delay in each of two functional areas; or
- If appropriate, standardized instruments are administered yielding a score of 2.0 deviations below mean in one functional area or a score of 1.5 standard deviations below the mean in each of two functional areas.

Additional information on this process is contained within OPWDD policy guidance. Any future changes to this process/requirements will be contained within OPWDD policy guidance.

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)*:

◉ **The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.**

○ **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.

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 initial stage of the Level of Care process begins when a person and/or family contact one of the state-operated Regional Offices to request services. In 2001, the OPWDD Eligibility Advisory "DETERMINING ELIGIBILITY FOR SERVICES: SUBSTANTIAL HANDICAP AND DEVELOPMENTAL DISABILITY" was issued to the field. The primary purpose of this policy advisory was to establish fair and consistent criteria by which the presence of developmental disability or substantial handicap could be confirmed by a Regional Office. This advisory provides detailed information regarding establishment of qualifying conditions, demonstration of substantial handicap via use of standardized adaptive behavior scales, age of onset of qualifying diagnoses and accompanying substantial handicaps, and expectations regarding indefinite continuation of the developmental disability (DD). A three-step eligibility review process has since been established by OPWDD to ensure careful and consistent review of all applications received. The general process for the first stage of the LOC process is as follows:

Step One Determinations: Requests for a DD determination are submitted to the local Regional Office that contains the county in which the applicant resides. In Step One, an intake worker and intake coordinator are involved as well as a masters-level or licensed psychologist and other clinical staff, if needed. The person or party who is requesting the eligibility determination is expected to provide the clinical information needed to make a determination. Once a complete documentation packet is received including all necessary psychological testing/evaluations as indicated in the eligibility advisory guidelines, the local Regional Office Eligibility Determination coordinator(s) makes a decision on eligibility for OPWDD services. If the individual is found eligible based on the criteria contained within the eligibility guidelines, the Regional Office notifies the party that requested the determination so that appropriate services and/or referrals for services may begin. If not found eligible at Step One, the individual's eligibility must be reviewed at Step Two.

Step Two Determinations: In Step Two DD Determinations the local Regional Office Director or their designee, and a second, licensed psychologist are involved in the determination at a minimum. Many Regional Offices now use a committee review process for Step Two determinations. They review the same information that was received and reviewed in Step One, as well as the decision rendered and reasons for said decision. If needed, those involved in the Step Two review can ask for additional clinical and/or historical information. The criteria for determinations of OPWDD eligibility at Step One and Step Two of the process are exactly the same, and are clearly delineated in the advisory guidelines. The final eligibility determination at Step Two is made by the Regional Office Director or their Designee, in conjunction with input from clinical/psychology staff and/or eligibility committee members. If the individual is found eligible, the Regional Office notifies the party that requested the determination so that appropriate services and/or referrals for services may begin. If the individual is found ineligible, the Regional Office provides the requesting party with a list of the materials or reports that were reviewed and a statement of the reasons for denial. In addition, if the individual is found ineligible, the opportunity to have eligibility reviewed by a third step review process is made known to the requesting party, in addition to other options (i.e., face to face meeting, fair hearing if applicable).

Step Three Determinations: Step Three DD Determinations can be requested by the individual and/or their advocate through the local Regional Office that made the original negative determination of eligibility (i.e., at the first and second levels of review). Upon the receipt of the complete documentation packet from the local Regional Offices, Third Step Review committees review the information to determine eligibility and then notify the local Regional Office of its recommendations. The purpose of the Third Step Review Committee is to review the clinical information submitted from the Regional Office and to make an independent eligibility determination on the basis of this paperwork in accordance with the criteria that was set forth in the OPWDD Eligibility Advisory issued on August 10, 2001, which parallels the language contained in Mental Hygiene Law (14 NYCRR 1.03 (22)). The Regional Office Director considers the recommendations from the Third Step Review committees and makes a final decision regarding eligibility or ineligibility.

In order to ensure consistent decision-making when it comes to determining eligibility for OPWDD services, the types and quality of information used must adhere to specific and standardized criteria (i.e., such as those established by many professional associations and health-care organizations). These practices are consistent with those established by a number of other state and federally funded programs (i.e., Social Security Administration, State Education) to ensure that determinations of eligibility for services follow clearly defined parameters so as to avoid inconsistent decision-making and to promote equity and fairness in those determinations rendered. The Eligibility guidelines and processes were established to ensure the definition set forth in MHL 1.03
(22) was met so as to avoid labeling any individual who truly did not meet the definition for Developmental Disability.

The DD Eligibility Determination process is the first step in completing the Initial Level of Care (LOC) evaluation for an individual seeking waiver services through OPWDD. In those cases where the individual is determined eligible for OPWDD services and has indicated they want some type of HCBS Waiver service and has a reasonable need for this type

of waiver service that is not available from other sources (e.g. State Education or Early Intervention), the clinical information gathered for the DD Eligibility Determination process is conveyed to the regional office staff responsible for completing initial LOC determinations. This professional uses the clinical information supporting the DD determination to complete the LOC form (i.e. psychological evaluation(s), medical or specialty report(s), psychosocial history), and also verifies NYS residency of the applicant and need for waiver services. After all preliminary screening is completed the Regional Office staff works with the person and family to identify specific types of services needed, and the frequency and scope of those services.

It is the responsibility of the participant's Care Manager to ensure that the annual Level of Care redetermination process is completed. It must also be reviewed and approved by a Qualified Intellectual Disability Professional (QIDP) who is familiar with the participant's functional level. During this process the most recent psychological evaluation, psychosocial history and medical history is reviewed to determine if the information is still accurate. By definition, a developmental disability is expected to continue indefinitely and pose a lifelong handicap to the individual and as such the psychological evaluation and psychosocial history profiles of individuals served through the waiver generally show little change. If there is any question as to the Level of Care needed by an individual currently authorized for services, a physician would be consulted during the Level of Care process.

The process and information outlined in Appendix B-6 reflects the current OPWDD policy and practices articulated in OPWDD's guidance documents. These policies may undergo revisions in the future and any such changes will be appropriately reflected in OPWDD's guidance documents.

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**
- ○ **Every six months**
- ○ **Every twelve months**
- ◉ **Other schedule**

  Specify the other schedule:

OPWDD requires an annual level of care redetermination (i.e., every 12 months) for all waiver participants to ensure that the person continues to meet the ICF/DD level of care. However, from an OPWDD audit perspective, OPWDD allows an additional one month time period to obtain the reviewers (i.e., Qualified Intellectual Disabilities Professional or physician or physician's assistant or nurse practitioner if so authorized by a physician) approval signature on the redetermination form.

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

- ○ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ◉ **The qualifications are different.**

  Specify the qualifications:

The initial LOC must be completed by a professional with at least one year of experience in conducting assessments or developing plans of care for people with developmental disabilities. Initial LOCs are reviewed by a physician and include the assessments conducted by "qualified practitioners" who may administer and interpret standardized measures of intelligence and adaptive behavior. A qualified professional is a person with a directly relevant master's degree or doctoral level education in psychology, who has training and supervised experience in the use and interpretation of such measures consistent with the recommendations contained in the respective test manuals for measures and with the requirements of ERA /APA/NCME (1999) standards for test administration and use and interpretation of individual test results.

It is the responsibility of the Care Manager to ensure the timely completion of the LOC redetermination process. The annual LOC redetermination must be reviewed and approved by a Qualified Intellectual Disability Professional (QIDP) who is familiar with the participant's functional level or a physician (or physician's assistant or nurse practitioner if so authorized by a physician).

To be designated as a QIDP for the purpose of completing an annual LOC redetermination, an individual must meet the definition set forth in federal regulations at 42 CFR 483.430(a):
(1) Has at least one year of experience working directly with individuals with intellectual disabilities or other developmental disabilities; and
(2) Is one of the following:
(i) A Doctor of medicine or osteopathy;
(ii) Registered Nurse (RN);
(iii) An individual who holds a least a bachelor’s degree in a professional category specified in paragraph (b)(5) of section 483.430(b)(5).

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):*

It is a function of the Care Manager to ensure the timely completion of the LOC redetermination. OPWDD's Division of Quality Improvement (DQI) conducts annual surveys and this survey includes a review of the timeliness of the LOC redetermination for a sample of participant records. The timely LOC reevaluation is also reviewed for a sample of participants during the annual DOH ISP/LP review.

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 §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

The OPWDD record retention standard for all major written and/or electronic records/documents related to service provision, including the level of care, exceeds the federal minimum of 3 years. The level of care documentation is kept in the participant's clinical record in a paper or electronic format maintained by the Care Coordination Organization (CCO) or FIDA-IDD, and must be retrievable upon request by the state or other appropriate authority. The CCO provides both Health Home Care Management and Basic Home and Community-Based Services (HCBS) Plan Support.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. Sub-Assurances:

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
The number and percent of initial ICF/DD Level of Care (LOC) determination forms present in sampled Care Manager records where the initial LOC was completed prior to the receipt of waiver services (Percentage=number of initial LOC forms present in the Care Manager record where the initial LOC was completed prior to the receipt of waiver services/total Care Manager records sampled).

Data Source (Select one):
Other
If 'Other' is selected, specify:
Division of Quality Improvement (DQI) Person-Centered Reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = +/-5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
The number and percent of LOC redetermination forms present in the sampled Care

Manager records that were re-evaluated within the previous 365 days. (Percentage=number of LOC redetermination forms present in the Care Manager record where the LOC form was re-evaluated within the previous 365 days/total Care Manager records sampled).

Data Source (Select one):
Other
If 'Other' is selected, specify:
DQI Person-Centered Review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = +/-5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
The number and percent of LOC redeterminations in sampled Care Manager records that meet waiver requirements for appropriate forms and processes (Percentage=number of LOC redeterminations that met requirements/total LOC redeterminations reviewed).

Data Source (Select one):
Other
If 'Other' is selected, specify:
DQI Person-Centered Review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = +/-5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The operating agency (OPWDD) conducts discovery activities for LOC determinations during the annual joint DOH/OPWDD ISP/LP review. The operating agency also conducts discovery activities for LOC determinations through Division of Quality Improvement (DQI) review activities, which involve the annual statewide sampling of Care Manager records to review initial and reevaluations of LOC determinations.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

Individual problems found for each of the three sub-assurances result in a letter from OPWDD describing the error that was found and requiring a response indicating the specific problem has been corrected. Error rates of greater than 10% result in a memo and/or e mail notices to the field citing the error trends found in the recent sample and advising all agencies to use their internal quality assurance process to determine if they have made similar errors.

If individual deficiencies are found they are documented on Exit Conference Form and the provider for care coordination review must remediate within 30 days and send attestation that they did so. If deficiencies are found that rise to the level of egregious, systemic, or pervasive, the provider/ will receive a Statement of Deficiency (SOD) requiring a Plan of Corrective Action (POCA). OPWDD verifies that the POCA has been implemented.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*

c. Timelines
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

- (●) **No**
- ( ) **Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

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).

The following entities/individuals are responsible for providing information about feasible alternatives and informing individuals or their legal representatives about their freedom of choice between waiver and institutional services:
- Care Coordination Organization (CCO) - Care Manager
- Partners Health Plan (PHP) – Care Manager

All applicants for services who the Regional Office has determined to have a developmental disability and may qualify for either ICF/DD or HCB services must be verbally informed of the choice they may make between the two types of Medicaid funded programs. After this discussion has occurred, but before enrollment, the person, his/her advocate or his/her legal representative must sign form "HCBS Form 02.03.97 (3/97)" that indicates the person has been informed of the two options of either ICF/DD or HCBS and has chosen HCBS. The form also states the person's choice of CCO/Care Manager and the right to choose waiver service providers they prefer. The form must be signed by the applicant, family/advocate, Care Manager and a Regional Office representative.

b. Maintenance of Forms. Per 45 CFR §92.42, 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.

HCBS Form 02.03.97 (3/97) must permanently be kept in the enrollment section of the person's care management record. It must be retrievable within 24 hours upon demand from an authorized state or federal agency.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency 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):

It is the policy of OPWDD to provide effective communication to any person, family member, or designee in receipt of seeking services. OPWDD Language Access Policy and Procedures has a mechanism for providing interpretation/translation, filing complaints, staff training, and monitoring.

At the point of contact staff is trained to assess language access needs and provide interpretation via telephone or in person. OPWDD materials are translated into Spanish, Russian, Chinese, Haitian (Creole), Urdu, Yiddish, Italian and Korean. Additional translations requests follow the process identified in the OPWDD Language Access Policy and Procedures. OPWDD staff is training annually for effective communication. People are informed of their rights for effective communication by the translated Website, at the point of admission and through Rights and Responsibilities 14 NYCRR 633.4. OPWDD assessment tools have been updated to require communication needs for individuals, family members, or designees.

- Title VI of the Civil Rights Act of 1964
- N.Y.S. Mental Hygiene Law §13.09(e)
- 14 NYCRR 633.4(a)(15) Meeting the communication needs of non-English speaking persons seeking or receiving services

Voluntary provider agencies under the auspices of OPWDD are required to adhere to the above laws and statues as they relate to effective communication. OPWDD allows agencies to access its telephonic interpretation service and its translated documents to benefit individuals and families who speak a language other than English. OPWDD modification to current assessment tools is also applicable to provider agencies. Providers will be required to capture language spoken by individuals, family members, or designees. To ensure compliance with said laws and regulations, OPWDD will be requiring that voluntary provider agencies in the receipt of Waiver funding have an Effective Communication Policy and Procedure. The Effective Communication Policy and Procedure should identify a process for the following:

1. Training staff about Cultural and Linguistic Competence;
2. Service provision that includes interpretation/translation; and,
3. Mechanisms for determining the communication needs of the service area and individuals accessing services.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. *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:*

Service Type	Service		
Statutory Service	**Day Habilitation**		
Statutory Service	**Live-in Caregiver (42 CFR §441.303(f)(8))**		
Statutory Service	**Prevocational Services**		
Statutory Service	**Residential Habilitation**		
Statutory Service	**Respite**		
Statutory Service	**Supported Employment (SEMP)**		
Supports for Participant Direction	**Community Transition Services**		
Supports for Participant Direction	**Fiscal Intermediary (FI)**		
Supports for Participant Direction	**Individual Directed Goods and Services**		
Supports for Participant Direction	**Support Brokerage**		
Other Service	**Assistive Technology - Adaptive Devices**		
Other Service	**Community Habilitation**		
Other Service	**Environmental Modifications (Home Accessibility)**		
Other Service	**Family Education and Training**		
Other Service	**Intensive Behavioral Services**		
Other Service	**Pathway to Employment**		
Other Service	**Plan of Care Support Services**		

Service Type	Service		
Other Service	Vehicle Modifications		

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:

Statutory Service

Service:

Day Habilitation

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04020 day habilitation
Category 2:	**Sub-Category 2:**
15 Non-Medical Transportation	15010 non-medical transportation
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Assistance with acquisition, retention or improvement in self-help, socialization and adaptive skills including communication, travel and adult education that regularly takes place in a non-residential setting, separate from the person's private residence or other residential arrangement. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, community inclusion, relationship building, self-advocacy and informed choice.

Day Habilitation services may also be used to provide support retirement activities. As some people get older they may no longer desire to work and may need supports to assist them in meaningful retirement activities in their communities. This might involve altering schedules to allow for more rest time throughout the day, support to participate in hobbies, clubs and/or other senior related activities in their communities.

There are two main categories of Day Habilitation Services for service dates prior to 10/1/2015 : Individual Day Habilitation (a one-to-one, individual-to-worker provided service with an hourly unit of service) and Group Day Habilitation (delivered in a group setting). The Individual Day Habilitation methodology will ‘sunset’ effective 9/30/2015. Group Day Habilitation services are furnished 4 or more hours per day on a regularly scheduled basis for 1 or more days per week or less frequently as specified in the participant's service plan. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day).

A supplemental version of both Individual (available to participants through 9/30/2015) and Group Day Habilitation is available for individuals who do not reside in a certified 24/7 location. This supplemental Day Habilitation is provided outside the 9-3 weekday time period, and includes late afternoon, evenings, and weekends. None of the services can be delivered at the same time.

All Day Habilitation services (Individual, Group and Supplemental services) have the same service description and focus on enabling the participant to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational or speech therapies in the service plan. In addition, Day Habilitation services may serve to reinforce skills, behaviors or lessons taught in other settings.

When the transportation cost is included in the provider’s day habilitation rate, the day habilitation program is responsible for "to and from" transportation and transportation involved in delivering day habilitation services. There is no separate Medicaid billing for transportation to and from a Day Habilitation service. The NYS Department of Health (DOH) will be sending a one-time budget survey to all Day Habilitation providers requesting “to and from” transportation cost data. This data will be reviewed and a determination of Day Habilitation reimbursement will be made by DOH to be included in the July 1, 2018 rates. Additional details are available in Addendum A of this Waiver application on page 31.

For dates of service beginning July 1, 2017 and ending June 30, 2021 provider agencies serving individuals with complex behavioral and/or medical support needs which exceed that of the IDD population at large will have the opportunity to apply for supplemental funding which would be available until the costs of providing care to these individuals are incorporated within their reimbursement rate. This supplemental funding, referred to as “Higher-Needs Funding” would be available to provider agencies serving individuals who are new to a Day Habilitation placement, or individuals that are currently receiving Day Habilitation services and who experienced a significant change in their behavioral and/or medical status (such as; an accident resulting in hospitalization). The interim rate will be based upon the utilization of a separately calculated threshold level that the individual falls within. The only difference between the interim rate and the provider’s rate calculated in accordance with the methodology described in the OPWDD Comprehensive Waiver agreement is the inclusion of additional direct care support hours based on an initial clinical review.

An initial clinical review will be conducted to determine an individual’s threshold level in one of the three “Higher-Needs Funding” threshold levels described below. The “Higher-Needs Funding” (interim rate) will cease when the additional costs for serving the individual(s) with Higher-Needs are included in a Provider’s CFR used for the purpose of rebasing. Following the initial clinical review, individuals who qualify for “Higher-Needs Funding” will be subject to a clinical review every 6 months to determine their current threshold level based upon their needs since their initial clinical review conducted during their Day Habilitation placement or significant change in their medical and/or behavioral status. Using a 10% sample, on an annual basis, the State will verify the fiscal integrity of the Higher-Needs Funding.

The “Higher-Needs Funding” establishes three tiers:

• Tier 1 – individuals who receive Day Habilitation services and have a Developmental Disabilities Profile (DDP-2) with a behavioral or medical score that is at or higher than 1.5 standard deviations from the mean in either category, and lower than 2 standard deviations. Funding for an additional .95 direct support hours per unit will be provided.
• Tier 2 - individuals who receive Day Habilitation services and have a DDP-2 with a behavioral or medical score that is at or higher than 2 standard deviations from the mean in either category, and lower than 2.5 standard deviations.Funding for an additional 1.89 direct support hours per unit will be provided.
• Tier 3 - individuals who receive Day Habilitation services and have a DDP-2 with a behavioral or medical score that is at or higher than 2.5 standard deviations from the mean in either category. Funding for additional direct support hours will be determined based upon a standardized assessment and core exception process, which is structured by the need of additional staffing, provider qualifications, higher clinical support hours and other influential factors provided for each individual.

Beginning July 1, 2021, OPWDD will utilize blended data from both the Developmental Disabilities Profile-2 (DDP-2) and the Coordinated Assessment System (CAS) to determine individuals' complex needs for "Higher-Needs Funding" reimbursement. The State (OPWDD) will submit an amendment to this waiver to CMS to change reimbursement methodology for date of service after June 30, 2023 to incorporate the use of a CAS-based methodology and any corresponding reimbursement identified in Addendum A.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Group DH , Individual DH, and supplemental GDH/IDH cannot be billed as overlapping services. Supplemental services are not available to individuals residing in certified residential settings, because the residence is paid for staffing on weekday evenings and anytime on weekends.

OPWDD has established a maximum daily amount of services that are available to individuals based upon their residence. Individuals residing in certified settings are limited to a maximum of six hours of non-residential services (or its equivalent) which must commence no later than 3 pm on weekdays.

Effective with service dates of 7/1/14 Day Habilitation services will not include funding for direct, hands-on physical therapy, occupational therapy, speech therapy, nutrition, or psychology services. In addition, effective 7/1/14 only nutrition services directly related to the habilitation service and psychology services that support the person's need for behavioral supports in the service setting will be included in the rate for the Day Habilitation Service. Between 7/1/14 and 12/31/15 , any instances where agencies' service provision does not comply with these requirements, will be addressed in the compliance process described in Addendum A. OPWDD will be eliminating waiver funding for direct hands-on therapies in Day Habilitation programs effective 1/1/16 .

Federal Financial Participation (FFP) will be claimed for Individual Day Habilitation (including Supplemental Individual Day Habilitation) from 7/1/14 through the end date of Individual Day Habilitation service provision on 9/30/15.

The rate paid to a Day Habilitation provider of service may be a "Special Populations Funding" rate for an individual who has been discharged from a more restrictive residential setting such as a developmental center as described in Addendum A to this waiver. This higher rate is designed to provide additional supports required to assist an individual transitioning to a less restrictive setting. The supports that are funded may include additional behavioral planning and staff training, and/or higher staffing ratios to support individuals whose need for supervision or for physical support exceeds that of the IDD population at large. Special Populations Funding will be in effect through June 30, 2017.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	non-profit organization or state

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Habilitation

Provider Category:

Agency

Provider Type:

non-profit organization or state

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

OPWDD establishes standards for providers of waiver services, reviews completed provider applications and for qualified providers, issues Waiver provider agreements that allow participation in the waiver program, provides the application for eMedNY and issues operating certificates for all waiver services. The DOH Division of Operations then reviews the completed eMedNY application and recommendations made by OPWDD, completes an in depth review that incorporates four different sanction searches: eMedNY Sanction, NYS OMIG, HHS-OIG, and Excluded Parties List on the providers board members and managing employees. If found to be appropriate, the DOH Division of Operations then issues a Medicaid provider agreement to enroll the voluntary provider in the NYS Medicaid program in accordance with regulations found at Part 504 of 18 NYCRR. For contracted providers of the FIDA-IDD Plan that deliver waiver services the FIDA-IDD is responsible to ensure that the provider is one that is approved by OPWDD to provide HCBS waiver services .

OPWDD directly provides HCBS waiver services through its regional offices. In addition, HCBS waiver services are provided by provider agencies which are non-profit organizations. Non-profit organizations include: non- profit corporations formed under New York State Law or authorized to do business in New York, local government units, or organizations created by an act of the New York State Legislature for charitable purposes which include providing services to persons with developmental disabilities.

If the provider agency employs professional clinical staff, that staff person must have the appropriate credentials stipulated by the OPWDD and/or the NYS Department of Education under the following regulations and laws:

- Nursing (8 NYCRR Part 64, and Education Law Title 8, Article 139)
- Speech Language Pathologist (8 NYCRR Part 75, and Education Law Title 8, Article 159)
- Psychology (8 NYCRR Part 72, and Education Law Title 8, Article 153)
- Social Work (8 NYCRR Part 74, and Education Law Title 8, Article 154)
- Rehab Counselor (14 NYCRR Part 679.99)
- Dietetics/Nutrition (8 NYCRR Part 79, and Education Law Title 8, Article 157)
- Occupational Therapy (8 NYCRR Part 76, and Education Law Title 8, Article 156)
- Physical Therapy (8 NYCRR part 77, and Education Law Title 8, Article 136)
- Applied Behavioral Sciences Specialist (8 NYCRR Part 79, and Education Law Title 8, Article 167).
- Behavioral Intervention Specialist (14 NYCRR part 633-16.b(32)

Direct support professionals must have completed the training stipulated in 14 NYCRR Part 633.8. Provider agencies must comply with 14 NYCRR Part 633, "Protections of Individuals Receiving Services", including Criminal Background Check (CBC) screening. Provider agencies must also comply with the Part 624, "Reportable Incidents and Client Abuse", and Part 635, "General Quality Control and Administrative Requirements". OPWDD directs provider agencies to screen staff against the Medicaid Excluded Provider lists maintained by the Department of Health and the HHS Office of the Inspector General.

Verification of Provider Qualifications

Entity Responsible for Verification:

For contracted providers of the FIDA-IDD Plan that deliver waiver services the FIDA-IDD is responsible to ensure that the provider is one that is approved by OPWDD to provide HCBS waiver services. The OPWDD approval is based upon its review that the entity is fiscally viable and meets the minimum standards to deliver HCBS waiver services including satisfactory character, competence, education and experience. The FIDA-IDD is responsible for verifying appropriate credentials for professional staff and compliance with applicable State and Federal regulations and requirements when licensed staff deliver waiver services .

OPWDD is responsible to verify provider qualifications. Annual reviews of all providers are performed by OPWDD's Division of Quality Improvement (DQI). During these reviews, DQI reviews provider compliance with the Criminal Background Check (CBC) regulations, the Part 633.8 training requirements, . and all other applicable requirements.

Frequency of Verification:

NYS performs an annual review of all OPWDD providers including providers contracted with the FIDA-IDD Plan. For providers that bill eMedNY directly for waiver services, annual reviews of providers and/or samples of individuals in the waiver are performed by OPWDD's Division of Quality Improvement (DQI). Providers are reviewed on a yearly basis and may receive an operating certificate for up to a 3 year period of time.

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:

Statutory Service

Service:

Live-in Caregiver (42 CFR §441.303(f)(8))

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
07 Rent and Food Expenses for Live-In Caregiver	07010 rent and food expenses for live-in caregiver
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Live-in Caregiver is an unrelated care provider who resides in the same household as the waiver participant and provides supports to address the participant's physical, social, or emotional needs in order for the participant to live safely and successfully in his or her own home. The Live-in Caregiver must be unrelated to the participant by blood or marriage to any degree.

Payment for this service will cover 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. Room and board includes rent, utilities and food. The method for determining the amount paid is specified in Appendix I-6.

Payment will not be made directly to the live-in caregiver. Payment will be made to a provider agency that will in turn transfer the appropriate amount of funds to the participant.

The participant must reside in their own home or leased residence. Payment will not be made when the participant lives in the caregiver's home, in a residence that is owned or leased by the provider of Medicaid services, in a Family Care home, or any other residential arrangement where the participant is not directly responsible for the residence.

The need for Live-in Caregiver will be documented in the participant's plan of care.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

No limits will be applied to the service rendered by the live-in caregiver to the enrollee.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	non-profit organization, state, or self-directed with fiscal employer agent

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Live-in Caregiver (42 CFR §441.303(f)(8))

Provider Category:
Agency
Provider Type:

non-profit organization, state, or self-directed with fiscal employer agent

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

OPWDD establishes standards for providers of waiver services, reviews completed provider applications and for qualified providers, issues Waiver provider agreements that allow participation in the waiver program, provides the application for eMedNY and issues operating certificates for all waiver services. The DOH Division of Operations then reviews the completed eMedNY application and recommendations made by OPWDD, completes an in depth review that incorporates four different sanction searches: eMedNY Sanction, NYS OMIG, HHS-OIG, and Excluded Parties List on the providers board members and managing employees. If found to be appropriate, the DOH Division of Operations then issues a Medicaid provider agreement to enroll the voluntary provider in the NYS Medicaid program in accordance with regulations found at Part 504 of 18 NYCRR. For contracted providers of the FIDA-IDD Plan that deliver waiver services the FIDA-IDD is responsible to ensure that the provider is one that is approved by OPWDD to provide HCBS waiver services .

OPWDD directly provides HCBS waiver services through its regional offices. In addition, HCBS waiver services are provided by provider agencies which are non-profit organizations. Non-profit organizations include: non- profit corporations formed under New York State Law or authorized to do business in New York, local government units, or organizations created by an act of the New York State Legislature for charitable purposes which include providing services to persons with developmental disabilities.

If the provider agency employs professional clinical staff, that staff person must have the appropriate credentials stipulated by the OPWDD and/or the NYS Department of Education under the following regulations and laws:

- Nursing (8 NYCRR Part 64, and Education Law Title 8, Article 139)
- Speech Language Pathologist (8 NYCRR Part 75, and Education Law Title 8, Article 159)
- Psychology (8 NYCRR Part 72, and Education Law Title 8, Article 153)
- Social Work (8 NYCRR Part 74, and Education Law Title 8, Article 154)
- Rehab Counselor (14 NYCRR Part 679.99)
- Dietetics/Nutrition (8 NYCRR Part 79, and Education Law Title 8, Article 157)
- Occupational Therapy (8 NYCRR Part 76, and Education Law Title 8, Article 156)
- Physical Therapy (8 NYCRR part 77, and Education Law Title 8, Article 136)
- Applied Behavioral Sciences Specialist (8 NYCRR Part 79, and Education Law Title 8, Article 167).
- Behavioral Intervention Specialist (14 NYCRR part 633-16.b(32)

Direct support professionals must have completed the training stipulated in 14 NYCRR Part 633.8. Provider agencies must comply with 14 NYCRR Part 633, "Protections of Individuals Receiving Services", including Criminal Background Check (CBC) screening. Provider agencies must also comply with the Part 624, "Reportable Incidents and Client Abuse", and Part 635, "General Quality Control and Administrative Requirements". OPWDD directs provider agencies to screen staff against the Medicaid Excluded Provider lists maintained by the Department of Health and the HHS Office of the Inspector General.

Verification of Provider Qualifications

Entity Responsible for Verification:

For contracted providers of the FIDA-IDD Plan that deliver waiver services the FIDA-IDD is responsible to ensure that the provider is one that is approved by OPWDD to provide HCBS waiver services. The OPWDD approval is based upon its review that the entity is fiscally viable and meets the minimum standards to deliver HCBS waiver services including satisfactory character, competence, education and experience. The FIDA-IDD is responsible for verifying appropriate credentials for professional staff and compliance with applicable State and Federal regulations and requirements when licensed staff deliver waiver services .

OPWDD is responsible to verify provider qualifications. Annual reviews of all providers are performed by OPWDD's Division of Quality Improvement (DQI). During these reviews, DQI reviews provider compliance with the Criminal Background Check (CBC) regulations, the Part 633.8 training requirements,. and all other applicable requirements.

Frequency of Verification:

NYS performs an annual review of all OPWDD providers including providers contracted with the FIDA-IDD Plan. For providers that bill eMedNY directly for waiver services, annual reviews of providers and/or samples of individuals in the waiver are performed by OPWDD's Division of Quality Improvement (DQI). Providers are reviewed on a yearly basis and may receive an operating certificate for up to a 3 year period of time.

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:

Statutory Service

Service:

Prevocational Services

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04010 prevocational services
Category 2:	**Sub-Category 2:**
15 Non-Medical Transportation	15010 non-medical transportation
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

Prevocational Services are those services that provide learning and work experiences, including volunteering, where participants can develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated community settings. Services are expected to occur over a defined period of time which is determined based upon a person-centered planning process , and with specific outcomes to be achieved, as determined by the individual and their service and supports planning team through an ongoing person-centered planning process.

Individuals receiving prevocational services must have employment-related goals in their person centered services and supports plan; the general habilitation activities must be designed to support such employment goals. Competitive, integrated employment in the community for which an individual is compensated at or above minimum wage is considered to be the optimal outcome of prevocational services.

Prevocational services should enable each individual to attain the highest level of work in the most integrated setting and with the job matched to the individual's interests, strengths, priorities, abilities and capabilities, while following applicable federal wage guidelines from the U.S. Department of Labor. Services are intended to develop and teach general skills. Examples include, but are not limited to: ability to communicate effectively with supervisors, co-workers and customers; generally accepted community workplace conduct and dress; ability to follow directions; ability to attend to and complete tasks; punctuality and attendance; appropriate behaviors in and outside the workplace; workplace problem solving skills and strategies; mobility training; career planning; proper use of job-related equipment and general workplace safety.

Services include activities that are not primarily directed at teaching skills to perform a particular job, but at underlying habilitative goals (e.g., attention span, motor skills, interpersonal relations with co-workers and supervisors) that are associated with building skills necessary to perform work and optimally to perform competitive, integrated employment.

Prevocational services do not include vocational services provided in facility based work settings that are not integrated settings in the general community workforce.

Beginning July 1, 2015 there will be two separate types of prevocational services: Site Based Prevocational Services and Community Prevocational Services. Site based prevocational services are prevocational services that are delivered in OPWDD certified non-residential facilities. Community prevocational services are prevocational services that are delivered in the most integrated setting appropriate to the needs of the individual, except under limited circumstances specified in the regulations (e.g. when service delivery in the community may jeopardize the health and safety of individuals).

Documentation must be maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.)

The service may be provided in the community or a worksite (where the person makes less than 50% of the minimum or prevailing wage) to introduce the participant to the world of work, use of transportation options and adult education resources that will contribute to learning about employment. Transportation costs may be part of an agency rate depending upon the needs of the individual(s) and the availability of public transportation. The NYS Department of Health (DOH) will be sending a one-time budget survey to all Prevocational Services providers requesting "to and from" transportation cost data. This data will be reviewed and a determination of Prevocational Services reimbursement will be made by DOH to be included in the July 1, 2018 rates. Additional details are available in Addendum A of this Waiver application on page 45.

Community Prevocational Services will be reimbursed at an hourly fee and Site Based Prevocational Services will be reimbursed at a daily fee.

The rate paid to a Prevocational Services provider of service may be a "Special Populations Funding" rate for an individual who has been discharged from a more restrictive residential setting such as a developmental center as described in Addendum A to this waiver. This higher rate is designed to provide additional supports required to assist an individual transitioning to a less restrictive setting. The supports that are funded may include additional behavioral planning and staff training, and/or higher staffing ratios to support individuals whose need for supervision or for physical support exceeds that of the IDD population at large. Special Populations Funding will be in effect

through June 30, 2017.

NYS and CMS entered into a Transformation Agreement in 2013 that included commitments to increase access to employment in the community and close sheltered workshops. The variation noted in the service utilization for Waiver Year (WY) 3 demonstrate the success in this area. The State is amending this waiver agreement to reflect the lower utilization.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

OPWDD has established a maximum daily amount of services that are available to individuals based upon their residence. Individuals residing in certified settings are limited to a maximum of six hours of non-residential services (or its equivalent) which must commence no later than 3 pm on weekdays. The exception to this time of day restriction is employment services, as many individuals have jobs where supports are required on weekday evenings and weekends.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	non-profit organization or state

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Prevocational Services

Provider Category:
Agency
Provider Type:

non-profit organization or state

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

OPWDD establishes standards for providers of waiver services, reviews completed provider applications and for qualified providers, issues Waiver provider agreements that allow participation in the waiver program, provides the application for eMedNY and issues operating certificates for all waiver services. The DOH Division of Operations then reviews the completed eMedNY application and recommendations made by OPWDD, completes an in depth review that incorporates four different sanction searches: eMedNY Sanction, NYS OMIG, HHS-OIG, and Excluded Parties List on the providers board members and managing employees. If found to be appropriate, the DOH Division of Operations then issues a Medicaid provider agreement to enroll the voluntary provider in the NYS Medicaid program in accordance with regulations found at Part 504 of 18 NYCRR. For contracted providers of the FIDA-IDD Plan that deliver waiver services the FIDA-IDD is responsible to ensure that the provider is one that is approved by OPWDD to provide HCBS waiver services.

OPWDD directly provides HCBS waiver services through its regional offices. In addition, HCBS waiver services are provided by provider agencies which are non-profit organizations. Non-profit organizations include: non- profit corporations formed under New York State Law or authorized to do business in New York, local government units, or organizations created by an act of the New York State Legislature for charitable purposes which include providing services to persons with developmental disabilities.

If the provider agency employs professional clinical staff, that staff person must have the appropriate credentials stipulated by the OPWDD and/or the NYS Department of Education under the following regulations and laws:

- Nursing (8 NYCRR Part 64, and Education Law Title 8, Article 139)
- Speech Language Pathologist (8 NYCRR Part 75, and Education Law Title 8, Article 159) • Psychology (8 NYCRR Part 72, and Education Law Title 8, Article 153)
- Social Work (8 NYCRR Part 74, and Education Law Title 8, Article 154)
- Rehab Counselor (14 NYCRR Part 679.99)
- Dietetics/Nutrition (8 NYCRR Part 79, and Education Law Title 8, Article 157)
- Occupational Therapy (8 NYCRR Part 76, and Education Law Title 8, Article 156)
- Physical Therapy (8 NYCRR part 77, and Education Law Title 8, Article 136)
- Applied Behavioral Sciences Specialist (8 NYCRR Part 79, and Education Law Title 8, Article 167)
- Behavioral Intervention Specialist (14 NYCRR part 633-16.b(32).

Direct support professionals must have completed the training stipulated in 14 NYCRR Part 633.8. Provider agencies must comply with 14 NYCRR Part 633, "Protections of Individuals Receiving Services", including Criminal Background Check (CBC) screening. Provider agencies must also comply with the Part 624, "Reportable Incidents and Client Abuse", and Part 635, "General Quality Control and Administrative Requirements". OPWDD directs provider agencies to screen staff against the Medicaid Excluded Provider lists maintained by the Department of Health and the HHS Office of the Inspector General.

Verification of Provider Qualifications

Entity Responsible for Verification:

For contracted providers of the FIDA-IDD Plan that deliver waiver services the FIDA-IDD is responsible to ensure that the provider is one that is approved by OPWDD to provide HCBS waiver services. The OPWDD approval is based upon its review that the entity is fiscally viable and meets the minimum standards to deliver HCBS waiver services including satisfactory character, competence, education and experience. The FIDA-IDD is responsible for verifying appropriate credentials for professional staff and compliance with applicable State and Federal regulations and requirements when licensed staff deliver waiver services.

OPWDD is responsible to verify provider qualifications. Annual reviews of all providers are performed by OPWDD’s Division of Quality Improvement (DQI). During these reviews, DQI reviews provider compliance with the Criminal Background Check (CBC) regulations, the Part 633.8 training requirements, and all other applicable requirements.

Frequency of Verification:

NYS performs an annual review of all OPWDD providers including providers contracted with the FIDA-IDD Plan. For providers that bill eMedNY directly for waiver services, annual reviews of providers and/or samples of individuals in the waiver are performed by OPWDD's Division of Quality Improvement (DQI). Providers are reviewed on a yearly basis and may receive an operating certificate for up to a 3 year period of time.

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:

Statutory Service

Service:

Residential Habilitation

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02011 group living, residential habilitation
Category 2:	**Sub-Category 2:**
15 Non-Medical Transportation	15010 non-medical transportation
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Individually tailored supports that assist with the acquisition, retention or improvement in skills related to living in the community. These supports include adaptive skill development, assistance with activities of daily living (hands-on), community inclusion and relationship building, training and support for independence in travel, transportation, adult educational supports, social skills, leisure skills, self-advocacy and informed choice skills, and appropriate behavior development that assists the participant to reside in the most integrated setting appropriate to his/her needs. Residential habilitation services are provided to individuals living in the following certified locations: Supervised Individualized Residential Alternatives (Supervised IRAs), Supportive Residential Alternatives (Supportive IRAs), and Family Care Residences. The services included in the residential habilitation rate for these settings are described below.

Nursing supervision of direct care staff and coordination of residents' health care needs, including prescriptions, medication administration and medication administration training and oversight, coordinating needed medical appointments, follow-up reports from medical appointments, follow-up and interface with hospital staff regarding Emergency Room visits and other hospitalizations.

Professional services of a Registered Nurse or Licensed Practical Nurse, delivered in the residence, may be accessed using State Plan Nursing, under the following conditions:
- The service is ordered by a physician and prior authorized by the Department of Health based upon the health care needs of the person that cannot be met with residential staffing alone (both Direct Support Professionals & clinicians who work for the Residential Habilitation service provider); and
- The Registered Nurse or Licensed Practical Nurse who delivers the State Plan Nursing service is not employed by the agency providing the Residential Habilitation service to the person.

Supervised IRAs: In addition to habilitation, protective oversight, and supervision services delivered at the residence, the Medicaid residential habilitation rate for Supervised IRA homes shall reimburse the additional services and supplies outlined below. Since funding for these services and supplies is included in the residential habilitation rate, there will be no separate Medicaid billing of equivalent State Plan or waiver services on behalf of Supervised IRA residents:
- Program-related transportation, including transportation to and from recreational and community inclusion activities.
- Non-emergency transportation to and from all outpatient medical, dental, and clinical service appointments required by residents.
- Habilitation, protective oversight, and supervision services promoting community inclusion, socialization, and recreational activities outside of the premises during weekday evenings and anytime on weekends.

There is an exception for supported employment, prevocational services, and pathway to employment provided at an integrated work or volunteer site located in the community and not in setting that is certified by OPWDD. An exception is also allowed for community habilitation or personal care services that are provided at the resident's place of integrated, competitive employment.

Effective 4/1/13 and thereafter, the services of personal care attendants, home health aides in the residence on weekdays or in the residence or in other locations on weekday evenings or anytime on weekends (unless related to employment as noted above).

Supportive IRAs: In addition to habilitation, protective oversight, and supervision services delivered at the residence, the Medicaid residential habilitation rate for Supportive IRA homes shall reimburse the additional services outlined below. Since funding for these services is included in the residential habilitation rate, there will be no separate Medicaid billing of equivalent State Plan or waiver services on behalf of Supportive IRA residents:
- Program-related transportation, including transportation to and from recreational and community inclusion activities.
- Non-emergency transportation to and from all outpatient medical, dental, and clinical service appointments required by residents.
- Effective 6/1/14 and thereafter, the following additional services shall be included in the supportive IRA residential habilitation rate:
- Habilitation, protective oversight, and supervision services promoting community inclusion, socialization, and recreational activities outside of the premises during weekday evenings and anytime on weekends.There is an exception of supported employment, prevocational services, and pathway to employment provided at an integrated work or volunteer site located in the community and not in setting that is certified by OPWDD. An exception is also allowed for community habilitation or personal care services that are provided at the resident's place of integrated,

competitive employment.
• Services of personal care attendants and home health aides in the residence on weekdays or in the residence and in other locations on weekday evenings or anytime on weekends (unless related to employment as noted above).

Family Care Homes: In addition to habilitation, protective oversight, and supervision services delivered at the residence, the Medicaid residential habilitation rate for Family Care Homes shall reimburse the additional services outlined below. Since funding for these services is included in the residential habilitation rate, there will be no separate Medicaid billing of equivalent State Plan or waiver services on behalf of Family Care Home residents:
• Program-related transportation, including transportation to and from recreational and community inclusion activities.
• Effective 6/1/14 and thereafter, the following additional services shall be included family care residential habilitation rate:
• Habilitation, protective oversight, and supervision services promoting community inclusion, socialization, and recreational activities outside of the premises during weekday evenings and anytime on weekends. There is an exception for supported employment, prevocational services, and pathway to employment provided at an integrated work or volunteer site located in the community and not in setting that is certified by OPWDD. An exception is also allowed for community habilitation or personal care services that are provided at the resident's place of integrated, competitive employment.
• Services of personal care attendants and home health aides in the residence during weekdays or in the residence and in other locations on weekday evenings or anytime on weekends (unless related to employment as noted above).

Payment is not made for the cost of room and board, including the cost of building maintenance, upkeep and improvement. The method by which the costs of room and board are excluded from payment for Residential Habilitation is specified in Appendix I-5. Payment is not made, directly or indirectly, to members of the individual's immediate family, except as provided in Appendix C-2.

For dates of service beginning July 1, 2017 and ending June 30, 2021 provider agencies serving individuals with complex behavioral and/or medical support needs which exceed that of the IDD population at large will have the opportunity to apply for supplemental funding which would be available until the costs of providing care to these individuals are incorporated within their reimbursement rate. This supplemental funding, referred to as "Higher-Needs Funding" would be available to provider agencies serving individuals who are new to an Supervised/Supportive IRA placement, or individuals that are currently living in an Supervised/Supportive IRA and who experienced a significant change in their behavioral and/or medical status (such as; an accident resulting in hospitalization). The interim rate will be based upon the utilization of a separately calculated threshold level that the individual falls within. The only difference between the interim rate and the provider's rate calculated in accordance with the methodology described in the OPWDD Comprehensive Waiver agreement is the inclusion of additional clinical/direct care support hours based on an initial clinical review.

An initial clinical review will be conducted to determine an individual's threshold level in one of the three "Higher-Needs Funding" threshold levels described below. The "Higher-Needs Funding" (interim rate) will cease when the additional costs for serving the individual(s) with Higher-Needs are included in a Provider's CFR used for the purpose of re-basing. Following the initial clinical review, individuals who qualify for "Higher-Needs Funding" will be subject to a clinical review every 6 months to determine their current threshold level based upon their needs since their initial clinical review conducted during their residential placement or significant change in their medical and/or behavioral status. Using a 10% sample, on an annual basis, the State will verify the fiscal integrity of the Higher-Needs Funding.

The "Higher-Needs Funding" establishes three tiers:
• Tier 1 – individuals who live in a Supervised or Supportive IRA and have a Developmental Disabilities Profile (DDP-2) with a behavioral or medical score that is at or higher than 1.5 standard deviations from the mean in either category, and lower than 2 standard deviations. Funding for an additional 1,000 annual clinical/direct support hours will be provided for individuals living in a Supervised IRA. Funding for an additional 400 annual clinical/direct support hours will be provided for individuals living in a Supportive IRA.
• Tier 2 - individuals who live in a Supervised or Supportive IRA and have a DDP-2 with a behavioral or medical score that is at or higher than 2 standard deviations from the mean in either category , and lower than 2.5 standard deviations. Funding for an additional 2,000 annual clinical/direct support hours will be provided for individuals living in a Supervised IRA. Funding for an additional 800 annual clinical/direct support hours will be provided for individuals living in a Supportive IRA.

• Tier 3 – individuals who live in a Supervised IRA and have a DDP-2 with a behavioral or medical score that is at or higher than 2.5 standard deviations from the mean in either category. Funding for additional annual clinical/direct support hours will be determined based upon a standardized assessment and core exception process, which is structured by the need of additional staffing, provider qualifications, higher clinical support hours and other influential factors provided for each individual.

Beginning July 1, 2021, OPWDD will utilize blended data from both the Developmental Disabilities Profile-2 (DDP-2) and the Coordinated Assessment System (CAS) to determine individuals' complex needs for "Higher-Needs Funding" reimbursement. The State (OPWDD) will submit an amendment to this waiver to CMS to change reimbursement methodology for date of service after June 30, 2023 to incorporate the use of a CAS-based methodology and any corresponding reimbursement identified in Addendum A.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

With the implementation of Community Habilitation (see Appendix C), Residential Habilitation services will be limited to individuals who reside in provider-managed or OPWDD certified residential settings including family care.

Effective with service dates of 7/1/14 Residential Habilitation services will not include funding for direct, hands-on physical therapy, occupational therapy, speech therapy, nutritional or psychological services. In addition, effective 7/1/14 only nutrition services directly related to the habilitation service and psychology services that support the person's need for behavioral supports in the service setting will be included in the rate for the Residential Habilitation Service. Between 7/1/14 and 12/31/15, any instances where agencies' service provision does not comply with these requirements, will be addressed in the compliance process described in Addendum A.

Effective 10/1/2015, the Residential Habilitation provider is responsible for the payment of all Aide Services provided in the Residence: personal care services, home health aide services, homemaker services, and consumer directed personal assistance programs. In addition, after 10/1/2015 Supportive IRAs and CRs and Family Care Homes are responsible for the reimbursement of residents' Supplemental Group Day Habilitation. Residents of Supportive IRAs and CRs and Family Care Home can continue to receive Community Habilitation on weekday evenings and anytime on weekends however, the service must be reimbursed by the Residential Habilitation provider.

Effective with service dates of 10/1/2015, the Residential Habilitation provider is responsible for the payment and provision of nutrition and psychology services to residents in Supervised IRAs and CRs. Nutritional services that are related to Residential Habilitation include meal planning and monitoring, assessment of dietary needs and weight changes, development of specialized diets, diet education, and food safety and sanitation. Psychology services such as behavioral assessment and intervention planning, delivery and review or monitoring of behavioral interventions and behavioral support services that are directly related to Residential Habilitation. These services must be provided by Licensed Psychologists, Licensed Clinical Social Workers or Behavioral Intervention Specialists.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	non-profit organization or state

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:

Agency

Provider Type:

non-profit organization or state

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

OPWDD establishes standards for providers of waiver services, reviews completed provider applications and for qualified providers, issues Waiver provider agreements that allow participation in the waiver program, provides the application for eMedNY and issues operating certificates for all waiver services. The DOH Division of Operations then reviews the completed eMedNY application and recommendations made by OPWDD, completes an in depth review that incorporates four different sanction searches: eMedNY Sanction, NYS OMIG, HHS-OIG, and Excluded Parties List on the providers board members and managing employees. If found to be appropriate, the DOH Division of Operations then issues a Medicaid provider agreement to enroll the voluntary provider in the NYS Medicaid program in accordance with regulations found at Part 504 of 18 NYCRR. For contracted providers of the FIDA-IDD Plan that deliver waiver services the FIDA-IDD is responsible to ensure that the provider is one that is approved by OPWDD to provide HCBS waiver services .

OPWDD directly provides HCBS waiver services through its regional offices. In addition, HCBS waiver services are provided by provider agencies which are non-profit organizations. Non-profit organizations include: non- profit corporations formed under New York State Law or authorized to do business in New York, local government units, or organizations created by an act of the New York State Legislature for charitable purposes which include providing services to persons with developmental disabilities.

If the provider agency employs professional clinical staff, that staff person must have the appropriate credentials stipulated by the OPWDD and/or the NYS Department of Education under the following regulations and laws:

- Nursing (8 NYCRR Part 64, and Education Law Title 8, Article 139)
- Speech Language Pathologist (8 NYCRR Part 75, and Education Law Title 8, Article 159)
- Psychology (8 NYCRR Part 72, and Education Law Title 8, Article 153)
- Social Work (8 NYCRR Part 74, and Education Law Title 8, Article 154)
- Rehab Counselor (14 NYCRR Part 679.99)
- Dietetics/Nutrition (8 NYCRR Part 79, and Education Law Title 8, Article 157)
- Occupational Therapy (8 NYCRR Part 76, and Education Law Title 8, Article 156)
- Physical Therapy (8 NYCRR part 77, and Education Law Title 8, Article 136)
- Applied Behavioral Sciences Specialist (8 NYCRR Part 79, and Education Law Title 8, Article 167)
- Behavioral Intervention Specialist (14 NYCRR part 633-16.b(32).

Direct support professionals must have completed the training stipulated in 14 NYCRR Part 633.8. Provider agencies must comply with 14 NYCRR Part 633, "Protections of Individuals Receiving Services", including Criminal Background Check (CBC) screening. Provider agencies must also comply with the Part 624, "Reportable Incidents and Client Abuse", and Part 635, "General Quality Control and Administrative Requirements". OPWDD directs provider agencies to screen staff against the Medicaid Excluded Provider lists maintained by the Department of Health and the HHS Office of the Inspector General.

Verification of Provider Qualifications

Entity Responsible for Verification:

For contracted providers of the FIDA-IDD Plan that deliver waiver services the FIDA-IDD is responsible to ensure that the provider is one that is approved by OPWDD to provide HCBS waiver services. The OPWDD approval is based upon its review that the entity is fiscally viable and meets the minimum standards to deliver HCBS waiver services including satisfactory character, competence, education and experience. The FIDA-IDD is responsible for verifying appropriate credentials for professional staff and compliance with applicable State and Federal regulations and requirements when licensed staff deliver waiver services.

OPWDD is responsible to verify provider qualifications. Annual reviews of all providers are performed by OPWDD’s Division of Quality Improvement (DQI). During these reviews, DQI reviews provider compliance with the Criminal Background Check (CBC) regulations, the Part 633.8 training requirements, and all other applicable requirements, including physical plant and fire safety.

Frequency of Verification:

NYS performs an annual review of all OPWDD providers including providers contracted with the FIDA-IDD Plan. For providers that bill eMedNY directly for waiver services, annual reviews of providers and/or samples of individuals in the waiver are performed by OPWDD's Division of Quality Improvement (DQI). Providers are reviewed on a yearly basis and may receive an operating certificate for up to a 3 year period of time.

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09011 respite, out-of-home
Category 2:	**Sub-Category 2:**
09 Caregiver Support	09012 respite, in-home
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Services provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the participant. Respite care is not furnished or provided for the purpose of compensating relief or substitute staff in certified community residences.

Respite services are provided in the following locations: individual's home or place of residence or any other non-certified community location; Family Care home; Medicaid certified ICF/DD; Individualized Residential Alternative (IRA) or Community Residence (CR); and free-standing Respite facility under the auspices of OPWDD.

Federal financial participation will not be claimed for the cost of room and board except when provided as part of respite care in a facility approved by the State that is not a private residence.

Effective July 1, 2017, Respite services will be identified as the following models of services:

- In-Home Respite Services – these services are provided in the person's family home and may include staff accompanying the person to community (non-certified) settings.
- Camp Respite Services – these services that are delivered at site based locations that have been permitted under subpart 7 of the NYS sanitary code. For overnight Camp Respite Services, no more than 14 days of Camp Respite Services per Calendar year may be billed for an individual. For day-only Camp Respite Services, no more than 10 hours of service may be delivered per individual per day.
- Recreational Respite Services - these services focus on recreational activities and community integration activities. Service billing is limited to no more than 10 hours per individual per day.
- Site-Based Respite Services – these services are provided in OPWDD-licensed Free Standing Respite facilities or in other community sites.
- Intensive Respite Services – there are two types of Intensive Respite services that will be authorized at the OPWDD Regional Office level for individuals with high medical or behavioral needs who are precluded from participating in one of the other four categories of Respite Services. Due to the unique supports of individuals with high medical or behavioral needs, the staff overseeing or providing the service are either licensed professionals, behavioral intervention specialists (BIS) or NYS Systemic, Therapeutic Assessment, Resources and Treatment (START) Clinical Team Leader. The qualifications for START Clinical Team Leaders are described in the Respite Provider Qualifications section of this application. Licensed professionals for individuals with high medical needs include Registered Nurses (RNs) and Licensed Practical Nurses (LPNs). For individuals with high behavioral needs, licensed professionals include psychologists and Licensed Master Social Workers (LMSW). Intensive Respite Services may be delivered in any of the above Respite models (e.g., Intensive Respite may be provided At Home or in a Site-Based Respite program). The billing for Intensive Respite Services is subject to the same limits that apply to billing to the model in which the Intensive Respite Services are provided.

Overnight services may be delivered under the In-Home, and Site Based Models. Reimbursement for Respite Services is identified in Appendix I, Addendum A of this waiver. Beginning July 1, 2017 thru June 30, 2021, Overnight billing and/or 24 hour per day reimbursement will be allowed at the rates identified in Appendix I, Addendum A, for 42 days in a 180 day period. If the Respite overnight/24 hour per day service exceeds 42 days in a 180 day period, the reimbursement for days in excess of 42 will be limited to the provider's Supervised IRA Residential Habilitation daily rate or the regional average daily rate paid for Supervised IRA services. This limit also applies to those individuals who choose to self-direct their Respite services.

Beginning July 1, 2021 all overnight/24 hours reimbursement will be limited to the provider's Supervised IRA Residential Habilitation daily rate or the regional average daily rate paid for Supervised IRA services.

The State will assess the provider cost of overnight service provision and will reevaluate its funding methodology effective for service dates after June 30, 2021. If needed, the State will submit to CMS a proposed reimbursement method /waiver amendment based on needs assessment and provider cost data. Camp Respite has different overnight limits described above.

Effective July 1, 2017, the time documented and billed as Respite Services begins when the agency provides or pays for the transportation to the Respite service and returns the individual home or to another service setting at the conclusion of Respite service delivery.

Authorization for Respite services will continue to be made by OPWDD Regional Offices based upon an individual's documented behavioral support and/or medical support needs during the hours that Respite is being provided in order to maintain the health and safety of the individual or others in the Respite environment, such as

peers or staff. Intensive Respite Services authorization is based upon the individual's needs and is not tied to a particular Respite category or Respite setting. Intensive Respite services may be delivered in any Respite site location or as an "In-Home Respite" service, however, there cannot be any duplicative billing. In all cases, when Intensive Respite Services are billed, the provider agency must demonstrate that the staffing and oversight of the Respite service meets the requirements described above.

Individuals who self-direct their Community Habilitation, Respite and Supported Employment services with budget authority, may be eligible for "Special Populations Funding" if they have been discharged from a more restrictive residential setting such as a developmental center as described in Addendum A to this waiver and will be in effect until June 30, 2021. A new PRA approach , to be submitted as a waiver amendment to CMS, will be effective July 1, 2021 and will replace the Special Population Funding for individuals who self-direct their services with budget authority using the Coordinated Assessment System (CAS). As described in Appendix E, the eligible individual's budget may be increased up to the level of the Special Populations Funding and therefore could be used to fund self-directed, "self-hired" staff who deliver Respite. The rate paid for the self-directed services follows the same limitations as are in place for all Individuals who exercise budget authority. The higher PRA funding is designed to provide additional supports required to assist an individual transitioning to a less restrictive setting.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	non-profit organization or state

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:

non-profit organization or state

Provider Qualifications
License *(specify):*

The required qualifications for a START Clinical Team Leader are as follows:
• Master's degree in social work, counseling, psychology or human service field with a
• Minimum of 2 years' experience providing services to with people who have IDD and mental health and/or challenging behavior needs
• At least one year supervisory experience
• Must be a certified START Coordinator within 12 months of employment as Team Leader
• Prior experience as a START Coordinator preferred.
• Directly overseen by a START Clinical Director who has a Ph.D. or Psy.D. in psychology or has a Master's degree in mental health, psychology or social work with a minimum of 7 years' clinical experience working with the IDD/mental health population.

Certificate *(specify):*

Other Standard *(specify):*

OPWDD establishes standards for providers of waiver services, reviews completed provider applications and for qualified providers, issues Waiver provider agreements that allow participation in the waiver program, provides the application for eMedNY and issues operating certificates for all waiver services. The DOH Division of Operations then reviews the completed eMedNY application and recommendations made by OPWDD, completes an in depth review that incorporates four different sanction searches: eMedNY Sanction, NYS OMIG, HHS-OIG, and Excluded Parties List on the providers board members and managing employees. If found to be appropriate, the DOH Division of Operations then issues a Medicaid provider agreement to enroll the voluntary provider in the NYS Medicaid program in accordance with regulations found at Part 504 of 18 NYCRR. For contracted providers of the FIDA-IDD Plan that deliver waiver services the FIDA-IDD is responsible to ensure that the provider is one that is approved by OPWDD to provide HCBS waiver services.

OPWDD directly provides HCBS waiver services through its regional offices. In addition, HCBS waiver services are provided by provider agencies which are non-profit organizations. Non-profit organizations include: non- profit corporations formed under New York State Law or authorized to do business in New York, local government units, or organizations created by an act of the New York State Legislature for charitable purposes which include providing services to persons with developmental disabilities.

If the provider agency employs professional clinical staff, that staff person must have the appropriate credentials stipulated by the OPWDD and/or the NYS Department of Education under the following regulations and laws:
- Nursing (8 NYCRR Part 64, and Education Law Title 8, Article 139)
- Speech Language Pathologist (8 NYCRR Part 75, and Education Law Title 8, Article 159)
- Psychology (8 NYCRR Part 72, and Education Law Title 8, Article 153)
- Social Work (8 NYCRR Part 74, and Education Law Title 8, Article 154)
- Rehab Counselor (14 NYCRR Part 679.99)
- Dietetics/Nutrition (8 NYCRR Part 79, and Education Law Title 8, Article 157)
- Occupational Therapy (8 NYCRR Part 76, and Education Law Title 8, Article 156)
- Physical Therapy (8 NYCRR part 77, and Education Law Title 8, Article 136)
- Applied Behavioral Sciences Specialist (8 NYCRR Part 79, and Education Law Title 8, Article 167)
- Behavioral Intervention Specialist (14 NYCRR part 633-16.b(32).

Direct support professionals must have completed the training stipulated in 14 NYCRR Part 633.8. Provider agencies must comply with 14 NYCRR Part 633, "Protections of Individuals Receiving Services", including Criminal Background Check (CBC) screening. Provider agencies must also comply with the Part 624, "Reportable Incidents and Client Abuse", and Part 635, "General Quality Control and Administrative Requirements". OPWDD directs provider agencies to screen staff against the Medicaid Excluded Provider lists maintained by the Department of Health and the HHS Office of the Inspector General.

Verification of Provider Qualifications

Entity Responsible for Verification:

For contracted providers of the FIDA-IDD Plan that deliver waiver services the FIDA-IDD is responsible to ensure that the provider is one that is approved by OPWDD to provide HCBS waiver services. The OPWDD approval is based upon its review that the entity is fiscally viable and meets the minimum standards to deliver HCBS waiver services including satisfactory character, competence, education and experience. The FIDA-IDD is responsible for verifying appropriate credentials for professional staff and compliance with applicable State and Federal regulations and requirements when licensed staff deliver waiver services.

OPWDD is responsible to verify provider qualifications. Annual reviews of all providers are performed by OPWDD's Division of Quality Improvement (DQI). During these reviews, DQI reviews provider compliance with the Criminal Background Check (CBC) regulations, the Part 633.8 training requirements, . and all other applicable requirements.

Frequency of Verification:

NYS performs an annual review of all OPWDD providers including providers contracted with the FIDA-IDD Plan. For providers that bill eMedNY directly for waiver services, annual reviews of providers and/or samples of individuals in the waiver are performed by OPWDD's Division of Quality Improvement (DQI). Providers are reviewed on a yearly basis and may receive an operating certificate for up to a 3 year period of time.

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

Supported Employment (SEMP)

HCBS Taxonomy:

Category 1:	Sub-Category 1:
03 Supported Employment	03010 job development
Category 2:	**Sub-Category 2:**
03 Supported Employment	03021 ongoing supported employment, individual
Category 3:	**Sub-Category 3:**
03 Supported Employment	03022 ongoing supported employment, group

Service Definition *(Scope):*

Category 4:	**Sub-Category 4:**
03 Supported Employment	03030 career planning

Supported Employment (SEMP) services are the ongoing supports to participants who, because of their disabilities, need on- going support to obtain and maintain a job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce for which an individual is compensated at or above the minimum wage. The outcome of this service is paid employment at or above minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals; as such, career planning is also an allowable service. Supported employment services can be provided through many different service models. Some of these models can include evidence-based supported employment or customized employment for individuals with significant disabilities.

Supported employment services may be provided individually or in groups of two (2) to eight (8) workers with disabilities. Group employment may include training activities and employment services provided in regular business, industry and community settings. Examples include mobile crews and other business-based workgroups employing small groups of workers with disabilities in employment in the community. Supports provided to a group must be provided in a manner that promotes integration into the workplace and interaction between participants and people without disabilities in those workplaces.

Supported employment services may include any combination of the following services: vocational/job-related discovery or assessment, person-centered employment planning, job placement, job development, negotiation with prospective employers, job analysis, job carving, training and systematic instruction, job coaching, benefits support, training and planning, transportation, asset development and career advancement services, and other workplace support services including services not specifically related to job skill training that enable the waiver participant to be successful in integrating into the job setting.

SEMP services may also include services and supports that assist the participant in achieving self-employment through the operation of a business including home-based self-employment. However, Medicaid funds are not used to defray the expenses associated with starting up or operating a business. Assistance for self-employment may include: (a) aiding the participant to identify potential business opportunities; (b) assistance in the development of a business plan, including potential sources of business financing and other assistance in developing and launching a business; (c) identification of the supports that are necessary in order for the participant to operate the business; and (d) ongoing assistance, counseling and guidance once the business has been launched.

Beginning July 1, 2015 SEMP services will consist of two distinct phases : Intensive SEMP and Extended SEMP which can be provided on an individual or group basis. Intensive SEMP services include job development and/or intensive job coaching. An individual is eligible for Intensive SEMP if he or she is not employed or has been employed for less than 365 days. If an individual is not employed, the service provider must document, in a format prescribed by OPWDD, the individual's need for Intensive SEMP services, including information on how the services will assist the individual in obtaining employment. Extended SEMP services include ongoing job coaching and career development services for individuals who are employed. An individual is eligible for Extended SEMP if he or she is employed in an integrated workplace and earning at least minimum wage.

Individuals receiving supported employment services may also receive prevocational, day habilitation and Pathway to Employment.

Beginning 10/1/14, individuals who are self-directing their SEMP services, using 'self-hired' staff paid by the Fiscal Intermediary, will have claims submitted for hourly service provision. The maximum rate of the self-hired service will be no
higher than the corresponding CH fee identified in addendum A to this waiver application. Beginning July 1, 2015 SEMP will be reimbursed at an hourly rate. . For individuals who are self-directing their SEMP services using 'self-hired' staff, the maximum payment rate allowed will be adjusted to the new fees that take effect July 1, 2015.

Documentation must be maintained indicating that Supported Employment services are not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.). Federal financial participation cannot be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
1. Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment; or
2. Payments that are passed through to users of supported employment services.

Supported employment supports do not include vocational services provided in facility based work settings or other similar types of vocational services furnished in specialized facilities that are not a part of general community workplaces.

Supported employment supports do not include volunteering. Such volunteer learning and un-paid training activities that prepare a person for entry into the paid workforce are addressed through pre-vocational and pre-employment services.

Supported employment supports do not include payment for supervision, training, support and adaptations typically available to other workers without disabilities filling similar positions in the business.

Personal care/assistance may be a component part of the supported employment services, but may not comprise the entirety of the service.

Individuals receiving supported employment services may also receive prevocational, day habilitation, and Pathway to Employment. A participant's service plan may include two or more types of non-residential habilitation services. However, different types of non-residential habilitation are not billed during the same period of time.

Individuals who self-direct their Community Habilitation, Respite and Supported Employment services with budget authority, may be eligible for “Special Populations Funding” if they have been discharged from a more restrictive residential setting such as a developmental center as described in Addendum A to this waiver and will be in effect until June 30, 2021. A new PRA approach, to be submitted as a waiver amendment to CMS, will be effective July 1, 2021 and will replace the Special Population Funding for individuals who self-direct their services with budget authority using the Coordinated Assessment System (CAS). As described in Appendix E, the eligible individual’s budget may be increased up to the level of the Special Populations Funding and therefore could be used to fund self-directed, “self-hired” staff who deliver Supported Employment). The rate paid for the self-directed services follows the same limitations as are in place for all Individuals who exercise budget authority. The higher PRA funding is designed to provide additional supports required to assist an individual transitioning to a less restrictive setting.

NYS and CMS entered into a Transformation Agreement in 2013 that included commitments to decrease rates of institutionalization and support community-based living in the most independent setting possible, increase access to self-direction and increase access to employment. The variations noted in the service utilization in Waiver Year (WY) 3 demonstrate the success in these areas and the higher than anticipated utilization of essential services that support these objectives. SEMP is a critical component of the OPWDD
employment initiative. The State is amending this waiver agreement to reflect the higher utilization.

Supported employment supports do not include vocational services provided in facility based work settings or other similar types of vocational services furnished in specialized facilities that are not a part of general community workplaces.

Supported employment supports do not include volunteering. Such volunteer learning and un-paid training activities that prepare a person for entry into the paid workforce are addressed through pre-vocational and pre-employment services.

Supported employment supports do not include payment for supervision, training, support and adaptations typically available to other workers without disabilities filling similar positions in the business.

Personal care/assistance may be a component part of the supported employment services, but may not comprise the entirety of the service.

Individuals receiving supported employment services may also receive prevocational, day habilitation, and Pathway to Employment. A participant's service plan may include two or more types of non-residential habilitation services. However, different types of non-residential habilitation are not billed during the same period of time.

Individuals who self-direct their Community Habilitation, Respite and Supported Employment services with budget authority, may be eligible for “Special Populations Funding” if they have been discharged from a more restrictive residential setting such as a developmental center as described in Addendum A to this waiver and will be in effect until June 30, 2021. A new PRA approach, to be submitted as a waiver amendment to CMS, will be effective July 1, 2021 and will replace the Special Population Funding for individuals who self-direct their services with budget authority using the Coordinated Assessment System (CAS). As described in Appendix E, the eligible individual’s budget may be increased up to the level of the Special Populations Funding and therefore could be used to fund self-directed, “self-hired” staff who deliver Supported Employment). The rate paid for the self-directed services follows the same limitations as are in place for all Individuals who exercise budget authority. The higher PRA funding is designed to provide additional supports required to assist an individual transitioning to a less restrictive setting.

NYS and CMS entered into a Transformation Agreement in 2013 that included commitments to decrease rates of institutionalization and support community-based living in the most independent setting possible, increase access to self-direction and increase access to employment. The variations noted in the service utilization in Waiver Year (WY) 3 demonstrate the success in these areas and the higher than anticipated utilization of essential services that support these objectives. SEMP is a critical component of the OPWDD
employment initiative. The State is amending this waiver agreement to reflect the higher utilization.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

OPWDD has established limits in regulation regarding the maximum number of hours of day service that a person can receive based upon where he/she resides. These limits are outlined in 14 NYCRR 635-10.5 and for individuals residing in non- certified settings limit services to no more than 1.5 units of service per day (or its equivalent in hourly unit services) or roughly 8-9 hours of service. Individuals residing in certified settings are limited to the equivalent of six hours of services which can be received only on weekdays beginning prior to 3 pm, except in the instance of non-site-based employment services which can also be received in the evening/weekend within the hourly limit.

Beginning on 7/1/15, Intensive and Extended SEMP services are limited as follows: unless OPWDD authorizes an extension of the number of hours or length of the term of service, no more than 250 hours of services across 365 days can be reimbursed for an individual receiving Intensive SEMP services and no more than 200 hours of services across 365 days can be reimbursed for an individual receiving Extended SEMP services. If a service provider considers that an individual needs more than 365 days of Intensive or Extended services and/or additional hours, the service provider may submit a written request to OPWDD in accordance with the guidelines established in regulation.

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	non-profit organization or state

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Supported Employment (SEMP)

Provider Category:

Agency

Provider Type:

non-profit organization or state

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

OPWDD establishes standards for providers of waiver services, reviews completed provider applications and for qualified providers, issues Waiver provider agreements that allow participation in the waiver program, provides the application for eMedNY and issues operating certificates for all waiver services. The DOH Division of Operations then reviews the completed eMedNY application and recommendations made by OPWDD, completes an in depth review that incorporates four different sanction searches: eMedNY Sanction, NYS OMIG, HHS-OIG, and Excluded Parties List on the providers board members and managing employees. If found to be appropriate, the DOH Division of Operations then issues a Medicaid provider agreement to enroll the voluntary provider in the NYS Medicaid program in accordance with regulations found at Part 504 of 18 NYCRR . For contracted providers of the FIDA-IDD Plan that deliver waiver services the FIDA-IDD is responsible to ensure that the provider is one that is approved by OPWDD to provide HCBS waiver services.

OPWDD directly provides HCBS waiver services through its regional offices. In addition, HCBS waiver services are provided by provider agencies which are non-profit organizations. Non-profit organizations include: non- profit corporations formed under New York State Law or authorized to do business in New York, local government units, or organizations created by an act of the New York State Legislature for charitable purposes which include providing services to persons with developmental disabilities.

If the provider agency employs professional clinical staff, that staff person must have the appropriate credentials stipulated by the OPWDD and/or the NYS Department of Education under the following regulations and laws:

- Nursing (8 NYCRR Part 64, and Education Law Title 8, Article 139)
- Speech Language Pathologist (8 NYCRR Part 75, and Education Law Title 8, Article 159)
- Psychology (8 NYCRR Part 72, and Education Law Title 8, Article 153)
- Social Work (8 NYCRR Part 74, and Education Law Title 8, Article 154)
- Rehab Counselor (14 NYCRR Part 679.99)
- Dietetics/Nutrition (8 NYCRR Part 79, and Education Law Title 8, Article 157)
- Occupational Therapy (8 NYCRR Part 76, and Education Law Title 8, Article 156)
- Physical Therapy (8 NYCRR part 77, and Education Law Title 8, Article 136)
- Applied Behavioral Sciences Specialist (8 NYCRR Part 79, and Education Law Title 8, Article 167)
- Behavioral Intervention Specialist (14 NYCRR part 633-16.b(32).

Direct support professionals must have completed the training stipulated in 14 NYCRR Part 633.8. Provider agencies must comply with 14 NYCRR Part 633, "Protections of Individuals Receiving Services", including Criminal Background Check (CBC) screening. Provider agencies must also comply with the Part 624, "Reportable Incidents and Client Abuse", and Part 635, "General Quality Control and Administrative Requirements". OPWDD directs provider agencies to screen staff against the Medicaid Excluded Provider lists maintained by the Department of Health and the HHS Office of the Inspector General.

Verification of Provider Qualifications

Entity Responsible for Verification:

For contracted providers of the FIDA-IDD Plan that deliver waiver services the FIDA-IDD is responsible to ensure that the provider is one that is approved by OPWDD to provide HCBS waiver services. The OPWDD approval is based upon its review that the entity is fiscally viable and meets the minimum standards to deliver HCBS waiver services including satisfactory character, competence, education and experience. The FIDA-IDD is responsible for verifying appropriate credentials for professional staff and compliance with applicable State and Federal regulations and requirements when licensed staff deliver waiver services.

OPWDD is responsible to verify provider qualifications. Annual reviews of all providers are performed by OPWDD’s Division of Quality Improvement (DQI). During these reviews, DQI reviews provider compliance with the Criminal Background Check (CBC) regulations, the Part 633.8 training requirements, and all other applicable requirements.

Frequency of Verification:

NYS performs an annual review of all OPWDD providers including providers contracted with the FIDA-IDD Plan. For providers that bill eMedNY directly for waiver services, annual reviews of providers and/or samples of individuals in the waiver are performed by OPWDD's Division of Quality Improvement (DQI). Providers are reviewed on a yearly basis and may receive an operating certificate for up to a 3 year period of time.

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:

Supports for Participant Direction

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.

Support for Participant Direction:

Information and Assistance in Support of Participant Direction

Alternate Service Title (if any):

Community Transition Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
16 Community Transition Services	16010 community transition services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Community Transition Services are non-recurring set-up expenses for individuals who are transitioning from an institutional or other provider-operated living arrangement to a living arrangement in a private residence in the community where the person is directly responsible for his or her own living expenses. Allowable expenses are those reasonable and necessary to enable a person to establish a basic household. Items purchased are the property of the individual receiving the service. The service must be identified in the plan of care. The service is administered by a Fiscal Intermediary (FI) agency for billing purposes, even if this is the only self-directed service that the person accesses.

Allowable items include: (a) security deposits that are required to obtain a lease on an apartment or home; (b) essential household furnishings including furniture, window coverings, food preparation items, and bed/bath linens; (c) set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; (d) services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy; (e) moving expenses.

Items NOT allowable include monthly rental or mortgage expenses, food, regular utility charges, and/or items that are intended for purely diversion or recreational purposes such as televisions, cable television access, video games, stereos and/or DVD players.

Only those services not reimbursable under the Community First Choice Option (CFCO) State Medicaid Plan will be reimbursable under the HCBS Waiver. CFCO is the only NY State Plan mechanism for receiving Community Transition Services. Community Transition Services will have its own R/E code that will prevent Medicaid billing for individuals who are not enrolled in the OPWDD HCBS Waiver.

The increased access to Community Transition Services for WY 3 demonstrates the success of the Transformation Agreement in supporting the movement to community-based, and more independent settings. The State is amending this waiver agreement to reflect the higher utilization.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Through July 31, 2017 this service is a one-time reimbursement of actual expenses not to exceed $3,000. Effective August 1, 2017, this service is a one-time reimbursement of actual expenses not to exceed $5,000. This service may not be used to pay for furnishing living arrangements that are owned or leased by a waiver provider where the provision of these items and services are inherent to the service they are already providing. CTS is fundable through this HCBS waiver agreement in cases where the individual is not eligible for the State Plan benefit.

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	non-profit organization or state

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction
Service Name: Community Transition Services

Provider Category:

Agency

Provider Type:

non-profit organization or state

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

OPWDD establishes standards for providers of waiver services, reviews completed provider applications and for qualified providers, issues Waiver provider agreements that allow participation in the waiver program, provides the application for eMedNY and issues operating certificates for all waiver services. The DOH Division of Operations then reviews the completed eMedNY application and recommendations made by OPWDD, completes an in depth review that incorporates four different sanction searches: eMedNY Sanction, NYS OMIG, HHS-OIG, and Excluded Parties List on the providers board members and managing employees. If found to be appropriate, the DOH Division of Operations then issues a Medicaid provider agreement to enroll the voluntary provider in the NYS Medicaid program in accordance with regulations found at Part 504 of 18 NYCRR . For contracted providers of the FIDA-IDD Plan that deliver waiver services the FIDA-IDD is responsible to ensure that the provider is one that is approved by OPWDD to provide HCBS waiver services.

OPWDD directly provides HCBS waiver services through its regional offices. In addition, HCBS waiver services are provided by provider agencies which are non-profit organizations. Non-profit organizations include: non- profit corporations formed under New York State Law or authorized to do business in New York, local government units, or organizations created by an act of the New York State Legislature for charitable purposes which include providing services to persons with developmental disabilities.

If the provider agency employs professional clinical staff, that staff person must have the appropriate credentials stipulated by the NYS Department of Education.

Direct support professionals must have completed the training stipulated in 14 NYCRR Part 633.8. Provider agencies must comply with 14 NYCRR Part 633, "Protections of Individuals Receiving Services", including Criminal Background Check (CBC) screening. Provider agencies must also comply with the Part 624, "Reportable Incidents and Client Abuse", and Part 635, "General Quality Control and Administrative Requirements". OPWDD directs provider agencies to screen staff against the Medicaid Excluded Provider lists maintained by the Department of Health and the HHS Office of the Inspector General.

Verification of Provider Qualifications

Entity Responsible for Verification:

For contracted providers of the FIDA-IDD Plan that deliver waiver services the FIDA-IDD is responsible to ensure that the provider is one that is approved by OPWDD to provide HCBS waiver services. The OPWDD approval is based upon its review that the entity is fiscally viable and meets the minimum standards to deliver HCBS waiver services including satisfactory character, competence, education and experience. The FIDA-IDD is responsible for verifying appropriate credentials for professional staff and compliance with applicable State and Federal regulations and requirements when licensed staff deliver waiver services.

OPWDD is responsible to verify provider qualifications. Annual reviews of all providers are performed by OPWDD's Division of Quality Improvement (DQI). During these reviews, DQI reviews provider compliance with the Criminal Background Check (CBC) regulations, the Part 633.8 training requirements, and all other applicable requirements.

Frequency of Verification:

NYS performs an annual review of all OPWDD providers including providers contracted with the FIDA-IDD Plan. For providers that bill eMedNY directly for waiver services, annual reviews of providers and/or samples of individuals in the waiver are performed by OPWDD's Division of Quality Improvement (DQI). Providers are reviewed on a yearly basis and may receive an operating certificate for up to a 3 year period of time.

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:

Supports for Participant Direction

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.

Support for Participant Direction:

Financial Management Services

Alternate Service Title (if any):

Fiscal Intermediary (FI)

HCBS Taxonomy:

Category 1:	Sub-Category 1:
12 Services Supporting Self-Direction	12010 financial management services in support of self-directio
Category 2:	**Sub-Category 2:**
12 Services Supporting Self-Direction	12020 information and assistance in support of self-direction
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

Effective 10/1/14, the Fiscal Intermediary (FI) service is evolved from the Financial Management Services (FMS) from the previous waiver.

Any individual eligible for HCBS waiver services may self-direct some or all of his/her services. The person self-directing receives an individualized portable budget that is directed by the individual pursuant to an approved plan.

If an individual chooses to self-hire their own staff, the employer of record must be either the Fiscal Intermediary or once the "common law employer" status is implemented, the individual or family may act in this capacity. In addition to using a Fiscal Intermediary to pay staff that the person "self-hires" an individual must choose an FI agency if the following services are included in their budget in order to provide for appropriate billing and claiming: Individual Directed Goods and Services, Live-in Caregiver, Support Brokerage, or Community Transition Services.

The most typical set of tasks that the FI supports the individual self-directing is with billing and payment of approved goods and services, fiscal accounting and reporting, ensuring Medicaid and corporate compliance, and general administrative supports.

For individuals that choose to self-direct some or all of their services, the individual has the option of choosing the level of FI supports that fall under three levels of service:

- Level 1 – There are no self-hired staff in the individual's budget; FI supports the individual with billing and payment of approved goods and services.
- Level 2 – The Individual/family is the employer of record; FI supports the individual with services including but not limited to training related to his/her employer responsibilities, staff management, and other related tasks. (When available in the future)
- Level 3 - FI is the employer of record; the FI assists the individual with self-hiring staff which includes but is not limited to providing and supporting hiring and discharge practices for self-direct staff, verifying staff citizenship status, completing required background checks, arranging for back-up staffing, and other related tasks. There are two payment tiers within level 3 based on the person's PRA (as described in Addendum A).

If the individual chooses to be the employer of record, the FI supports includes the provision of training to the individual on his/her employer responsibilities by providing the participant with orientation and support in areas of staff hiring (including assistance with job descriptions), staff management, performance evaluations, staff conflict resolution, and reviewing federal Department of Labor information and agency employment policies with the individual.

The higher-than-anticipated engagement in self-direction resulted in the increased utilization of FI services for WY 3. The State is amending this waiver agreement to reflect the higher utilization.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Under self-hired model, the maximum rate that can be paid is limited to the rate paid to provider agencies as noted in Addendum A (Rate Setting).

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☐ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	non-profit organization

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction
Service Name: Fiscal Intermediary (FI)

Provider Category:

Agency

Provider Type:

non-profit organization

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

OPWDD establishes standards for providers of waiver services, reviews completed provider applications and for qualified providers, issues Waiver provider agreements that allow participation in the waiver program, provides the application for eMedNY and issues operating certificates for all waiver services. The DOH Division of Operations then reviews the completed eMedNY application and recommendations made by OPWDD, completes an in depth review that incorporates four different sanction searches: eMedNY Sanction, NYS OMIG, HHS-OIG, and Excluded Parties List on the providers board members and managing employees. If found to be appropriate, the DOH Division of Operations then issues a Medicaid provider agreement to enroll the voluntary provider in the NYS Medicaid program in accordance with regulations found at Part 504 of 18 NYCRR. For contracted providers of the FIDA-IDD Plan that deliver waiver services the FIDA-IDD is responsible to ensure that the provider is one that is approved by OPWDD to provide HCBS waiver services.

FI services are provided by provider agencies which are non-profit organizations. Non-profit organizations include: non-profit corporations formed under New York State Law or authorized to do business in New York, local government units, or organizations created by an act of the New York State Legislature for charitable purposes which include providing services to persons with developmental disabilities.

If the provider agency employs professional clinical staff, that staff person must have the appropriate credentials stipulated by the NYS Department of Education.

Direct support professionals must have completed the training stipulated in 14 NYCRR Part 633.8. Provider agencies must comply with 14 NYCRR Part 633, "Protections of Individuals Receiving Services", including Criminal Background Check (CBC) screening. Provider agencies must also comply with the Part 624, "Reportable Incidents and Client Abuse", and Part 635, "General Quality Control and Administrative Requirements". OPWDD directs provider agencies to screen staff against the Medicaid Excluded Provider lists maintained by the Department of Health and the HHS Office of the Inspector General.

Verification of Provider Qualifications

Entity Responsible for Verification:

For contracted providers of the FIDA-IDD Plan that deliver waiver services, the FIDA-IDD is responsible to ensure that the provider is one that is approved by OPWDD to provide HCBS waiver services. The OPWDD approval is based upon its review that the entity The FIDA-IDD is also responsible for verifying appropriate credentials for professional staff delivering waiver services and compliance with all applicable state and federal regulations and requirements.

OPWDD is responsible to verify provider qualifications. Annual reviews of all providers are performed by OPWDD’s Division of Quality Improvement (DQI). During these reviews, DQI reviews provider compliance with the Criminal Background Check (CBC) regulations, the Part 633.8 training requirements., and all other applicable requirements.

Frequency of Verification:

NYS performs an annual review of all OPWDD providers including providers contracted with the FIDA-IDD Plan. For providers that bill eMedNY directly for waiver services, annual reviews of providers and/or samples of individuals in the waiver are performed by OPWDD’s Division of Quality Improvement (DQI). Providers are reviewed on a yearly basis and may receive an operating certificate for up to a 3 year period of time.

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:

Supports for Participant Direction

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.

Support for Participant Direction:

Other Supports for Participant Direction

Alternate Service Title (if any):

Individual Directed Goods and Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
17 Other Services	17010 goods and services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Available only for services provided 10/1/14 or later, Individual Directed Goods and Services (IDGS) are services, equipment or supplies not otherwise provided through this waiver or through the Medicaid State Plan that addresses an identified need in an individual's service plan, which includes improving and maintaining the individual's opportunities for full membership in the community. Individuals who choose to self-direct their services with budget authority may receive IDGS as a waiver service. Individuals may manage their IDGS budget, as described in their individualized service plan, to fully purchase or put funds towards their personal fiscal resources to purchase items or services which meet the following criteria:

- Are related to a need or goal identified in the State-approved person-centered care plan;
- Are for the purpose of increasing independence or substituting for human assistance, to the extent the expenditures would otherwise be made for that human assistance;
- Promote opportunities for community living integration and inclusion;
- Are able to be accommodated without compromising the participant's health or safety; and,
- Are provided to, or directed exclusively toward, the benefit of the participant.

Service Eligibility Criteria:

- Available for individuals who are self-directing services

Services provided in non-integrated settings cannot be funded with IDGS, or in other settings that OPWDD determines do not comport with federal regulations governing home and community based settings. Additional information regarding the service can be found in Addendum A of this waiver, this Addendum describes the types of purchases/services that can be paid for within the IDGS budget, the specifications of these goods/services and the pricing parameters for each purchased item/service.

The individual directed budget must be preapproved on an annual basis by OPWDD or the FIDA-IDD and only those goods and services reflected on the approved budget are available for purchase through this service. A maximum monthly stipend will be made available to the individual for whom funds can be saved or accumulated for the purchase of goods and services within the approved budget year. The annual budget allocation may only be adjusted (increased or decreased) when changes have occurred regarding the member's assessed needs and may only exceed the maximum annual limit when authorized by the Commissioner of OPWDD or their designee. Review of the budget is required annually.

The higher-than-anticipated engagement in self-direction resulted in the increased utilization of IDGS services for WY 3. The State is amending this waiver agreement to reflect the higher utilization.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The billing for this service is limited to $32,000 per year per person not to exceed a person's Personal Resource Allocation (PRA). Limits to specific subcategories of IDGS are identified in Addendum A to this waiver.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☐ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Fiscal Intermediary

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction
Service Name: Individual Directed Goods and Services

Provider Category:
Agency
Provider Type:

Fiscal Intermediary

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

OPWDD establishes standards for providers of waiver services, reviews completed provider applications and for qualified providers, issues Waiver provider agreements that allow participation in the waiver program, provides the application for eMedNY and issues operating certificates for all waiver services. The DOH Division of Operations then reviews the completed eMedNY application and recommendations made by OPWDD, completes an in depth review that incorporates four different sanction searches: eMedNY Sanction, NYS OMIG, HHS-OIG, and Excluded Parties List on the providers board members and managing employees. If found to be appropriate, the DOH Division of Operations then issues a Medicaid provider agreement to enroll the voluntary provider in the NYS Medicaid program in accordance with regulations found at Part 504 of 18 NYCRR. For contracted providers of the FIDA-IDD Plan that deliver wavier services, the FIDA-IDD is responsible to ensure that the provider is one that is approved by OPWDD to provide HCBS waiver services.

OPWDD directly provides HCBS waiver services through its regional offices. In addition, HCBS waiver services are provided by provider agencies which are non-profit organizations. Non-profit organizations include: non- profit corporations formed under New York State Law or authorized to do business in New York, local government units, or organizations created by an act of the New York State Legislature for charitable purposes which include providing services to persons with developmental disabilities.

If the provider agency employs professional clinical staff, that staff person must have the appropriate credentials stipulated by the NYS Department of Education.

Direct support professionals must have completed the training stipulated in 14 NYCRR Part 633.8. Provider agencies must comply with 14 NYCRR Part 633, "Protections of Individuals Receiving Services", including Criminal Background Check (CBC) screening. Provider agencies must also comply with the Part 624, "Reportable Incidents and Client Abuse", and Part 635, "General Quality Control and Administrative Requirements". OPWDD directs provider agencies to screen staff against the Medicaid Excluded Provider lists maintained by the Department of Health and the HHS Office of the Inspector General.

Verification of Provider Qualifications

Entity Responsible for Verification:

For contracted providers of the FIDA-IDD Plan that deliver waiver services the FIDA-IDD is responsible to ensure that the provider is one that is approved by OPWDD to provide HCBS waiver services. The OPWDD approval is based upon its review that the entity is fiscally viable and meets the minimum standards to deliver HCBS waiver services including satisfactory character, competence, education and experience. The FIDA-IDD is responsible for verifying appropriate credentials for professional staff and compliance with applicable State and Federal regulations and requirements when licensed staff deliver waiver services.

OPWDD is responsible to verify provider qualifications. Annual reviews of all providers are performed by OPWDD's Division of Quality Improvement (DQI). During these reviews, DQI reviews provider compliance with the Criminal Background Check (CBC) regulations, the Part 633.8 training requirements and all other applicable requirements.

Frequency of Verification:

NYS performs an annual review of all OPWDD providers including providers contracted with the FIDA-IDD Plan. For providers that bill eMedNY directly for waiver services, annual reviews of providers and/or samples of individuals in the waiver are performed by OPWDD's Division of Quality Improvement (DQI). Providers are reviewed on a yearly basis and may receive an operating certificate for up to a 3 year period of time.

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:

Supports for Participant Direction

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.

Support for Participant Direction:

Other Supports for Participant Direction

Alternate Service Title (if any):

Support Brokerage

HCBS Taxonomy:

Category 1:	Sub-Category 1:
12 Services Supporting Self-Direction	12020 information and assistance in support of self-direction
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

Through 9/30/2014, Support Brokerage is a service available for participants who self-direct their services through Consolidated Supports and Services (CSS). On or after 10/1/14, the service description will remain the same, however, Support Brokerage will be available as a standalone service to individuals who self-direct their services with budget authority.

Support Brokers assist waiver participants (or the participant's family or representative as appropriate) to self-direct and manage some or all of their waiver services. Support Brokerage does not duplicate or replace care management services and differs from care management in terms of intensity, frequency, and scope. The Care Manager identifies services, helps the participant make an informed choice of service providers, refers the person/family to the service chosen, and maintains and updates the plan of care. The Support Broker then takes the person beyond just the referral by becoming involved with the participant in the day-to-day management of those services and provides support and training to participants and their families regarding the ongoing decisions and tasks associated with participant direction.

The Support Broker provides assistance and practical skills training to the participant in the areas of: understanding and managing the responsibilities involved with self-direction; developing daily implementation of and managing the self-directed plan and budget; monitoring expenditures; negotiating terms and service arrangements with providers in the self-directed plan and budget; employer responsibilities such as recruiting, supervising, and training of participant-hired staff; service documentation requirements to ensure agreement with program and Medicaid standards; risk assessment, planning and ensuring safeguards are identified and met; developing and maintaining the Circle of Support and facilitating Circle of Support meetings.

The extent of the assistance provided is determined by the participant and specified in a written agreement between the participant and Support Broker. The broker service also needs to be reflected as part of the person centered plan (e.g. Individualized Service Plan/Life Plan). The participant has the authority to choose among qualified support brokers.

A participant may receive Support Brokerage and care management concurrently as long as those services do not duplicate each other. In those instances where nominal overlapping is likely to occur the participant’s service plan will clearly delineate service responsibilities.

An agency providing Support Brokerage may provide other services; however an individual Support Broker is not permitted to provide other waiver services to a participant they serve.

The higher-than-anticipated engagement in self-direction resulted in the increased utilization of Support Brokerage services for WY 3. The State is amending this waiver agreement to reflect the higher utilization.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	non-profit organization, state, self-directed with the FI or person employed by the FIDA-IDD

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction
Service Name: Support Brokerage

Provider Category:

Agency

Provider Type:

non-profit organization, state, self-directed with the FI or person employed by the FIDA-IDD

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

All potential Support Brokers participate in a specialized two-day Broker training (Broker Training Institute) developed by OPWDD and complete specific courses. These additional courses are: Person Centered Planning for Brokers (Introduction to Person Centered Planning and Advanced Person Centered Planning), Self-Direction Budget Template and , Self-advocacy/Self-determination. These trainings are standardized statewide. All brokers are expected to remain actively involved with a local Support Brokerage Learning Network. Active participation includes attendance in 12 hours of annual training.

OPWDD establishes standards for providers of waiver services, reviews completed provider applications and for qualified providers, issues Waiver provider agreements that allow participation in the waiver program, provides the application for eMedNY and issues operating certificates for all waiver services. The DOH Division of Operations then reviews the completed eMedNY application and recommendations made by OPWDD, completes an in depth review that incorporates four different sanction searches: eMedNY Sanction, NYS OMIG, HHS-OIG, and Excluded Parties List on the providers board members and managing employees. If found to be appropriate, the DOH Division of Operations then issues a Medicaid provider agreement to enroll the voluntary provider in the NYS Medicaid program in accordance with regulations found at Part 504 of 18 NYCRR. For contracted providers of the FIDA-IDD Plan that deliver waiver services the FIDA-IDD is responsible to ensure that the provider is one that is approved by OPWDD to provide HCBS waiver services.

OPWDD directly provides HCBS waiver services through its regional offices. In addition, HCBS waiver services are provided by provider agencies which are non-profit organizations. Non-profit organizations include: nonprofit corporations formed under New York State Law or authorized to do business in New York, local
government units, or organizations created by an act of the New York State Legislature for charitable purposes which include providing services to persons with developmental disabilities.
If the provider agency employs professional clinical staff, that staff person must have the appropriate credentials stipulated by the OPWDD and/or the NYS Department of Education.

Direct support professionals must have completed the training stipulated in 14 NYCRR Part 633.8. Provider agencies must comply with 14 NYCRR Part 633, "Protections of Individuals Receiving Services", including Criminal Background Check (CBC) screening. Provider agencies must also comply with the Part 624, "Reportable Incidents and Client Abuse", and Part 635, "General Quality Control and Administrative Requirements". OPWDD directs provider agencies to screen staff against the Medicaid Excluded Provider lists maintained by the Department of Health and the HHS Office of the Inspector General.

Verification of Provider Qualifications

Entity Responsible for Verification:

For contracted providers of the FIDA-IDD Plan that deliver waiver services the FIDA-IDD is responsible to ensure that the provider is one that is approved by OPWDD to provide HCBS waiver services. The OPWDD approval is based upon its review that the entity is fiscally viable and meets the minimum standards to deliver HCBS waiver services including satisfactory character, competence, education and experience. The FIDA-IDD is responsible for verifying appropriate credentials for professional staff and compliance with applicable State and Federal regulations and requirements when licensed staff deliver waiver services.

OPWDD is responsible to verify provider qualifications. Annual reviews of all providers are performed by OPWDD’s Division of Quality Improvement (DQI). During these reviews, DQI reviews provider compliance with the Criminal Background Check (CBC) regulations, the Part 633.8 training requirements, and all other applicable requirements.

Frequency of Verification:

NYS performs an annual review of all OPWDD providers including providers contracted with the FIDA-IDD Plan. For providers that bill eMedNY directly for waiver services, annual reviews of providers and/or samples of individuals in the waiver are performed by OPWDD's Division of Quality Improvement (DQI). Providers are reviewed on a yearly basis and may receive an operating certificate for up to a 3 year period of time.

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Assistive Technology - Adaptive Devices

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 2:	**Sub-Category 2:**
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Assistive Technology - Adaptive Devices means an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of participants. Assistive Technology - Adaptive Device service means a service that directly assists a participant in the selection, acquisition, or use of an assistive technology device. The devices and services must be documented in the participant's individualized service plan (ISP)/ life plan (LP) as being essential to the person's habilitation, ability to function, or safety and essential to avoid or delay institutionalization.

Assistive Technology - Adaptive Device Services include:
A. the evaluation of the assistive technology needs of a participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant;
B. services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for the participants;
C. services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;
D. coordination and use of necessary therapies, interventions, or services with assistive technology devices, such as therapies, interventions, or services associated with other services in the service plan;
E. training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates or authorized representatives of the participant; and
F. training or technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of participants.

Assistive Technology - Adaptive Devices include:
a. Direct selection communicators.
b. Alphanumeric communicators.
c. Scanning communicators.
d. Encoding communicators.
e. Speech amplifiers.
f. Electronic speech aids/devices.
g. Voice activated, light activated, motion activated and electronic devices.
h. Standing boards/frames and therapeutic equipment for the purpose of maintaining or improving the participant's strength, mobility or flexibility to perform activities of daily living.
i. Adaptive switches/devices.
j. Meal preparation and eating aids/devices/appliances.
k. Specially adapted locks.
l. Motorized wheelchairs.
m. Guide dogs, hearing dogs, service dogs (as defined in New York Civil Rights Law Article 47-b(4)and simian aids (capuchin monkeys or other trained simians that perform tasks for persons with limited mobility).
n. Electronic, wireless, solar-powered or other energy powered devices that demonstrate to the satisfaction of the commissioner, or designee, that the device(s) will significantly enable the participant to live, work or meaningfully participate in the community with less reliance on paid staff supervision or assistance. Such devices may include computers, observation cameras, sensors, telecommunication screens and/or telephones and/or other telecare support services/systems that enable the participant to interact with remote staff to ensure health and safety. Such devices cannot be used for the purpose of surveillance, but to support the person to live with greater independence.
o. Devices to assist with medication administration, including tele-care devices that prompt, teach or otherwise assist the participant. Repairs to such adaptive devices that will be cost-effective and approved by the regional office.
p. Portable generators necessary to support equipment or devices needed for the health or safety of the person.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Assistive Technology - Adaptive Devices are expected to be a one-time only purchase. Replacements, repairs, upgrades, or enhancements made to existing equipment will be paid if documented as a necessity and approved by the regional office. Ongoing monitoring associated with telecare support services or other approved systems authorized under this definition may be provided if necessary for health and safety and documented to the satisfaction of the regional office Director or designee. The regional office will ensure, that where appropriate, justification from physicians, or other specialists or clinicians has been obtained.

In FFS, NYS is the provider of record for Assistive Technology for billing purposes. Services/devices are selected through a standardized bid process following the rules established by the Office of the State Comptroller. In the FIDA-IDD the plan is the payer and may contract with an approved network provider for the technology. The Assistive Technology is only billed to Medicaid once the device is delivered or the work is verified as complete; the amount billed is equal to the contract or vendor value.

Only those devices/services not reimbursable under the State Medicaid Plan will be reimbursable under the HCBS Waiver.

Children eligible for a motorized wheelchair through the Early Periodic Screening, Diagnostic and Treatment (EPSDT) State Plan benefit Durable Medical Equipment (DME) may only access HCBS Waiver funding for such technology if they are unable to obtain the device through the State Plan due to a previous request for a similar device within the required time period.

Effective with claims submitted to eMedNY on or after 4/1/13 maximum expenditure for adaptive technology services for the benefit of an individual Medicaid beneficiary may not exceed $35,000 in any consecutive two years period. Effective with the alignment of the currently approved CFCO State Plan, the service limit will be $15,000. This amount may be exceeded due to medical necessity and with prior authorization from the Single State Medicaid Agency.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	State or FIDA-IDD

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Assistive Technology - Adaptive Devices

Provider Category:
Agency
Provider Type:

State or FIDA-IDD

Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

OPWDD , the state operating agency, or the FIDA-IDD is the service provider. The state or FIDA-IDD, are approved Medicaid providers and contract with approved network providers.

Verification of Provider Qualifications

Entity Responsible for Verification:

OPWDD, the state operating agency, or the FIDA-IDD is the service provider.

Frequency of Verification:

All OPWDD regional offices are approved by the Department of Health (DOH) to provide any of the services included in the waiver.

The FIDA-IDD will be authorized by article 44 of the NYS Public Health Law to act as a Manage Care Entity.

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Community Habilitation

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04070 community integration
Category 2:	**Sub-Category 2:**
15 Non-Medical Transportation	15010 non-medical transportation
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

Community Habilitation is similar in scope to residential habilitation supports and day habilitation supports, however, the focus of this new service is directed towards service delivery occurring largely in the community (non-certified) settings to facilitate and promote independence and community integration. Community Habilitation is defined as a face to face service in the waiver and in all guidance issued by OPWDD. Therefore, in order for a service to be billed, the staff must be with the individual. NYS-OPWDD wishes to add this service to provide another option to participants and families who wish to have their habilitation services available in a variety of every-day community settings.

Community Habilitation will offer skill training and supports as follows: adaptive skill development, assistance with activities of daily living, travel, health, adult educational supports, communication, social skills, leisure skills, money management, socially appropriate behaviors, life safety, hands-on-assistance provided by staff as necessary, professional oversight services as necessary (for example QIDP oversight), self-advocacy, informed choice, community inclusion, and relationship building. Community Habilitation may also include personal care, health care, protective oversight and supervision, including in the person's home, and program-related transportation but these components do not constitute the entirety of the service.

Community Habilitation services are generally not vocational in nature. However, Community Habilitation services do support individuals in their attainment of life goals, including career goals. Therefore, Community Habilitation may include habilitation activities such as volunteering, learning about different types of jobs, visiting job sites and other experiences that are not long-term vocational commitments; yet the person is exposed to the world of work and the experience broadens his or her understanding of the types of employment they may wish to actively pursue in the future.

Once an individual is employed, community habilitation services may be used in a work setting to facilitate and promote independence, community inclusion, relationship building and socially appropriate behaviors. Community habilitation services cannot be used for job coaching related activities and cannot be provided at the same time as supported employment services.

Through its ongoing review of waiver services, OPWDD's DQI reviews the CH service to ensure that services are provided in accordance with the requirements.

Community Habilitation participants will be offered the opportunity to participant-direct the service as outlined in Appendix E or participants may use a provider managed service delivery model.

Individuals who self-direct their Community Habilitation, Respite and Supported Employment services with budget authority, may be eligible for "Special Populations Funding" if they have been discharged from a more restrictive residential setting such as a developmental center as described in Addendum A to this waiver and will be in effect until June 30, 2021. A new PRA approach, to be submitted as a waiver amendment to CMS, will be effective July 1, 2021 and will replace the Special Population Funding for individuals who self-direct their services with budget authority using the Coordinated Assessment System (CAS). As described in Appendix E, the eligible individual's budget may be increased up to the level of the Special Populations Funding and therefore could be used to fund self-directed, "self-hired" staff who deliver Community Habilitation. The rate paid for the self-directed services follows the same limitations as are in place for all Individuals who exercise budget authority. The higher PRA funding is designed to provide additional supports required to assist an individual transitioning to a less restrictive setting.

The service definition of Community Habilitation will not change with the alignment of the currently approved CFCO State Plan and the fee schedule is realigned with other service systems. Only those services not reimbursable under the currently approved Community First Choice Option (CFCO) State Medicaid Plan will be reimbursable under the HCBS Waiver.

Community Habilitation is a core service within self-direction. It is also used to support individuals to live in independent living arrangements as an alternative to placement in a provider-owned residential setting and as an alternative to site-based day habilitation services. The State is amending this waiver agreement to reflect the higher utilization in WY 3.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Individuals living in their own home/leased residence or family home may receive Community Habilitation services at any time. People living in Family Care homes and IRAs or Community Residences may only receive Community Habilitation Services on week day days (start time prior to 3:00 pm) unless the CH service is delivered at the person's integrated and competitive job and the CH service allows the person to maintain employment. Services may not be delivered in a certified location.

In addition to payment edits barring weekend CH for individuals receiving residential habilitation services, payment combination edits also preclude payment of CH services for residential habilitation recipients who already have a full contingent of day services on a given day.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	non-profit organization or state

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community Habilitation

Provider Category:

Agency

Provider Type:

non-profit organization or state

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

OPWDD establishes standards for providers of waiver services, reviews completed provider applications and for qualified providers, issues Waiver provider agreements that allow participation in the waiver program, provides the application for eMedNY and issues operating certificates for all waiver services. The DOH Division of Operations then reviews the completed eMedNY application and recommendations made by OPWDD, completes an in depth review that incorporates four different sanction searches: eMedNY Sanction, NYS OMIG, HHS-OIG, and Excluded Parties List on the providers board members and managing employees. If found to be appropriate, the DOH Division of Operations then issues a Medicaid provider agreement to enroll the voluntary provider in the NYS Medicaid program in accordance with regulations found at Part 504 of 18 NYCRR . For contracted providers of the FIDA-IDD Plan that deliver waiver services the FIDA-IDD is responsible to ensure that the provider is one that is approved by OPWDD to provide HCBS waiver services.

OPWDD directly provides HCBS waiver services through its regional offices. In addition, HCBS waiver services are provided by provider agencies which are non-profit organizations. Non-profit organizations include: non- profit corporations formed under New York State Law or authorized to do business in New York, local government units, or organizations created by an act of the New York State Legislature for charitable purposes which include providing services to persons with developmental disabilities.

If the provider agency employs professional clinical staff, that staff person must have the appropriate credentials stipulated by the OPWDD and/or the NYS Department of Education under the following regulations and laws:

- Nursing (8 NYCRR Part 64, and Education Law Title 8, Article 139)
- Speech Language Pathologist (8 NYCRR Part 75, and Education Law Title 8, Article 159)
- Psychology (8 NYCRR Part 72, and Education Law Title 8, Article 153)
- Social Work (8 NYCRR Part 74, and Education Law Title 8, Article 154)
- Rehab Counselor (14 NYCRR Part 679.99)
- Dietetics/Nutrition (8 NYCRR Part 79, and Education Law Title 8, Article 157)
- Occupational Therapy (8 NYCRR Part 76, and Education Law Title 8, Article 156)
- Physical Therapy (8 NYCRR part 77, and Education Law Title 8, Article 136)
- Applied Behavioral Sciences Specialist (8 NYCRR Part 79, and Education Law Title 8, Article 167)
- Behavioral Intervention Specialist (14 NYCRR part 633-16.b(32).

Direct support professionals must have completed the training stipulated in 14 NYCRR Part 633.8. Provider agencies must comply with 14 NYCRR Part 633, "Protections of Individuals Receiving Services", including Criminal Background Check (CBC) screening. Provider agencies must also comply with the Part 624, "Reportable Incidents and Client Abuse", and Part 635, "General Quality Control and Administrative Requirements". OPWDD directs provider agencies to screen staff against the Medicaid Excluded Provider lists maintained by the Department of Health and the HHS Office of the Inspector General.

Verification of Provider Qualifications

Entity Responsible for Verification:

For contracted providers of the FIDA-IDD Plan that deliver waiver services the FIDA-IDD is responsible to ensure that the provider is one that is approved by OPWDD to provide HCBS waiver services. The OPWDD approval is based upon its review that the entity is fiscally viable and meets the minimum standards to deliver HCBS waiver services including satisfactory character, competence, education and experience. The FIDA-IDD is responsible for verifying appropriate credentials for professional staff and compliance with applicable State and Federal regulations and requirements when licensed staff deliver waiver services.

OPWDD is responsible to verify provider qualifications. Annual reviews of all providers are performed by OPWDD’s Division of Quality Improvement (DQI). During these reviews, DQI reviews provider compliance with the Criminal Background Check (CBC) regulations, the Part 633.8 training requirements, and all other applicable requirements.

Frequency of Verification:

NYS performs an annual review of all OPWDD providers including providers contracted with the FIDA-IDD Plan. For providers that bill eMedNY directly for waiver services, annual reviews of providers and/or samples of individuals in the waiver are performed by OPWDD's Division of Quality Improvement (DQI). Providers are reviewed on a yearly basis and may receive an operating certificate for up to a 3 year period of time.

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Environmental Modifications (Home Accessibility)

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Those physical adaptations to the participant's home, required by the participant's service plan, that are necessary to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence in the home and without which the person would require institutionalization and/or more restrictive and expensive living arrangement.
Adaptations include: installation of ramps, hand rails and grab-bars, widening of doorways doorways(but not hallways), modifications of bathroom facilities, installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies needed for the welfare of the recipient, lifts and related equipment, elevators when no feasible alternative is available, automatic or manual door openers/bells, modifications of the kitchen necessary for the participant to function more independently in his home, medically necessary air conditioning, Braille identification systems, tactile orientation systems, bed shaker alarm devices, strobe light smoke detection and alarm devices, small area drive-way paving for wheel-chair entrance/egress from van to home, safe environment modifications for behaviorally challenged participants require the prior review of a behavioral specialist and include window protections, reinforcement of walls, durable wall finishes, open-door signal devices, fencing, video monitoring systems and shatter-proof shower doors; and future technology devices that allow the participant to live more safely and independently to avoid possible institutional placement or placement in a more restrictive living environment, which are available at a reasonable cost in comparison to living in a more restrictive residential setting. The scope of environmental modifications will also include necessary assessments to determine the types of modifications needed.

Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the participant. Adaptations that add to the total square footage of the home's footprint are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair). Also excluded are pools and hot tubs and associated modifications for entering or exiting the pool or hot tub. If Environmental Modifications are needed in order for the person to move into his/her new home, FFP may be claimed for work completed prior to the person's enrollment date as long as the service appears in the preliminary individualized service plan (PISP)/ life plan (LP) and work is completed within 30 days prior to the person moving into the home.

NYS is the provider of record for Environmental Modifications for billing purposes. The work is done by a contractor who is selected through a standard bid process, following the rules established by the Office of the State Comptroller. The e-mod is only billed to Medicaid once the contract work is verified as complete and the amount billed is equal to the contract value.

Environmental Modifications are limited to individual or family owned or controlled homes.

NYS has not made any programmatic or fiscal policy changes that would negatively affect the number of waiver enrollees utilizing Environmental Modifications for WY 3. The decrease in utilization for Environmental Modifications during WY 3 was based upon waiver enrollees decreased need for the service during the October 1, 2016 to September 31, 2017 timeframe. The State is amending this waiver agreement to reflect the lower utilization in WY 3.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

In most instances a specific type of Environmental Modification is a one-time benefit. However, in reasonable circumstances determined and approved by the State, a second modification may be considered for funding as follows: if a person moves to another home; if the current modifications are in need of repair, worn-out or unsafe; or if a participant wishes to spend considerable time with a non-cohabitating parent in their home and such modifications are required to ensure health and safety during these periods. An OPWDD memorandum dated February 21, 2012 limited to e-mods to Individual or Family Owned residences. State policy places certain limitations on environmental modifications requested when the home/apartment is a leased space, including property owner sign-off on the modification and limitations on federal/state liability for the cost of removal/replacement/repair of items in public spaces of rental properties.

Only those devices/services not reimbursable under the State Medicaid Plan will be reimbursable under the HCBS Waiver.

Effective with claims submitted to eMedNY on or after 4/1/13 maximum expenditure for Environmental Modifications for the benefit of an individual Medicaid beneficiary may not exceed $60,000 in any consecutive five year period. Effective with the alignment of the currently approved CFCO State Plan, the service limit will be $15,000. This amount may be exceeded due to medical necessity and with prior authorization from the Single State Medicaid Agency.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	State or FIDA-IDD

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Modifications (Home Accessibility)

Provider Category:
Agency
Provider Type:

State or FIDA-IDD

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

OPWDD , the state operating agency, or the FIDA-IDD is the service provider. The state or FIDA-IDD, are approved Medicaid providers and contract with approved network providers.

Verification of Provider Qualifications

Entity Responsible for Verification:

OPWDD, the state operating agency, or the FIDA-IDD is the service provider.

Frequency of Verification:

All OPWDD regional offices are approved by the Department of Health (DOH) to provide any of the services included in the waiver.

The FIDA-IDD will be authorized by Article 44 of the NYS Public Health Law to act as a managed care entity.

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Family Education and Training

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09020 caregiver counseling and/or training
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Family Education and Training (FET), is training given to families of participants enrolled in the HCBS waiver. The purpose of FET is to enhance the decision making capacity of the family unit, provide orientation regarding the nature and impact of a developmental disability on the person and his or her family, including behavioral management practices, and teach the family about service alternatives. FET is distinct from care management in that the purpose is to support the family unit in understanding and coping with the developmental disability. The information and knowledge imparted in FET increases the chances of creating a supportive environment at home and decreases the chances of a premature residential placement outside the home.

FET sessions may be private or in groups of families covering subject matter that enhances the ability of a family to handle the demands of nurturing a family member with a developmental disability. Personnel knowledgeable in the topics covered may conduct the sessions. Most frequently, this will be a care manager or behavioral specialist, but it may also include other clinicians and experts in such fields as law and finances pertaining to disabilities.

NYS has not made any programmatic or fiscal policy changes that would negatively affect the number of waiver enrollees utilizing Family Education and Training for WY 3. The decrease in utilization in Family Education and Training during WY 3 was based upon waiver enrollees decreased need for the service and increased utilization of natural and community supports during the October 1, 2016 to September 31, 2017 timeframe. The State is amending this waiver agreement to reflect the lower utilization in WY 3.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

FET has a unit of service of up to two hours in length. Two units of service will be provided per year. The regional office may authorize additional units of service for participants demonstrating extreme behavioral management needs if there is sufficient clinical data.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	non-profit organization or state

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family Education and Training

Provider Category:
Agency
Provider Type:

non-profit organization or state

Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

OPWDD establishes standards for providers of waiver services, reviews completed provider applications and for qualified providers, issues Waiver provider agreements that allow participation in the waiver program, provides the application for eMedNY and issues operating certificates for all waiver services. The DOH Division of Operations then reviews the completed eMedNY application and recommendations made by OPWDD, completes an in depth review that incorporates four different sanction searches: eMedNY Sanction, NYS OMIG, HHS-OIG, and Excluded Parties List on the providers board members and managing employees. If found to be appropriate, the DOH Division of Operations then issues a Medicaid provider agreement to enroll the voluntary provider in the NYS Medicaid program in accordance with regulations found at Part 504 of 18 NYCRR.

OPWDD directly provides HCBS waiver services through its regional offices. In addition, HCBS waiver services are provided by provider agencies which are non-profit organizations. Non-profit organizations include: non- profit corporations formed under New York State Law or authorized to do business in New York, local government units, or organizations created by an act of the New York State Legislature for charitable purposes which include providing services to persons with developmental disabilities.

If the provider agency employs professional clinical staff, that staff person must have the appropriate credentials stipulated by the OPWDD and/or the NYS Department of Education under the following regulations and laws:

- Nursing (8 NYCRR Part 64, and Education Law Title 8, Article 139)
- Speech Language Pathologist (8 NYCRR Part 75, and Education Law Title 8, Article 159)
- Psychology (8 NYCRR Part 72, and Education Law Title 8, Article 153)
- Social Work (8 NYCRR Part 74, and Education Law Title 8, Article 154)
- Rehab Counselor (14 NYCRR Part 679.99)
- Dietetics/Nutrition (8 NYCRR Part 79, and Education Law Title 8, Article 157)
- Occupational Therapy (8 NYCRR Part 76, and Education Law Title 8, Article 156)
- Physical Therapy (8 NYCRR part 77, and Education Law Title 8, Article 136)
- Applied Behavioral Sciences Specialist (8 NYCRR Part 79, and Education Law Title 8, Article 167)
- Behavioral Intervention Specialist (14 NYCRR part 633-16.b(32).

Direct support professionals must have completed the training stipulated in 14 NYCRR Part 633.8. Provider agencies must comply with 14 NYCRR Part 633, "Protections of Individuals Receiving Services", including Criminal Background Check (CBC) screening. Provider agencies must also comply with the Part 624, "Reportable Incidents and Client Abuse", and Part 635, "General Quality Control and Administrative Requirements". OPWDD directs provider agencies to screen staff against the Medicaid Excluded Provider lists maintained by the Department of Health and the HHS Office of the Inspector General.

Verification of Provider Qualifications

Entity Responsible for Verification:

OPWDD is responsible to verify provider qualifications. Annual reviews of all providers are performed by OPWDD’s Division of Quality Improvement (DQI). During these reviews, DQI reviews provider compliance with the Criminal Background Check (CBC) regulations, the Part 633.8 training requirements, and all other applicable requirements.

Frequency of Verification:

Annual reviews of all provider agencies are performed by OPWDD's Division of Quality Improvement (DQI). Providers are reviewed on a yearly basis and may receive an operating certificate for up to a 3 year period of time.

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Intensive Behavioral Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10040 behavior support
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Intensive Behavioral Services is a waiver service, which is available under the following circumstances:

(1) For individuals who reside in a non-certified residential location, their own home or family home, or a family care home; and

(2) The individual or a party acting on behalf of the individual certifies through written documentation that the individual is at risk of imminent placement in a more restrictive living environment due to challenging behavioral episodes.

Intensive Behavioral Services are short-term, outcome-oriented, and of higher intensity than other behavioral interventions and are focused on developing effective behavioral management strategies to ensure health and safety and/or improve quality of life. Intensive Behavioral Services differ from services available through the State Plan as follows: the service will be available in the person's home; the service is short-term designed to achieve community stabilization; the service is of high intensity; the intent is to develop effective behavioral strategies that will be maintained, if necessary, through transitioning to other appropriate services to help the person to sustain the behavioral strategies long-term.

The components of Intensive Behavioral Services may include:

-completing the functional behavioral assessment,

-gathering information from other sources such as family, community supports or other affected service providers,

-developing a Behavior Support Plan

-implementation and monitoring of behavioral interventions and strategies with the individual,

-collateral contacts that are for the direct benefit of the individual and enhance the effectiveness of the service,

-training of the primary caregivers and/or staff in the utilization of the behavioral interventions, and

-transitional planning with family, collateral and other agencies to refer the individual to appropriate services to maintain the behavioral strategies long-term.

NYS has not made any programmatic or fiscal policy changes that would negatively affect the number of waiver enrollees utilizing Intensive Behavioral Services for WY 3. The decrease in utilization of Intensive Behavioral Services during WY 3 was based upon waiver enrollees increased access to alternate models of crisis response services funded through the Balancing Incentive’s Program and State resources during the October 1, 2016 to September 31, 2017 timeframe. The State is amending this waiver agreement to reflect the lower utilization in WY 3.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

OPWDD's regional offices will authorize services if there is written documentation that substantiates that the individual is at risk of imminent placement in a more restrictive living environment due to behavioral episodes. The regional office's review to confirm that there is written documentation that substantiates the individual's risk may include the individual's ISP/Life Plan, an intake or application form, a clinical inventory, current receipt of services, and additional supporting documentation. The risk assessment is consistently applied, but based on the person's available records different types of documents may need to be assessed.

Intensive Behavioral Services are authorized by the regional office and consists of the development of a functional behavioral assessment and behavioral support plan, and service hours to assist in implementing the behavior plan. Service hours may be authorized for up to a twelve month period and a maximum of 75 hours. Payment for the development of the person's functional behavioral assessment and behavior support plan is limited to once every three years.

To the extent that any listed services are covered under the state plan, the services under the waiver would be limited to additional services not otherwise covered under the state plan, but consistent with waiver objectives of avoiding institutionalization.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	non-profit organization or state

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Intensive Behavioral Services

Provider Category:
Agency
Provider Type:

non-profit organization or state

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Provider agencies must demonstrate a capacity to deliver effective Intensive Behavioral Services. This demonstration of capacity must include the employment of and/or access to professional staff to deliver Intensive Behavioral services and to supervise the delivery of these services as outlined in this section.

Individuals who provide Intensive Behavioral Services, including development of the Functional Behavioral Assessment (FBA) and Behavior Support Plan (BSP) must meet required credentials and experiential requirements as follows:

-- Required Credentials: NYS Licensed Clinical Social Workers LCSW; or NYS licensed psychologists; or NYS Licensed Master Social Workers; or master's degree in psychology; or master's degree in a related human services field subject to the approval of OPWDD on a case-by-case basis.

LCSWs or NYS licensed psychologists must supervise individuals who are authorized to provide Intensive Behavioral Services as outlined above (i.e., LMSW or individuals with masters degrees). LCSWs or NYS licensed psychologists serving in a supervisory role must have at least two years of post-licensure experience in clinical supervision, and at least two years of post-licensure experience in treating or working with individuals with developmental disabilities and maladaptive or inappropriate behavior (the clinical supervision and post- licensure experience may occur concurrently). All clinical supervision must be provided in accordance with New York State requirements. If LCSWs or NYS licensed psychologists are delivering Intensive behavioral services, clinical supervision by other LCSWs or NYS licensed psychologists is not required.

All professional clinical staff persons must have the appropriate credentials stipulated by the NYS Department of Education. Provider agencies must comply with 14 NYCRR Part 633, "Protections of Individuals Receiving Services", including Criminal Background Check (CBC) screening. Provider agencies must also comply with the Part 624, "Reportable Incidents and Client Abuse", and Part 635, "General Quality Control and Administrative Requirements". OPWDD directs provider agencies to screen staff against the Medicaid Excluded Provider lists maintained by the Department of Health and the HHS Office of the Inspector General.

Agencies providing Intensive Behavioral Services must demonstrate that they have systems in place to monitor the progress of individuals receiving Intensive Behavioral Services; to evaluate the outcome of the services; and to transition the individuals served to appropriate services to maintain their behavioral strategies. Provider outcome evaluation systems must focus on quantitative and qualitative measures of outcomes achieved.

Provider agencies must further demonstrate that they have effective clinical supervision systems and oversight controls in place that address the following:

- the number of supervisees assigned to each licensed/credentialed supervisor
- the type of supervision (in-person individual or group)
- the required frequency of supervision
- the provision of a contingent emergency supervisor if the assigned supervisor is not immediately available
- requirements for the supervisor's record or log of supervision including: the name and title of the supervisee; the date, length and location of supervision; the type of supervision; the nature of supervision (i.e., review of treatment/interventions, observations, in-service training); the signature and title of the supervisor;
- the effectiveness of supervision

For contracted providers of the FIDA-IDD Plan that deliver waiver services the FIDA-IDD is responsible to ensure that the provider is one that is approved by OPWDD to provide HCBS waiver

services.

OPWDD establishes standards for providers of waiver services, reviews completed provider applications and for qualified providers, issues Waiver provider agreements that allow participation in the waiver program, provides the application for eMedNY and issues operating certificates for all waiver services. The DOH Division of Operations then reviews the completed eMedNY application and recommendations made by OPWDD, completes an in depth review that incorporates four different sanction searches: eMedNY Sanction, NYS OMIG, HHS-OIG, and Excluded Parties List on the providers board members and managing employees. If found to be appropriate, the DOH Division of Operations then issues a Medicaid provider agreement to enroll the voluntary provider in the NYS Medicaid program in accordance with regulations found at Part 504 of 18 NYCRR.

OPWDD directly provides HCBS waiver services through its regional offices. In addition, HCBS waiver services are provided by provider agencies which are non-profit organizations. Non-profit organizations include: non- profit corporations formed under New York State Law or authorized to do business in New York, local government units, or organizations created by an act of the New York State Legislature for charitable purposes which include providing services to persons with developmental disabilities.

Verification of Provider Qualifications

Entity Responsible for Verification:

For contracted providers of the FIDA-IDD Plan that deliver waiver services the FIDA-IDD is responsible to ensure that the provider is one that is approved by OPWDD to provide HCBS waiver services. The OPWDD approval is based upon its review that the entity is fiscally viable and meets the minimum standards to deliver HCBS waiver services including satisfactory character, competence, education and experience. The FIDA-IDD is responsible for verifying appropriate credentials for professional staff and compliance with applicable State and Federal regulations and requirements when licensed staff deliver waiver services.

OPWDD is responsible to verify provider qualifications. Annual reviews of all providers are performed by OPWDD's Division of Quality Improvement (DQI). During these reviews, DQI reviews provider compliance with the Criminal Background Check (CBC) regulations, the Part 633.8 training requirements, and all other applicable policies and regulations. DQI will review to ensure that staff providing Intensive Behavioral Services meet the educational and experiential criteria in accordance with OPWDD policies.

Frequency of Verification:

NYS performs an annual review of all OPWDD providers including providers contracted with the FIDA-IDD Plan. For providers that bill eMedNY directly for waiver services, annual reviews of providers and/or samples of individuals in the waiver are performed by OPWDD's Division of Quality Improvement (DQI). Providers are reviewed on a yearly basis and may receive an operating certificate for up to a 3 year period of time.

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Pathway to Employment

HCBS Taxonomy:

Category 1:	Sub-Category 1:
03 Supported Employment	03030 career planning
Category 2:	**Sub-Category 2:**
03 Supported Employment	03010 job development
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

The Pathway to Employment is a person-centered, comprehensive career planning and support service that provides assistance for participants to obtain, maintain or advance in competitive employment or self- employment.

The Pathway to Employment service will be available to individuals expressing an interest in competitive employment or self- employment including (but not limited to) individuals who receive Day Habilitation, Pre-Vocational and Supported Employment services, as well as students leaving high school.

It is a focused, time limited service that engages a participant in identifying a career direction, provides instruction and training in pre-employment skills, and develops a plan for achieving competitive, integrated employment at or above the state minimum wage. Within 12 months, or sooner, the outcome of this service is documentation of the participant's stated career objective; a detailed career plan used to guide individual employment supports; and preparation for supported employment services that assist a participant in obtaining, maintaining or advancing in competitive employment or self-employment.

Pathway to Employment participants must have competitive employment or self-employment as a stated goal in their service plans. The Pathway to Employment service will combine an individualized career planning process that identifies the person's support needs with the provision of services that will strengthen the skills needed to obtain, maintain or advance in competitive employment. Services provided under the Pathway to Employment service will be person-centered and may include; but not be limited to: vocational assessment; situational assessment; job readiness training including individualized and appropriate work- related behaviors; community experiences; pre-employment skills including tasks necessary to obtain employment based on the individualized needs of the participant; job related discovery; experiential learning in career exploration and vocational discovery; experiential learning to achieve a specific vocational outcome; assessment for use of assistive technology to increase independence in the workplace; community experiences through paid or unpaid internships, mentorships, apprenticeships, job clubs, work site visits, job placement, and other job exploration modalities; education and counseling around benefits management and employment; person-centered vocational planning; customized job development; individualized, ongoing job coaching; travel training; and behavioral interventions and supports.

The Pathway to Employment service may also provide planning for self-employment. Specific services include: identifying skills that could be used to start a business, and identifying business training and technical assistance that could be utilized in achieving self-employment goals.

Employment Related Goals: All Pathway to Employment participants will develop a specific individualized career plan with the Pathway to Employment provider for services that will focus on the individual's unique employment needs, talents, employment goals, and natural supports. At the end of Pathway to Employment, the provider in cooperation with the individual will create a formal vocational plan that will allow the individual to have a map of their career path. This Pathway to Employment career plan will outline the responsibilities of the participant and the responsibilities of the provider towards achievement of the employment goals.

It is anticipated that the majority of the Pathway to Employment service will be provided in community settings or at particular work sites. The cost of any reimbursable transportation associated with Pathway to Employment is included in the Pathway to Employment fee.

Documentation must be maintained indicating that the services provided under Pathway to Employment are not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

Pathway to Employment is a critical component of the OPWDD employment initiative. The State is amending this waiver agreement to reflect the higher utilization in WY 3.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

A detailed vocational career plan and preparation for supported employment services that assist an individual in obtaining competitive, integrated employment at or above the state minimum wage is the expected outcome from this service.

There is a lifetime limit of 556 hours for the service.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	non-profit organization or state

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Pathway to Employment

Provider Category:

Agency

Provider Type:

non-profit organization or state

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Only providers that currently offer both Day Habilitation and Supported Employment services (or have an equivalent agreement approved by OPWDD) will be authorized to provide Pathway to Employment services.

A Medicaid Provider Agreement is issued by DOH to the HCBS Waiver Provider based on an OPWDD recommendation (based on applicable OPWDD regulations) and in accordance with regulations found at Part 504 of 18 NYCRR. The Medicaid Provider Agreement is issued based on the determination that the agency will have, or continues to have, satisfactory character, competence, education, and experience to deliver waiver services, and that the agency is fiscally responsible and viable.

OPWDD establishes standards for providers of waiver services, reviews completed provider applications and for qualified providers, issues Waiver provider agreements that allow participation in the waiver program, provides the application for eMedNY and issues operating certificates for all waiver services. The DOH Division of Operations then reviews the completed eMedNY application and recommendations made by OPWDD, completes an in depth review that incorporates four different sanction searches: eMedNY Sanction, NYS OMIG, HHS-OIG, and Excluded Parties List on the providers board members and managing employees. If found to be appropriate, the DOH Division of Operations then issues a Medicaid provider agreement to enroll the voluntary provider in the NYS Medicaid program in accordance with regulations found at Part 504 of 18 NYCRR.

OPWDD directly provides HCBS waiver services through its regional offices. In addition, HCBS waiver services are provided by provider agencies which are non-profit organizations. Non-profit organizations include: non-profit corporations formed under New York State Law or authorized to do business in New York, local government units, or organizations created by an act of the New York State Legislature for charitable purposes which include providing services to persons with developmental disabilities.

If the provider agency employs professional clinical staff, that staff person must have the appropriate credentials stipulated by the OPWDD and/or the NYS Department of Education under the following regulations and laws:

- Nursing (8 NYCRR Part 64, and Education Law Title 8, Article 139)
- Speech Language Pathologist (8 NYCRR Part 75, and Education Law Title 8, Article 159)
- Psychology (8 NYCRR Part 72, and Education Law Title 8, Article 153)
- Social Work (8 NYCRR Part 74, and Education Law Title 8, Article 154)
- Rehab Counselor (14 NYCRR Part 679.99)
- Dietetics/Nutrition (8 NYCRR Part 79, and Education Law Title 8, Article 157)
- Occupational Therapy (8 NYCRR Part 76, and Education Law Title 8, Article 156)
- Physical Therapy (8 NYCRR part 77, and Education Law Title 8, Article 136)
- Applied Behavioral Sciences Specialist (8 NYCRR Part 79, and Education Law Title 8, Article 167)
- Behavioral Intervention Specialist (14 NYCRR part 633-16.b(32).

Direct support professionals must have completed the training stipulated in 14 NYCRR Part 633.8. Provider agencies must comply with 14 NYCRR Part 633, "Protections of Individuals Receiving Services", including Criminal Background Check (CBC) screening. Provider agencies must also comply with the Part 624, "Reportable Incidents and Client Abuse", and Part 635, "General Quality Control and Administrative Requirements". OPWDD directs provider agencies to screen staff against the Medicaid Excluded Provider lists maintained by the Department of Health and the HHS Office of the Inspector General.

Verification of Provider Qualifications

Entity Responsible for Verification:

For contracted providers of the FIDA-IDD Plan that deliver waiver services the FIDA-IDD is responsible to ensure that the provider is one that is approved by OPWDD to provide HCBS waiver services. The OPWDD approval is based upon its review that the entity is fiscally viable and meets the minimum standards to deliver HCBS waiver services including satisfactory character, competence, education and experience. The FIDA-IDD is responsible for verifying appropriate credentials for professional staff and compliance with applicable State and Federal regulations and requirements when licensed staff deliver waiver services.

OPWDD is responsible to verify provider qualifications. Annual reviews of all providers are performed by OPWDD's Division of Quality Improvement (DQI). During these reviews, DQI reviews provider compliance with the Criminal Background Check (CBC) regulations, the Part 633.8 training requirements, and other applicable requirements.

Frequency of Verification:

NYS performs an annual review of all OPWDD providers including providers contracted with the FIDA-IDD Plan. For providers that bill eMedNY directly for waiver services, annual reviews of providers and/or samples of individuals in the waiver are performed by OPWDD's Division of Quality Improvement (DQI). Providers are reviewed on a yearly basis and may receive an operating certificate for up to a 3 year period of time.

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Plan of Care Support Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
01 Case Management	01010 case management
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Plan of Care Support Services (PCSS) was terminated on June 30, 2018. Effective July 1, 2018, all individuals with I/DD receive care management services via the State Plan. Individuals receive Health Home Care Management authorized by the Health Home State Plan and provided by a Care Coordination Organization/Health Home (CCO/HH) of their choice or Basic HCBS Plan Support provided by a CCO of their choice.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	non-profit organization

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Plan of Care Support Services

Provider Category:
Agency
Provider Type:

non-profit organization

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

N/A

Frequency of Verification:

N/A

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Vehicle Modifications

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Vehicle Modifications are physical adaptations to the participant's vehicle, required by the participant's service plan, that are necessary to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence. These physical adaptations include: portable electric/hydraulic and manual lifts, ramps and ancillary equipment or modifications necessary to guarantee full access to, and safety in, a motor vehicle.

In FFS, NYS is the provider of record for Vehicle Modifications for billing purposes. The work is done by a contractor who is selected through a standard bid process, following the rules established by the Office of the State Comptroller. In the FIDA-IDD the plan is the payer and may contract with an approved network provider for the technology. The Vehicle Modification is only billed to Medicaid once the contract work is verified as complete and the amount billed is equal to the contract value.

Vehicle Modifications are limited to the primary vehicle of the recipient.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

In most instances a specific type of Vehicle Modification is a one-time benefit to motor vehicles used by the participant. However, in reasonable circumstances determined and approved by the State, a second modification may be considered for funding if the current modifications are in need of repair, worn-out or unsafe. Replacements, repairs, upgrades, or enhancements made to existing equipment will be paid if documented as a necessity. In addition, when the vehicle's adaptive equipment must be replaced or repaired, a depreciation schedule will be used to determine the limit of the amount to be applied to the cost.

Modifications to motor vehicles used by the participant will be limited to a maximum expenditure of $35,000 once in a five (5) year period. Effective with the alignment of the currently approved CFCO State Plan, the service limit will be $15,000. This amount may be exceeded due to medical necessity and with prior authorization from the Single State Medicaid Agency. In instances when the vehicle's adaptive equipment must be replaced or repaired, a depreciation schedule will be used to determine the limit of the amount to be applied to the cost.

Only those devices/services not reimbursable under the State Medicaid Plan will be reimbursable under the HCBS Waiver.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	State or FIDA-IDD

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Vehicle Modifications

Provider Category:
Agency
Provider Type:

State or FIDA-IDD

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

OPWDD, the state operating agency, or the FIDA-IDD is the service provider. The state or FIDA-IDD, are approved Medicaid providers and contract with approved network providers

Verification of Provider Qualifications

Entity Responsible for Verification:

OPWDD, the state operating agency, or the FIDA-IDD is the service provider.

Frequency of Verification:

All OPWDD regional offices are approved by the Department of Health (DOH) to provide any of the services included in the waiver.

The FIDA-IDD will be authorized by article 44 of the NYS Public Health Law to act as a Manage Care Entity.

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.

◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

☒ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*

☐ **As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*

☒ **As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*

☐ **As an administrative activity.** *Complete item C-1-c.*

☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*

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

Care management services are conducted by a Care Coordination Organization (CCO) or the FIDA-IDD.

For individuals not enrolled in a managed care FIDA-IDD, care management services are provided through the robust Health Home Care Management model (SPA# NY-17-0025) or through the Basic HCBS Plan Support option (SPA# NY-18-0058). Also see Appendix D for more information.

For individuals enrolled in a managed care FIDA-IDD, care management is provided as part of the FIDA-IDD's care management responsibilities through the FIDA-IDD directly or through an appropriate network provider under the FIDA-IDD's auspices.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

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):

○ **No. Criminal history and/or background investigations are not required.**

◉ **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):

Fingerprinting of staff is required of waiver service providers as described in Mental Hygiene Law 16.34, Exec. L. 845-b and 14 NYCRR
Sections 633.22 and 701 which states:
1) all potential employees and volunteers of non-state provider agencies providing waiver services who will have regular and substantial unsupervised or unrestricted physical contact with an individual receiving services; and
2) family care providers and every person over the age of 18 years who will reside in a family care home.
3) employees of contractors of waiver providers which provide transportation services (e.g. bus companies) or staff.

These positions include direct care staff and their supervisors, job coaches, clinicians providing clinical services, individuals working at certified sites or providing transportation services, care managers, and other positions deemed to have regular and substantial unsupervised contact with individuals.

Additionally, Civil Service Law 50(4) and Labor Law 201-a require fingerprinting for all potential employees of OPWDD providing waiver services.

Criminal History Check Process:

An applicant for employment who meets the criteria for a criminal history record check must complete the required consent forms. Fingerprints are submitted via the New York State Justice Center for the Protection of People with Special Needs (The Justice Center) to the New York State Division of Criminal Justice Services (DCJS), which conducts a search of state records and records maintained by the Federal Bureau of Investigation. Results are sent to the Justice Center’s criminal background check (CBC) unit electronically through the DCJS's E-Justice website, generally within three days of fingerprinting.

The CBC unit notifies the prospective employer (OPWDD or the non-state provider) of the determination indicating denial, pending denial, abeyance (meaning that a determination cannot be made at that time) or non-denial for each applicant. At the time of notification, the CBC unit will also inform the prospective employer what actions shall or may be taken regarding the applicant.

While the results of the CBC check are pending, applicants may be temporarily approved for supervised contact with individuals receiving services subject to the restrictions specified in 14 NYCRR 633.22(f). Applicants may not have unsupervised contact until the results of the check are received.

After the initial CBC determination has been made, the Justice Center CBC unit will send notice to the authorized person if the subject party is arrested after the original determination. In accordance with OPWDD regulations, the authorized person is responsible for conducting a safety assessment of the service environment and taking all appropriate steps to protect the health and safety of the persons receiving services. In addition, the provider is responsible for monitoring the outcome of any pending charge and this assessment must be documented and available for review by OPWDD.

Oversight:
Criminal Background Checks:
All waiver provider agencies undergo an annual OPWDD Division of Quality Improvement (DQI) quality survey. Surveyors review provider records to ensure that criminal history record checks have been conducted for appropriate employees. Any problems uncovered are reported to the agency which is given an opportunity to develop a plan of correction for systemic issues and must also ensure that any individuals who are found to have not been screened must be appropriately supervised until their clearance is granted. The implementation of the plan is later verified by the DQI unit.

Excluded Providers:

OPWDD and the Department of Health have notified non-state providers about rules concerning persons excluded from providing services under the Medicaid or Medicare program. The State list is maintained by the NYS Department of Health and the Federal list is maintained by the United States HHS Office of Inspector General.

Lists of all employees and vendors involved with services provided by OPWDD (the operating agency) are submitted to the Office of the Medicaid Inspector General on a quarterly basis for screening against the database of

excluded providers. All potential OPWDD employees and vendors are screened against the two excluded provider lists.

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):

○ **No. The state does not conduct abuse registry screening.**

◉ **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):

Abuse/neglect history checks:
1) Staff Exclusion List (SEL) check: As per Social Services Law 495 and 14 NYCRR 633.24, all state and non-state providers of waiver services (and specified contractors) are required to request a check of the SEL list from the Justice Center for employees, volunteers, and family care providers. The SEL contains the names of current or former custodians (employees, volunteers, family care providers, contractors, consultants, etc.) who have a substantiated “Category One” report of abuse or neglect, or more than one substantiated “Category Two” reports within a specified period of time. The reports concern abuse or neglect that occurred on or after June 30, 2013 in programs certified or operated by OPWDD (as well as specified programs overseen by other State Agencies). A description of “Category One” conduct and “Category Two” conduct can be found in Social Services Law 493.

SEL Process: The waiver provider (or certain contractors of the waiver provider) are required to submit SEL check requests to the Justice Center for potential employees, volunteers, family care providers, adults in the family care home, and contractors, consultants and interns who will have regular and substantial contact with individuals receiving services. If the applicant is on the SEL the provider may not hire or otherwise allow the applicant to have regular and substantial contact with individuals receiving services. The applicant is not permitted to have regular and substantial contact with individuals receiving services until the results of the check are received.

2) MHL 16.34 check: As per Mental Hygiene Law 16.34 and 14 NYCRR 633.24, all state and non-state providers or waiver services (and specified contractors) are required to request an “MHL 16.34 check” from OPWDD. The MHL 16.34 check is requested for all applicants receiving a CBC check, except family care providers and adults in the family care home. The check concerns physical abuse, sexual abuse, psychological abuse and serious neglect that occurred prior to June 30, 2013 in programs certified or operated by OPWDD.

MHL 16.34 Process: The waiver provider (or certain contractors of the waiver provider) submits a request to OPWDD. After a reasonably diligent search of records, if a substantiated report of abuse or neglect is found that is dis-closable, OPWDD sends a summary report to the provider (or contractor). The provider or contractor is required to review the information provided and to make a decision about whether to hire or otherwise allow the party to have regular and substantial contact with an individual receiving services. The applicant is not permitted to have unsupervised contact with individuals receiving services until the results of the check are received.

3) As per Executive Law 562 check: Executive Law 562 and 14 NYCRR 633.24, when a criminal history record check is requested (except for a family care provider or adult living in a family care home) , the Justice Center will also search its records to see if there is a finding of “Category Two” conduct concerning the applicant. This means that the person has been substantiated for “Category Two” abuse and neglect which occurred on or after June 30, 2013 (see the discussion of SEL check for a description).

Executive Law 562 Process: The check is automatically done by the Justice Center when it receives a CBC request. If there is a finding of Category Two conduct the Justice Center will send a summary report to the waiver provider or contractor. The provider or contractor is required to review the information provided and to make a decision about whether to hire or otherwise allow the party to have regular and substantial contact with an individual receiving services.

4) Check of the Statewide Central Register of Child Abuse and Maltreatment (SCR): As per Social Services Law 424-a and 14 NYCRR 633.24, waiver programs which are certified or operated by OPWDD are required to conduct this check (this excludes non-certified waiver programs such as Community Habilitation and Supported Employment unless the program is operated by OPWDD). The NYS Office of Children and Family Services maintains this register of indicated reports of child abuse and maltreatment, generally consisting of reports of familial abuse but including some reports of institutional abuse that occurred prior to June 30, 2013. The check is required for employees, volunteers, contractors, family care providers and adults who live in the family care home, who have the potential for regular and substantial contact with individuals receiving services.

SCR Check Process: The waiver provider submits a request to the SCR. Specified contractors submit a request to OPWDD which then submits the request to the SCR. The provider or contractor is notified whether an indicated report exists concerning the applicant; if a report exists, the provider or contractor is required to obtain pertinent information about the indicated report and review the information to make a decision about whether to hire or otherwise allow the party to have regular and substantial contact with an individual receiving services. The applicant is not permitted to have unsupervised contact with individuals receiving services until the results of the check are

received.

Oversight:
OPWDD provides oversight by reviewing the abuse and mistreatment requirements during the DQI survey process. OPWDD's DQI surveyors review agency documentation and review personnel files of new employees to confirm compliance with the required SCR check. If an SCR check cannot be validated for a staff person, a deficiency statement will be issued and the staff person will not be allowed to work unsupervised until an SCR check request is submitted to OCFS and a response is received identifying no indicated abuse. If there is an indication of abuse, the process outlined above must be followed. DQI follows up to ensure that individual remediation action has been taken and that there is subsequent compliance with this requirement; DQI also confirms that the provider has established systems to prevent the recurrence of these findings.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

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

○ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**

◉ **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. Types of Facilities Subject to §1616(e). Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type	
Community Residence	
Family Care	
Individualized Residential Alternative	

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.

To be in compliance with regulation (14 NYCRR 686.3), a community residence must provide an environment that ensures participant rights, promotes freedom of movement, and increases opportunities for participants to make decisions and to participate in regular community activities consistent with their needs and capability. The residence must maximize the level of independence consistent with the participant's disability and functional level. Compliance with this regulation is the driving consideration in designing certified residences for waiver participants and every effort is made to ensure that participants have ample opportunities to become contributing members of their community.

Residential habilitation services are provided in community-based certified homes to allow the residents to feel part of a community and a neighborhood (NYCRR 635-10). For example, training in meal preparation, routine shopping, laundry and cleaning are encouraged to be included in a participant's habilitation plan when appropriate to the needs of the individual. Training in appropriate social behaviors for the community (e.g. behavior in restaurants, and use of money for purchases) is also provided under Individualized Residential Habilitation plans.

Training to maximize independence in travel to and from community destinations (including the use of public transportation) may also be included in habilitation plans to encourage the individual's interaction with their community and to allow for participation in activities of choice. Larger homes generally have transportation and sufficient staff available to take participants to activities or appointments in the community.

Using the established Universal Protocol for on-site surveys, OPWDD's DQI verifies the integration of individuals living in community-based certified homes into the community. The Universal Protocol looks explicitly for evidence that residents of Individualized Residential Alternatives, Community Residences, and Family Care homes participate in community activities. The following examples from the Universal Protocol demonstrate the types of evidence which surveyors examine to document integration.
*(#2) Participants are engaged in activities which are meaningful to the participant and which contribute to their home, work and social environment(s);

*(#4) The community activities are consistent with participant's needs and interests;

*(#8) Habilitation plans are directed toward acquiring, maintaining and improving the life skills a participant needs to be a member of the community;

*(#10) The habilitation plans are actively implemented (i.e. there is on-site documentation demonstrating that habilitation services outlined in the habilitation plan are provided);

In reviewing documentation, the surveyor will also check for the presence of a written individualized plan of services, based on an assessment of the participant's functional capacity which has as its goal maximizing that person's abilities to cope with his/her environment, fostering social competency and enabling him/her to live as independently as possible which is reviewed periodically relative to the participant's response to services (#6).

Every effort is made to make the residence itself as non-institutional as possible. As per 14 NYCRR Part 635, larger homes are required to provide participants residing there with full access to habitable common rooms such as a living room or lounge (which is not used for programmatic purposes) and dining rooms (which can be used as program space if it does not interfere with the primary purpose of dining). Each participant must have a minimum square footage of bedroom space as well as use of toilet rooms and bathrooms which are designed to provide personal privacy. All habitable spaces should have natural light and screens when windows are used for ventilation.

These rules result in group homes where participants have access to cooking facilities, traditional dining rooms, and comfortable living rooms. There are no more than two individuals per bedroom, and the houses have private bathroom facilities. The presence of this access is confirmed by DQI prior to issuance of certification, and is monitored during annual site reviews.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Community Residence

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Family Education and Training	☐
Community Habilitation	☐
Support Brokerage	☐
Individual Directed Goods and Services	☐
Vehicle Modifications	☐
Pathway to Employment	☐
Respite	☐
Fiscal Intermediary (FI)	☐
Assistive Technology - Adaptive Devices	☐
Environmental Modifications (Home Accessibility)	☐
Supported Employment (SEMP)	☐
Prevocational Services	☐
Residential Habilitation	☒
Plan of Care Support Services	☐
Live-in Caregiver (42 CFR §441.303(f)(8))	☐
Community Transition Services	☐
Day Habilitation	☐
Intensive Behavioral Services	☐

Facility Capacity Limit:

14 participants

Scope of Facility Sandards. For this facility type, please specify whether the state's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☒
Physical environment	☒
Sanitation	☒
Safety	☒

Standard	Topic Addressed
Staff : resident ratios	☒
Staff training and qualifications	☒
Staff supervision	☒
Resident rights	☒
Medication administration	☒
Use of restrictive interventions	☒
Incident reporting	☒
Provision of or arrangement for necessary health services	☒

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:

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Family Care

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Family Education and Training	☐
Community Habilitation	☐
Support Brokerage	☐
Individual Directed Goods and Services	☐
Vehicle Modifications	☐
Pathway to Employment	☐
Respite	☐
Fiscal Intermediary (FI)	☐
Assistive Technology - Adaptive Devices	☐
Environmental Modifications (Home Accessibility)	☐
Supported Employment (SEMP)	☐
Prevocational Services	☐
Residential Habilitation	☒
Plan of Care Support Services	☐

Waiver Service	Provided in Facility
Live-in Caregiver (42 CFR §441.303(f)(8))	☐
Community Transition Services	☐
Day Habilitation	☒
Intensive Behavioral Services	☒

Facility Capacity Limit:

4 participants (as per current Family Care program policy)

Scope of Facility Sandards. For this facility type, please specify whether the state's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☒
Physical environment	☒
Sanitation	☒
Safety	☒
Staff : resident ratios	☒
Staff training and qualifications	☒
Staff supervision	☒
Resident rights	☒
Medication administration	☒
Use of restrictive interventions	☒
Incident reporting	☒
Provision of or arrangement for necessary health services	☒

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:

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Individualized Residential Alternative

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Family Education and Training	☐
Community Habilitation	☐
Support Brokerage	☐
Individual Directed Goods and Services	☐
Vehicle Modifications	☐
Pathway to Employment	☐
Respite	☒
Fiscal Intermediary (FI)	☐
Assistive Technology - Adaptive Devices	☐
Environmental Modifications (Home Accessibility)	☐
Supported Employment (SEMP)	☐
Prevocational Services	☐
Residential Habilitation	☒
Plan of Care Support Services	☐
Live-in Caregiver (42 CFR §441.303(f)(8))	☐
Community Transition Services	☐
Day Habilitation	☒
Intensive Behavioral Services	☐

Facility Capacity Limit:

14 participants

Scope of Facility Sandards. For this facility type, please specify whether the state's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☒
Physical environment	☒
Sanitation	☒
Safety	☒
Staff : resident ratios	☒
Staff training and qualifications	☒
Staff supervision	☒
Resident rights	☒
Medication administration	☒
Use of restrictive interventions	☒
Incident reporting	☒

Standard	Topic Addressed
Provision of or arrangement for necessary health services	☒

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:

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

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*:

○ **No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**

◉ **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 ***extraordinary care*** 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. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

OPWDD recognizes that there are certain circumstances where paying a relative to provide essential services is both justifiable and beneficial to participants. These circumstances may include: a lack of available non-related staff persons in remote geographic regions who can furnish services at necessary times and places; extraordinary and specialized skills or knowledge by relatives in the provision of services and supports in the approved ISP/Life Plan; and efficiency and cost effectiveness. However, it is important to ensure that there are systems to guard against conflicts of interest, inadvertent limits on participant choice, and potential fraud. Therefore, OPWDD has adopted the following policy: OPWDD will allow relatives to be paid as service providers as long as (a) they are at least 18 years of age and not the parents, legal guardians, spouses, or adult children (including sons and daughters-in-law) of the participant, and (b) the service is a function not ordinarily performed by a family member, and (c) the service is necessary and authorized and would otherwise be provided by another qualified provider of waiver services, and (d) the relative does not reside in the same residence as the participant. In extraordinary circumstances, the following are exceptions to this policy:

-The Commissioner or designee may authorize a parent or legal guardian of an adult child (over the age of 18) to be paid to provide waiver services, when it can be clearly documented that the arrangement is in the best interests of the participant.

-The Commissioner or designee may authorize an otherwise qualified relative who resides in the same residence as the participant to be paid to provide waiver services when it can be clearly demonstrated that the arrangement is pursuant to the participant's choice, is in the best interests of the participant, and does not potentially jeopardize the health, safety, rights and informed choice of the participant.

Additional safeguards will be required by the Commissioner or designee including frequent monitoring of this arrangement if either exception is authorized.

OPWDD providers have discretion to determine if relatives may be paid to be service providers under this policy. When the provider authorizes relatives to be paid under this policy, the OPWDD provider must document the review and approval including that the arrangement is necessary, beneficial, and does not pose any significant risk factors to the participant and is in the participant's best interests. OPWDD's regional office must receive written notification of these arrangements and are responsible for oversight.

The services under this waiver for which relatives may be paid include the following: residential habilitation in family care homes; community habilitation; habilitative supports under consolidated supports and services; and respite. After 10/1/14, with the sunset of CSS, family members can be employed to deliver self-directed Respite and self-directed Community Habilitation.

Relatives that are paid to provide services as outlined above must meet the same requirements and qualifications as other providers/staff and are subject to the same oversight levels as outlined in this application.

When providing services, relatives act as an employee of a non-for-profit agency or as a self-directed/self-hired staff person under the administration of the FMS Agency For agency provided services, the Medicaid payment is made to the agency and the rate methodology does not differ if the staff person is a family member or is unrelated to the person served. For self-directed services under self-direction, the Medicaid payment is made to the FMS agency and the wage limit for the self-hired worker does not differ between self-hired staff who are related to the individual and those self-hired staff persons who are not related to the person.

☒ **Self-directed**

☒ **Agency-operated**

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*:

○ **The state does not make payment to relatives/legal guardians for furnishing waiver services.**

◉ **The state makes payment to relatives/legal guardians under specific circumstances 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. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

OPWDD recognizes that there are certain circumstances where paying a relative to provide essential services is both justifiable and beneficial to participants. These circumstances may include: a lack of available non-related staff persons in remote geographic regions who can furnish services at necessary times and places; extraordinary and specialized skills or knowledge by relatives in the provision of services and supports in the approved ISP/Life Plan; and efficiency and cost effectiveness. However, it is important to ensure that there are systems to guard against conflicts of interest, inadvertent limits on participant choice, and potential fraud.

Therefore, OPWDD has adopted the following policy: OPWDD will allow relatives to be paid as service providers as long as
(a) they are at least 18 years of age and not the parents, legal guardians, spouses, or adult children (including sons and daughters-in-law) of the participant, and (b) the service is a function not ordinarily performed by a family member, and (c) the service is necessary and authorized and would otherwise be provided by another qualified provider of waiver services, and (d) the relative does not reside in the same residence as the participant.

In extraordinary circumstances, the following are exceptions to this policy:
-The Commissioner or designee may authorize a parent or legal guardian of an adult child (over the age of 18) to be paid to provide waiver services, when it can be clearly documented that the arrangement is in the best interests of the participant.
-The Commissioner or designee may authorize an otherwise qualified relative who resides in the same residence as the participant to be paid to provide waiver services when it can be clearly demonstrated that the arrangement is pursuant to the participant's choice, is in the best interests of the participant, and does not potentially jeopardize the health, safety, rights and informed choice of the participant.

Additional safeguards will be required by the Commissioner or designee including frequent monitoring of this arrangement if either exception is authorized.

OPWDD providers that bill eMedNY directly have discretion to determine if relatives may be paid to be service providers under this policy. For individuals enrolled in FIDA-IDD, the provider agency has discretion to determine if relatives may be paid to be service providers under this policy. When the provider as applicable authorizes relatives to be paid under this policy, the OPWDD provider must document the review and approval including that the arrangement is necessary, beneficial, and does not pose any significant risk factors to the participant and is in the participant's best interests. OPWDD Regional Offices must receive written notification of these arrangements from providers that bill eMedNY directly and are responsible for oversight of this arrangement from these particular providers.

The services under this waiver for which relatives may be paid include the following: residential habilitation in family care homes; community habilitation; habilitative supports under consolidated supports and services; and respite. After 10/1/14, with the sunset of CSS, family members can be employed to deliver self-directed Respite and self-directed Community Habilitation.

Relatives that are paid to provide services as outlined above must meet the same requirements and qualifications as other providers/staff and are subject to the same oversight levels as outlined in this application.

When providing services, relatives act as an employee of a non-for-profit agency or as a self-directed/self-hired staff person under the administration of the Fiscal Intermediary Agency. For agency provided services, the Medicaid payment is made to the agency and the rate methodology does not differ if the staff person is a family member or is unrelated to the person served.

For self-directed services under self-direction, the Medicaid payment is made to the Fiscal Intermediary agency and the wage limit for the self-hired worker does not differ between self-hired staff who are related to the individual and those self- hired staff persons who are not related to the person.

○ **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-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

○ **Other policy.**

Specify:

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:

OPWDD makes information readily available to potential waiver providers (including those who are interested in enrolling in the FIDA-IDD Plan) through its Regional Offices located throughout New York State which provide support and oversight to the agencies in their geographic catchment areas. OPWDD's comprehensive public website, e-mail address, and toll free hotline also provides information to potential providers on the provider enrollment process.

In November 2011, OPWDD enhanced its new provider application process to ensure consistency and transparency in the application process for individuals/organizations seeking approval to become OPWDD funded non-profit providers. These enhancements include the completion of statewide standardized application on the new provider's program, governance, and fiscal capabilities. The application is reviewed and scored based on established criteria. Only those providers that receive a passing score based on these criteria will be considered to provide OPWDD services.

The new process will help ensure that a non-profit agency that is approved to provide services under OPWDD auspices will have:
a) a well thought out plan for providing quality services to unserved or underserved individuals, b) an understanding of regulatory and program requirements,
c) solid governance practices as demonstrated by a diverse Board of Directors that actively provides agency oversight, and
d) a sound fiscal plan that includes a well thought out budget, an understanding of good business practices and a staff/board member with fiscal expertise.

A PDF copy of the New Agency Interest Application, the scoring criteria, and related information can be found on the OPWDD website at "Become a Service Provider".

Additional reforms completed in April 2012, ensure that key staff of new provider agencies are qualified for positions they are or will be holding as the new provider application requires new providers to submit written job descriptions that include required credentials for each key position as well as resumes of those hired to ensure that they have appropriate credentials. The new provider applicant must also attest that the experience and credentials have been verified.

OPWDD accepts provider enrollment applications on a continuous and ongoing basis. Any non-profit organization may apply to be a provider. Non-profit organizations include: non-profit corporations under New York State Law, local government units, or organizations created by an act of the New York State Legislature for charitable purposes including providing services to persons with developmental disabilities.

Steps to become a provider include the following:

1. An entity interested in becoming funded by OPWDD contacts the local regional office to get information on how to become an OPWDD provider.
2. The regional office sends out a “new provider” form letter with an information packet that provides information the interested entity will need to know in order to become an OPWDD funded provider. The letter also includes a New Agency Interest Application and an application for the type of service the agency is interested in providing (e.g., Home and Community Based Services). In the letter, the interested entity will be advised to read the information packet and to complete the New Agency Interest Application and the application for the type of service the agency wishes to provide. The New Agency Interest Application is similar to an abbreviated CON and will require an agency to demonstrate that it has it has an organization and financial plan, that it has an understanding of the services it wishes to provide, that it can identify a population or individuals in need of these services and that it has the business capacity to operate an agency.
3. The interested entity submits a completed New Agency Interest Application and a completed application for the type of service it wishes to provide to the local regional office.
4. Regional office staff ensure that the potential new agency answers all applicable questions on the New Agency Interest Application and the service specific application and submits all the documents requested (recent 990s, recent financial statements, outline of policy and procedure manual for service agency intends to provide, resumes of board members and staff already hired, attestations).
5. Regional office staff make the submitted New Agency Interest Application and the application for the service the agency wishes to provide available electronically through sharepoint to staff of the Division of Quality Assurance.
6. Regional office staff review the potential new agency’s background and program qualifications to ensure the agency has the requisite knowledge and skills to provide the service(s) it proposes to provide and to ensure that the service(s) is needed in the district. Included in this review is a check of the Medicaid excluded lists to ensure that

none of the agency's staff or board members are on any of these lists. Regional office staff use the scoring sheet to score the background and program sections of the New Agency Interest Application. The potential new agency must receive a 20 or above out of a potential 30 points to pass the program section of the New Agency Interest Application. If the potential new agency scores below a 20 on the program section, regional office staff will use the Program and Fiscal Requirements Checklist to indicate which areas the interested agency must strengthen in order to show that it has good program practices in place. If the agency scores a 20 or above but regional office staff feel that there are some areas that can be strengthened, regional office staff will complete the Program and Fiscal Improvement Checklist in order to help the agency achieve long term success.

7. Bureau of Compliance Management (BCM) staff review the potential new agency's governance and fiscal qualifications to determine whether the interested agency has a good board that will be able to provide fiscal and program oversight and whether the interested agency is prepared fiscally to provide OPWDD services. BCM staff use the scoring sheet to score the governance and fiscal sections of the New Agency Interest Application. The potential new agency must receive a 16 or above out of a potential 25 points to pass the governance section and a 20 out of 33 points to pass the fiscal section of the New Agency Interest Application. If the potential new agency receives below a 16 in the governance section and/or receives below a 20 on the fiscal section, BCM staff will use the Program and Fiscal Requirements Checklist to indicate which areas the interested agency must strengthen in order to show that it has good governance and good fiscal practices in place. If the interested agency receives passing scores on both the governance (16 or above) and fiscal sections (20 or above), but BCM staff feel that there are some areas that can be strengthened, BCM staff will complete the Program and Fiscal Improvement Checklist.

8. After both regional office and BCM staff have completed their review, regional office staff will tally up the total score. The potential agency must pass the program, governance and fiscal sections but also must have a total score of 70 to be recommended to become an OPWDD provider.

a. If the potential agency doesn't receive a passing score, regional office staff will send the potential agency a letter explaining that the agency must strengthen certain areas as indicated in the Program and Fiscal Requirements Checklist in order to become an approved OPWDD provider. If the agency is strong programmatically but poor fiscally, the regional office may recommend that the potential agency contract with an established agency to provide the service.

b. If the potential agency receives a passing score, regional office staff will advise Division of Quality Improvement (DQI) staff to review the agency's service specific application. If DQI staff approve the service specific application, DQI staff will advise the regional office. Regional office staff will then alert the regional Associate Commissioner to go to the sharepoint site to review the agency's New Agency Interest Application, the Application Scores, the Program and Fiscal Improvement Checklist and the service specific application. The regional Associate Commissioner will have the final authority about whether to approve the agency to become an OPWDD funded provider.

9. For qualified providers, OPWDD issues Waiver provider agreements that allow participation in the waiver program, provide the application for eMedNY and issues operating certificates for all waiver services. The DOH Division of Operations then reviews the completed eMedNY application and recommendations made by OPWDD, completes an in depth review that incorporates four different sanction searches: eMedNY Sanction, NYS OMIG, HHS-OIG, and Excluded Parties List on the providers board members and managing employees. If found to be appropriate, the DOH Division of Operations then issues a Medicaid provider agreement to enroll the voluntary provider in the NYS Medicaid program in accordance with regulations found at Part 504 of 18 NYCRR.

10. If after one year, the new provider has not provided services to OPWDD participants, the agency will be required to submit updated information to ensure OPWDD has the most current information on the agency.

11. All new agencies will be responsible for ensuring that their board members attend an OPWDD approved board training within six months of becoming an OPWDD provider.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
The number and percent of new waiver provider applicants that meet OPWDD standards for issuance of HCBS Provider Agreements. (Percentage=the number of waiver provider applicants that meet the standards/total waiver provider applicants).

Data Source (Select one):
Other
If 'Other' is selected, specify:
DQI New Provider Review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
The number and percent of waiver service providers that meet OPWDD certification/HCBS standards during the annual HCBS waiver reviews i.e, ongoing basis.(Percentage=the number of providers that meet certification standards/total providers reviewed).

Data Source (Select one):
Other
If 'Other' is selected, specify:
DQI Survey

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100%**

		Review
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

Performance Measure:
The number and percent of certified sites that are complaint with fire safety requirements including that fire alarms are operational. (Percentage=number of certified sites are complaint with fire safety/total number of certified sites).

Data Source (Select one):
Other
If 'Other' is selected, specify:
DQI Survey

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
The number of certified IRAs/CRs and Day Settings reviewed for whether heightened scrutiny is triggered (number of certified IRAs/CRs and Day Settings under heightened scrutiny/total number of certified IRAs/CRs and Day Settings).

Data Source (Select one):
Other
If 'Other' is selected, specify:
DQI Survey

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: One-Time	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: One-Time

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are

identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Non-applicable

Data Source (Select one):
Other
If 'Other' is selected, specify:
N/A

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: N/A	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: N/A
	☒ **Other** Specify: N/A	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: N/A	☐ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: N/A

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
The number and percent of front line staff who demonstrate competencies to effectively perform their job functions (Percentage = number of front line staff who demonstrate competencies to effectively perform their job functions/total number of front line staff).

Data Source (Select one):
Other
If 'Other' is selected, specify:
DQI Survey

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**

☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

OPWDD's Division of Quality Improvement (DQI) QI Functions:
DQI is the administrative division within OPWDD primarily responsible for monitoring regulatory compliance, overseeing all programs and providers including HCBS providers, and certification/licensing functions. DQI is specifically responsible for coordinating the following related to discovery and remediation:

1. DQI conducts HCBS waiver survey reviews annually of providers that are not enrolled in the FIDA-IDD network. These reviews include observation of program implementation, interviews, documentation reviews, outcomes of service delivery, and a review of individual health and safety. DQI also conducts "unannounced" visits to all certified sites where HCBS services are provided at least annually. These unannounced visits focus on physical plant safety and the safety of individuals served.

2. Site surveys include a review of the environmental/physical plant; medication administration; infection control; personal allowance; rights; informed consent; incident reporting; and individualized planning.

3. OPWDD''s Early Alert (EA) Committee: EA is a process to proactively identify providers that may show signs of decreased quality, enabling OPWDD to take timely and definitive action. The committee is chaired by the Deputy Commissioner of Quality Improvement, and comprised of agency leadership. At each meeting there is a focus on specific agencies that have repeated certification deficiencies impacting the quality of care or have significant fiscal concerns that threatens its fiscal viability. Remedial actions may be required by the EA committee based on a variety of factors, including the size of the agency, the extent of the problems identified and the agency's past history as an OPWDD provider. Remedial actions would include meeting with the agency Executive staff and/or the BOD to discuss the circumstances in which the agency finds itself. At this juncture OPWDD may require the agency to develop and implement a management plan that has been reviewed and approved by OPWDD staff, to address governance, fiscal or programmatic issues. An agency that has been placed on the Early Alert list can be removed from the list if it complies in full, with OPWDD's recommendations and provides evidence to show that issues that were of concern, have been corrected and a system has been put in place to prevent recurrence. The other occasion when an agency will be removed from the list is when OPWDD takes action to transition service(s) to another agency. Enhancements to the Early Alert process were implemented in 2012 including the public disclosure of providers with Early Alert status on OPWDD's website and revisions to the Early Alert process to include state operated providers of service and fines/sanctions.
4. OPWDD's Centralized Incident Management, Statewide Committee on Incident Reporting, and Mortality Review (See Appendix G):
5. Provider Performance Transparency Reporting: Effective in 2012, OPWDD has developed a performance page in order to help keep people informed of the performance of service providers, and aware of any concerns that may exist. As a first step, OPWDD is sharing the results of Medicaid Service Coordination (MSC) reviews. These reports provide information about how well an agency meets OPWDD's regulations/requirements and also how an agency meets quality standards for service coordination in the following categories: vendor performance, qualified provider, choice, rights, service planning, responsiveness of service coordinator, advocacy and monitoring, satisfaction with service coordination. Each category has an overall grade in the form of a star and under each star rating is a listing of the items measured and the percentage at which the service met the regulatory or quality requirement. The provider performance webpage is kept updated through OPWDD DQI''s surveys and performance data is continually added to the web page. By the end of 2012, additional information on all providers, including state operations, is expected to be available online.
In 2011-12, OPWDD is focusing efforts on enhancing fire safety and prevention in state and voluntary operated programs and facilities (see below).

The Office of Audit Services conducts financial accountability and corporate governance audits for all provider agencies that operate under OPWDD's auspices. In addition to overall fiscal accountability, these reviews focus on board governance, oversight of executive directors, internal controls, use of agency resources, and fiscal viability.

NYS's oversight of managed care FIDA-IDD will include an annual care coordination review, the continuation of MHL on-site certification/recertification activities described above, and reviews of managed care FIDA-IDD operations in accordance with the contracts and federal/state requirements. Please see the FIDA-IDD Memorandum of Understanding and Three-Way Contract for further information on oversight of the FIDA-IDD Plan.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

The methods used by DQI to remediate individual problems as they are discovered include the following:
-Through annual and recertification survey visits/activity, notification is provided to all providers of all regulatory deficiencies.
--When warranted, generation of Statements of Deficiency (SODs) which require a Plan of Corrective Action (POCA).
--Review and analysis by DQI of all POCAs submitted by providers. If the POCA is deemed unacceptable by DQI, the provider will be required to amend and submit an updated/acceptable POCA. DQI conducts follow up visits when warranted to ensure that corrective actions have been implemented by provider agencies. Corrective actions are also reviewed by DQI upon recertification of operating certificates and during HCBS reviews.
--When significant issues are found in provider agency operations providers are referred for mandatory board training conducted by OPWDD or an approved trainer/training entity.
--DQI conducts statewide provider training to update the provider community on changes in policy, clarify expectations, and to share best practices and remediation strategies.
Providers experiencing difficulty receive technical assistance from the OPWDD Regional Office which works collaboratively with DQI and the Early Alert Committee to assist the agency to resolve difficulties that create obstacles to quality of care, regulatory compliance, and overall quality management.
--Referral to Early Alert described above. Through the discovery activities described throughout this application and other internal OPWDD activities and processes, provider agencies that experience fiscal or programmatic issues are referred to the Early Alert Committee. The Committee works with these providers to develop strategic and systemic remediation
actions. For example, the Committee may meet with an agency's board of directors to review audit findings and to discuss how the agency can develop and implement a fiscal recovery plan which is then monitored by the Early Alert
Committee. The Early Alert Committee is the entity that ultimately recommends whether an HCBS Medicaid Provider Agreement should be renewed or terminated based on provider performance. As a quality management and improvement function, the Early Alert Committee will develop and implement statewide fiscal, management, and programmatic policy improvements based on their remediation activities to prevent and deter similar situations from occurring in other provider agencies.

In 2011-12, OPWDD is focused efforts on enhancing fire safety and prevention in state and voluntary operated programs and facilities. Fire safety practices have been standardized across the system including uniform fire drill and evacuation processes and formats (May 2012) and standardizing requirements for reporting fire events in OPWDD certified residences (April 2012). A new fire safety curriculum was developed and implemented in conjunction with the NYS Office of Fire Prevention and Control (OFPC). OFPC now receives all reports of fire events in OPWDD certified residences and reviews for cause and origin. OFPC in partnership with OPWDD convened national and state experts in fire safety construction to review progress made to date in the gap analysis study of existing homes in order to prioritize fire safety upgrades in homes. In addition, processes to analyze and trend information on the cause and origin of fires will be used in system improvements for fire prevention efforts.
Strengthening the Workforce 2011-12 efforts: OPWDD has focused considerable efforts on system improvements related to enhancing the OPWDD workforce and the workforce of voluntary providers. The bar has been raised on the minimum qualifications and criteria for hiring new direct support professionals in OPWDD state operated programs and facilities including high school diploma or equivalent, psychological and fitness testing, and mandatory drug testing in addition to requirements that were already in existence such as criminal background checks. OPWDD has also restructured and streamlined the disciplinary review process to create a statewide disciplinary review panel to increase consistency and improve the management of OPWDD''s Employee Performance Management Program. Consistent policies related to the issuance of Notices of Discipline and suspension without pay for substantiated disciplinary cases for serious abuse and neglect were also implemented for OPWDD staff. An enhanced focus on consistent training for direct support professionals and supervisors statewide to prevent abuse and neglect in state and voluntary operated programs and facilities has also been implemented. The training initiatives include: implementation of PROMOTE which is designed to emphasize the importance of positive relationships and proactive measures to prevent challenging behavior; statewide training to reinforce principles of respect, dignity and professional ethics for people served; the promulgation of regulations that require annual training on promoting positive relationships, incidents/abuse reporting, and abuse prevention. An additional systems improvement initiative implemented beginning in 2011, resulted in the development and implementation of consistent statewide competencies for direct support professionals and supervisors in both state and voluntary operated programs and facilities.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

◉ **Not applicable**- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

○ **Applicable** - The state imposes additional limits on the amount of waiver services.

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; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **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.
Furnish the information specified above.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☐ **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.
Furnish the information specified above.

☐ **Other Type of Limit.** The state employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

As indicated in Attachment 2 of this Waiver, OPWDD has conducted analysis of the HCBS Setting requirements and has cross walked the federal regulations with OPWDD's existing regulations, to determine which rules are in alignment, those that are silent and those that need modification. From this analysis OPWDD has developed a timeline for revising its waiver regulations.

While OPWDD has conducted a review of a sample of IRAs/CRs to assess baseline system performance (results included in Attachment 2), the agency has not begun on-site assessments of Family Care settings as of the writing of this application. Assessment Plans are included within this appendix. The following provides an overview of how OPWDD's existing regulations contain some of the major qualities required from the HCBS settings standards rules and how OPWDD is proceeding with assessment of these settings and ongoing monitoring for continued compliance with the rules.

Family Care Homes:
Family Care Providers are certified/licensed and monitored by OPWDD and operate in accordance with OPWDD Regulations, Part 687, "Family Care Homes for the Developmentally Disabled" and the requirements outlined in the Family Care Manual available on OPWDD's website. These requirements cover the certification and recertification requirements including health and safety requirements and background checks, duties and expectations of Family Care providers, as well as individual rights that are expected to be safeguarded. In addition, the Family Care Manual includes the survey tools used by OPWDD to ensure that the Family Care Home is operated and maintained in accordance with OPWDD's requirements. OPWDD's Family Care Program provides people with intellectual/developmental disabilities the opportunity for community-based residential housing in certified private homes. The Family Care Program enables individuals with intellectual/developmental disabilities to have the support, guidance and companionship inherent in a family unit. Family Care homes provide an extended supportive family for participants, helping them become productive and active members of their community and to develop meaningful relationships.

As the Family Care Home is a private home, it is considered a community integrated residential setting option for individuals with developmental disabilities who prefer (or need) a shared living arrangement without the level of responsibility that typically comes with owning a home or renting an apartment. The intent of the Family Care Program as outlined in Part 687.2 is that the participant experiences a "family oriented, home life environment" and in all cases, the Family Care Home provides a residential environment that approximates, as closely as possible, a family setting which enables and encourages individuals to participate in the family and community life on an equal status with other members of the household.

Part 687.2 also states that one of the primary goals of Family Care is the acceptance of the individual as a full member of the household so as to share in that household's pleasures and responsibilities. These principles are exactly what the new HCBS regulations are designed to promote—that is community integrated, community inclusion outcomes, and quality of life experiences that are similar to that enjoyed by non-disabled individuals.

In addition to the regulatory crosswalk, OPWDD plans to conduct assessments of all Family Care Homes, with self-assessments based on the CMS Exploratory Questions. This assessment will be completed by the Family Care Home Liaison, a staff person of the sponsoring agency, who acts as a direct link between the Family Care Provider (FCP) and the sponsoring agency through required monthly home visits, with the Family Care Coordinator validating a 10% sample of assessments. The Family Care Coordinator is an employee of OPWDD who is responsible for managing Family Care services in a particular region of the state.

Community Residences (CRs)
OPWDD's Community Residences (CRs) are OPWDD certified residential settings providing housing, supplies and services for people with intellectual and/or developmental disabilities who need supportive interpersonal relationships, supervision, and training assistance in the activities of daily living. CRs are designed to accomplish two major goals (1) provide a home environment; (2) provide a setting where persons can acquire the skills necessary to live as independently as possible.

As required under OPWDDD regulations, Part 686.3, CRs provide an environment that ensures rights, promotes freedom of movement, and increases opportunities for individuals to make decisions and to participate in regular community activities to the maximum level of independence of each individual. In accordance with Part 686.3 (a)(3) a Community Residence, through both staff and individual activities, shall endeavor to become an integral part of the neighborhood and community. Furthermore, residents of community residences "shall be encouraged to become participating members of the community in which they live"; 'accordingly, CR staff are responsible for facilitating individual access to appropriate community resources that is sufficiently variable to meet the needs and interests of individuals and wherever possible utilize the same community resources as used by persons who are non-disabled.'

There are two types of certified CRs:
A. Supportive Individualized Residential Alternatives (IRAs): a community residence that is certified by OPWDD that has a maximum capacity of 4 individuals or fewer. Supportive IRAs enable individuals with intellectual and/or developmental

disabilities to enjoy the benefits of community residential life with habilitation support staffing tailored to the times and circumstances that is most needed by residents to remain living independently. And;
B. Supervised Individualized Residential Alternatives (IRAs): a community residence that is certified by OPWDD that has a maximum capacity of 14 individuals or fewer and is staffed at all times when persons are present at the home.

Both types of CRs are subject to OPWDD Regulations under Part 686, “Operation of Community Residences”; Part 633, Protection of Individuals Receiving Services in Facilities Operated and/or Certified by OPWDD’; Part 624, Reportable Incidents and Notable Occurrences; and other applicable OPWDD requirements for person centered planning and service delivery. A description of OPWDD’s on-site assessment of IRAs/CRs is included in Attachment 2. During 2016-17 survey cycle, OPWDD will be visiting certified IRA/CR and day settings (over 7,000 sites) to determine which settings are subject to heightened scrutiny. HCBS settings standards will be incorporated into ongoing reviews of settings and providers effective October 1, 2016.

Day Habilitation Settings:
OPWDD’s regulations at Part 635-10.2 specify that the intent of Home and Community Based Services (HCBS) is to create an individualized service environment consistent with meeting the needs, preferences, and personal goals of individuals through the supports and services necessary to enable a person with a developmental disability to live, work, socialize and participate in the community. Each support or service is expected to contribute to the person’s current or future capacity for self-determination, integration with the community, independence and productivity. Furthermore, waiver services are designed to facilitate the flexible arrangement of preferred and needed services, individually tailored to the unique needs and personal goals of each person approved for participation.
OPWDD reviews Day Habilitation providers at least annually to ensure compliance with OPWDD regulatory requirements including Part 633, Protection of Individuals Receiving Services in Facilities Operated and/or Certified by OPWDD’; and Part 624, Reportable Incidents and Notable Occurrences; and other applicable OPWDD requirements for person centered planning and service delivery.

During the 2016-17 survey cycle, OPWDD will be visiting Day settings where waiver services are delivered to determine which settings are subject to heightened scrutiny. Beginning on 10/1/16, HCBS settings standards will be reviewed as part of routine survey activity for certified IRAs/CRs and Day settings in which waiver services are delivered.

OPWDD will be reviewing a sample of waiver participants. The sample includes a review of person centered planning and service delivery for 1500 individuals who receive services in both community and a certified settings. Beginning with the 2016-17 survey cycle, included within the random sample of 1,500 are 400 individuals selected by the NYSDOH for its annual Service Plan review and the implementation of the new Person-Centered Review Tool by OPWDD’s Division of Quality Improvement. The Person-Centered Review Tool will include HCBS settings standards to ensure that person-centered planning principles described in federal regulations are met and that people are not isolated from the broader community and have choice of where they live and receive services including the choice of a non-disability specific setting. Beginning in 2018, OPWDD DQI will survey a total of 1,500 individuals for the fully implemented Person-Centered Review, 400 individuals provided by the DOH random sample and an additional 1,100 individuals. Additional review of a purposive sample including Willowbrook class members will also continue.

Specifically, the new Person Centered review tool will include the review of every applicable service provided to the individual against quality and regulatory standards. Findings from the review for each service will be recorded in DQI’s Protocol IT application, currently under development with an anticipated completion date of April 1, 2018. Enhanced reporting which is also under development to be implemented by April 1, 2018, will allow for the analysis of recorded findings according to parameters selected. Additional sampling and reviews will occur for Willowbrook class members’ care management services, for delivery of individualized safeguards and protections during site visits, and ad hoc. Sampling will be expanded in late 2017.

OPWDD will have the ability to analyze data and survey findings in order to make improvements to the Person-Centered Review Tool. Data will be analyzed to identify trends and contributing factors related to trends. In addition to statewide trend analysis, information may be analyzed by OPWDD region, sector, service type, living arrangement, agency size, or other survey standard. This data analysis will enable OPWDD to more accurately consider factors contributing to the negative findings and make focused decisions on systemic improvements. Implementation of systemic improvements will be dependent on the identified issues, which may include but are not limited to provider agency training, new training curriculums, agency policy and procedure recommendations, revised oversight activities, etc.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

The Individualized Service Plan (ISP) or Life Plan (LP)

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 *(select each that applies):*

- ☐ **Registered nurse, licensed to practice in the state**
- ☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law**
- ☐ **Licensed physician (M.D. or D.O)**
- ☐ **Case Manager** (qualifications specified in Appendix C-1/C-3)
- ☒ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
  Specify qualifications:

For individuals enrolled in FIDA-IDD, the care manager is responsible for the development of the Life Plan. Care managers must meet qualifications which are described in the FIDA-IDD Three-Way Contract between CMS, OPWDD, and Partners Health Plan (PHP). The qualifications are as follows:
(1) are required to have a Bachelor's Degree and one year experience working with individuals with IDD;
(2) must be a licensed professional such as an Registered Nurse (RN), Licensed Clinical Social Worker, or Psychologist and have knowledge of physical health, developmental disability services, aging, appropriate support services in the community (e.g., Community-based and Facility-based LTSS), frequently used medications and their potential negative side-effects, depression, challenging behaviors, Alzheimer's disease and other disease-related dementias, behavioral health, and issues related to accessing and using durable medical equipment as appropriate;
(3) must have the experiences, qualifications and training appropriate to the individual needs of the participant, and the FIDA-IDD Plan must establish policies for appropriate assignment of Care Managers;

For individuals not enrolled in FIDA-IDD, the Care Manager is responsible for the development of the Life Plan. Care Managers must meet all required qualifications outlined in the Health Home Care Management State Plan (SPA# NY-17-0025), Basic HCBS Plan Support (SPA# NY-18-0058) and OPWDD/DOH Health Home and care management policies. The following are the minimum requirements:

Care Managers must meet the following qualifications:
(a) A Bachelor's degree with two (2) years of relevant experience, or
(b) A License as a Registered Nurse (RN) with two (2) years of relevant experience, which can include any employment experience and is not limited to case management/service coordination duties, or
(c) A Master's degree with one (1) year of relevant experience.

Former Medicaid Service Coordination (MSC) Service Coordinators are "grandfathered" to facilitate continuity for the person receiving care management. Documentation of the employee's prior status as a MSC Service Coordinator may include a resume or other record created by the MSC Agency or CCO demonstrating that the person was employed as a MSC Service Coordinator prior to July 1, 2018.

CCO Care Manager qualifications will be waived for former MSC Service Coordinators who apply to serve as Care Managers in CCOs. CCOs will be required to provide core services training for former MSC Service Coordinators that transition to the CCO program and do not meet the minimum education and experience requirements. Such training shall be provided by the CCO within six (6) months of contracting with a MSC Service Coordinator.

CCOs are required to ensure that all Care Managers are qualified to provide and meet the standards and requirements of Health Home Care Management and deliver the six (6) core Health Home services: Comprehensive Care Management, Care Coordination, Health Promotion, Comprehensive Transitional Care from Inpatient to Other Settings (including appropriate follow-up), Individual and Family Support (which includes authorized representative) and Referral to Community and Social Support Services. All CCOs must ensure Care Managers are trained in the Skill Building areas identified in the CCO/Health Home (HH) Application and can employ the skills aligned with each area in the delivery of Health Home Care Management. The CCO will adjust training activities for Care Managers serving individuals enrolled in Basic HCBS Plan Support.

The FIDA-IDD Plan is responsible for case management training. The FIDA-IDD Three-Way Contract between CMS, OPWDD, and PHP establishes these training requirements which is further described in D.1 d.

☐ **Social Worker**
Specify qualifications:

☐ **Other**
Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

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

○ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

◉ **Entities and/or individuals that have responsibility for service plan development may provide 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. *Specify:*

People receiving HCBS Waiver Services through Fee-for-Service (FFS) have a service plan called an “Individualized Service Plan (ISP)” or “Life Plan." People participating in the FIDA-IDD demonstration have a service plan called a “Life Plan.” The FIDA-IDD is a separate corporate entity and is not, itself, a direct provider of services other than care coordination.

Informed choice is the foundation for all OPWDD services including care management. As described in 14 NYCRR Part 636, NYS OPWDD Person-Centered Planning regulations and throughout this appendix, a person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his/her services and makes informed choices about the services and supports that he/she receives. The planning process includes the presentation of options for the person and guides the delivery of services and supports. If an individual resides in a certified residential setting, there must be documentation that the residence was chose by the individual, and document the alternative residential settings consider by the individual, including alternative settings that are available to individuals without disabilities. In addition, for all individuals who are new to the OPWDD service system, they participate in education and training by the Developmental Disabilities Regional Office (DDRO) staff who provide an overview of all available service and support options that can be accessed in response to a person-centered planning process.

Continued in section D-1 c. below

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

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.

Continued from D-1 b. above

Currently the following safeguards ensure that the service plan (ISP/Life Plan) development is conducted in the best interests of the waiver participant:
1. The participant requesting initial access to HCBS Waiver services meets with a representative of the local OPWDD Regional Office to receive information about the choice to enter into managed care or to receive services in FFS Medicaid. The person is further advised of the available FIDA-IDD Plan for individuals who are 21 or older, dually eligible for Medicare and Medicaid, and, if so the person will be referred to the State's enrollment broker who can provide information on which service providers are available in managed care. The OPWDD Regional Office will advise participants as to and service providers that are also available in FFS. The Regional Office explains that the participant has a choice of managed care entity and service providers and provides information regarding managed care options which includes the continuous education of contract enrollment brokers on the available managed care entities and service providers in order to allow the participant to make an informed choice;
2. The participant completes a Documentation of Choices form indicating that they have chosen to receive HCBS Waiver services in lieu of ICF/IDD, they have selected an agency to provide care management or the FIDA-IDD, and they have been informed of all the available options with regard to managed care and service providers, including service coordination services. The participant is also informed that they have the right to exercise changes in choice of managed care or FFS service providers at any time.
3. If enrolled in a Care Coordination Organization (CCO) or the FIDA-IDD, the Care Manager or the FIDA-IDD Plan is responsible for providing the participant with information regarding their choice of waiver services and providers;
4. Throughout the Individualized Service Plan (ISP)/Life Plan process, the Care Manager is responsible for providing the participant with information about the full range of waiver services available from all service providers;
5. Using a person-centered planning process, the Care Manager is required to ensure that the content of the ISP/Life Plan reflects the participant's, the advocate's, and the service provider's input;
6. Each ISP/Life Plan contains a list of the services provided, the provider of each service, and the duration and frequency of each service;
7. Upon completion of the development and implementation of the ISP/Life Plan, the document is signed by the participant, their advocate, the Care Manager and the Care Manager's Supervisor. The participant, their advocate and the waiver habilitation service providers receive a copy of the signed ISP/Life Plan;
8. Effective 7/1/18, care management will be provided by either the FIDA-IDD or a CCO. Individuals and providers of care management must not 1) be related by blood or marriage to the individual, or to any paid caregiver of the individual, 2) be financially responsible for the individual, 3) be empowered to make financial or health-related decisions on behalf of the individual or 4) be Individuals who would benefit financially from the provision of assessed needs and services;
9. Effective 7/1/19, all Care Managers will be directly hired by the CCOs. At this time, HCBS Waiver service provision will be entirely separate from care management. The CCO/FIDA-IDD is a separate corporate entity and is not a provider of waiver services;
10. OPWDD's Division of Quality Improvement reviews the FIDA-IDD and surveys CCOs annually in order to assure the quality of the service. Surveyors inquire if care management is the only direct service provided to a participant by his/her care manager;
11. OPWDD's Division of Quality Improvement also surveys providers of HCBS waiver services annually and includes a review of the participant's ISPs/Life Plans in order to assure that it protects the participant's health and welfare, and reflects participant choice;
12. The redesigned DOH/OPWDD Individual Service Plan (ISP)/ Life Plan review includes: 1. An annual review by OPWDD of a DOH generated, statistically valid sample of ISPs/Life Plans. DOH Waiver Management Unit (WMU) oversees this OPWDD review to assure that service plan development meets the assurances set forth by CMS; 2. Annually, DOH WMU performs the fiscal component of the ISP/Life Plan review for a statistically valid sub-sample from the larger DOH generated sample. This DOH WMU fiscal review verifies that only the waiver services documented in the ISP/Life Plan are billed to Medicaid (as evidenced in the Data Mart Claim Detail Report) for the concurrent time period; 3. DOH also conducts an annual ISP/Life Plan Inter-rater Reliability Review. DOH selects a subset of ISPs/Life Plans from the larger, DOH generated sample of ISPs/Life Plans to validate that the OPWDD ISP/Life Plan review process, using components of the agreed upon review tool, is performed as required.

The Care Manager is specifically prohibited from providing services other than care management to a person on their caseload. The Care Manager provides linkage and referral to the necessary and appropriate services and supports that are based on the individual's preferences and the assessed need of the individual. The Care Manager must have the ability to develop and maintain a thorough working knowledge of available service and supports (both traditional OPWDD funded and community based resources). For individuals enrolled in the FIDA-IDD, the individual's Care Manager is employed

by the FIDA-IDD Plan to provide care coordination services. The FIDA-IDD Plan separately contracts with HCBS Waiver providers to deliver HCBS Waiver services. The separation of care coordination and the delivery of Waiver services for FIDA-IDD enrollees in the IDT policy and Three-Way contract.

Together, DOH and OPWDD engage in the continuous quality improvement process. Individual deficiencies identified in the reviews are remediated by OPWDD and reported to DOH. DOH has also revised performance metrics in Administrative Authority in order to broaden and enhance oversight of waiver participants' health and welfare, access to choice, and service plan development.

Continued in section D-1 d. below

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

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):

Continued from section D-1 c. above

At OPWDD's front door, the individual and family begin the HCBS waiver application process. This process starts with Regional Office staff engaging with the individual and his or her family and advocates with information and education regarding the range of service options that are offered within the HCBS waiver and the service providers that are available in the community, to ensure that the individuals and those that are involved in service planning can make informed choices.

OPWDD has devoted significant staff resources to ensure that there is a consistent approach to educating and informing individuals and families as they first approach OPWDD or not-for-profit agencies in the IDD system for services. This is a multimedia approach that includes written materials, interactive videos and one-on-one sessions that are the start of a person centered planning process. The materials and information gathering templates that are used at the front door focus on promoting opportunities for self-direction and for employment or the development of vocational skills.

Additionally, OPWDD recommends courses that are targeted to participants and their families in order to inform them of choices. These include the following courses; "Information for Parents and Professionals on OPWDD", "Our Community", "Our Experience is the Best Teacher", "We've Got Choices", "Circle of Support", and "Guide for Families to Understanding Supports & Services Administered by OPWDD."

During the conversations at the front door, the individual selects a Care Manager who continues the person-centered planning process with the individual and the people who support the person during the planning process. It is the responsibility of the Care Manager to invite representatives of the participant's choice to be involved in the ISP/Life Plan development. The Care Manager is required to include the participant, their advocate, and any other family or friends that the participant would like to be involved.

Additionally, the Care Manager is required to include a representative from each of the HCBS waiver services that are providing services. It is ultimately the decision of the participant and their advocate to decide who will participate in the service/life plan development process.

The development of the participant's Life Plan is a person-centered process. This process includes participation from the participant, family, friends, clinicians, support brokers, advocates, caregivers and waiver service providers. The development of the ISP/Life Plan occurs through the collaboration of these participants.

At the point when the individual first approaches the Regional Office for services, a person-centered process is used to assist in the identification of service interests and needs. If the participant is enrolled in the FIDA-IDD Plan, the Life Plan will be the interim plan used during the application for HCBS Waiver services. The initial Life Plan must be finalized within 60 days of enrollment in the CCO or the HCBS Waiver, whichever comes first. For individuals enrolled in the FIDA-IDD, the initial Life Plan remains in place for the first 90 days of enrollment in the FIDA-IDD Plan after which a more comprehensive Life Plan is required. The participant and their advocate are afforded the opportunity to make informed decisions in the development of the Life Plan. The Care Manager will build on this process for the full development of the updated Life Plan.

The full development of the participant's ISP/Life Plan is completed using a person-centered process which, to the maximum extent possible, the participant directs the planning of his or her services and makes informed choices about the services and supports that he or she receives. The planning process guides the delivery of services and supports to the participant in a way that leads to outcomes or results in areas of the participant's life that are most important to him or her (e.g. health, relationships, work, and home). This process involves waiver service providers and people chosen by the participant, often known as the participant's Circle of Support. The participant's Circle of Support participates in the process as needed, and as defined by the participant except to the extent that decision-making authority is conferred by another by State law. In addition, the participant's ISP/Life Plan focuses on OPWDD's mission to help people with developmental disabilities live richer lives. It includes the vision of ensuring that people with developmental disabilities enjoy meaningful relationships with friends, family and others in their lives, experience personal health and growth, live in the home of their choice and fully participate in their communities. Focus is also placed on OPWDDs guiding principles that frame how OPWDD conducts its business. These include "putting the person first", and maximizing

opportunities for people with developmental disabilities to lead productive and fulfilling lives.

The Care Manager and the Circle of Support assists the person in decision-making by among other things, explaining issues to be decided, answering the individual's questions encouraging the individual to actively participate in decision-making and, where necessary, assisting the individuals to communicate his or her preferences. During the Person-Centered Planning the Care Manager seeks to listen, discover and understand the participant. The person-centered planning process requires that supports and services are based on the individual's interests, preferences, strengths, capacities, and needs. In addition, the supports and services are designed to empower the individual by fostering skills to achieve desired personal relationships, community participation, dignity, and respect. It is a process of learning how the participant wants to live and describes what needs to be done to help the participant move toward that life. The planning process capitalizes and builds on a participant's abilities and skills to form a quality lifestyle for the participant. Though other factors that impact the participant's life are considered, knowing abilities and skills sets a direction, gives guidance, provides positive motivation and increases the likelihood of success. Though planning may start with some general ideas of what the participant wants and needs, it evolves into a clear vision of a positive and desirable future. Through a collaborative planning process the participant is always the central focus. The wider the representation of people involved in planning, the richer and more meaningful the planning will be.

OPWDD trains Care Managers to use the five sequential steps to planning. These include: gathering information as the basis for planning (a listening and learning step that increases the understanding of the participant); identifying themes in the participant's life (summary statements that are used as cues or indicators to what the person needs and wants for successful living and the keys that impact the participant's day-to-day life); choosing personal valued outcomes; identifying safeguards that are needed to keep a participant safe from harm including any risk factors; and developing the action steps, strategies, resources and funding sources needed. Once these steps are completed, the information learned is included in the service plan development and implementation.

The Three-Way FIDA-IDD Contract describes the training requirements for FIDA-IDD Plan members of the Interdisciplinary Team (IDT). Partners Health Plan (PHP) provides training to all FIDA-IDD Plan members including care managers on the following approved training on the person-centered planning processes: cultural competence; disability; accessibility and accommodations; and wellness principles, along with other required training, as specified by the State. This will include ADA/Olmstead requirements.

The ISP/Life Plan includes the participant's goals and desired outcomes; the participant's strengths and preferences; the necessary and appropriate services and supports (paid and unpaid) that are based on the participant's preferences and needs and that will assist the participant to achieve his or her identified goals; the services that the participant elects to self-direct; if an individual resides in a certified residential setting, documentation that the residence was chosen by the individual, and document the alternative residential settings considered by the individual; and the individual and/or entity responsible for monitoring the plan.

During this development process, the Care Manager ensures that the ISP/Life Plan contains the type of waiver services, Medicaid State plan and other services to be furnished, the amount, frequency and duration of each service, and the provider who will furnish each service. The ISP/Life Plan specifies the supports and services to be provided to the waiver participant including: natural supports and community resources, Medicaid State Plan services, federal, state, and county services, waiver services and other services that may be funded by other entities. The Care Manager assists the participant in obtaining and coordinating the services that are outlined in the ISP/Life Plan. The ISP/Life Plan reflects coordination between major service providers involved with the participant. As waiver services are developed and responsibilities are assigned to waiver service providers, further assessment of specific skills are included as a component of the activities associated with waiver services.

The process of developing the Life Plan also includes an assessment of the participant's clinical, functional and health care needs. The Care Manager must identify information regarding health and safety needs that will be reflected in the ISP/Life Plan safeguarding section. Safeguards are supports needed to keep the participant safe from risk and harm, actions to be taken when the health or welfare of the participant is at risk, and measures in place to minimize risk, including individual specific back-up plans and strategies when needed. Safeguards are significant issues discovered during the planning process that are individualized and specific to the participant. The safeguarding section of the ISP/Life Plan includes a description of the supervision and oversight that may be required in such areas as fire safety, medication management, allergies, community inclusion activities, diet, behavioral concerns, financial transactions, and vulnerabilities at home and in the community. Safeguards are not meant to be so wide-ranging that routine supports are

always identified.

The Plan is written in a way that is understandable to the participant, i.e., written in plain language and in a manner that is accessible to the participant, it is finalized and agreed to with the participant's written informed consent and signed by the provider(s) responsible for implementing the person-centered service plan, Care Manager distributes the ISP/Life Plan to the participant and parties involved in the implementation of the plan. The participant, circle of support, the service providers, and Care Manager review the person-centered service plan and the Care Manager must revise such plan if necessary, at least twice annually; when the capabilities, capacities, or preferences of the individual have changed and warrant a review; or at the request of the participant. Person centered planning is a collaborative and recurring process between the individual, the circle of support waiver service providers and the Care Manager. The Care Manager ensures that the ISP/Life Plan is kept current, adapted to the changing outcomes and priorities of the person, as growth, temporary setbacks, and accomplishments occur. However, OPWDD requires that the service plan be reviewed at least twice per year by the Care Manager, the participant, their advocate (if applicable) and, as needed the waiver habilitation service providers. As changes are identified the Care Manager updates the ISP/Life Plan to reflect the changes. Additionally, the ISP/Life Plan should be updated any time changes to HCBS Waiver services occur to reflect a change in a service.

The Care Manager is responsible to oversee and monitor the implementation of the ISP/Life Plan. When reviewing the ISP/Life Plan, the Care Manager ensures that its contents are kept current, and that services provided continue to address the participant's needs, preferences and desired outcomes as they develop and change. OPWDD requires that the ISP/Life Plan be reviewed at least twice annually on a twelve month basis (i.e. semi-annually) and we suggest that providers seek to do this review/update every six months, however, we allow flexibility in the six month schedule to incorporate changes to the ISP/Life Plan that may occur before or after the six month point based on the unique events and circumstances happening in each individual's life. An individual's ISP/Life Plan must be updated within 12 months of the previous plan review.

The primary difference between Health Home Care Management and Basic Home and Community-Based Services (HCBS) Plan Support is the intensity of the care management provided. Health Home Care Management offers ongoing and comprehensive care management support on a monthly basis. Those who do not require such an intensive level of care management support can choose to be enrolled in Basic HCBS Plan Support which offers a maximum of four months of care management service per year (a minimum of two services per year with an optional two additional services if needed by the individual). The primary functions of each service are similar: including the development and ensuring implementation of the ISP/Life Plan, and ensuring continued waiver and other service eligibility; yet the frequency of support is less intense with Basic HCBS Plan Support. This option is available to anyone who is eligible for OPWDD care management services – except for Willowbrook Class members who by decree must receive monthly care management via the CCO/HH care management service. The care management needs of the individual are used to determine which model is provided. The majority of individuals receiving OPWDD care management receive Health Home Care Management as opposed to Basic HCBS Plan Support.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

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.

An assessment of the participant's level of skills, and dignity of risk are identified during the service plan development process through person-centered planning. To evaluate “risk” and the individual’s responsibility and ability to calculate the risk, the participant, his/her circle of support, and the Care Manager take into consideration the benefits to the individual and the rights of the individual, ways to empower the person to improve their ability to make informed decisions through education and self-advocacy skills, possible resources and environmental adaptations that can allow the person to take the “risk,” but mitigate potential hazards.

In order to assure the health and safety of each waiver participant, the plan of care includes a safeguarding section. This safeguarding section identifies the supports needed to keep the participant safe from harm and actions to be taken when the health or welfare of the person is at risk. Safeguards are significant issues discovered during the planning process that are individualized and specific to the participant; these include relevant medical and behavioral information.

Additionally, participants residing in OPWDD certified residential settings known as Individualized Residential Alternatives (IRA) are required to have a plan for protective oversight, based on an analysis of the participant's safeguarding needs. This plan is reviewed at least annually and revised as needed and integrated with other services received as appropriate. The plan for protective oversight is attached or incorporated into the ISP/Life Plan. The OPWDD DQI survey process verifies that participants are receiving appropriate protective oversight, that staff have received training appropriate to the oversight needs of participants, and that the participant's plan is implemented as specified in their ISP/Life Plan. In addition, OPWDD certified residential settings are required to implement a facility evacuation plan. The DQI survey process verifies that staff and participants are trained and evaluated regarding their performance to execute the facility evacuation plan. Each participant's ISP/Life Plan safeguarding section contains a current evaluation of the fire evacuation capacity of the participant based on actual performance.

When risks to a participant's health and safety are identified, every effort is made to assist the participant to understand his or her risks and to address them. The identification of risks for participants includes addressing these risks through specific habilitative plans and services. It is the responsibility of all staff working with a participant to include strategies that address health and safety.

OPWDD regulations, Part 633 Protection of Individuals Receiving Services, sets forth requirements for ensuring and/or promoting the protection of individuals served which are applicable to facilities operated and/or certified by OPWDD. Provider agencies assure the rights of individuals by developing and implementing policies and procedures which ensure ongoing compliance with Part 633. Providers must ensure that participants and/or their parents, guardians or correspondents receive information regarding rights and responsibilities, the process for resolving objections, problems, or grievances relative to the person's rights, and information on where to go to report/resolve these issues. OPWDD DQI surveyors verify provider compliance with the Part 633 requirements during the survey process. In addition, the FIDA-IDD is required to comply with all federal and state requirements related to rights and grievances for their members.

Certified residential settings are required to develop plans for back up by having a communication system which ensures the prompt contacting of on-duty personnel and the prompt notification of responsible personnel in the event of an emergency. The FIDA-IDD is required to provide 24-hour contact information to access appropriate personnel in the event of an emergency or other circumstances as defined in the contract with NYS. During the person centered planning process, the participant, their family, involved provider agencies and the Care Manager develop back up arrangements for those participants residing in their own homes.

Person-Centered Planning is focused on positive safeguarding, not risk elimination. The safeguarding plan should be positive and should focus on the strengths and skills of the individual. Potential risk is measured based on an activities potential harm and the person’s ability to make informed choices. Through work with statewide representative stakeholders a tool was developed to assist with planning for needed safeguards.

This tool can be found at https://opwdd.ny.gov/node/5521. Some specific examples of habilitation plan services include:

- A person receiving services who has a risk related to a history of choking would have a plan with services requiring supervision during dining and other specific dining guidelines that are necessary to follow for safe eating.
- A person receiving services who has a history of behavioral challenges and aggression towards their peers would have a behavior support plan in place.
- A person receiving services who enjoys shopping but does not fully understand the value of money would have a plan with services providing education with budgeting and supervision with money management and shopping.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

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 application to the Regional Office for participation in the HCBS Waiver, the Regional Office provides the participant and their family or advocate with information about the range of services and supports that are offered through the waiver and information regarding all service providers (including the FIDA-IDD network) that are available in their geographic location, to ensure that informed choice of services and providers of services can be made.

The participant requesting HCBS Waiver services meets with a representative of the local OPWDD Regional Office and an enrollment broker if enrolled in managed care to receive information about the FFS and managed care services and service providers. The Regional Office explains that the participant has a choice of service providers and provides information regarding service providers in order to allow the participant to make an informed choice for individuals in FFS and managed care.

The participant completes a Documentation of Choices form indicating that they have chosen to receive HCBS Waiver services, they have selected an agency to provide care management through the CCO/FIDA-IDD, and they have been informed of all the available options with regard to service providers, including care management services. The participant is also informed that they have the right to exercise changes in choice of service providers at any time. For individuals who opt to participate in managed care, they will be provided information from the FIDA-IDD about the choice of managed care providers and choice within its network providers.

The Care Manager is responsible for providing the participant with information regarding their choice of all waiver service providers or network providers. All service providers are listed in the participant's ISP/Life Plan. Semi-annually (i.e., twice per year), the ISP/Life Plan and all service providers listed are reviewed with the participant. The participant's satisfaction with service providers is assessed at this time and if the participant is dissatisfied with services, the Care Manager will help the participant to obtain information regarding other service providers and will assist the participant in the selection of service providers.

Additionally, OPWDD's website provides a public e-mail address to request information. OPWDD’s website includes comprehensive information on available services. OPWDD's toll-free hotline is another source of information. The information line is designed to help people get answers to questions regarding supports and services. It is equipped with InterpreTALK, a telephonic interpreting service. Callers, regardless of what language they speak, are able to communicate their questions or concerns without delay. Linkages are made to the appropriate Regional Office for follow-up and assistance.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

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):

In August, 2010, the State realized that there was a great deal of overlap and duplication between the service plan reviews conducted by OPWDD's Division of Quality Improvement and the annual ISP review conducted jointly between DOH WMU and OPWDD's Division of Person Centered Supports. As a result, the two agencies have worked together, with the assistance of the National Quality Enterprise (NQE), to devise strategies to better ensure the following:

- Participant Eligibility is determined;
- Participant Level of Care is performed and re-evaluated annually;
- Services are furnished in accordance with the ISP;
- Participant access to waiver services is identified in the ISP;
- Participant exercises choice of provider;
- Services meet participant's needs;
- Participant health and welfare safeguards are clearly outlined in the ISP and reflect the participant's current health status and need for safeguards;
- Participant has access to non-waiver services (including medical, dental, ancillary health and rehabilitative services) and that these services are listed in the service plan.

Current Strategy:
Changes to the execution of Administrative Authority have been implemented to accomplish the following goals:
a. to strengthen and broaden the scope of the SMA oversight of the OPWDD Comprehensive HCBS Waiver, especially in the areas of health and welfare, qualified providers, and service plans;
b. assure that SMA oversight is current, timely and reflective of OPWDD's present reform initiatives.

1. Performance Measures and revised QIS
- DOH conducts administrative oversight by evaluating the results of the ISP/Life Plan review using the revised performance measures and QIS established by DOH and OPWDD with assistance from NQE. (Appendix A and Appendix H)

2. DOH Oversight of OPWDD DQI Service Plan Review (implemented in the 2011-2012 waiver year): DOH performs oversight of a review of a statistically valid sample of ISPs/Life Plans completed by OPWDD DQI. DOH continues to perform the Medicaid billing validation (fiscal) review for a subset of the statistically valid sample.
- The annual review of a statistically valid representative sample of ISPs/Life Plans, previously completed by DOH, is conducted by OPWDD DQI. However, DOH oversight activities ensure the following:
  - o OPWDD is using the agreed upon review tool and the defined performance measures;
  - o OPWDD DQI surveyor ISP/Life Plan reviews are accurate, complete, and are performed as per the agreed upon process;
  - o DOH tracks individual deficiencies identified in the ISP/Life Plan review and monitors both individual and systemic remediation activities related to these deficiencies.
- DOH will continue to select the statistically valid representative sample annually and provide the sample to OPWDD DQI. DQI will subsequently complete the review, using a review tool and a timeline agreed upon by DOH and OPWDD.
- OPWDD DQI provides a semi-annual report to DOH that summarizes the ISP/Life Plan Review results and identifies trends observed by each assurance category. This report includes OPWDD's performance measure data as it relates to the Person-Centered review.

3. DOH Fiscal Review: DOH continues to perform the Medicaid billing validation review for a statistically valid sample of the DOH statistically valid sample that DOH provides annually to OPWDD DQI for review. DOH monitors identified deficiencies to assure that appropriate remediation is completed by OPWDD and reported to DOH in the agreed upon timeframe.

4. DOH ISP/Life Plan Validation Review Process referred to as IRR: DOH also reviews a select subset of ISPs/Life Plans to validate that the review process was performed as required and that the CMS assurances are met.
- DOH randomly selects a subset of ISPs/Life Plans from the annual DOH larger statistically valid sample. Those ISPs/Life Plans and related documents are electronically scanned by DQI and submitted to DOH for review;

*DOH uses applicable parts of the OPWDD DQI Review Tool concurrently used by DQI so that the results can be compared and validated; DOH reviews these selected ISPs/Life Plans for the following:
* eligibility;
* required dates and signatures that ensure appropriate persons are involved in authorizing, planning and providing services; * documentation specifying that an individual enrolled in the waiver, and his/her circle of supports, are part of the planning, implementation, and evaluation process;
* accurate, complete, and timely Level of Care and CCO consent forms;
* accurate, complete, and timely Document of Choice/Freedom of Choice forms that verify that the individual and his/her advocate have been informed of the choice between institutionalization or community-based waiver support

services and that the participant's choice has been indicated.
*inclusion of valued outcomes ;
*habilitative, health and safety, medical, dental, behavioral health, community inclusion and support needs of the waiver participant are addressed and re-evaluated as needed.
*ultimately, the goal of the IRR process is to assure that any deficiency identified by either OPWDD or DOH is remediated in the agreed upon timeframe.

CONTINUED IN D.2.a.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

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:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ○ **Every twelve months or more frequently when necessary**
- ◉ **Other schedule**

Specify the other schedule:

OPWDD requires that the ISP/Life Plan be reviewed at least twice annually on a twelve month basis (i.e. semi-annually) and we suggest that providers seek to do this review/update every six months, however, we allow flexibility in the six month schedule to incorporate changes to the ISP/Life Plan that may occur before or after the six month point based on the unique events and circumstances happening in each individual's life. An individual's ISP/Life Plan must be updated within 12 months of the previous plan review. To ensure that these decisions are made in the best interests of the individual served and not for the convenience of the Care Manager, OPWDD instructs Care Managers to document in the care management record the reason why the ISP/Life Plan review occurs at a time other than the recommended six month interval. In addition, OPWDD requires the Care Manager to keep the ISP/Life Plan up to date in accordance with all OPWDD/DOH policy guidance.

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 §92.42. Service plans are maintained by the following *(check each that applies):*

- ☐ **Medicaid agency**
- ☐ **Operating agency**
- ☒ **Case manager**
- ☒ **Other**

Specify:

CCO or the FIDA-IDD Plan.

Appendix D: Participant-Centered Planning and Service Delivery

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.

Continued from D.1.g.

5. Sampling Methodology: DOH continues to assure that the annual DOH OPWDD DQI ISP/Life Plan sample is both statistically valid and representative of all waiver participants, including individuals who receive both state-operated services and services delivered by not-for-profit agencies.

- Based on the guidance of NQE, DOH WMU annually selects the sample size of 400 ISPs/Life Plans for the annual ISP/Life Plan Review using the Raosoft. Inc® calculator (5% margin of error, 95% confidence interval, and a 50% response distribution). The response distribution was reset from 95% to 50% to reflect the transition from the traditional DOH ISP/Life Plan review process to the redesigned ISP/Life Plan review process described in this section.
- The DOH ISP/Life Plan review is conducted annually. The sample size will be recalculated periodically and the response distribution readjusted accordingly when warranted.
- Sample selection process: DOH runs a query through the NYS Data Warehouse to identify all OPWDD HCBS Waiver participants during the sample time period. DOH selects a random statewide sample, using a random number generated table, based on the number of approved waiver slots at the beginning of the review year. The DOH sampling methodology generates a list that includes all waiver services and all authorized residential options including private homes and certified residential settings.

Several layers of monitoring of the implementation of the plan of care occur within the NYS OPWDD Waiver.

For individuals not enrolled in the FIDA-IDD, upon completion of the plan of care (Life Plan), the Care Manager must submit the plan to the Care Manager Supervisor for review, signature and approval of the plan. Any time a significant change is made to the plan of care and portions are revised and rewritten, the Care Manager Supervisor must review, sign and approve the changes to the plan. Once the plan of care has been approved, the Care Manager is responsible for monitoring the implementation of the plan of care and the participant's continued health and welfare. The Care Manager will have contact and face to face meetings with the participant based on the individualized needs and circumstances of each individual and the professional judgement of the Care Manager and the Care Manager Supervisor in consultation with the individual based on assessment to assure that the services are meeting the participant's needs and that the participant is satisfied with the services being provided. This activity is documented in the care management notes.

For individuals enrolled in the FIDA-IDD, the lead care manager is responsible to ensure that the plan is completed, implemented, and monitored. In addition to the lead care manager, the managed care entity will use an Interdisciplinary Team (IDT) that is available to address the specialized planning needs of the person. The FIDA-IDD is responsible to contract members with different expertise and specialty backgrounds (e.g., nurse, education specialist, employment specialist, etc.). These members are available to the participant on the IDT as dictated by the enrollee's care plan needs.

Additionally, the OPWDD Division of Quality Improvement (DQI) performs a series of oversight and monitoring activities to ensure that the service plan/life plan implementation is adequate. When a provider is authorized to provide HCBS Waiver services in a residential or day certified setting, they will receive an operating certificate. Prior to the renewal of a provider's operating certificate, DQI staff complete a survey visit. During this visit, DQI staff will review a sample of 5% of waiver participants' plans of care. The focus of this review includes a review of the participant's valued outcomes, habilitation services, health and welfare, staffing, rights, health services and medications, incident management, and physical plant surroundings. DQI staff will conduct observations, interviews with provider staff and participants and will review records. When serious or systemic deficiencies are identified, the DQI issues a Statement of Deficiencies (SOD) and requires that the provider respond in writing with a Plan of Corrective Action (POCA). Upon approval of the POCA, DQI will issue a renewal of the provider's operating certificate.

When a provider is authorized to provide HCBS Waiver services to participants in non-certified settings, the DQI staff annually review a sample of waiver participants' plans of care. The focus of this review is similar in scope to the previously mentioned survey visit, but is completed via a desk review. For example, Community Habilitation can be provided in a non-certified setting. A Community Habilitation worker may take an individual to a community setting to work on completing a valued outcome described in his/her Community Habilitation plan.

DQI staff complete annual survey visits to all certified programs. Annual visits are limited in scope and focus primarily on participant health and safety issues and a review of the provider's implementation of previous POCAs.

Individuals included in the sample are interviewed during each DQI survey regarding satisfaction with their service plan, outcomes in the plan, involvement in plan development and care received. Annually a sample of individuals is selected for a review of their service planning, service plans, service delivery and the effectiveness. Each agency is included in sampling. Each review requires direct discussion with the person and observation when appropriate. In situations when more information is needed or communication is difficult, contacts are made with the person's family/advocates and those that know them best.

The exercise of free choice of provider is reviewed in the current MSC protocol and included in the person centered protocol. Verification will occur through interview with the person and advocates. Back-up plans, when needed, are by regulation required to be included in the service plan. Protocol for review of services by DQI includes verification that the service plan is implemented as written and that the services are meeting the desired outcomes of the individual. DQI's review protocol includes verification that individuals are provided information necessary to make decisions about services, services environments and mechanisms, including non-waiver services. Discussion with the individual and/or advocate will be completed to verify they have been given information necessary and made an informed decision. This decision making is also required to be documented in the service plan. Reviews will ensure that documentation and report from the individuals are accurate.

Service plan implementation and monitoring is also achieved through the DQI Person-Centered Review. DQI annually reviews a 5% sample of participants receiving services from a care management provider to assess the quality of services provided. The sample is representative of the variety of participants' residential living arrangements within the provider agency. The audit components include a review of the development, implementation and maintenance of the participant's plan of care and other required documentation. The DQI staff will review relevant sections of the participant's record, conduct interviews and make observations, as appropriate, to determine whether or not the Care Manager has completed the required documentation in a timely manner and the outcomes, as written, accurately reflect the participant's life goals, aspirations, valued outcomes and required supports. Through their review the DQI staff ensure that the participant and their advocate meaningfully participated in the development, implementation and review of the plan of care and after interviewing the participant and making observations where and when appropriate, the participant's actual activities and services correspond to what is written and to the participant's valued outcomes. They ensure that the participant's choices are incorporated into the plan of care. Statements of Deficiency (SOD) are issued and Plans of Corrective Action(POCA) are received to address any systemic, pervasive or egregious deficiencies. An agency has 20 days to submit a POCA once the SOD has been received. In the event of a 45 day letter, an agency has 10 days to complete the POCA from the receipt of the 45 day letter.

In accordance with OPWDD's November 2013 Quality Strategy and the goals outlined in OPWDD's Self-Direction Policy, OPWDD is engaged in survey redesign to lay the foundation for new protocols that will better support our review of the effectiveness of person centered and person directed service delivery including the incorporation of the new federal standards related to home and community based services and person centered planning and process requirements. Work with OPWDD stakeholders to determine the quality standards and characteristics that will be included in new protocols resulted in the development of quality indicators outlining standards and criteria for high quality service provision. This information can be viewed on OPWDD's website at:
http://www.opwdd.ny.gov/opwdd_services_supports/service_providers/provider_performance/aqpwg. As OPWDD develops and implements these new protocols, it will be necessary to revise the sampling percentages and strategies referenced above to ensure that we are getting at the stratification levels that can best ensure that our person samples represent the wide range of agency supports and services and the diversity of needs in our population and to ensure that we can review each person in the sample from a person centered perspective. These revisions will help to ensure that our person samples are not siloed by site or program and that instead the entire array of the person's supports are reviewed to ensure that the Plan is effectively implemented based upon the person's preferences, needs and outcomes.

Providers that deliver HCBS Waiver Services under the FIDA-IDD provider network will be reviewed by DQI through the annual care management review of the managed care entity. New York State OPWDD will conduct an annual on-site review of the effectiveness of every managed care entities Care Management Function. During this review OPWDD will pull a statistically valid sample of all individuals served by the managed care entity and will review life plans and the overall effectiveness of care management to produce results that reflect the person's assessed needs, communicated choices and preferences. The on-site Care Management Review will include a record review, interviews with the person and their advocates/circles of support, and interviews with managed care personnel and staff engaged in the care management function. This review may also include operational and administrative elements included in the FIDA-IDD contract such as a review of the QI Plan, policies and procedures, and grievance systems.

b. Monitoring Safeguards. *Select one:*

○ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**

◉ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide 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. *Specify:*

Effective 7/1/18, care management will be provided by either the FIDA-IDD or a CCO. Individuals and providers of care management must not 1) be related by blood or marriage to the individual, or to any paid caregiver of the individual, 2) be financially responsible for the individual, 3) be empowered to make financial or health-related decisions on behalf of the individual or 4) be individuals who would benefit financially from the provision of assessed needs and services.

Effective 7/1/19, all Care Managers will be directly hired by the CCOs. At this time, HCBS Waiver service provision will be entirely separate from care management. A CCO/FIDA-IDD is a separate legal entity and the only direct service that it provides is care management. The individual Care Manager is not permitted to provide waiver services to a participant that they serve. This practice avoids a potential conflict of interest and promotes the independence of the Care Manager.

The following safeguards ensure that the service plan (also referred to as the Individualized Service Plan (ISP) or Life Plan) development is conducted in the best interests of the waiver participant:
1. The participant requesting initial access to the HCBS Waiver services meets with a representative of the local OPWDD Regional Office to receive information about the choice to enter into managed care or to receive services in Fee-For-Service (FFS) Medicaid. The person is further advised of the availability of the FIDA-IDD Plan for individuals who are 21 or older, dually eligible for Medicaid and Medicare, and if so the person will be referred to the State's enrollment broker who can provide information on which service providers are available in managed care. The OPWDD Regional Office will advise as to the service providers that are available in FFS. In addition the Regional Office explains that the participant has a choice of enrolling in the managed care plan and using service providers that are part of the managed care network. Interested participants will be referred to the enrollment broker to provide education on managed care and service providers in order to allow the participant to make an informed choice;
2. The participant completes a Documentation of Choices form indicating that they have chosen to receive HCBS Waiver services in lieu of ICF/IDD, they have selected an agency to provide care management or the FIDA-IDD to provide care management, and they have been informed of all the available options with regard to managed care and FFS service providers, including care management services. In addition, the participant is also informed that they have the right to exercise changes in choice of managed care or FFS and service providers at any time.
3. The Care Manager is responsible for providing the participant with information regarding their choice of all waiver service providers and other service providers;
4. For individuals who do not choose to enroll in the FIDA-IDD Plan when initially requesting waiver access, the CCO and participant are responsible for completing the Health Home Care Management or Basic HCBS Plan Support consent form prior to the participant's enrollment in a CCO for the delivery of care management services. This consent form identifies the Care Manager and/or the CCO selected to provide care management. The Care Manager is responsible for providing the participant with information about other Care Managers within the same CCO or the other CCOs available within the participant's region when the participant requests a change in care management or becomes dissatisfied with their current Care Manager. The Health Home Care Management and Basic HCBS Plan Support consent forms are amended in accordance with OPWDD/DOH policy when applicable changes occur.
5. Throughout the Individualized Service Plan (ISP)/ Life Plan (LP) process, the Care Manager is responsible to provide the participant with information about the full range of waiver services available from all applicable service providers;
6. Using a person-centered planning process, the Care Manager is required to ensure that the content of the ISP/Life Plan reflects the participant's goals, strengths, needs, and the appropriate service providers;
7. Each ISP/Life Plan contains a list of the services provided, the provider of each service, and the duration and frequency of each waiver service;
8. Upon completion of the development and implementation of the initial or rewritten ISP/Life Plan, the document is signed by the participant, their advocate, the Care Manager and the Care Manager Supervisor. The participant, their advocate and the waiver habilitation service providers receive a copy of or electronic access to the signed ISP/Life Plan;
9. Effective 7/1/18, care management will be provided by either the FIDA-IDD or a CCO. Individuals and providers of care management must not 1) be related by blood or marriage to the individual, or to any paid caregiver of the individual, 2) be financially responsible for the individual, 3) be empowered to make financial or health-related decisions on behalf of the individual or 4) be individuals who would benefit financially from the provision of assessed needs and services;
10. Effective 7/1/19, all Care Managers will be directly hired by the CCOs. At this time, HCBS Waiver service

provision will be entirely separate from care management. The CCO/FIDA-IDD Plan is a separate corporate entity and is not a provider of waiver services;
11. OPWDD's Division of Quality Improvement reviews the FIDA-IDD and surveys care management provider agencies annually in order to assure the quality of the service. Surveyors inquire if care management is the only direct service provided to a participant by his/her Care Manager;
12. OPWDD's Division of Quality Improvement also surveys providers of HCBS waiver services annually and includes a review of the participant's ISP/Life Plan in order to assure that it protects the participant's health and welfare, and reflects participant choice;
13. The DOH oversight function includes an annual review of a statistically valid sample of ISPs/Life Plans. The review is conducted on an annual basis. The review assures that each sample participant's health and welfare are protected, and reflects participant choice. Please refer to Appendix G: QIS: Performance Measures G.i.10 through G.i.12, and Appendix D: D.1.g.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
The number and percent of ISPs/Life Plans that include an assessment of the health and safety risks of the individual (Percentage = number of ISPs/Life Plans that include an assessment of the health and safety risks of the individual/ total number of ISPs/Life Plans reviewed).

Data Source (Select one):
Other
If 'Other' is selected, specify:
DQI Person-Centered Review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	Specify:

Performance Measure:
The number and percent of ISPs/Life Plans in which the waiver ISPs/Life Plans support the individual's valued outcomes and include preferred activities (Percentage = number of ISPs/Life Plans in which the waiver service plans support the individual's valued outcomes and include preferred activities/total number of ISPs/Life Plans reviewed).

Data Source (Select one):
Other
If 'Other' is selected, specify:
ISP/Life Plan Sample/DQI

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
The number and percent of individuals who have an integrated job in the community (Percentage = number of individuals who have an integrated job in the community/total number of individuals who participated in the NCI Consumer Survey).

Data Source (Select one):
Other
If 'Other' is selected, specify:
NCI Consumer Survey

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative**

		Sample Confidence Interval = +/-5%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
The number and percent of individual who do not have an integrated job in the community but would like one (Percentage = number of individuals who do not have an integrated job in the community but would like one/total number of individuals who participated in the NCI Consumer Survey).

Data Source (Select one):
Other
If 'Other' is selected, specify:
NCI Consumer Survey

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = +/-5%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
The number and percent of ISPs/Life Plans that demonstrate that changes were made

to the plan in response to a change in the individual's needs (Percentage = number of plan ISP/Life Plan changes made when individual's needs changed/total number of ISP/Life Plan changes made).

Data Source (Select one):
Other
If 'Other' is selected, specify:
ISP/Life Plan Sample/DQI

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = +/- 5%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
The number and percent of ISPs/Life Plans which reflect that the ISP/Life Plan was reviewed at least semi-annually on a twelve month basis (Percentage = number of ISPs/Life Plans which reflect that it was reviewed at least semi-annually on a twelve month basis/total number of ISPs/Life Plans reviewed).

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
ISP/Life Plan Sample/DQI

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = +/-5%
☐ **Other** Specify:	☒ **Annually**	☒ **Stratified** Describe Group:

		OPWDD Regional Office
	☐ **Continuously and Ongoing**	☒ **Other** Specify: Proportional representation of three core services: residential, day, and individualized services.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
The number and percent of ISPs/Life Plans reviewed in which the services in the approved plan were provided in the scope, type, amount, frequency and duration specified in the plan. (Percentage=total number of case records sampled that met the requirements/total reviewed).

Data Source (Select one):
Other
If 'Other' is selected, specify:
ISP/Life Plan Sample

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = +/-5%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

e. ***Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
The number and percent of National Core Indicator (NCI) self-directing respondents who reported that they received information about the services and supports that are available to their family (Percentage = number of NCI self-directing respondents who reported that they received information about the services and supports that are available to their family/total number of individuals reviewed).

Data Source (Select one):
Other

If 'Other' is selected, specify:
NCI Adult Consumer Survey

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = +/-5%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other**	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
Specify:	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
The number and percent of ISPs/Life Plans reviewed where the Documentation of Choices form was completed to identify a choice of community services rather than institutional care. (Percentage= ISPs/Life Plans/Documentation of Choice Forms completed correctly from review/total ISP/Life Plan/Documentation of Choice Forms reviewed.)

Data Source (Select one):
Other
If 'Other' is selected, specify:
ISP/Life Plan Sample/DQI

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = +/-5%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
The number and percent of individuals sampled where the individual responded that he/she was given a choice of providers (Percentage = number of individuals where the individual responded that he/she was given a choice of providers/total number of individuals reviewed).

Data Source (Select one):
Other
If 'Other' is selected, specify:
DQI Person-Centered Review

Responsible Party for data	**Frequency of data collection/generation**	**Sampling Approach** *(check each that applies):*

collection/generation *(check each that applies):*	*(check each that applies):*	
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = +/-5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

See Appendix C-Quality Improvement ii for details.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

The methods used by DQI to remediate individual problems as they are discovered include the following:

-Through annual and recertification survey visits/activity, notification is provided to all providers of all regulatory deficiencies.

--When warranted, generation of Statements of Deficiency (SODs) which require a Plan of Corrective Action (POCA).

--Review and analysis by DQI of all POCAs submitted by providers. If the POCA is deemed unacceptable by DQI, the provider will be required to amend and submit an updated/acceptable POCA. DQI conducts follow up visits when warranted to ensure that corrective actions have been implemented by provider agencies. Corrective actions are also reviewed by DQI upon recertification of operating certificates and during HCBS reviews.

Remediation activities completed by OPWDD in response to the DOH ISP/LP review include: ongoing training on identified issues and trends; "e-visory alerts" sent to providers addressing issues and trends; ongoing technical assistance to providers; DQI provider training of "hot topics"; and revisions to training curriculums of courses offered on plan of care topics.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

◉ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

○ **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):*

○ **Yes. The state requests that this waiver be considered for Independence Plus designation.**

◉ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

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.

Self-Direction is a central tenet of the OPWDD transformation agenda and is a core element of the education and outreach that is provided at the front door. Once a person enters the front door and selects a CCO/Care Manager, he or she assists the person in accessing all HCBS services and presents self-direction as an option for service delivery. Care Managers provide information on the supports and services available through OPWDD so participants can make informed choices on the service options that best meet their needs and that will enable them to live as independently as possible in the community. For individuals seeking more control and authority over their supports and services or individuals seeking an alternative to traditional provider managed services, the Care Manager informs them about OPWDD participant-directed service options. The OPWDD HCBS waiver offers participant-direction options with varying degrees of employer authority and/or budget authority. Individuals may choose to participant-direct some or all of their waiver services.

Effective 10/1/14, the waiver-funded program called Consolidated Supports and Services (CSS) discontinued and in its place, a new approach to self-direction will be implemented that offers employer and/or budget authority. This approach offers options for the individual allowing choice and flexibility in the range of support the individual and his or her advocate want with the exercise of employer authority and budget authority. The options include:

Agency Supported Self Direction: In this option the individual selects an agency with which he or she wants to work. The individual and the agency enter into a Memorandum of Understanding (MOU) governing the responsibilities of the agency and the individual and his or her advocate(s). A template version of the MOU is available on the OPWDD web site at the following link: http://www.opwdd.ny.gov/node/6199.

In this option, the MOU specifies that the participant will work cooperatively with the provider to hire, train, and oversee staff selected by the participant. The participant oversees the staff's schedule and chooses the level and type of support to be provided by the staff in accordance with his/her ISP/Life Plan and habilitation plans. The staff person is hired by the agency and paid at the agency's rate of pay. Under this option, the person can exercise employer, but not budget authority. This co-management option is offered for Community Habilitation, Supported Employment, and Respite services.

Self-Direction with Budget Authority and Self-Hired Staffing: Under this option, the individual and his or her family can exercise budget authority with the assistance of a Fiscal Intermediary that provides varying levels of support based on the complexity of the person's service plan and the level of support the individual elects to receive from the FI. In this option, the person can hire a staff person, and the FI provides payroll, mandatory training and fingerprinting/background check services for the employee and bills Medicaid for services rendered. If the self-directing individual chooses, the FI may provide additional supports such as non-mandatory training for staff or assisting with arranging back-up staffing.

An individual may self-direct Community Habilitation, Supported Employment, Respite, Live-in Caregiver, and Community Transition Services. These self-directed services can be part of the person’s person-centered plan of support that may include other, non-self-directed services, For example, individuals can have both traditional supports from provider agencies and self-directed supports within their plan. When a person opts to exercise budget authority, the following additional services are also available to support the person to exercise self-direction with budget authority, and are also considered self-directed services: Individual Directed Goods and Services (IDGS), Fiscal Intermediary, Community Transition Services and Support Brokerage services. Individuals who choose to enroll in a FIDA I/DD will have the same opportunities to access self-direction services in the same manner through the FIDA I/DD.

To facilitate participant direction, self-direction participants are assisted by a freely chosen planning team, also known as a Circle of Support. This team consists of paid and unpaid members chosen by the participant to help with person-centered planning necessary to develop and manage a Self-Direction budget.

Self-direction participants access support brokerage services under this waiver to provide information and assistance in support of participant direction. Support Brokers may be hired by the participant to assist them to direct and manage a self-directed service option. The Support Broker assists the participant in developing a self-direction budget that address his/her immediate and long-term needs while also addressing health and safety. Each OPWDD Regional Office has at least one "self-direction liaison" who works with the person, the planning team, the Support Broker and the Care Manager to develop and monitor both the Service Plan and the budget. The self-direction participant's annualized budget (Personal Resource Account-PRA) is developed for each participant and are portable. The budget covers the cost of recruitment, selection and supervision of staff hired by the participant, staff salaries, as well as for other approved supports and services in the self-direction budget.

Self-Direction participants access financial management services through a Fiscal Intermediary. The FI is a non-profit provider agency authorized by OPWDD to provide HCB waiver services, including FI services. Under this model, the FI provides a range of supports to the self-direction participant. The FI may serve as an employer of record while the person served is the managing employer. Alternately, the self-direction participant may elect to take on a majority of employer responsibility, and the FI's then serves as a payroll service with the FI's level of reimbursement reduced.

The FI agency manages and directs the disbursement of funds in the budget, facilitate the employment of staff chosen by the participant by completing criminal background checks and other employment related processes, processing timesheets and payroll, withholding and paying taxes, fiscal accounting and expenditure reporting for the person, representatives, and state authorities.

Beginning with the 10/1/14 waiver renewal, the FI model provides a continuum of administrative assistance for the self-directing participant, which at the extreme end represents either (a) basic fiscal management services (e.g., screening potential self-hired employees, acting as employer of record, and conducting documentation and accounting functions only), or (b) active co-management of all staff supports, purchases, and documentation required by the participant. Participants, in conjunction with their Circles of Support, natural support systems, and support brokers, determine the degree of administrative assistance they desire from their FI.

Through the tools described above, OPWDD is committed to continuing to promote participant direction in the waiver-funded services.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

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

○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, 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.

○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, 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.

◉ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

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

☒ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**

☒ **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.**

☒ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

People who live in certified residences (Individual Residential Alternatives (IRAs), Community Residences (CRs) or Family Care Residences, may self-direct their non-residential services. IRAs and CRs contain one to fourteen bedrooms and Family Care Residences contain one to four bedrooms.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

- ○ **Waiver is designed to support only individuals who want to direct their services.**
- ◉ **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.**
- ○ **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.**

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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.

Every individual who seeks services from OPWDD is informed of the opportunity to self-direct their services and is encouraged to explore these opportunities through the new standardized OPWDD entry point to services, called the "Front Door." In addition, all individuals who receive services through the OPWDD Home and Community Based Services (HCBS) waiver must have access to care management services (See Appendix D for more information on care management). Care Managers assure that participants have the information necessary to make informed choices regarding the supports available to them, including self-direction services, and helps ensure the participant's personal choices are incorporated into the waiver supports and services chosen to meet their needs. This includes the use of natural and generic community supports as well as paid supports. The FIDA-IDD is required to provide education regarding self-direction to all enrollees in their managed care plan.

For individuals seeking more control and authority over their supports and services or individuals seeking an alternative to traditional provider-managed services, the Care Manager will continue the education that begins at the front door about OPWDD participant-directed service options. The OPWDD HCBS waiver offers participant-direction options, with varying degrees of participant employer authority and/or participant budget authority. Individuals may choose to participant-direct some or all of their waiver services.

Multiple written resources and videos are available to assist individuals to understand participant-directed options. The Care Manager assists in connecting participants to the local regional office Self-Direction Liaison for further information. Self-Direction Liaisons offer self-direction sessions to individuals and their families that provide detailed information on the benefits fo self-directing, the responsibilities and liabilities, and how to get started if they are interested. These sessions are offered regionally about once a month. In addition, the Self-Direction Liaisons will also have one-on-one sessions if requested by an individual. The Care Manager may also connect the participant with a local Self-Advocacy Coordinator.

It is through one of these resources that individuals begin to understand the many responsibilities of full participant-direction (e.g., staff recruitment, hiring, scheduling, supervising, and discharging workers; plan development, budget management, and documentation requirements). If a participant continues to be interested in pursuing self-directed service options, it is the role of the Circle of Support, which includes the Care Manager and broker, and the Regional Self-Direction Liaison to help the participant determine the degree to which he/she wants to direct services and help him/her identify the most appropriate supports and services to self-direct.

OPWDD's website and the Self-Advocacy Association of New York State (SANYS) website have a plethora of resources to inform current participants self-directing services and those who may be interested in self-directing services in the future.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

○ **The state does not provide for the direction of waiver services by a representative.**

◉ **The state provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

☒ **Waiver services may be directed by a legal representative of the participant.**

☒ **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:

A) Waiver services are participant-directed when the individual receiving the services: is an adult who is capable and willing to make informed choices and manage the self-directed options.

B) Waiver services are directed by a designee of the participant when the individual receiving services is:

a. a capable adult who has designated another adult who is capable and willing to make informed choices and manage the waiver services for the participant; or
b. a capable adult who has designated another adult who is capable and willing to make informed choices and manage the waiver services for the participant, and the participant has given the other adult a power of attorney to make informed choices and manage the waiver services for the participant.

C)Waiver Services are directed by the guardian of the individual receiving services. The guardian's decisions and actions shall afford the individual the greatest amount of independence and self-determination with respect to waiver services and service planning, in light of the individual's functional limitations, and personal wishes, preferences and desires. A guardian will act in this capacity when the individual receiving services:
a. is an adult whom a court of competent jurisdiction has determined is incapable of making informed choices and for whom such court has appointed a guardian who is a natural person to make informed choices regarding waiver services; or
b. is a minor whose parents(s) or guardian is an adult capable of making informed choices regarding waiver services; or
c. is a minor
i. whose parent(s) or guardian is capable; but
ii. has designated another adult to make informed choices regarding waiver services; and
iii. the other adult is capable and willing to make informed choices regarding waiver services.

Some of the responsibilities of the legal guardian and/or the identified adult, on behalf of the participant include:
(a) recruiting staff;
(b) making recommendations for staff selection and discharge of staff;
(c) managing the staff schedule; and
(d) identifying when and on what schedule the habilitation activities identified in the individual's Plan will be addressed.
(e) determining staff salary if the person has self-hired staff and budget authority

During the planning stages for self-direction, a Care Manager identifies safeguards that need to be in place to ensure that the best interests of the individual are met.

In OPWDD's service system, it is assumed that everyone has the ability and the right to direct his/her services. OPWDD authorizes waiver services as part of the Front Door process and if, based on these intake/assessment activities, it is established that a person is unable to communicate choice, understand information, comprehend consequences of decisions, and unable to compare options, the person may designate a representative who can act on the person's behalf. If there is no person to act as a representative, the person will be directed to other service options. Once the person is engaged in self-direction, the freely chosen circle of support is developed with people who are willing and able to assist the person in developing a service plan that is appropriate for the person. The Care Manager and broker, if there is one, assist in the development of the circle of support.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

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-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Community Habilitation	☒	☒

Waiver Service	Employer Authority	Budget Authority
Support Brokerage	☐	☒
Individual Directed Goods and Services	☐	☒
Respite	☒	☒
Fiscal Intermediary (FI)	☐	☒
Supported Employment (SEMP)	☒	☒
Live-in Caregiver (42 CFR §441.303(f)(8))	☐	☒
Community Transition Services	☐	☒

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

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*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i)*.

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**

☒ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

◉ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

Fiscal Intermediary

○ **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

Non-profit organizations that are HCBS waiver authorized as an FI agency may furnish FMS. Approved agencies have Medicaid provider agreements, and must adhere to all applicable tax, labor and other law related to employment.

When a person makes an application for self-directed services, the Regional Office provides information about approved FIs in his or her region among which the person may choose.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

FIs are compensated through a monthly fee for service.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

- [x] **Assist participant in verifying support worker citizenship status**
- [x] **Collect and process timesheets of support workers**
- [x] **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- [x] **Other**

Specify:

The FI is the employer of record on behalf of the participants who self-direct pending the development of an option for individuals or their families to act as a common law employer. The FI ensures that criminal background checks are performed for each person the participant is interested in hiring.

Supports furnished when the participant exercises budget authority:

- [ ] **Maintain a separate account for each participant's participant-directed budget**
- [x] **Track and report participant funds, disbursements and the balance of participant funds**
- [x] **Process and pay invoices for goods and services approved in the service plan**
- [x] **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other services and supports**

Specify:

Additional functions/activities:

- [ ] **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- [x] **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- [x] **Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other**

Specify:

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.

FIs are closely monitored by the Regional Office, the participant, their family and the Care Manager. At a minimum, the participant, family and Care Manager will review the FI performance at each semi-annual review of the plan of care (ISP/Life Plan).

The FI agency performs fiscal accounting and provides regular expenditure reports to the participant, and others as identified by the individual, tracking and reporting participant funds, disbursements and the balance of participant funds, and providing OPWDD with reports of expenditures and the detailed status of the participant-directed budget when requested. FI agencies are closely monitored by the OPWDD Regional Office staff, the participant, their family and the Care Manager. At a minimum, the participant, the circle of support and Care Manager will review the FI performance at the time of the 6 month review of the plan of care (ISP/Life Plan). The participant has the opportunity to express satisfaction with the fiscal performance of the FI during regular planning team meetings and ISP/Life Plan reviews or at any time there is a concern.

In addition, OPWDD uses the NCI survey (self-directed supports section) to assess satisfaction with self-directed services. This section of the NCI survey reviews whether a person can make changes to their budget and services when needed; whether there is someone to assist the person in how to use their budget and services; whether the person receives information on how much money is left in their budget; and other related questions.

The Division of Quality Improvement (DQI) reviews all service providers for regulatory compliance and quality of care.

Certified cost reports are reviewed annually.

Until 9/30/2014, OPWDD required CSS providers to perform a calendar year reconciliation of expenditures to revenues, and if excess revenue was received, a recovery is made by OPWDD as described below.

After 10/1/14, services are billed to eMedNY as Self-Directed services using separately identified rate codes and FIs will no longer perform a reconciliation. Therefore FIs bill only for those goods and services that are in the approved self-direction budget and do not bill Medicaid until there has been expenditures for those approved goods and services.

OPWDD and the OMIG have a joint audit plan which ensures coverage of all waiver services including any services that are self-directed (as described in Appendix I-1).

OPWDD's Office of Audit Services (OAS), in conjunction with OMIG will develop an audit program(s) to audit the new self-directed services billed through Fiscal Intermediaries (FI) and all existing waiver services (that FI are to be claiming) are already being audit by OAS.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

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)*:

☒ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

Care management is the vehicle that drives all HCBS services including self-directed service options. Every individual who receives services through the HCBS waiver must have access to care management. Care management services are designed to assist individuals to gain access to needed waiver services, state plan, and other appropriate supports regardless of the funding source. Care Managers provide information on the supports and services available through OPWDD so participants can make informed choices on the service options that best meet their needs and that will enable them to live as independently as possible in the community.

A primary responsibility of the Care Manager is to maintain and update the ISP/Life Plan and ensure that approved supports and services are delivered, regardless of participant-direction or traditional provider-managed services, and to help determine whether the participant is satisfied with their participant-directed services. Through these processes, the Care Manager provides information and assistance in support of the services the person receives. The Care Manager acts as a link between the Regional Office and the participant and their Circle of Support. The Care Manager must notify the Regional Office Self-Direction Liaison of issues involving the participant's dissatisfaction as well as issues that may compromise health and safety and obstacles that prevent the participant's plan from being fully implemented.

☒ **Waiver Service Coverage.**

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Family Education and Training	☐
Community Habilitation	☒
Support Brokerage	☒
Individual Directed Goods and Services	☒
Vehicle Modifications	☐
Pathway to Employment	☐
Respite	☒
Fiscal Intermediary (FI)	☒
Assistive Technology - Adaptive Devices	☐
Environmental Modifications (Home Accessibility)	☐
Supported Employment (SEMP)	☒
Prevocational Services	☐
Residential Habilitation	☐
Plan of Care Support Services	☐
Live-in Caregiver (42 CFR §441.303(f)(8))	☒
Community Transition Services	☒
Day Habilitation	☐
Intensive Behavioral Services	☐

☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

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:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

○ **No. Arrangements have not been made for independent advocacy.**

◉ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

The first level of independent advocacy available in participant-directed services stems from the participant's freely chosen planning team (or Circle of Support) whose members are natural supports to the participant and assist in ensuring that approved supports and services are delivered. Planning Team members often provide temporary, short-term back up supports if needed. The Planning Team meets, minimally, each quarter.

Individuals utilizing participant-directed services continue to receive care management (Health Home Care Management or Basic HCBS Plan Support). The Care Manager is a required member of the Planning Team. A primary responsibility of the Care Manager is to ensure that approved supports and services are delivered, regardless of participant-direction or traditional provider-managed services, and to help determine whether the participant is satisfied with their participant-directed services. The Care Manager acts as a link between the Regional Office and the participant and their Planning Team. The Care Manager must notify the Regional Office Self-Direction Liaison of issues involving the participant's dissatisfaction as well as issues compromising health & safety and obstacles preventing the participant's plan from being fully implemented.

If an individual is not pleased with the performance of the FI, he/she can contact people in his/her circle of support or Care Manager for assistance in resolving any issues. If necessary, the Regional Office staff is available to assist, or the person can contact the OPWDD Hotline to register a complaint with Central Office.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

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:

Individuals may choose at any time to terminate their self-directed service options. This process is facilitated through the Care Manager or the support broker. A period of at least 30 days is requested to allow the FI to appropriately discharge staff and notify any contracted service providers. The Care Manager will work with the participant to ensure continuity of service provision and health and safety.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

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.

In situations where participant-direction is through employer authority or a co-management model with a provider agency, the Co-Management Memorandum of Understanding contains a section for discontinuation of the self-directed services. This can be prompted by either the participant or the provider agency. In the event that it is the provider agency who is requesting the discontinuation of self-direction, the provider agency will continue to provide traditional (non-self-directed) supports to the participant. If appropriate, the participant will work with their Care Manager to secure alternative services.

In situations where participant-direction is supported by an FI, the FI may choose to involuntarily terminate a participant who has demonstrated a history of non-compliance with service delivery, budget authority, and/or documentation compliance. The FI must demonstrate efforts undertaken to assist the participant in addressing these issues. These efforts include written notification of pending termination if the issues are not addressed within a minimum 30 day timeframe. This notification must also be sent to the participant’s Care Manager who will work with the participant to secure alternative participant-directed or traditional services.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

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		6500
Year 2		8500
Year 3		9500
Year 4		12000
Year 5		17500

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

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. *Select one or both*:

☒ **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.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

Non-profit entities may serve as co-employers.

☐ **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. *Select one or more decision making authorities that participants exercise*:

☒ **Recruit staff**
☒ **Refer staff to agency for hiring (co-employer)**
☒ **Select staff from worker registry**
☐ **Hire staff common law employer**
☒ **Verify staff qualifications**
☐ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

☐ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

☒ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
☒ **Determine staff wages and benefits subject to state limits**
☒ **Schedule staff**
☒ **Orient and instruct staff in duties**
☒ **Supervise staff**
☒ **Evaluate staff performance**
☒ **Verify time worked by staff and approve time sheets**
☐ **Discharge staff (common law employer)**
☒ **Discharge staff from providing services (co-employer)**
☒ **Other**

Specify:

Provide or arrange for any necessary training/assistance as requested by the participant and Circle of Support members.

Ensure that all staff have received Incident Reporting training prior to the start of employment. This training is available through the FIs.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

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. *Select one or more*:

- ☒ **Reallocate funds among services included in the budget**
- ☒ **Determine the amount paid for services within the state's established limits**
- ☒ **Substitute service providers**
- ☒ **Schedule the provision of services**
- ☒ **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- ☒ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- ☒ **Identify service providers and refer for provider enrollment**
- ☒ **Authorize payment for waiver goods and services**
- ☒ **Review and approve provider invoices for services rendered**
- ☒ **Other**

Specify:

Identify providers he or she no longer wants to work with and refer for provider dis-enrollment.

Monitor monthly expenses to ensure that spending levels are consistent with the approved annual budget.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

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.

A resource allocation, called a Personal Resource Account (PRA), is established for each participant. The PRA represents a target amount of resources available to the participant for the cost of the supports and services they need. The budget for a self-direction participant is limited to the maximum PRA based on ISPM score, which is outlined in Addendum A of this amendment. Participants may not budget for more than the maximum PRA amount and the FI will not be reimbursed for services and supports that are above the maximum.

Personal Resource Account (PRA) values were developed by linking participant characteristics and need for services to the actual Medicaid billings for a reference group over one calendar year. The process evolved in several steps:

-The focus was mainly on persons receiving waiver services from voluntary providers. However, for comparison purposes, community ICF residents served by voluntary agencies were also included. In total, 20,595 consumers met the selection criteria.

-Medicaid expenditures were obtained for residential and day services billed in the specified calendar year. Miscellaneous services not clearly falling into either category were equally divided between residential and day services. For persons receiving HCBS, IRA Residential Habilitation or At Home Residential Habilitation, and State Plan Personal Care Service, billings for personal care services were obtained.

-For each person identified above, data were drawn from OPWDD's Developmental Disabilities Profile (DDP) Information System. Specifically, the DDP provides three summary measures of skills and needs: Adaptive (0-500), Health/medical (0-31) and Challenging Behavior (0-200), where low scores indicate low needs (high skills) and high scores indicate high
needs (low skills). Based on extensive OPWDD research on personal resource consumption, the DDP Adaptive and Health scores were further combined into a Direct Support score (0-136), where low scores indicate low direct (hands-on) support needs and high scores indicate high direct support needs. (see chart below)

After preliminary analyses, the Direct Support Scores were cut into levels forming eight roughly equal-sized groups and the Challenging Behavior Scores were cut into four levels forming roughly equal-sized groups. These two variables were the basis of assigning persons to selected groupings for cost analysis purposes. (see chart below)

Direct Support Levels	Scoring Range	Challenging Behavior Levels	Scoring Range
1	0 to 17.61	1	0 to 3.99
2	17.62 to 23.53	2	4.00 to 25.66
3	23.54 to 29.30	3	25.67 to 69.32
4	29.31 to 35.62	4	69.33 to 200.00
5	35.63 to 43.06		
6	43.07 to 52.84		
7	52.85 to 68.54		
8	68.55 to 136.00		

-Personal resource allocation target amounts were then established by analyzing the variations in Medicaid residential and day billings by the DDP ability levels. However, before the analyses were undertaken, the lowest and highest 2.5 percent of the billings in each category were trimmed to reduce the influence of extremely low and high expenditure cases.

-The final Personal Resource Account target values are based upon persons receiving waiver residential services and day habilitation services in non-profit organizations. ICF and Clinic service recipients were included for comparison purposes only.

PRAs are then further refined based on the age of the person and his or her certified residential status. Individuals who live in certified residential settings may choose to direct their day services (not their residential services), and therefore, the PRA is reduced to reflect only the person’s day service needs. Also, children living at home may self-direct (or family-direct) their services, but the PRA is also reduced to reflect their status as a minor, dependent child and a recipient of services through the school.

Additionally, individuals who qualify for the "Special Population Funding" rate (e.g., an individual who has been discharged from a more restrictive residential setting such as a developmental center as described in Addendum A to this waiver) has an adjusted PRA which is set at a higher rate that is designed to provide additional supports required to assist an individual transitioning to a less restrictive setting and will be in effect through June 30, 2021.

This information is available to Support Brokers assisting individuals who choose participant-direction via the Regional Office Self-Direction Liaison and is available to the public upon request.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

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.

Participants who choose to direct their services can get information on their PRA target value from their Regional Office Self Direction Liaison or their Support Brokerage Services agent at the beginning of the planning process. Participants are given a target value based on historical costs of individuals with similar service needs. These are only meant to be, as stated, a targeted value. A person's budget can be less than or equal to the target value, but cannot exceed the target value. Through the person-centered planning process, the person defines their own specific needs and with the assistance of the support broker designs their self-direction budget.

Participants can also request to change any aspect of their self-directed service plan and budget during the implementation phase to achieve evolving personal goals and valued outcomes, and to prevent institutionalization. There are two set opportunities to make changes to the service plan and budget yearly plan (through 9/30/14) or the Self Direction Budget (after 10/1/14) which align with the semi-annual reviews of the ISP/Life Plan. Individuals are afforded an immediate opportunity to request a change to their budget if circumstances occur that imminently threaten the life, safety and/or welfare of the participant. Participants are assisted through these change processes by their support broker and/or their local Regional Office Self-Direction Liaison.

A participant has a right to a Fair Hearing on a denial, termination or reduction of a self-direction budget, as long as the budget amount the person is requesting does not exceed the target value. A request to exceed the budget target amount is not a fair hearable issue.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

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

- (●) **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ( ) **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:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

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:

There are a number of safeguards and other resources designed to prevent the premature depletion of the participant-directed individualized budget as well as to address potential problems related to service delivery.

The main function of Support Brokers is to assist the participant to manage his/her self-direction budget. Support brokers review monthly expenditure reports with the participant to ensure that monthly expenses are appropriate. Circles of Support (the Support Broker is a member) act as a primary safeguard as well. Circles are required to meet at least once every three months (quarterly) but will meet as often as the participant requires to assist with staffing, scheduling, risk management and other issues. Other areas of support include:

--continual identification of revised or emerging valued outcomes and the supports needed to address them;
--on-going planning and maintenance of the self-directed budget;
--budgeting for emergency back-up support if needed;
--review of individualized budget expenditure reports to ensure that available resources remain adequate to meet approved services and supports;
--assistance in ensuring that risk, responsibilities, and consequences are understood and adhered to and that safeguards are revised, if needed, to adequately address needs, and;
--helping to ensure that health and safety concerns are immediately identified and addressed.

The participant may also identify a Circle member as their his/her liaison or authorized designee to the Fiscal Intermediary (FI) agency for issues related to the co-management of his or her self-directed direction budget.

A core function of FI Services is to develop and implement an accounting and information system to track and report participant-directed support funds, labor expenses, and non-labor expenses. The FI makes payments based on a current, approved budget which outlines the annual costs the participant will incur and how these costs will be paid over the course of the year. The FI must ensure that there are sufficient funds available within the individual’s budget to make the necessary payments.

The FI must develop a mechanism to identify those participants who incur expenses in excess of expected spending or those participants who are significantly under-utilizing their allotted funds. Either circumstance must immediately be reported to the participant (or authorized designee where appropriate) and to the local OPWDD office. The FI must also generate detailed expenditure reports to individuals and others as identified by the individual. These reports must be customized, as appropriate to their intended audience, to ensure that participants and members of their Circle of Support can understand them.

The participant will work with his or her Support Broker and Circle of Support to determine the need to revise the self-direction budget.

An FI checklist, which highlights the general responsibilities of the FI, is shared with all individuals using FI to self-direct services. On-going training is also provided to all parties on their roles and responsibilities.

In order to prevent a conflict of interest, the Regional Office reviews self-direction budgets and confirms the services/purchases are utilized through self-direction.

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.

The Regional Office Director designee notifies the individual and his/her guardian or involved family member of the right to request a fair hearing. The Notice of Decision (NOD) explains the agency's decision (e.g., denial or termination of HCBS enrollment) and offers the individual the opportunity to appeal the decision. It also includes the name and telephone number of a Regional Office staff person who can answer any questions the individual may have about the NOD and agency action. Instructions on how to request a fair hearing are included in the NOD. The instructions also explain how the individual can continue to receive current services during the pendency of the appeal.

Individuals request a fair hearing by contacting the Office of Administrative Hearings, New York Office of Temporary Disability and Assistance (NYS OTDA) within sixty days from the date of the NOD.

The NODs are sent to the individual, his/her guardian or involved family member, as well as his/her service/care coordinator. A copy of the notice is kept at the Regional Office. NYS OTDA notifies OPWDD when a fair hearing has been requested by or on behalf of the individual.

For individuals enrolled in the HCBS Waiver and enrolled in the Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities (FIDA-IDD) demonstration, appeal systems will be required to comply with 42 CFR 438, Article 44 of New York PHL ,applicable New York State regulations and the requirements outlined in the FIDA-IDD Three Way Contract.

Individuals enrolled in the FIDA-IDD can appeal any update to or reauthorization of the Life Plan (LP) or an action taken by the FIDA-IDD Plan related to Covered Items or Services. There are four levels of the appeals process for individuals enrolled in the FIDA-IDD. Level one appeal is an initial appeal to the FIDA-IDD Plan. An Appeal of the Plan’s action can be requested by the individual/guardian or designee and must be requested within sixty days from the date of the Coverage Determination Notice (CDN). The CDN explains the Plan’s decision and any decision that is not wholly in the individuals favor is automatically sent to the states Integrated Administrative Hearing Office (IAHO), NYS OTDA for a fair hearing, this serves as level two appeal. If the IAHO decision is not in the individual's favor, the individual can appeal that decision to the Medicare Appeals Council (MAC). The individual/guardian or designee can request a MAC through the IAHO within sixty days of the adverse decision by the IAHO. A MAC appeal serves as level three appeal. If there is an adverse decision by the MAC the individual can appeal to the Federal District Court which serves as level four appeal.

People with developmental disabilities will also be able to seek assistance from OPWDD and/or an independent advocate of their choice or the Independent Consumer Advocacy Network (ICAN) to assist them to navigate the grievance/appeals process through the FIDA-IDD when the person is dissatisfied with services and/or believes he or she should receive a service that the FIDA-IDD Plan has not provided to them.

Medicaid Fair Hearing requirements will continue to be applicable as the last step in the grievance process.

Appendix F: Participant-Rights

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:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The state operates an additional dispute resolution process**

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.

OPWDD regulations provide for an internal dispute resolution process (14 NYCRR Section 633.12). This process requires providers of service to offer informal dispute resolution for an individual's objection to the adequacy of his/her plan of care, and for provider initiated changes related to reduction, suspension or discontinuance of Home and Community Based waiver services. An individual is advised of the process to resolve objections to services upon enrollment in the HCBS waiver program and as changes occur. A provider must give the individual written notification when such provider proposes a reduction, suspension or withdrawal of waiver services.

If the provider and individual are unable to reach agreement, Regional Office staff will be asked to assist in resolving the issues. Ultimately, the OPWDD Commissioner may appoint a hearing officer to resolve outstanding issues. Individuals who use the process at 14 NYCRR Section 633.12 are told they may request a fair hearing at any time when the objection results from a determination made by OPWDD. The dispute resolution mechanism under Part 633.12 is not a pre-requisite or substitute for a Fair Hearing.

Objections to service plans may be raised at any time. The provider of service is required to inform the individual of the process and the timelines to be followed. When a 633.12 hearing is requested by an individual, OPWDD contacts the parties within 14 days to schedule a mutually convenient time to hold the hearing. The hearing officer's recommendation to the Commissioner is sent to the parties within 2 weeks of the conclusion of the hearing. The parties have 14 days to submit replies and the Commissioner issues a final decision within 14 days of receipt of the replies.

For individuals who are denied waiver services or whose waiver services are discontinued because they are determined not to have a qualifying developmental disability, individuals are notified in writing that they may request (1) a face to face meeting with staff involved in the determination; (2) request a Third Step Review of the determination by a Central Office committee of psychologists; and/or (3) request a fair hearing. A formal notice of decision with fair hearing rights is included with the notification. The individual may request one, two or all three of the options. Neither the meeting nor the Third Step Review is a prerequisite or substitute for the fair hearing.

See answer to question F-1 describing the appeal process applicable to individuals enrolled in the FIDA-IDD Plan.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

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

- ○ **No. This Appendix does not apply**
- ◉ **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**

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

The grievance system is operated by the NYS Department of Health, the lead Medicaid Agency. The lead Medicaid Agency will work with OPWDD to address any grievances registered by individuals with IDD who are enrollees in the People First Waiver or are served by the FIDA-IDD demonstration.

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).

For individuals enrolled in the HCBS Waiver and the FIDA-IDD demonstration, the grievance systems will be required to comply with 42 CFR 438, Article 44 PHL, applicable New York State regulations and as outlined in the FIDA-IDD Three Way Contract. Article 44 PHL requires a review of grievance procedures prior to a certificate of authority being issued by New York State. The FIDA-IDD will be required to track all grievances received (oral or written grievances), and these grievance tracking logs will be required to be made available to OPWDD and DOH upon request. New York State will perform a review of grievances for multiple purposes, including but not limited to, as part of the State's required quality strategy, as a quality outcome indicator, and to assess responsiveness of the FIDA-IDD.

For all People First Waiver services delivered through the FIDA-IDD demonstration, the NYS grievance system is available for use by all People First Waiver Enrollees. The NYS Grievance System comports with regulations in Subpart F of 42 CFR Part 438 and applies to an "expressions of dissatisfaction" by enrollees. A grievance is filed and decided at the FIDA-IDD Plan level. All grievances must be filed within 60 calendar days of the incident or whenever there is dissatisfaction.

Grievances that can be immediately decided (same day) to the individual/guardian or designee’s satisfaction do not need to be responded to in writing. The FIDA-IDD is required to document the grievance and decision, and log and track the grievance and decision for quality improvement purposes. If the grievance cannot be decided immediately (same day), the FIDA-IDD must decide if grievance is expedited or standard.

Expedited and Standard Grievances
Grievances must be decided and notification provided as fast as member's condition requires, but no more than:
Expedited:
Upon paper review within 24 hours
- If the grievance involves the Plan’s decision to invoke an extension on an organizational decision; or
- If the Plan refuses to grant an expedited review of an organizational determination; or

- 48 hours from receipt of all necessary information, but no more than 7 calendar days from the receipt of the grievance.

Standard:
Within 30 calendar days of the FIDA-IDD plan receiving a written or oral grievance.

Grievance decisions are communicated to the individual/guardian or designee by the Grievance Decision Notice (GDN). If the individual/guardian or designee is not satisfied with the Plan’s decision they can file an external grievance. The external grievance is reviewed by an organization that is not connected to the Plan. The individual can file an external grievance with Medicare or NYS Department of Health.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that

the state uses to elicit information on the health and welfare of individuals served through the program.

b. 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).

OPWDD has a rigorous and comprehensive system for identifying, reporting, and investigating incidents and reports of abuse, and for assuring appropriate corrective actions to protect individuals receiving services from harm. OPWDD Regulations (14 NYCRR Part 624 and 625) provide the foundation for OPWDD's incident management system.

Part 624 specifies the standards for identifying, reporting, investigating, reviewing, and following-up on all reportable incidents including reports of abuse, significant incidents and notable occurrences under the auspices of an agency. Part 625 specifies standards for events and situations not under the auspices of an agency. These regulations apply to all OPWDD operated, certified, sponsored or funded facilities, programs, and services. All providers of service must have a system that complies with Part 624 and Part 625 including appropriate policies and procedures that address all regulatory components and one or more Incident Review Committees to review and monitor reportable incidents of abuse/neglect, significant incidents, and notable occurrences.

Part 624 outlines categories of incidents that must be recorded, reported and investigated: 1. Reportable Incidents that include abuse and neglect including physical, sexual and psychological abuse, deliberate inappropriate use of restraints, aversive conditioning, obstruction of reporting of reportable incidents, unlawful use or administration of a controlled substance and neglect; 2. Reportable Significant Incidents that include situations such as conduct between individuals receiving services, seclusion, unauthorized use of time out, medication errors with adverse effects, inappropriate use of restraints, missing persons, choking with a known risk and self-abusive behavior with injury; 3. Serious Notable Incidents that include injury, unauthorized absence, death choking with no known risk, theft or financial exploitation, ICF violations and sensitive situations. Part 625 events and situations not under the auspices of an agency require notification to OPWDD. Part 625 events and situation include physical, sexual and emotional abuse, active passive and self-neglect, financial exploitation, death and other for events/situations that an agency may want to report to OPWDD.

As of January 1, 2016, changes are made to categories of significant incidents and serious notable occurrences. Significant incidents will include: conduct between individuals receiving services, seclusion, unauthorized use of time out, medication errors with adverse effects, inappropriate use of restraints, missing persons, choking with a known risk, self-abusive behavior with injury, choking with no known risk, unauthorized absence, injury, with hospital admission, theft/financial exploitation and other significant incident, mistreatment. Serious Notable Occurrences will include death and sensitive situation. ICF violation will no longer be a category.

Specific details on the types of incidents that fall into each of these categories are outlined in Part 624 and 625 regulations.

Reporting requirements for various types of incidents are outlined in Parts 624 and 625. Reportable incidents, including all reports of abuse and neglect, significant incidents, and serious notable occurrences must be reported to OPWDD immediately and then subsequently entered into the Incident Report and Management Application (IRMA), OPWDD's web based data base. Immediate protective measures must be put in place to protect the person(s) served. In addition, for facilities operated or certified by OPWDD, agencies must report all reportable incidents to the Vulnerable Persons Central Register (VPCR) operated by the New York State Justice Center for the Protection of People with Special Needs (The Justice Center).

When services are provided by State Direct Support Professionals, employees are removed from all contact with participants in all instances of suspected abuse/neglect that would potentially result in seeking termination of an employee if substantiated. If evidence being collected leads OPWDD to reasonable belief that the allegation will be substantiated, the employee is suspended pending termination.

All reportable incidents and notable occurrences must be investigated. This is completed by the provider agency at which the incident occurred and must meet the OPWDD regulations to assure a thorough and independent investigation. For all abuse/neglect in state operations, OPWDD’s Office of Investigations and Internal Affairs or The Justice Center will complete the investigation. In all cases, the investigator must prepare an investigative report using the Required Investigative Report format. Effective June 30 2013, with the implementation of the Protection of People with Special Needs Act (PPSNA), the Justice Center may assume responsibility for the investigation of certain incidents or occurrences.

In all cases, the investigator must prepare an investigative report using the Required Investigative Report format. All reports of abuse or neglect must include a finding of substantiated or unsubstantiated. Current investigators in the

OPWDD system must view the New York State Justice Center for the Protection of People with Special Needs OPWDD State Oversight Agency Investigator Training prior to completing an investigation of a Reportable Incident or Serious Notable Occurrence as well as any other OPWDD required training.

The investigative report is submitted to the agency's Incident Review Committee. The Incident Review Committee assures that the agency has taken necessary corrective and protective actions; determines whether additional measures are necessary; determines whether the agency reporting/review was adequate; identifies trends and makes recommendations to the director of the agency for improvements. The provider agency where the incident occurred is further required to take appropriate action to minimize the potential for recurrence of the incident and similar incidents.

OPWDD has developed criteria for when OPWDD certified investigators will assume responsibility for, or closely monitor the conduct of investigations in the voluntary sectors. For deaths which occur during the provision of services by State staff, which may involve abuse/neglect, there is a clear “arm’s length” separation of the individuals involved in an incident and those investigating the incident. State Direct Support Professionals report to the Deputy Commissioner of the Division of Service Delivery. Deaths are reported by State staff through the IRMA system; the Director of the Office of Investigations and Internal Affairs (OIIA) reports directly to the Commissioner. Any instance of abuse/neglect related to a death is investigated by the Justice Center in any state operated or voluntary operated certified setting. This independent chain of command allows investigations to be conducted independent of conflicting interests.

The reporting agency is always responsible for remediation. The review of incident reporting systems is a component of the OPWDD Division of Quality Improvement’s annual routine survey activity for all service providers, including HCBS waiver providers. In addition to assessing the overall quality and effectiveness of the provider’s incident management system, DQI reviews the provider’s investigations and follow up activities. DQI surveyors also review program communication logs, medical records, and interview staff and individuals served to ensure that all incidents were reported as required. Effective 1/1/2015, corrective action plans are required of the provider agency if any deficiencies are identified; submitted into IRMA and reviewed by OPWDD Incident Management Unit staff to ensure that the corrective action plan is adequate.

The New York State Justice Center for the Protection of People with Special Needs, provides an additional level of oversight and reports directly to the Office of the Governor. Investigators assigned to the Justice Center will be responsible for conducting investigations or providing oversight and monitoring of serious abuse/neglect and deaths as defined in legislation. Justice Center legislation, effective 6/30/2013, requires that the director of every agency provide feedback regarding the agency’s corrective action response to incidents falling under the purview of the Justice Center. IRMA includes a page on which the agency director indicates their approval of the corrective action plan by checking specific actions and certifying the activities. The Justice Center has access to IRMA to review this information.

Effective for incidents of abuse and neglect January 1, 2015, OPWDD IMU implemented a system for IMU staff review each correction action plan that is submitted by providers. If a corrective action plan is not adequate, IMU will to return it to the provider and work with the provider agency until an adequate corrective action plan has been submitted. Each corrective action plan must also include documentation of each corrective action. This is also reviewed during site visits by OPWDDs Bureau of Program Certification.

Effective January 1, 2015, OPWDD will require both state operated and voluntary providers of services to submit the full investigative record for incidents of deaths.

Providers enrolled in the Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities (FIDA-IDD) Plan will follow the same incident management protocols currently required by OPWDD in Part 624 and 625 regulations.

c. 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.

All staff who provide services in the OPWDD system must be trained annually by the provider agency in identifying an incident of abuse, their responsibility to report, and how to do so. In addition, OPWDD requires that all staff are trained annually in Promoting Positive Relationships.

Upon employment or initial volunteer, contract, or sponsorship arrangements, and annually thereafter, an agency will provide the agency's policies and procedures on incident management to agency employees, interns, volunteers, consultants, contractors, and family care providers.

Custodians with regular and substantial contact in facilities and programs operated or certified by OPWDD, must read and sign annually the Code of Conduct adopted by the Justice Center.

Custodians are defined as a party that meets one of the following criteria: (1) a director, operator, employee, or volunteer of an agency; or (2) a consultant or an employee or volunteer of a corporation, partnership, organization, or governmental entity that provides goods or services to an agency pursuant to contract or other arrangement that permits such party to have regular and substantial contact with individuals receiving services; or (3) a family care provider; or (4) a family care respite/substitute provider.

OPWDD ensures participant training and education in a variety of ways. OPWDD has developed informational brochures and seminars for participants and families/advocates. This information is made available at provider agencies, OPWDD Regional Offices, family support and self-advocacy meetings, and through OPWDD's website. In addition, the Division of Quality Improvement has conducted numerous state-wide trainings on the requirements for incident management. These trainings are open to all providers of services. OPWDD has issued numerous guidance documents to providers of services throughout the past year.

OPWDD also operates a toll-free information line to provide information and referral services and to receive complaints. All complaints are immediately referred from the information line to OPWDD District Offices and to the Division of Quality Improvement for review and investigation. In addition, the OPWDD Division of Quality Improvement reviews that all staff of provider agencies have received the required training.

For all reportable incidents and notable occurrences, OPWDD requires agencies to provide telephone notice to one of the following: a person’s guardian, a parent, spouse or adult child within 24 hours. However, the agency shall not provide such notice to any party if the person receiving services is a capable adult who objects to such notification being made or if the guardian, parent, spouse or adult child is the alleged abuser.

If the person does not have a guardian, parent, spouse or adult child, and the person is a capable adult, the agency provides notice to the person receiving services; otherwise, the agency provides notice to the person's advocate or correspondent.

d. 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.

Each provider in the OPWDD system is responsible for the investigation of critical events/incidents. For all reportable incidents, including reports of abuse and neglect and notable occurrences the investigation must begin immediately. The investigator is assigned by the agency's CEO or designee.

OPWDD's centralized Office of Investigations and Internal Affairs (OIIA) ensures the independence of investigations and the standardization of processes and outcomes in state-operated programs.

The OIIA takes responsibility for the conduct of certain investigations of allegations and/or incidents reported to have occurred in voluntary agencies either at the request of the voluntary agency or at the direction of OPWDD administration. The OIIA utilizes specific criteria for when OPWDD certified investigators will assume responsibility for or closely monitor the conduct of investigations in the voluntary sector.

As noted previously, OPWDD must be notified immediately of reportable incidents and serious notable occurrences. The OPWDD Incident Management Unit evaluates each incident and ensures that protections are put in place and are adequate. All incidents which may constitute a crime are reported to law enforcement. OPWDD regulations and guidance documents require notification to law enforcement whenever there is a report of physical or sexual abuse, whenever a potential crime has been committed by a “custodian” against an individual receiving services, and when the provider feels it is warranted. The regulations also direct providers to notify 911 for all emergency situations.

Final Investigative Reports must be completed in the format required by OPWDD no later than 30 days after the incident occurred or was discovered, unless the agency has been granted an extension after review of the circumstances.

Once the investigator completes the investigation and a report is submitted, the incident review committee accepts the investigation as complete or identifies additional investigative tasks which need to be completed. In the instance where the OPWDD OIIA or the Justice Center has completed the investigation, this is determined by the chain of command in that unit, or agency, not the incident review committee. The agency reporting the incident is always responsible for notification to outside entities. The Justice Center receives reports directly and also has access to IRMA and is able to view all incidents on a regular basis. The agency reporting the incident is also responsible for reporting to law enforcement.

As noted above, NYS has implemented a larger system of oversight to ensure the health and welfare of individuals receiving services through the implementation of the Protection of People with Special Needs Act (PPSNA), effective June 30, 2013 which has led to additional improvement in the oversight within the system. This legislation established the Justice Center, which is charged with the ultimate oversight of state agencies serving people with special needs. Implementation of the Justice Center will result in changes to the oversight structures described in this waiver application.

e. 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.

OPWDD has centralized its oversight of critical incidents and events. All oversight activities are assigned to OPWDD's Division of Quality Improvement. OPWDD's Incident Management Unit (IMU) provides real time oversight of critical elements of incident management across the state. This unit reviews incidents that are reported to assure adequate measures are put in place to protect persons with disabilities, including required notifications to law enforcement where required. This is accomplished through the use of the Incident Report and Management Application (IRMA), which is a secure web-based statewide database. IRMA is used to ensure consistency in incident reporting and is used by State operations and non-profit providers in the OPWDD system. The OPWDD Incident Management Unit includes off hours staff to received notifications and provides technical assistance to provider agencies. Both Voluntary Providers and State Operations Offices must notify the IMU of Reportable Incidents and Serious Notable Occurrences. Appropriate notifications to IMU are made by telephone for Reportable Incidents. Notification may be made by email for incidents that do not fall in the Reportable category.

All reportable incidents, including all abuse and neglect and serious notable occurrences must be reported to OPWDD immediately and the subsequently entered into the Incident Report and Management Application (IRMA), OPWDD's web based data base. In addition, immediate protective measures must be put in place to protect the person(s) served. OPWDD's Division of Quality Improvement (DQI) Incident Management Unit reviews each incident and protections put in place to ensure they are adequate. All incidents which may constitute a crime are reported to law enforcement. The OPWDD Incident Management Unit reviews every reportable incident including all abuse and neglect and serious notable occurrences.

As noted in d above, the OPWDD Office of Investigations and Internal Affairs has developed criteria for when OPWDD certified investigators will assume responsibility for or closely monitor the conduct of investigations in the voluntary sector. This criteria is available upon request from CMS.

The OPWDD Statewide Committee on Incident Review (SCIR) reviews data on incident reports and disseminates best practices and guidance based on this review to assist in the management and prevention of incidents. SCIR reviews regulations and develops policy documents that provide clear directions to service providers regarding regulatory requirements. SCIR designs and delivers training programs and other materials to promote safety awareness and incident prevention strategies. SCIR also publishes FAQs on the OPWDD website in response to stakeholder questions.

The review of incident reporting systems is a component of DQI's annual routine survey activity for all service providers, including HCBS waiver providers. In addition to assessing the overall quality and effectiveness of the providers' incident management systems, DQI reviews the provider's investigations and follow up activities. DQI surveyors also review program communication logs, medical records, and interview staff and individuals served to ensure that all incidents were reported as required. Corrective actions are required of the provider agency if any deficiencies are identified.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

○ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

◉ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. 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). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

In some cases, persons with developmental disabilities may require the use of interventions aimed at developing new adaptive behaviors; maintaining, increasing, or maximizing existing adaptive behaviors; or ameliorating maladaptive behaviors. Such interventions should emphasize positive approaches in modifying behavior, focus on teaching new behaviors, and provide persons with the skills needed to enhance their everyday functions and quality of life.

OPWDD requires that the use of positive approaches which are consistent with standards of professional practice always be the preferred method for addressing maladaptive or inappropriate behavior. However, OPWDD recognizes that positive approaches alone may not always be effective and it may also be necessary to incorporate approaches that are considered restrictive and/or intrusive into a behavior management plan to address such behavior.

For situations where circumstances necessitate the use of restraints, OPWDD has issued policy guidance on their appropriate use. Through this document, OPWDD limits the use of interventions to medication, physical interventions, time-out, mechanical restraining devices, and aversive conditioning; the inappropriate use of any of these interventions requires submission of an incident report and investigation by the provider and/or by OPWDD. Seclusion, as defined in our state regulations is prohibited by OPWDD.

OPWDD's policy and guidance documents pertaining to Behavior Management recommend that any behavior plans that incorporate the use of restrictive interventions require multiple levels of review (i.e. Behavior Management/Human Rights Committee) and must include effective safeguards to ensure the safety of the program participants. These safeguards include:

* A program planning team assigned by the provider agency which assesses the needs of the participant and ensures that the participant's behavioral plan is primarily based on positive approaches to behavior support and management, and only includes restrictive interventions when these restraints are clinically necessary and appropriate. All plans are developed or written by staff (the Behavioral Intervention Specialist or BIS) who have specialized training or experience in assessment techniques and development of behavioral support plans. In addition, any plan which includes a restrictive/intrusive intervention must be developed under the supervision of an appropriately licensed professional (e.g. licensed psychologist). The BIS assesses the antecedent, behavior, and consequences as part of completing the functional behavioral assessment prior to developing the behavioral support plan. The review is conducted on at least a semi-annual basis, or more frequently as needed.

* A committee created by the provider agency specifically to protect the rights of a person with DD, which reviews all participant behavior plans that include restrictive interventions. The committee can sanction clinically appropriate plans, or refuse to sanction proposed behavior management plans if the included interventions are considered to be too restrictive or intrusive. If the committee sanctions the intervention, the committee establishes a sanctioned time period
(not to exceed one year) during which the intervention can be utilized and is considered authorized.

* Appropriate record keeping methods which maintain the participant specific behavior management plan. This plan must include a description of the behavior that justifies the need for the intervention along with what positive approaches have been utilized. The plan must have been developed by a program planning team, approved by the review committee, and have an effective time-frame. When applicable, informed consent documentation should be included in the records.

The guidance documents outline specific rules regarding general use and emergency use for each of the restraints. For example:
* Physical intervention can only be used by those who have been trained in, and show a mastery of the Strategies for Crisis Intervention and Prevention-Revised (SCIP-R)physical intervention techniques. The use of SCIP-R physical intervention is limited to circumstances when a participant's behavior creates an unacceptable risk of physical harm to self or others. Any injury must be reported under the incident reporting criterion outlined in 14 NYCRR Part 624. SCIP-R related activities are monitored by Master Trainers employed by OPWDD.

The SCIP-R curriculum supports staff awareness of the needs of persons with developmental disabilities and

methods of preventing crises. Because of this approach, direct care staff can only be certified when they have completed a minimum of 17 hours of SCIP-R training. If staff are trained in restrictive physical interventions (e.g. take downs and floor holds), they must also be trained in basic first aid and cardiopulmonary resuscitation in order to be certified in SCIP-R to use such techniques. Eventually PROMOTE will replace the SCIP-R curriculum (see state oversight responsibility below and the QI Timeline section for more info on PROMOTE).

* OPWDD guidance documents define time out as a separate item from seclusion; OPWDD guidance prohibits the use of seclusion. The OPWDD definition of time out clearly states that the participant would be free to leave the time out area except for the direct and continuous action of the staff monitoring the participant. Time out requires constant auditory and visual monitoring of the participant, and the staff member must release the participant from the time out room once the participant is calm but no longer than one hour after the participant entered the time out room. Time out must be included in the behavioral plan of the participant prior to utilization by staff.

* Use of psychotropic drugs to manage or control behavior or to treat a diagnosed psychiatric condition requires a physician's order for the specific participant and it must be included in the participant's behavioral plan prior to utilization. In addition, informed consent for each psychotropic medication must be obtained in writing as per 14 NYCRR Part 681.13 prior to starting the medication. The only time this consent may be overridden is in circumstances where the participant's behavior constitutes an immediate, significant danger to the participant or others, when the participant is engaging in destructive conduct in the facility posing a significant risk to self or others, or when in a physician's judgment, an emergency exists creating an immediate need for the administration of such medication. These medications may only be administered by individuals who meet the criteria established under 14 NYCRR Part 633.17.

OPWDD proposed regulations that included a requirement for a Consultative Panel for the review of the use of psychiatric medications. In response to public commentary on these proposed regulations, OPWDD removed the language surrounding the requirement of a Consultative Panel for the review of the use of psychiatric medications. There will no longer be a separate review required.

The revised language, found on page 43 of the final regulations, Section 633.16(d), states "A semi-annual medication regimen review that includes any medications prescribed to treat a co-occurring diagnosed psychiatric disorder, or to prevent, control, modify or eliminate challenging behavior(s) must be conducted in accordance with section 633.17 of this Part. The results of these medication regimen reviews shall be shared with the person's program planning team and the prescriber, and documented in the person's record, in order to assist healthcare providers and the team to evaluate whether the benefits of continuing the medication(s) outweigh the risk inherent in potential side effects."

The regulations (14 NYCRR Section 633.16) were promulgated on 1/1/13 with an effective date of 4/1/13. This lag in implementation was due to the impact of Hurricane Sandy, along with issues in the field in preparing for the implementation of these requirements. The Person-Centered Behavioral Intervention regulations can be found on the OPWDD website.

* The use of Mechanical Restraining Devices also requires a physician's order for the specific device and it must be included in the participant's behavioral plan prior to utilization by staff unless in the physician's judgment an emergency exists creating an immediate need for use of the device to ensure health and safety of the participant. Additional monitoring and review criteria are required if mechanical devices are used to manage maladaptive behaviors, or are used for medical purposes. Emergency use is no longer permitted for waiver participants. Aversive conditioning is not allowed within the OPWDD service system.

Mechanical restraining devices which may be used without specific OPWDD approval are listed in 14 NYCRR Section
633.16 (j)(4). The items listed in the regulation are considered a type of restrictive/intrusive intervention if these items are being used for behavioral control purposes. As such, the use of these items would require informed consent as well
as review and approval by the Behavior Plan/Human Rights Committee. The use of mechanical restraining devices must be spelled out in the person's behavioral support plan which is developed by the program

planning team. As noted above, mechanical devices can only be incorporated into a behavior support plan if specifically ordered by a physician.

Additional protections pertaining to the use of restraint and seclusion are required under 14 NYCRR Part 624, which provides the standards for incident reporting when participants are injured or any circumstance where restraints are used to immobilize a participant. Under Part 624, incidents which must be reported as reportable or serious reportable incidents include any unauthorized, inappropriate or unnecessary use of personal/physical interventions (SCIP-R), time out, mechanical restraint, or aversive conditioning. Seclusion, which is prohibited by OPWDD is considered a form of abuse, and must always be reported as a serious incident.

Also under Part 624,the use of aversive conditioning without appropriate permission is considered abuse. Under the regulation, this includes, but is not limited to the use of the technique for convenience, as a substitute for programming, or for disciplinary/punishment purposes.

The provider agency in which the incident occurred is responsible for recording, reporting, and conducting the initial investigation of incidents. The local OPWDD Regional Office receives initial reports of all incidents required in accordance with the Part 624 regulations. Each report is reviewed by an assigned staff member commonly referred to as an incident coordinator. The incident coordinator secures any required information and refers the incident to appropriate staff for comprehensive follow up. Incidents deemed to be critical by the Regional Office are referred to the Associate Commissioner and to the Deputy Commissioner of the Division of Quality Improvement for further review.

In accordance with Part 624, every provider must have one or more standing committees to review and monitor Reportable Incidents, Serious Reportable Incidents, and all reports of abuse. The standing committee must ascertain that incidents were reported, managed, investigated, and documented in accordance with regulations and that necessary and appropriate corrective actions were taken to protect individuals. The standing committees are also responsible to review and monitor investigation procedures; monitor trends in incidents and recommend appropriate corrective, preventive, and/or disciplinary action to safeguard against recurrences; and to monitor implementation of their recommendations for appropriate safeguards and improvements to the incident management system.

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

OPWDD is the State agency responsible for overseeing the use of restraints by service providers. OPWDD employs numerous levels of review and oversight to ensure the safety of participants.

OPWDD's Bureau of Behavior and Clinical Solutions (BBCS), provides oversight at the highest level by developing guidance documents on the acceptable and unacceptable use of restraints and promulgating any changes in regulation. This Bureau also ensures that agency practices are in keeping with national trends. The Bureau collaborates with other state agencies as needed to maintain consistency where appropriate with restraint practices, monitoring and oversight, documentation, and trending.

BBCS also develops and implements the SCIP-R curriculum and training. The group updates and revises the curriculum as warranted based on information gleaned from national trends in behavior management, review of statewide incidents and trends, and the solicitation of feedback from the field regarding participant needs and agency needs. BBCS also oversees utilization and implementation of the curriculum by regularly meeting with Master Trainers employed by OPWDD Regional Offices.

As part of its ongoing efforts to prevent incidents and abuse, in 2012, OPWDD promulgated regulations that require all employees, volunteers, and family care providers in the OPWDD system receive annual training on promoting positive relationships, incidents/abuse reporting, and abuse prevention. OPWDD has implemented statewide training to reinforce the principles of respect, dignity, and professional ethics for all people served. In addition, OPWDD has designed/developed the Positive Relationships Offer More Opportunities for Everyone (PROMOTE) curriculum, which is designed to emphasize the importance of positive relationships and proactive measures to prevent challenging behaviors. The PROMOTE training is being rolled out to Master Instructors, Instructor Trainers, and Instructors throughout 2012 and will be required training for all direct support professionals and supervisors starting in 2013. The PROMOTE curriculum will eventually replace the existing SCIP-R curriculum.

Finally, BBCS reviews all Part 624 reportable incidents regarding the use of restraints, to ensure that policy and training materials appropriately incorporate information and trends learned from this review, including appropriate safety.

BBCS developed a new database and tracking systems to collect the use of restrictive interventions on a statewide basis (i.e., the Restrictive Intervention Application (RIA); the database was piloted with state staff in early 2012. Effective July 30, 2012, BBCS issued policy guidance to the field which outlined the appropriate safeguards, levels of administrative review and reporting requirements necessary for protecting the physical health and safety of individuals when SCIP-R restrictive personal/physical interventions are used as part of a behavior plan or in an emergency to address challenging behaviors that pose a risk of harm to self or others. This guidance also implemented the requirement of all providers to report the use of SCIP-R restrictive physical interventions into a new database and tracking system within five days of the occurrence. This database will interface with the Incident Report and Management Application (IRMA) used for all reports of abuse.

OPWDD Regional Offices provide technical support and guidance to provider agencies in their catchment areas. These offices employ Master SCIP Trainers to track utilization, provide technical assistance to agencies using the SCIP-R curriculum, mentor new SCIP-R Instructor Trainers, and provide curriculum updates to agencies as warranted. The Regional Offices also review the investigations and outcomes for all Part 624 Serious Reportable Incidents including all reports of abuse; Regional Offices provide guidance regarding any additional corrective actions as needed.

OPWDD Division of Quality Improvement (DQI) provides statewide oversight through annual surveys of all certified programs and HCBS waiver provider agencies. The DQI surveyors review the provider's investigations and follow up activities. The surveyors also review program communication logs, medical records, and interview staff and individuals served, among other things, to ensure that all incidents were reported as required and appropriate individual and/or systemic corrective actions were taken. If any survey deficiencies are identified, corrective action plans are required of the provider agency.

OPWDD has implemented a Statewide Incident Reporting Management System (IRMA). This system is used by all Regional Offices and provider agencies to report incidents, specify follow up and investigation

activity and other real time information that enables more efficient reporting and follow up activity and trend analysis by type of incident, locations, etc. and over time, results in the deployment of system-wide remediation strategies.

If an incident results in the death of a participant, OPWDD's Investigations Unit is notified and given the opportunity to review the situation. The NYS Commission on Quality of Care and Advocacy for Persons with Disabilities is also notified of all deaths.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

○ **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

◉ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

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.

OPWDD regulations in 14 NYCRR 633.4 outline the rights that are intended to establish the living and/or program environment that protects individuals and contributes to providing an environment in keeping with the community at large, to the extent possible, given the degree of the disabilities of such individuals. The regulations clarify that certain rights may need to be adapted to meet the needs of certain persons with the most severe handicaps and/or persons whose need for protection, safety and health care will justify such adaption. These regulations also state that it is the responsibility of the agency/facility or the sponsoring agency to ensure that rights are not arbitrarily denied. Limitations of client rights must be on an individual basis, for a specific period of time, and for clinical purposes only. Freedom from physical and psychological abuse; freedom from corporal punishment; freedom from the unnecessary use of mechanical restraining devices; and freedom from unnecessary or excessive medication are rights specifically outlined in these regulations.

NYS regulations categorize the violation of a person's civil rights as a form of abuse and are considered to endanger the physical or emotional wellbeing of the participant; therefore, all reports of abuse must be reported in writing to the appropriate Regional Office. Additionally, any willful action on the part of a provider which violate a person's human rights is considered an incident of mistreatment (14 NYCRR 624.4(c)(8)) and must also be reported as a part 624 reportable incident.

In accordance with Part 624, every provider must have one or more standing committees to review and monitor reports of abuse. The standing committee must ascertain that incidents were reported, managed, investigated, and documented in accordance with regulations and that necessary and appropriate corrective actions were taken to protect individuals. The standing committees are also responsible to monitor trends in incidents and recommend appropriate corrective, preventive, and/or disciplinary action to safeguard against recurrences; and to make and monitor implementation of recommendations for appropriate safeguards and improvements to the incident management system.

As in the case of incidents of unauthorized restraints, the provider agency is responsible for recording, reporting, and conducting the initial investigation of incidents. OPWDD receives initial reports of all incidents required in accordance with the Part 624 regulations and provides centralized oversight as appropriate.

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:

As in the case of physical restraints, OPWDD has a multi-level review process for the use of rights-limitations by provider agencies to control the behavior of participants in their programs.

OPWDD (DQI) provides statewide oversight through annual surveys of all certified programs and HCBS waiver provider agencies. The DQI surveyors specifically review records to determine if any limitations were imposed on any participant's rights and ensure that participants live free from abuse and neglect (14 NYCRR 633.2). If limitations were imposed, the surveyors verify that there is a clinical justification for the limitation and a specific time period for which it is to remain in effect. The DQI surveyors also review the provider's investigations and follow up activities regarding reports of abuse.

The OPWDD Regional Offices oversee the providers by reviewing the investigations and outcomes for all Part 624 reports of abuse; regional offices provide guidance regarding any additional corrective actions as needed. The Regional Office also enters any reportable incidents into the IRMA system for tracking, status review, and trend analysis.

Finally, BBCS reviews all Part 624 reportable incidents regarding the use of restraints, to ensure that policy and training materials appropriately incorporate information and trends learned from this review, including appropriate safety.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of

3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

Seclusion is prohibited by OPWDD and is considered a form of abuse and must always be reported as a serious incident under Part 624 of NYS regulations. OPWDD guidance regulations define time out as a separate item from seclusion. OPWDD guidance prohibits the use of seclusion (see section G-2-b above). OPWDD guidance does permit time out in certain limited circumstances, consistent with the behavioral plan of the individual. As discussed above in G-2 b, OPWDD regulations (14 NYCRR Part 633.16 “Person-Centered Behavioral Intervention”) describe safeguards and require that any behavior support plans that incorporate the use of restrictive interventions (including rights limitations) require multiple levels of review (i.e. Behavior Plan/Human Rights Committee) and must include effective safeguards to ensure the safety of the program participants.

The OPWDD definition of time out clearly states that the participant would be free to leave the time out area except for the direct and continuous action of the staff monitoring the participant. Time out requires constant auditory and visual monitoring of the participant, and the staff member must release the participant from the time out room once the participant is calm but no longer than one hour after the participant entered the time out room. Time out must be included in the behavior support plan of the participant prior to utilization by staff.

The OPWDD definition of time out clearly states that the participant would be free to leave the time out area except for the direct and continuous action of the staff monitoring the participant. Time out requires constant auditory and visual monitoring of the participant, and the staff member must release the participant from the time out room once the participant is calm but no longer than one hour after the participant entered the time out room. Time out must be included in the behavior support plan of the participant prior to utilization by staff.

Seclusion is prohibited by OPWDD and is considered a form of abuse and must always be reported as a serious incident under Part 624 of NYS regulations.

OPWDD is the State agency responsible for overseeing the use of restraints by service providers. OPWDD employs numerous levels of review and oversight to ensure the safety of participants.

OPWDD's Bureau of Behavior and Clinical Solutions (BBCS), provides oversight at the highest level by developing guidance documents on the acceptable and unacceptable use of restraints and promulgating any changes in regulation. This Bureau also ensures that agency practices are in keeping with national trends. The Bureau collaborates with other state agencies as needed to maintain consistency where appropriate with restraint practices, monitoring and oversight, documentation, and trending.

As part of its ongoing efforts to prevent incidents and abuse, in 2012, OPWDD promulgated regulations that require all employees, volunteers, and family care providers in the OPWDD system receive annual training on promoting positive relationships, incidents/abuse reporting, and abuse prevention. OPWDD has implemented statewide training (the PRAISE Curriculum – Promoting Relationships and Implementing Safe Environments) to reinforce the principles of respect, dignity, and professional ethics for all people served. In addition, OPWDD has designed/developed the Positive Relationships Offer More Opportunities for Everyone (PROMOTE) curriculum, which is designed to emphasize the importance of positive relationships and proactive measures to prevent challenging behaviors. OPWDD began rolling out the PROMOTE training is a required training for all direct support professionals and supervisors starting in 2013. The PROMOTE curriculum will eventually replace the existing SCIP-R curriculum.

Finally, BBCS reviews all Part 624 reportable incidents regarding the use of restraints, to ensure that policy and training materials appropriately incorporate information and trends learned from this review, including appropriate safety.

BBCS utilizes a database and tracking systems to collect the use of restrictive interventions on a statewide basis known as the Restrictive Intervention Application (RIA). Effective July 30, 2012, BBCS issued policy guidance to the field which outlined the appropriate safeguards, levels of administrative review and reporting requirements necessary for protecting the physical health and safety of individuals when SCIP-R restrictive personal/physical interventions are used as part of a behavior support plan or in an emergency to address challenging behaviors that pose a risk of harm to self or others. This guidance also implemented the requirement of all providers to report the use of SCIP-R restrictive physical interventions into the new database and tracking system within five days of the occurrence. Effective April 1, 2013, OPWDD's “Person-Centered Behavioral Intervention” regulations require that any use of a Time- out room in accordance with an individual’s behavior support plan be reported electronically to

OPWDD in the form and format specified by OPWDD. This form and format is RIA. This database interfaces with the Incident Report and Management Application (IRMA) used for reports of abuse.

OPWDD Division of Quality Improvement (DQI) provides statewide oversight through annual surveys of all certified programs and, HCBS waiver provider agencies that bill Medicaid directly either through the review of the provider and/or a sample of individuals in the waiver, and DISCOs with waiver providers in their networks. The DQI surveyors review the provider's investigations and follow up activities. The surveyors also review program communication logs, medical records, and interview staff and individuals served, among other things, to ensure that all incidents were reported as required and appropriate individual and/or systemic corrective actions were taken. If any survey deficiencies are identified, corrective action plans are required of the provider agency.

OPWDD has implemented a Statewide Incident Reporting Management System (IRMA) and has a centralized Incident Management Unit in DQI responsible to ensure that appropriate actions and safeguards have been taken for all incidents. This system is used by all Regional Offices and provider agencies to report incidents, specify follow up and investigation activity and other real time information that enables more efficient reporting and follow up activity and trend analysis by type of incident, locations, etc. and over time, results in the deployment of system-wide remediation strategies.

If an incident results in the death of a participant, OPWDD's Centralized Investigations Unit is notified and given the opportunity to review the situation. The NYS Commission on Quality of Care and Advocacy for Persons with Disabilities is also notified of all deaths.

In addition, for individuals enrolled in managed care, care coordinators are mandated reporters, and therefore FIDA-IDD has a responsibility to ensure that an incident report is made and to review data on incidents involving their members and within their provider network and will be expected to include this review and actionable quality improvement strategies in the Quality Improvement/Performance Improvement Plan (QI/PI Plan).

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of 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 seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

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:

○ **No. This Appendix is not applicable** *(do not complete the remaining items)*

◉ **Yes. This Appendix applies** *(complete the remaining items)*

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.

As per standard medical practice in New York State, the doctor prescribing a given medication has primary supervision over its use. Under the waiver program, Registered Professional Nurses (RNs) employed or contracted by the providers oversee the proper administration of medications to participants living in certified residential and non-residential settings.

Under OPWDD Regulations (Title 14 NYCRR Part 633.17), each provider is required to develop its own policies and procedures relative to prescribed and over-the-counter medications relevant to its needs provided they meet the requirements outlined in regulation. For example, the policies must require that the agency provide medical and nursing supervision of the staff responsible for administering medication. These policies must be established, submitted, and reviewed by OPWDD prior to the provider receiving OPWDD approval to operate the service.

Monitoring of medication regimes is done on a semi-annual basis, and can be done by an RN, physician, pharmacist or physician's assistant. The review covers all types of medication, but is designed to ensure careful review of certain types of medications. This review includes an evaluation that:

- The timing and dosage of medications is appropriate
- Any Special Precautions are implemented– for example individuals on atypical antipsychotic medications must be regularly screened for hyperglycemia
- Necessary consultation, lab-work and Physician appointments occur as needed
- Contraindications and interactions for all medications are noted, including those created by simultaneous administration of medications
- The effectiveness of each medication is evaluated
- Recommendations are made to the prescriber as needed for issues / concerns with any of the above.

Monitoring medication management can be done at a frequency determined by the RN. During visits to the home, the RN will check the actual medications and the area where they are stored to ensure that medications are not expired, they match the physician's orders and that they are being given as ordered. In addition, the RN will also assess the storage and maintenance of medications. Controlled substances must be under lock and key, and the "count" for controlled substances must be complete and correct. Syringes and sharps must be appropriately stored. The monitoring also confirms that the medication storage area is neat, clean and that staff administering medications have all appropriate supplies.

New York State Regulation (NYCRR 633.16(j) (5)) implements certain safeguards when medication is used to prevent, modify, or control challenging behavior or to treat symptoms of a co-occurring diagnosed psychiatric disorder. The use of medication cannot replace the need to develop an appropriate program plan and cannot be used for the convenience of staff or as a substitute for supervision. Medication cannot be intentionally administered in amounts that interfere with a person's ability to participate in programming or other activities nor can medication be used for disciplinary purposes. The use of medication to prevent, modify, or control challenging behavior, or to treat a co-occurring diagnosed psychiatric disorder that does not comport with these regulations, constitutes abuse and is subject to abuse reporting requirements described at length in the Waiver Agreement.

A semi-annual medication regimen review must be conducted in accordance with NYS regulations section 633.17. The results of these medication regimen reviews must be shared with the person's planning team and the prescriber, and documented in the person's record, in order to assist healthcare providers and the team to evaluate whether the benefits of continuing the medication(s) outweigh the risk inherent in potential side effects. Regulations further require that, at least semi-annually, and more frequently as needed, staff must consult with the prescriber regarding the administration and continued effectiveness of the medication. It is the responsibility of the OPWDD residential agency to ensure that the person or the party granting informed consent has been given clear, necessary information regarding the proposed medication including, but not limited to, its purpose, and the dose or dosage range and route of administration.

New York State Regulations (NYCRR 633.16 (f)) require that every agency with oversight responsibilities for one or more programs that serve people in need of behavior support plans that include restrictive/intrusive interventions and/or rights limitations must establish a behavior plan/human rights committee. The committee is charged with the protection of the rights of persons whose behavior support plans incorporate the use of restrictive/intrusive interventions and/or a limitation on a person's rights.

The committee must approve or refuse to approve, in writing, any proposed plan which contains a limitation on a person's rights and/or utilize one or more restrictive/intrusive interventions specified in in regulation. A behavior plan/human rights committee must have a minimum of four members including:

(a) A licensed psychologist or a behavioral intervention specialist, with training in assessment techniques and behavioral support plan development; and

(b) A clinician, currently licensed, certified, or registered in New York State as one of the following: social worker, physician, physician assistant, nurse practitioner, registered nurse, speech pathologist, occupational therapist, physical therapist, or pharmacist.

In providing monitoring, the frequency of RN visits to sites where Direct Support Professionals provide nursing tasks shall be at the discretion of the RN responsible for supervision but in no case shall visits occur less frequently than once during the month in which such nursing tasks are delivered (Administrative Memorandum #2015-03).

Additionally, a participant residing in a facility must have his/her medication regimen reviewed by a registered nurse, physician, physician's assistant, or pharmacist at least semi-annually. The review shall include at a minimum:

-A review of the person's medication record for potential adverse reactions, allergies, interactions, contraindications, or irregularities; related laboratory work shall be included in this review.

-An assessment of the person's response to the medication therapy to determine if the medication is achieving the stated objectives established by the prescribing practitioner.

-Recommendations to the primary and/or consulting practitioner of any indicated changes in the person's medication regimen.

-Determination of the need for a more frequent review depending upon the person's medical status.

-Documentation of the review, findings, and any recommendations made.

The provider's program planning team (with input from a registered nurse, physician, or physician's assistant) must evaluate participants within three months of their entrance into a residential facility regarding their ability to self-administer (with re- evaluation on an annual basis). The evaluation is based upon the following designations: independent self-administration, self-administration with supervision, self-administration with assistance, or incapable of self-administration.

Providers or Registered Nurses (RNs) are required by regulation to review all medication administration regimes semi-annually; this includes medication administration regimes for participants receiving behavior modifying medications.

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.

Through an established DQI survey procedure, OPWDD verifies the accuracy of the medication administration regime and documentation of the semi-annual review of the medication administration regime for participants in all certified residential facilities; the providers are audited against their own reporting procedure. OPWDD also requires in regulation that in all providers which assume the responsibility to administer medications (residential or non-residential) that there is person- specific information available regarding the medications made available to staff / family care providers.

OPWDD's Division of Quality Improvement (DQI) reviews these requirements as part of a provider's annual review. 100% of providers are reviewed through this process annually. Providers found to have issues in their review of medication administration regimes, or in the accurate administration of medication will be issued a Statement of Deficiency (SOD) which the provider must address by creating a Plan of Corrective Action (POCA) which DQI reviews, approves, and later verifies its implementation.

Any trends identified through the DQI survey process are reviewed; if appropriate, advisory letters will be issued by DQI to all providers. The provider has 20 days to submit a POCA from the receipt of the SOD and 10 days following receipt of a 45 day letter. Implementation and effectiveness of the POCA is verified during the following review of services. If a 45 day letter was received, correction is verified at the follow-up visit, which is scheduled following the 45 day timeframe. Results of the POCA implementation may be shared with individuals and/or advocates by the agency and/or requested of OPWDD.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

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

○ **Not applicable.** *(do not complete the remaining items)*

◉ **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.** *(complete the remaining items)*

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).

Policies:

The State Regulations governing the administration of medications by waiver providers are outlined in Title 14 NYCRR Part
633.17. Administrative Memorandum #2015-03 summarizes the requirements for providers and gives guidance to providers regarding the implementation of regulations.

The RN is responsible for developing an individualized plan for nursing services for any participant who requires nursing care, including those who require medication administration for diagnosed medical conditions. Such plans must be updated at least annually or whenever there is a significant change in the participant's condition.

The provider's program planning team (with input from a registered nurse, physician, or physician's assistant) must evaluate participants within three months of their entrance into a residential facility regarding their ability to self-administer (with re- evaluation on an annual basis). The evaluation is based upon the following designations: independent self-administration, self-administration with supervision, self-administration with assistance, or incapable of self-administration.

If anyone besides the RN administers medication in a facility, the RN must document that Direct Support Professionals (DSPs) have been educated about the chronic conditions and related health care needs of each participant in their care.

The RN shall also ensure that there is a participant specific medication sheet for each medication that is administered. This sheet shall include all of the information required by 14 NYCRR section 633.17(a)(17)(iii). If there is any change in the medication regimen, or if a new medication is added to the regimen, the staff is required to notify the RN prior to administering the medication.

If a participant is prescribed medication for behavior modification or to control maladaptive or inappropriate behavior, or for a co-occurring psychiatric disorder, she/he must provide informed consent. The team should confirm his/her capacity to provide informed consent. In those cases when the program planning team unanimously agrees that the person does not have capacity to give informed consent, the team shall provide an evaluation that includes a detailed analysis as the basis of its opinion. The results of the evaluation must be in writing and documented in the participant's clinical record and, if not completed by a NYS licensed psychologist or physician, must be confirmed by one of these licensed professionals. If the individual is found to lack capacity to consent, a capable person or a surrogate decision-maker must give informed consent to such medication after he or she is told the purposes, risks and benefits of the medication, and any alternatives to the administration of the medication, in addition to an instruction that the person is free to withdraw his or her consent at any time without prejudice.

It shall be the responsibility of the Registered Professional Nurse to determine which nursing procedures, including medication administration, unlicensed direct care staff will be allowed to perform, and which unlicensed DSPs will be allowed to perform them. The Registered Professional Nurse exercises professional judgment as to when delegation is unsafe and/or not in the participant's best interest.

When making a decision regarding a nursing task or activity, the RN assesses the following:
-complexity of the task;
-condition/stability of the participant; and
-training, skill and experience of the staff involved, including relevant factors related to the participant’s ability to safely provide nursing services.

Under the Nurse Practice Act, the State Education Department has allowed unlicensed staff to assist certain participants to administer their medications. This includes participants who are Self-Directing (but may not be able to physically take their medication), those who are Self-Administering but require supports, and individuals who are unable to administer their own medication.

Training:
RNs who do not have previous experience in the field of intellectual/developmental disabilities (I/DD) nursing will be required to complete an orientation for registered nurses in I/DD nursing within three months of being

hired.

It is the responsibility of the RN to provide initial and on-going training to unlicensed DSP staff in all nursing tasks and/or functions that they will perform, including medication administration. The RN must periodically review that the performance of unlicensed staff is consistent with standards of care and training. An RN can de-certify a direct care staff at any time if, in the opinion of the RN, the DSP staff is unsafe in medication administration.

“Periodically ” would be defined as, at a minimum, on an annual basis, or as determined by the RN. For example, if the RN is in a residence at the time that medications are being administered, or care is being provided, he/she has the option of observing the unlicensed staff in providing care at that time. If there are any complaints regarding care or if there are medication errors, the RN may determine it is necessary to go into a residence at the time the medications are being administered or care is being provided to observe and provide any additional training that may be required. “Periodically” may be different depending on the medical needs of the individuals within a home. If there are more needs, and/or more nursing tasks being delegated, an RN may determine that observations of staff are needed on a more frequent basis to ensure the standards of care and training are met.

Medication administration is taught utilizing a standard curriculum approved by OPWDD.

Unlicensed DSP staff are separately certified for medication administration by the provider’s RN. The training is standardized and the curriculum is provided by OPWDD. In order to be certified, the DSP must complete:
-4 workdays of training in medication administration;
-Two examinations of at least 50 questions each (a pool of questions provided by OPWDD for use by the provider) where the student must obtain a score of 80% or better; and
-A clinical practicum that includes pouring, administering, and recording medications with no errors on three separate occasions to all participants (defined as a medication pass) at the certified setting where the staff is permanently assigned. If a direct care staff is reassigned, they cannot administer medication until they complete an error-free medication pass supervised by an RN.

Each DSP must be recertified at least once a year by a registered nurse who reviews the DSP’s performance over the past year and observes one errorless medication pass. In addition, the RN will review the following with the unlicensed DSP:
-Updates on medications;
-Updates on policy;
-The "5 Rights" of medication administration which is ensuring that the right person receives the right medication, in the right dose, through the right route (e.g., by mouth, on the skin, etc.), at the right time
-One errorless medication pass

Certification to administer medication is not transferrable from one agency to another.

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

○ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
Complete the following three items:

(a) Specify state agency (or agencies) to which errors are reported:

(b) Specify the types of medication errors that providers are required to *record:*

(c) Specify the types of medication errors that providers must *report* to the state:

◉ **Providers responsible for medication administration are required to record 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:

In order to be certified by OPWDD, a provider must have a policy in place to review medication administration and to record/report errors. All medication administration errors must be documented in a participant's record, however, if the error does not result in an adverse effect, it is not required to be reported.

If an incident falls under the category of a serious reportable incident as defined by regulation part 624, a provider must report the incident to OPWDD through the electronic Incident Report Management Application (IRMA) for additional review. This would include a medication error where a person evidences marked adverse effects or a person's health or welfare is in jeopardy due to:
-The administration of medication in an incorrect dosage, in an incorrect specified form, by incorrect route of administration, or which has not been prescribed or ordered;
-Administration of a medication to the wrong person; and
-Failure to administer a prescribed medication.
Any medication administration which requires admission to a hospital falls under the category of a serious reportable incident, and must be reported to OPWDD in writing.

All medication errors that rise to the level of a serious reportable incident, including administration errors and procedural errors are trended by DQI.

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.

Ongoing Oversight

Through an established DQI survey procedure, OPWDD verifies the adherence to policies and procedures related to medication administration and the semi-annual review of the medication administration regime for participants in all certified residential facilities; the providers are audited against their own reporting procedure. OPWDD also ensures through regulation that all providers which assume the responsibility to administer medications (residential or non-residential) have person-specific information available regarding the medications made available to staff / family care provider.

OPWDD's Division of Quality Improvement (DQI) reviews these requirements as part of a provider's annual review. 100% of providers are reviewed through this process annually. Providers found to have issues in their review of medication administration regimes, or in the accurate administration of medication will be issued a Statement of Deficiency (SOD) which the provider must address by creating a Plan of Corrective Action (POCA) which DQI reviews, approves, and later verifies its implementation.

Any trends identified through the DQI survey process are reviewed; if appropriate, advisory letters will be issued by DQI to all providers. An agency has 20 days to submit a POCA from receipt of the SOD and 10 days to submit a POCA from the receipt of a 45 day letter.

When a review results in issuance of a statement of deficiencies, the agency is required to provide a POCA that describes activities taken and to be taken by the agency to correct immediate concerns, review that the deficient practice is not present for others, and processes to ensure the practice will not be repeated. DQI works with the agency until the plan is sufficiently potent to address the issue(s). In most cases the implementation and effectiveness is reviewed at the next routine review. For more serious issues when a 45 day letter is issued, verification activities begin approximately 45 days after issuance. If Imminent Danger is determined, a plan of correction is received during the review and the survey team will not leave until the strategies in the plan are implemented to address the immediate concern.

When an agency has continued systemic or egregious problems, or is unable to maintain compliance, they may be referred to the Early Alert Committee for consideration. If placed on early alert, the agency must not only have provided a POCA for identified deficiencies, but also a Management Plan that addresses broader influences on the effectiveness and appropriateness of service delivery and safeguards. The status and progress of these agencies are reviewed monthly by a committee of OPWDD management. Agencies may also be referred to the Fine Committee for consideration of a financial levy.

Poorly performing agencies receive more frequent monitoring of service delivery as determined by DQI leadership. Sustained poor performance or failure to improve or sustain improvement may result in action by OPWDD, within its authority to: seek surrender of operating certificate, facilitate the dissolution of an agency, and transfer of services to competent providers.

In 2017 DQI will begin to review QI planning and activities completed by agencies.

DQI has been expanding its data collection capabilities and in collaboration with ITS, protocols will be in an on-line application and review finding entered as close to real time as possible. With the collection of findings, DQI is also working with a team to report on the data collected via Business Intelligence mechanism, allowing examination by agency, region, service type, etc. This is still in process but will fully functional in 2017 with full reporting capabilities in April 2018. Findings and trends have been and will continue to be shared with provider agencies via DQI provider training semi-annually, special reporting, provider association meetings, etc. Trends may also be used to inform OPWDD on actions that may need to be taken, e.g. statewide training, etc.

Reportable Incident Review
If an incident falls under the category of a serious reportable incident as defined by part 624 of the regulations, a provider must enter the incident into IRMA. These incidents are reviewed by OPWDD's Incident Management Unit (IMU) staff, resulting in appropriate follow-up. Incident information is aggregated and reviewed by DQI staff for trends.

If an incident results in the death of a participant, the IMU reviews the situation. The NYS Commission on

Quality of Care and Advocacy for Persons with Disabilities also reviews all deaths of participants in the waiver program.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare
The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
The number and percent of critical incident investigations that were initiated within the appropriate timeframes. (Percentage=critical incident investigations that were initiated within the appropriate timeframes/total critical incident investigations).

Data Source (Select one):
Other
If 'Other' is selected, specify:
IRMA

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
The number and percent of critical incident investigations that were completed within the appropriate timeframes.(Reporting to be implemented 7 months after the

regulation is effective). (Percentage=number of critical incident investigations that were completed within the appropriate timeframes/total number of critical incident investigations completed).

Data Source (Select one):
Other
If 'Other' is selected, specify:
IRMA

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: Semi-Annually

Performance Measure:
The number and percent of physical and sexual abuse allegations that were appropriately reported to law enforcement.(Percentage= number of physical and sexual abuse allegations that were appropriately reported to law enforcement/total number of physical and sexual abuse allegations).

Data Source (Select one):
Other
If 'Other' is selected, specify:
IRMA

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: Semi-Annually

Performance Measure:
The number and percent of restrictive physical interventions (take downs and floor holds) recorded in the Restrictive Intervention Application (RIA) (Percentage = number of restrictive physical interventions recorded in RIA/total incidents reported). Note: will provide initial baseline information that will help to target continuous quality improvements to reduce the use of physical interventions.

Data Source (Select one):
Other
If 'Other' is selected, specify:
RIA

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of individuals and advocates who were informed of the process to express concerns and objections. (Percentage= Number of individuals and advocates who were informed of the process to express concerns and objections/total number of case management records reviewed).

Data Source (Select one):
Other
If 'Other' is selected, specify:
DQI survey sample

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 90%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
The number and percent of critical incidents reported within the required

timeframes. (Percentage= number of critical incidents reported within appropriate timeframes/total incidents reported).

Data Source (Select one):
Other
If 'Other' is selected, specify:
Incident Reporting Management Application (IRMA)

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
The number and percent of critical incident investigations where there was evidence that the necessary protections of affected individuals were implemented when appropriate. (Percentage= number of critical incident investigations where there was evidence that the necessary protections of affected individuals were implemented when appropriate/total number of critical incident investigations).

Data Source (Select one):
Other
If 'Other' is selected, specify:
DQI Survey

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: Semi-Annually

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the

method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
The number and percent of incidents of restrictive interventions reported/all incidents reported in IRMA (percentage= number of restrictive interventions reported/total incidents reported).

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
The number and percent of incidents of seclusion reported/all incidents reported in IRMA (percentage= number of incidents of seclusion reported/total incidents reported).

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to

analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
The number and percent of service plans/life plans implemented as written based on verification of service delivery. (Percentage= Number of service plans/life plans implemented as written based upon verification of service delivery/total number of service plans/life plans reviewed).

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

OPWDD has a comprehensive process for identification and remediation of problems and deficiencies that impact on the individual's health and welfare. The process begins with OPWDD DQI survey activity. All HCBS waiver providers and all certified programs/sites are reviewed annually by DQI and are also reviewed prior to renewal of operating certificates (recertification survey visits). DQI's survey protocols are extensive and reflect a review of the major elements of regulations, provider responsibilities, and health and safety of individuals served. These protocols include a review of provider compliance with 14 NYCRR Part 624 which outlines OPWDD's extensive processes for addressing all incidents including reports of abuse, significant incidents and notable occurrences for all OPWDD operated, certified, sponsored or funded agencies, and 14 NYCRR Part 633 "Protections of Individuals Receiving Services" which sets forth standards for ensuring and promoting the protection of persons served. Surveyors utilize a variety of techniques to gather information including observation, interviews, documentation reviews, and facility and physical plant reviews.

In 2011, OPWDD enhanced oversight of Incident Management by establishing a centralized unit within DQI, the sole function of which is to follow up on incidents of abuse and neglect to ensure that appropriate actions are taken. Together with the Statewide Committee on Incident Reporting (SCIR), the Incident Management Unit analyzes data from these incidents for systemic remediation and systems improvement. SCIR is an interdivisional committee and also comprised of OPWDD stakeholders: SCIR is chaired by a senior manager within OPWDD and meets regularly to review statewide data and trends from incident reports and investigations. SCIR monitors statewide issues related to identification, reporting and management of incidents involving care and treatment of individuals served. SCIR also develops statewide policy and alerts to the field to address issues identified through trend analysis. At least semi-annually incident data is aggregated to determine the most frequent causes of incidents/allegations and if there are common contributing factors. Based on this analysis, SCIR issues alerts to provider agencies and targets training to risk areas. Centralized Investigations of abuse and neglect: In 2011, OPWDD overhauled the OPWDD Investigations function by creating a centralized Investigation Unit with a lead investigator and centralizing the function to ensure an independent, unbiased process for investigations of state provided services/facilities. In addition, all providers are now required to immediately report all incidents of physical and sexual abuse that are possible crime to law enforcement. New regulations were promulgated that require all investigations (across state and voluntary provided operations) to be conducted at arm’s length.

In addition, the following oversight enhancements were completed in 2012-13: establishment of consistent investigator training and competencies; standardization of investigations report formats and entry into the State Incident Management Reporting Application (IRMA); establishment and monitoring of appropriate timeframes for the initiation and completion of investigations; establishment of criteria and processes when OPWDD’s Centralized Investigation Unit closely monitor the investigations of voluntary providers Mortality Review. Effective in 2012, NYS OPWDD partnered with the University of Massachusetts Medical School’s Center for Developmental Disabilities Evaluation and Research Center to establish an enhanced mortality review system across New York State, consistent with current national practice standards in the field of developmental disabilities and mortality review. At the center of this system is regional Mortality review committees and one statewide Central Mortality Review Committee. As part of ongoing quality improvement, OPWDD and DOH created an inter-agency Central Mortality Review Committee. This committee was created to provide an expert review of potentially preventable deaths, identify systems’ issues that increase risk of mortality, and propose solutions to improve the quality of supports and services across the system.

MANDATORY REPORTING on the USE of SCIP-R RESTRICTIVE PERSONAL/ PHYSICIAL INTERVENTIONSA
new database and tracking system has been developed to collect information pertaining to the use of SCIP-R restrictive personal/physical interventions in state and voluntary operated programs. This system, the Restrictive Intervention Application (RIA), is modeled after the Incident Report and Management Application (IRMA) system currently in place for incident management. Collection of this information will assist OPWDD and voluntary providers in tracking and trending the use of SCIP-R restrictive personal/physical interventions on a statewide basis. Ultimately, the RIA data will be linked to the IRMA data and will allow agencies to monitor, track/trend and analyze the relationship between SCIP-R restrictive personal/physical interventions, resulting injuries, abuse allegations and the frequency of staff involvement. This initiative is part of OPWDD's QI strategy. The baseline data collected (see PM above) helped target areas for quality improvement to reduce the need for physical interventions. These target areas included: establishment of consistent investigator training and competencies; standardization of investigation report formats and entry into the State Incident Management

Reporting Application (IRMA); establishment and monitoring of appropriate timeframes for the initiation and completion of investigations; establishment of criteria and processes when OPWDD's Centralized Investigations Unit closely monitored the investigations of voluntary providers and when OPWDD's Investigators actually conducted the investigations of voluntary providers.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

At the end of each DQI survey described above, survey teams conduct exit interviews and inform the agency of findings and if any findings represent issues requiring immediate correction. This information is documented on Exit Conference Forms which highlight all deficiencies and are presented to an authorized representative of the agency for signature acknowledging their receipt of the Exit Form. The form requires that all deficiencies be addressed within 30 days. For deficiencies that result in a 45 day letter, DQI verifies correction in 45 days. For all other deficiencies, corrections are verified during the next visit.

A Statement of Deficiency (SOD) is issued to an agency and a Plan of Corrective Action (POCA) required from the agency for serious, systemic and/or pervasive or egregious issues/deficiencies identified during the survey process. For example, situations in which it is determined that conditions or practices exist which, if allowed to continue, have a high probability of causing harm if the threat is not removed will result in an SOD requiring the agency to submit an acceptable POCA to DQI within 10-20 days depending upon the nature of the deficiency.

A POCA must outline the provider's planned action to correct every specific regulatory deficiency, the expected completion date of the correction, and provider actions to ensure continued regulatory compliance in the future. DQI reviews all POCAs and conducts follow up activity to ensure the problems and deficiencies have been corrected. Failure of an agency to submit and implement an acceptable POCA could result in the decertification and/or cancellation of the HCBS Medicaid Provider Agreement.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

- (●) **No**
- ( ) **Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 3)

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 Improvement 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.

CMS recognizes that a state's waiver Quality Improvement 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 Improvement 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 Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement 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 Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement 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/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from

CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

OPWDD's waiver assurance quality framework, a subset of OPWDD's larger statewide comprehensive quality improvement strategy (QIS), ensures that OPWDD achieves its mission, vision, values, guiding principles and strategic goals and objectives (including the developmental disability transformational goals outlined in the State's Partnership Agreement and the transition to a managed care infrastructure). OPWDD's waiver purpose is reinforced by the various components of OPWDD's QIS, designed to ensure that the expectations of waiver participants and stakeholders are met, that services are of the highest quality, and that individuals served are healthy and safe. The foundation of OPWDD's QIS is built upon discovery through performance metrics, reporting to stakeholders, and systems wide analysis and collaboration that leads to effective remediation strategies, quality of care enhancements, and ultimately mission-driven progress.

In 2011-12 OPWDD began enhancements to its Continuous Quality Improvement Infrastructure and Processes (detailed in the Quality Work Plan submitted to CMS on January 20, 2012). In partnership with national consulting groups (e.g. Optumas, University of Massachusetts, Council on Quality Leadership), OPWDD has continued to develop a quality improvement infrastructure that permeates through leadership, management, and Regional Office staff from all functional divisions/units and across stakeholder work groups. This construct establishes a series of committees (ongoing and ad hoc) that interface and create a framework to develop, monitor and revise quality improvement initiatives throughout the developmental disability service system in New York State.

OPWDD's Quality Improvement infrastructure includes: advisory committees and OPWDD leadership committees is charged with providing vision and strategic direction for transformation and quality improvement that results in system reform and continuous quality improvement across the OPWDD enterprise; and ad hoc quality committees that are formed for a specific purpose and are usually time limited. Examples of OPWDD's quality improvement advisory committee structure includes the New York State Developmental Disabilities Advisory Council (DDAC) (see: www.opwdd.ny.gov/opwdd_services_supports/people_first_waiver/history) and the Joint Advisory Council (JAC) for Managed Care (see: www.opwdd.ny.gov/opwdd_services_supports/people_first_waiver/opwdd-joint-advisory-council-managed-care).

In 2013, OPWDD established a more robust review of incidents and mortality through its Mortality Review Steering Committee and mortality regional committees and through the formation of a Statewide Committee on Incident Review (SCR). In addition to this existing committee structure, OPWDD has also sought recommendation from ad hoc committees and expert panelists, Recent examples include the Commissioner's Transformation Panel, see: http://www.opwdd.ny.gov/opwdd_about/commissioners_page/transformation-panel and the HCBS Setting Stakeholder Steering Committee and its subcommittees related to heightened scrutiny and non-residential settings.

OPWDD's stakeholder Transformation Panel teams and other stakeholder workgroups are designed to guide the system, identify critical areas for improvement, coordinate new and ongoing efforts, and develop strategies to make sure that the system is person-centered and sustainable. They focus on: preparing the system to transition to managed care; achieving transformation goals; and continuing to work with the provider community to find efficiencies and foster innovation.

The Enterprise Policy and Performance Measures Committee: OPWDD's key organizational divisions are engaged in trending, prioritizing and implementing systems improvements and transformation reforms. The Bureau of Strategic Planning and Performance Measures ensures that OPWDD has meaningful performance measures that result in accountability and continuous quality improvement throughout the enterprise; and spearheads OPWDD's involvement, implementation, and analysis of the National Core Indicators (NCI) used for quality improvement at the OPWDD systems level and is involved with the evaluation and accountability of OPWDD's transformation initiatives as outlined in the OPWDD Evaluation Plan and the OPWDD Accountability Plan incorporates components of the OPWDD Quality Strategy which was submitted to CMS in November 2013.

The Division of Person Centered Supports and Service Delivery have a responsibility for spearheading OPWDD's transformation initiatives related to: competitive employment; self-direction; expanding community integrated housing options, Money Follows the Person (MFP) and deinstitutionalization; development of the specialized managed care plans; and for developing continuous quality improvement strategies.

The Division of Quality Improvement (DQI) is responsible for monitoring regulatory compliance and certifying all community programs (both State operated and not-for-profit community residential, day, clinic, and free-standing respite programs), and review of HCBS Waiver and care management services. DQI compromised of: Bureau of Program Certification (BPC), Incident Management Unit (IMU), Bureau of Continuous Quality Improvement (CQI): BPC is responsible for review and certification of OPWDD's programs and services while IMU provides real-time oversight of the critical function of incident management statewide reviews incidents to ensure appropriate protective measures are taken and that required notifications to entities are completed as appropriate (i.e. law enforcement); provides feedback to providers if there are concerns related to the comprehensiveness and adequacy of corrective actions; works in conjunction with the New York State Justice Center for the Protection of People with Special Needs, OPWDD's Office of Investigations and Internal Affairs and the OPWDD Office of Employee Relations, as well as the OPWDD Statewide Committee on Incident Review and Local Incident Review Committees, to ensure a strong coordinated approach is taken in response to any incident of abuse/neglect or other serious incidents that may occur within voluntary and state-operated service providers; responsible for managing the Incident Report and Management Application (IRMA) and reviewing and analyzing the data to identify significant trends to ensure they are responded to appropriately to improve the quality of services to individuals served. IMU staff are available 24 hours per day seven days per week to consult with providers, to ensure that timely and appropriate safeguards are in place for individuals served and provide other DQI staff with pertinent information for monitoring and evaluation. They alert BPC staff of significant untoward events for immediate follow up, as needed and develop appropriate and standardized trend analysis reports for the OPWDD Commissioner and Leadership Teams review, as well as specific trend reports that will be required to be completed on an annual basis by all providers of service in accordance with Part 624 regulations.

CQI develops and implements projects critical to OPWDD's core mission as well as internal to DQI, which includes: developing, designing, and improving protocols and survey processes used by the Bureau of Program Certification in their on-site survey work; analyzing data and reporting on performance measures from these surveys; and recommending improvements resulting from the analysis. CQI designs and implements periodic provider training and works with other units/divisions within OPWDD in developing QI strategy. Data is aggregated and reported to OPWDD Leadership and is used to complete the annual waiver reports to the Centers for Medicare and Medicaid (CMS). CQI also oversees, coordinates and/or project manages a number of committees devoted to recommending quality priorities.

The Office of Audit Services (OAS) and Data Management and Performance Metrics staff also conduct provider oversight. OAS has responsibility for auditing provider agencies that operate under OPWDD's auspices and coordinates audit activities with The New York State Office of the Medicaid Inspector General (NYS OMIG). OAS, through its Bureau of Compliance Management, conducts billing and claiming audits of waiver services at provider agencies, per the requirements of recent amendments to OPWDD Waiver agreements with CMS. OAS coordinates the recoupment of Medicaid monies through the NYS OMIG.

Data Management and Performance Metrics carries out periodic post-payment reviews to identify overlapping or inappropriate HCBS waiver claims. Inappropriate claims are either voided or adjusted or the provider is required to repay the claim. The data is aggregated and reported on a monthly basis to the NYS OMIG.

OPWDD's committee and organizational framework is intended to evolve and change as quality improvement projects commence and are completed and new quality improvement priorities are initiated. These committees and/or relationships are useful in describing how continuous quality improvement is being designed, developed, implemented and evaluated with OPWDD's enterprise. OPWDD's Commissioner advised by the committees and organizational units described, and in conjunction with the Single State Medicaid Agency (DOH) and the Governor's Office, makes final decisions on the prioritization of systems improvement initiatives.

New York State Legislation enacted in 2013 provided a Joint Advisory Council (JAC) for Managed Care chaired by the OPWDD Commissioner. The DOH Commissioner is charged with advising both commissioners in regards to the oversight of the Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities (FIDA-IDD). This 12-member council includes individuals with developmental disabilities, their families and advocates, and service providers. Three members of the JAC will also be members of the special advisory review panel on Medicaid managed care. The charge of the JAC is to review all managed care options provided to individuals with developmental disabilities, including the adequacy of habilitation services, the record of compliance with person-centered planning, person-centered services and community integration, the adequacy

of rates paid to providers and the quality of life, health, safety and community integration for individuals with developmental disabilities enrolled in managed care. JAC findings and recommendations will be reported to the OPWDD Commissioner, the DOH Commissioner and New York State Legislative Leaders.

As the Single State Medicaid Agency, DOH's primary focus is to ensure that OPWDD's systemic operation of the HCBS waiver adheres to six waiver assurances. DOH's primary oversight activities take place in the following areas: Multifaceted Individualized Service Plan (ISP)/Life Plan (LP) reviews; Critical Significant Events (CSE) monitoring and participation in the monthly Central Mortality Review Committee; OPWDD's surveillance of waiver providers, including participation in the monthly OPWDD Early Alert Committee; Medicaid enrollment of qualified providers; participation in the OPWDD Joint Advisory Council Meeting; quarterly interagency (DOH and OPWDD) standing quality meetings and timely and accurate CMS 372 Reporting. The DOH Waiver Management Unit (WMU) continuously strives to enhance communication and collaboration with OPWDD, along with other divisions and units in DOH involved in waiver oversight activities described in Appendix A.2.b.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Quality Improvement Committee**	☒ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

The evaluation of systems design changes resulting from OPWDD's quality management and quality improvement activities is achieved through the committee processes described above. Ultimately, the OPWDD Leadership Team is the entity that prioritizes all agency-wide system improvement activities and is responsible for the effectiveness of strategic implementation. The OPWDD Leadership Team is advised by the Commissioner's DD Advisory Council established by NYS Mental Hygiene Law (13.05) and comprised of self-advocates, family members, provider representatives, and other stakeholders, and a broad array of other internal and external stakeholders that represent various constituencies including the following:
•OPWDD Provider Associations;
•The Self-Advocacy Association of New York State;
•The Statewide Committee for Family Support Services; and
•Tribal entities.

OPWDD engages in consistent and regular communications with these stakeholders on strategic priorities and systems improvement activities. These stakeholders, through various mechanisms, have a major role in providing input and recommendations to OPWDD. Stakeholders also play a major role in evaluating systems improvement actions. OPWDD collaborates with the Department of Health (DOH) (the Single State Medicaid Agency) to share quality improvement findings and best practices.

The DOH oversight of the OPWDD QIS consists of the following:

1. Annual review of Individual Service Plans (ISPs)/Life Plans : a) As a part of DOH oversight, a statistically valid sample of OPWDD ISPs/Life Plans are selected. All services and providers are represented in the sampling. This sample is provided to OPWDD to conduct the routine Person-Centered Reviews and report the findings, trends and deficiencies to DOH. Any deficiencies are discussed and documentation of remediation is provided to DOH. An Inter-rater reliability review (IRR) validation process described in Appendix D-4) is then conducted by DOH selecting a smaller sample from the larger on provided to OPWDD. DOH conducts an independent review using the OPWDD Person-Centered Review tool used by the OPWDD surveyors for their annual Person-Centered Review. When DOH discovers discrepancies or variances from the OPWDD DQI surveyors' results, DOH works with OPWDD to validate findings, to discuss identified discrepancies and to determine any necessary remediation. When needed, both agencies meet to perform the review together. OPWDD performs any agreed upon remediation to the identified cases. DOH follows up to ensure that the identified individual or systemic deficiencies are corrected. DOH and OPWDD continually work together to improve the IRR validation process. b) DOH completes a fiscal review of a subset of the statistically valid DOH sample of ISPs/Life Plans to assure that services documented in the ISP/Life Plan match the corresponding Medicaid Claims Detail Report (CDR) found in NYS Data Mart and that the ISP/Life Plan documentation is complete and accurate. DOH identifies individual and systemic deficiencies and works closely with OPWDD to monitor and evaluate remediation.
2. Critical and Significant Event (CSE) notification by OPWDD: a) DOH monitors OPWDD adherence to the interagency CSE Notification Policy and works closely with OPWDD to clarify policy and procedural issues with the goal of improved reporting; b) DOH and OPWDD confer frequently about CSE reporting practices and identified trends; c) DOH continuously monitors and trends reported CSEs; d) Monthly, DOH meets internally to review new CSEs and monitor monthly trends; DOH then shares this information with OPWDD for review and additional discussion as warranted; e)Annually and as needed, DOH and OPWDD Incident Management Unit (IMU) meet to discuss specific IMU policies, procedures and regulation changes that impact the IMU process; f) Annually, DOH selects a subsample of incidents (CSEs) for more in depth review and discussion with OPWDD IMU in order to verify that these CSEs have been appropriately resolved and closed and g) DOH and OPWDD IMU share data regarding the close out of all reported CSEs for the previous year.
3. Stakeholder communication: DOH assists OPWDD consumers, families and providers as requested. When applicable, DOH shares stakeholders' issues with OPWDD and the two agencies work together to address and resolve problems.
4. Standing Interagency Quarterly Meeting: DOH and OPWDD meet quarterly to review the overall waiver quality assurance program and use a standing quality assurance agenda to ensure consistency. Agenda items include: a) Status of ongoing quality assurance systemic remediation activities; b) Regulatory changes; c) Policy clarifications; d) Proposed activities; e) New quality assurance initiatives. The goal of the standing interagency meeting is to enhance interagency communication, collaboration and evaluation of waiver quality monitoring and quality improvement activities.
5. Medicaid Enrollment of OPWDD Waiver Providers: a) DOH ensures that OPWDD approved waiver service providers meet and maintain the standards for continued Medicaid enrollment and reimbursement; b) New waiver

service provider rosters are shared with DOH by OPWDD; c) DOH and OPWDD work together to dis-enroll waiver providers from Medicaid when required.
6. Oversight of OPWDD's surveillance of waiver service providers: a) DOH reviews the OPWDD DQI monthly report/Monthly Surveys with Deficiencies Report and when required, confers with OPWDD for clarification and updates; b) DOH participates in the monthly OPWDD DQI Early Alert meeting and monitors OPWDD's Early Alert process; c) DOH tracks the status of waiver service providers on the Early Alert list and updates DOH leadership as warranted.
7. Participation in OPWDD Waiver and Quality Assurance Statewide Trainings to assure that DOH's knowledge of OPWDD's policy and procedures remain current.
8. Policy liaison between affected DOH, OPWDD Medicaid systems and other affected state staffs and/or concerned parties to assure that Medicaid Evolution Projects and other systems activities that pertain to the Special Population Waivers are appropriate and if germane, that they are completed and running properly. a) Track Evolution Projects that are relevant to the effective, efficient and cost saving management of the OPWDD HCBS Waiver Program.
9. Track federal and state audits that pertain to OPWDD and in particular to the OPWDD HCBS Waiver to insure that these audits are resolved and followed up suitably in the best interest of all involved parties.
10. Monitor federal websites that present policy changes that often directly and tangentially affect the OPWDD HCBS Waiver Program.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

OPWDD's mission is to "help people with developmental disabilities live richer lives." OPWDD recognizes that this mission requires innovation and continuous quality management and improvement. This process must demonstrate accountability to the people we serve, to government entities that fund our services, to the taxpayers, and to other stakeholders.

Quality improvement and evaluation are not one time events. By definition, quality improvement is an ongoing effort to improve services and processes. As a result, OPWDD's HCBS quality improvement strategy is reevaluated at least annually based on the discovery, remediation and analysis activities described throughout this application. DQI, in collaboration with the Waiver Management Unit, the Quality Improvement Steering Committee and subcommittees and other appropriate units/divisions, is responsible to facilitate this reevaluation process. Recommended changes to the quality improvement strategy are reviewed by the OPWDD Leadership Team in consultation with appropriate stakeholders, and the Department of Health (DOH) (the Single State Medicaid Agency).

In January 2008, OPWDD adopted the National Core Indicators (NCI) to measure performance of NYS's developmental disability service delivery system and create strategies for system improvement. The NCI enhances OPWDD's quality improvement process by analyzing and sharing data on outcomes which are important to stakeholders, including people served and family members. The primary survey protocol used annually by OPWDD is the Consumer Survey, a standardized instrument designed to assess individual outcomes for people with developmental disabilities. The Consumer Survey measures constructs that define the quality of service delivery from the perspective of individuals with developmental disabilities and their families. Specifically, the Consumer Survey consists of indicators in the following domains: Home, Employment, Health and Safety, Choice, Community Participation, Relationships, Rights, and Individual Satisfaction.

After seven years of continuous data collection, NYS now has a data set of approximately 7,600 cases. OPWDD has been able to benchmark the agency's performance year to year and compare our outcomes with other states that have comparable service delivery systems. Outcomes are assessed on an annual basis and are shared with policy makers and the public through various reports.

Based upon specific outcomes from the data, OPWDD makes decisions that impact the service delivery system statewide. The NCI will continue to be an essential enterprise level set of performance measures in NYS and will help OPWDD assure quality in the HCBS Waiver.

DOH's continuous evaluation of effectiveness of the QIS process is as follows:

1. Continuous:
- Communication with OPWDD regarding any and all HCBS issues and concerns;
-Monitor reported OPWDD Critical Significant Events (CSE);
-Conduct DOH ISP/Life Plan Fiscal Reviews;
-Conduct DOH ISP/Life Plan IRR Reviews;
-Monitor OPWDD website and LISTSERVs;
-Track and monitor Federal and State Audits that pertain to OPWDD and in particular to the OPWDD HCBS Waiver;
- Track Evolution Projects that are relevant to the effective, efficient and cost saving management of the OPWDD HCBS Waiver Program.
- Monitor on an ongoing basis Federal websites that present policy changes that often directly and tangentially affect the OPWDD HCBS Waiver Program.
2. Monthly:
-Aggregate and analyze reported OPWDD CSE reports and conduct internal reviews of these reports for monitoring, tracking and trending;
-Maintain a DOH/OPWDD Communication Log for CSEs to ensure remediation timeliness and/or discuss strategies for improvement/new approaches.
-Participate in OPWDD Early Alert Committee meetings and review/analyze pertinent meeting data;
-Participate in OPWDD Central Mortality Review Committee meeting and review/analyze pertinent meeting data;
3. Quarterly: DOH and OPWDD meet to:
-Follow an agreed upon standing agenda to ensure all assurances are appropriately reviewed, tracked and data

sources are trended;
-Complete cross systems review; and
-Assure all outstanding remediation and QI issues are addressed and any new strategies are developed, along with a timeline for implementation.
4. Semi- annually: Receive and analyze aggregate reports from OPWDD about OPWDD DQI ISP/Life Plan Review of the DOH statistically valid sample.
5. Annually:
-Review all performance metrics;
-Identify issues/areas requiring systemic remediation;
-Identify needed systemic remediation with OPWDD;
-Establish methodology for evaluation of identified systemic remediation and create and implement timeline for systemic remediation when needed;
6. As Needed:
-Address reported Consumer identified issues;
Provide OPWDD with timely feed-back; and
Monitor all identified Consumer issues to ensure through resolution.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- ○ **No**
- ◉ **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ○ **HCBS CAHPS Survey :**
- ◉ **NCI Survey :**
- ○ **NCI AD Survey :**
- ○ **Other** *(Please provide a description of the survey tool used):*

Appendix I: Financial Accountability

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).*

HCBS Waiver services are provided directly by the State operating agency (OPWDD) through its regional offices or DDROs. HCBS Waiver services are also delivered by provider agencies, which are non-profit organizations. Non-profit organizations include not-for-profit corporations formed under New York State Law or authorized to do business in New York. All HCBS Waiver services are subject to independent financial audits.

Statewide audits of Medicaid funded programs are conducted by the office of the Office of the State Comptroller (OSC), the Office of the Attorney General (AG), the Department of Health, and the Office of the Medicaid Inspector General. In addition, the operating agency and local counties also conduct reviews and audits of Medicaid funded programs. Within 90-days following each calendar year the state will submit to CMS a report which identifies the oversight activities and associated results for the fiscal integrity activities / measures described in Appendix I that were performed and concluded within the calendar year.

Annual Cost Reporting and Auditing:

Cost reporting for both public (OPWDD) and non-profit HCBS waiver services will be subject to review. OPWDD HCBS waiver cost reporting will be made in a CMS agreed-upon format beginning with the State Fiscal Year ending March 31, 2014, and will be subject to independent examination. The OPWDD Cost Report will be submitted to CMS within 18 months after the close of the reporting period.

OPWDD will either contract with an auditing firm to perform audits, or perform their own audits of private provider cost reports for a representative sample of private providers on an annual basis; and complete these audits within 12-18 months of the date required or filing these cost reports. The state will contract with an independent auditing entity for the review of private provider (not-for-profit) HCBS cost reporting beginning on January 1, 2015 for private providers of services with fiscal years ending in calendar year 2013. Thereafter, OPWDD will implement audits of cost reports for all years that are the basis of rate development activities. The CFRs that are the basis of rate development are the 'base period CFR' described in Addendum A of this agreement. The sample used for these audits will cover all waiver services and a statistically valid sample of providers.

Delinquent Cost Reports for Non-State Providers

If a Non-State (NS) provider has not filed a complete and compliant annual Consolidated Fiscal Report (CFR) for any CFR reporting period ending between January 1, 2013 and January 1, 2015, the NS provider will be considered delinquent. The State shall give notice to delinquent providers that to avoid the loss of FFP effective April 1, 2016, a complete and compliant CFR must be submitted by October 1, 2015. The State will not claim Federal Financial Participation (FFP) for any Waiver Service provided by the delinquent NS provider after April 1, 2016.

For the CFR cost reporting periods of July 1, 2014 through June 30, 2015 and January 1, 2015 through December 31, 2015, NS providers are required to file an annual CFR to the State within 120 days (150 with a requested extension) following the end of the provider's fiscal reporting period. For CFR cost reporting periods beginning July 1, 2015 and thereafter, NS providers are required to file an annual CFR to the State by June 1st for providers reporting on the January 1st through December 31st period or December 1st for providers reporting on the July 1st through June 30th period. If a NS provider fails to file a complete and compliant CFR by the first day of the second month following the imposition of the 2% penalty, the State must provide timely notice to the delinquent provider that FFP will end on the first day of the eighth month following the imposition of the 2% penalty; and the State will not claim FFP for any Waiver service provided by the NS provider with a date of service after the first day of that eighth month. If the completed CFR is not submitted by either June 1st for providers reporting on the January 1st through December 31st period or December 1st for providers reporting on the July 1st through June 30th period, a 2% penalty will be imposed.

Billing and Claiming Reviews:

The MA Agency (Department of Health, DOH) conducts a sample of Individualized Service Plan/Life Plan reviews to validate that services listed in the ISP/Life Plan are reflected in the MA Claim Detail Report. Corrective action is taken as necessary. (See Appendix A: QIS A. ii- A.i.8)

The Operating Agency conducts Post Payment reviews of HCBS Waiver claim data, which are conducted by OPWDD's Division of Fiscal and Administrative Solutions (DFAS). In addition, OPWDD's Division of Service Delivery also conducts a corporate compliance function for OPWDD's HCBS Waiver services.

To ensure the integrity of provider claims for Medicaid payment of waiver services, the Office of the Medicaid Inspector

General (OMIG) conducts audits of waiver providers as part of the agency's fiscal audit plan. All waiver providers are subject to audits performed by the OMIG. Effective with services delivered on or after 4/1/13, OPWDD, working in conjunction with the OMIG, will adjust its audit strategy to subject all providers to audit, including state operations. Our selection strategy will ensure all waiver services including Consolidated Supports and Services receive coverage during the audit cycle.

Each year, OPWDD will establish an audit pool that includes all providers of waiver services, removing those that are scheduled for audit by the New York State Office of The Medicaid Inspector General (OMIG), or are held in abeyance due to a request by the New York State Attorney General's Medicaid Control Fraud Unit (MCFU). Remaining providers will be divided into Not-for-Profit New York City/Long Island, Not-for-Profit rest-of-state, and OPWDD state operations groupings. At least 30 Not-for-Profit providers will be selected from those pools using random, statistical selection; 15 from the New York City/Long Island and rest-of-state pool. After our random sample is drawn, additional audits will be added, if necessary, to ensure all waiver services for the audit period receive coverage.

OPWDD's audit approach will be modeled on that used by HHS-OIG, as described in the HHS-OIG audit report A-02-10-01027 and test coverage using a beneficiary-months approach. The audit scope will include all HCBS waiver services and will include no less than the two most recent calendar years of claims. The engagement letter will specify that NYS retains the right to extend the testing to older claim periods.

OPWDD will annually perform a statewide audit of state provided HCBS waiver services, using the HHS OIG Report A-02-10-01027 as our model. Our audit population will consist of all state provided HCBS waiver service billings for the most recent calendar year. Our sampling unit will be a beneficiary month; defined as all state provided HCBS waiver services provided to one individual for one month.

OPWDD will annually select a stratified, statistically valid, random sample of 100 beneficiary months from a population of approximately 100,000 beneficiary months. Using a 95% confidence interval, OPWDD determined the calculated precision of a sample size of 100 to be 17%. This result was based on a limited internal control study performed by the Office of Audit Services. To improve the calculated precision of 17%, OPWDD will select a stratified random sample. By stratifying the population, the variance in the population will decrease and therefore we expect the precision of the actual sample to improve. In addition, the stratification methodology will ensure all waiver services provided by the state are included in the random sample of 100 beneficiary months.

OPWDD currently contracts with the consulting firm, Karl Heiner Statistical Consulting (KHSC) to independently generate random samples; perform extrapolations of errors to the full population and provide expert technical advice. OPWDD provides the population of beneficiary months to the statistician who analyzes the population and develops an appropriate stratification from which to draw random samples.

Samples will be drawn by the statistician using the 'Random Sample' function in Mathematica. This function requires the strata sizes and strata sample sizes in order to generate random indices which are then applied to the population sampling frame. Mathematica reads the computer's clock and that time is used to select the "seed" used by the random sample function as the starting point for generating random numbers. The seed is documented for future re-performance if required.

A series of statistical tests are performed on the resulting sample to test for apparent randomness. If the sample does not pass the randomness tests, the process begins over. Randomness tests performed include Anderson-Darling, Cramer-von Mises, Distance-to- Boundary, Kolmogorov-Smirnov, KuipePerson χ^2, and Watson U^2.

The beneficiary months approach requires that for each agency selected, NYS identifies all waiver billings for the audit period. These billings are aggregated by individual/month to obtain the beneficiary-month. Any beneficiary-month with aggregated billing of under $100 will be removed from the pool. A random, statistically valid sample of beneficiary-months will be selected and all service documentation will be reviewed to support all waiver billing during the sample month. Any identified errors will be used to estimate total overpayments using statistical software. The revised audit plan will begin on 4/1/2014 and will initially review Calendar Year 2012 and 2013 claims. Individual audit results will be issued no later than 6 months after the close of field work, barring appeals or legal actions that might delay issuance. In conjunction with the OMIG audit results will be aggregated on a State Fiscal Year basis for performance measurement purposes.

Information regarding Financial Integrity Continues in Section QI-a.ii.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability Assurance:
The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered. *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
FAa1. # and % of deficiencies identified in the DOH ISP/Life Plan Fiscal Review that were remedied by OPWDD (note also Ai4). Any resulting recoveries will be completed by 9/30 of the year following the end of the waiver year, allowing for provider objection and due process if needed.(Numerator is the # of claims remedied and the denominator is the total # of deficient claims in DOH audit.)

Data Source *(Select one):*
Record reviews, off-site
If 'Other' is selected, specify:
DOH ISP/Life Plan Sample

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☐ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☒ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =*

		+/-5%
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☐ ***State Medicaid Agency***	☐ ***Weekly***
☒ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Performance Measure:
FAa2. # and % of claims that were denied payment because of the effectiveness of MA& HCBS individual eligibility edits & service or provider authorization edits if programmed in eMedNY.(Numerator is the # of claims denied payment, denominator is the total # of claims that should have failed the claim logic based on OPWDD's review of paid & non-

paid claims data.)

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
eMedNY

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☐ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☒ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☐ ***State Medicaid Agency***	☐ ***Weekly***
☒ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Performance Measure:
FAa3 The % and # of paid HCBS claims that are identified in post payment reviews involving res hab that are found to be submitted in error and are remedied. (Numerator is the # of remedied res hab claims & the denominator is the total # of conflicting res hab billings).

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
eMedNY

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☐ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☒ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and***	☐ ***Other***

	Ongoing	*Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☐ ***State Medicaid Agency***	☐ ***Weekly***
☒ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Performance Measure:
FAa4.The % and # of paid HCBS claims that are identified in post payment reviews involving weekend day hab that are found to be submitted in error and are remedied. (Numerator is the # of GDH paid claims w/ a weekend date of service remedied and the denominator is the total # of potentially conflicting GDH claims).

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
eMedNY

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*

☐ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☒ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☐ ***State Medicaid Agency***	☐ ***Weekly***
☒ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other***

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
	Specify:

Performance Measure:
FAa 5. The number and percent of HCBS waiver providers that are identified in OMIG audits for recovery and the error rates, and dollars recovered. Where the numerator is the number of providers with errors and the denominator is the total number of Waiver providers in the service system.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
OPWDD Recovery Database

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☐ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☒ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☒ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☐ ***State Medicaid Agency***	☐ ***Weekly***
☒ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☒ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Performance Measure:
FAa6 : The number and percent of HCBS waiver providers that were subject to Investigations that are complete, and the dollars recovered. Numerator is the number of HCBS waiver providers with completed investigations and the denominator is the total number of providers.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
OPWDD Recovery Database

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☐ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☒ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence*

		Interval =
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☐ ***State Medicaid Agency***	☐ ***Weekly***
☒ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Performance Measure:
FAa7: The number and percent of audits that are initiated annually in accordance with the approved audit plan described in Appendix I-1 of this waiver agreement (Numerator

is the number of audits from FAa5 & FAa6 initiated annually and the denominator is the annual commitment in Appendix I-1)

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
OPWDD/OMIG Audit Reports & Tracking Data

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☐ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☒ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☒ ***Other*** *Specify:* *OMIG*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☐ ***State Medicaid Agency***	☐ ***Weekly***
☒ ***Operating Agency***	☐ ***Monthly***

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of waiver claims paid using rates that follow the rate methodology in the approved waiver application (Percentage = percentage of claims paid using rates that follow the rate methodology in the approved waiver application/all waiver claims paid).

Data Source *(Select one):*
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☐ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☒ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample***

		Confidence Interval =
☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☒ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☐ ***State Medicaid Agency***	☐ ***Weekly***
☒ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

ii. *If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.*

OPWDD (Fiscal and Administrative Solutions-DFAS) has a calendar of post-payment reviews that are applied against HCBS Waiver claims, to identify overlapping or inappropriate claims. Inappropriate claims are either voided/adjusted or the provider is required to repay the claim. The data is aggregated and reported on a quarterly basis to the NYS Office of the Medicaid Inspector General (OMIG).

*********** *Continued from I-1 Fiscal Integrity*

The DOH employs methods to assure financial integrity and accountability through the support system of eMedNY, which is the New York statewide database for all NYS MA information. eMedNY allows for payment to the qualified MA provider who renders an approved MA service to an enrolled MA participant. In addition, the Data Mart is an internal DOH web tool that allows DOH staff to analyze data from eMedNY. The Data Mart may also be used to profile an individual's MA eligibility information, including verification of enrollment in the OPWDD HCBS Waiver, the date of enrollment, and, if appropriate, the date of termination from the Waiver. The Data Mart also provides information about the type(s) of waiver services billed for, including qualified provider, frequency and duration of these services.

Furthermore, as part of the MA agency oversight, the DOH Special Populations Group (SPG) reviews a statistically valid sample of OPWDD Individualized Service Plans (ISPs)/Life Plans annually to validate that claims are coded and paid in accordance with the reimbursement methodology specified in the waiver agreement and that waiver services billed match the type, amount, duration and frequency of these services as documented in the ISP/Life Plan.

The CMS Annual 372 Report demonstrates the cost neutrality of the HCBS waiver and contains detailed breakouts of waiver expenditures by category of service and for all services provided in a given year. It also documents the number of waiver recipients enrolled in each waiver service during the calendar review year. CMS 372 Report data is calculated by obtaining expenditure data generated by the DOH eMedNY system and is based on date of service for waiver recipients who are identified by program enrollment rosters maintained by the OPWDD.

Compilation of the CMS 372 begins with OPWDD, which prepares the fiscal portion of the report. Once completed, the report is forwarded to the DOH FMG as well as the SPG for review and approval. FMG compares data included in the CMS 372 report to actual MARS expenditure data for the period in question, and if necessary, follow-up with SPG and OPWDD to resolve any apparent discrepancies, or unusual trends. This review serves as a data check to verify that the fiscal data included in the CMS 372 is consistent with current expenditures. FMG uses the DOH Data Mart system to verify further that the recipient counts included in the 372 report are consistent with those counted on a "date-of-payment" methodology.
Again, when inconsistencies are identified, FMG works collaboratively with SPG and OPWDD to clarify and correct errors. Once FMG is satisfied that the CMS 372 Report data is accurate, the report is approved and returned to SPG for completion of the quality assurance portion of the report. SPG sends the completed CMS 372 Report to the Deputy Commissioner, NYS MA Director for final approval and when obtained, the CMS 372 report is forwarded to CMS.

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.*

For Performance Measure FAa1 remediation of claims means that Billing and Claiming problems discovered in OPWDD's post-payment desk reviews are handled through claim voids in eMedNY. Providers are issued letters listing the specific claims, reasons for the void and instructions for voiding the claims. Providers have an opportunity to dispute claim voids and submit documentation to prevent voids where appropriate. Claims not voided by providers in a given time frame are submitted to the Medicaid Agency for voiding/adjusting. Voids are reported to the OMIG quarterly.

The OMIG is responsible for on-site billing and claiming reviews for OPWDD's HCBS Waiver Providers.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
☐ ***State Medicaid Agency***	☐ ***Weekly***
☒ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☒ ***Quarterly***
☐ ***Other*** *Specify:*	☐ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

◉ ***No***

○ ***Yes***

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

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).*

The DOH establishes all payment rates for waiver services. These payment rates are subject to the approval of the New York State Division of the Budget (DOB).

The Rate Methodology for payment of HCBS Waiver services are described in Addendum A to this document. The public can access information regarding rates paid for waiver service on the DOH website at: https://www.health.ny.gov/health_care/medicaid/rates/mental_hygiene/ and the OPWDD website where the waiver application is published at: https://opwdd.ny.gov/opwdd_services_supports/people_first_waiver/HCBS_waiver_services.

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:*

There are two different billing flows, which are described below:

I. For services delivered by voluntary provider agencies, billings flow directly from the provider to New York State's MMIS (eMedNY).

II. All State Operated and OHCDS services billed prior to 5/1/2014 with service dates after 4/1/2014: OPWDD, through its Regional Offices and as an OHCDS, is also an HCBS Waiver provider. For OPWDD-delivered services, claims are submitted to the Medicaid Agency (New York State Department of Health - DOH) for payment of service. In addition, all claim specific information is forwarded, processed and adjudicated through the eMedNY. Any discrepancies between payment and adjudication are reconciled with the Medicaid Agency.
For all waiver services with a service date of 4/1/2014 or thereafter; the state (OPWDD) will process and adjudicate all claims for services, provided by public provides, claims for services provided by its OHCDS, and for any services provided by private providers, through the states MMIS prior to any claiming for Federal Financial Participation. Only valid adjudicated paid claims will be claimed on the quarterly expenditure CMS-64 reports. The claiming process for April and May 2014 services is described in I-3.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

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

- (●) ***No. state or local government agencies do not certify expenditures for waiver services.***
- ( ) ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government 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).(Indicate source of revenue for CPEs in Item I-4-a.)

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government 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). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

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:*

a) Claims for all HCBS waiver services are adjudicated by eMedNY. The eMedNY system identifies HCBS enrollees with codes that identify the person as HCBS-enrolled and the effective date of the enrollment. Payment system edits require the client record to indicate active Medicaid eligibility and HCBS Waiver enrollment for all dates of service billed. Any HCBS Waiver claim submitted to eMedNY is denied if the individual is not actively enrolled in Medicaid and the HCBS Waiver for the date of service billed.

b) Providers and subcontractors are required to certify that all billings are true and accurate and that services being billed are authorized in the Individualized Service Plan and, where applicable, are supported by a Habilitation Plan. Furthermore, the OPWDD issues Administrative Memoranda (ADMs) for waiver services that identify all elements required for billing Medicaid and provides recommended service documentation formats to ensure appropriate documentation of service. ADMs are available on the OPWDD website. The identification of Waiver services in the recipient's plan is subject to semi-annual review by the case manager. Identification of HCBS services in the person's plan is also the subject of several reviews that are described in New York State's Quality Improvement Strategy for this waiver and in section I-1.

c) OPWDD's Office of Audit Services is responsible for auditing waiver services on a sample basis to ensure that providers are appropriately documenting service provision. OPWDD's Division of Service Delivery performs a corporate compliance function that reviews service documentation of the OPWDD's Waiver claims on a sample basis. Claims not substantiated are subject to recovery. Additionally, the OMIG audits waiver providers as part of the OMIG's fiscal audit plan.

d) As part of the oversight of the SMA agency, the DOH WMU reviews a statistically valid sample of OPWDD Individualized Service Plans (ISPs)/Life Plans annually, (as described in Appendix D.1.g 7/8, #3) to validate that Medicaid claims are coded appropriately and paid in accordance with the reimbursement methodology specified in the Waiver agreement, as well as OPWDD policy and acceptable Medicaid practices. As part of this process, ISPs/Life Plans are thoroughly reviewed to assure that services billed via the Claim Detail Report (CDR) match the scope, amount, frequency and duration of services documented in the ISP/Life Plan. Claims not substantiated in the ISPs/Life Plans are subject to inquiry and if found to be unauthorized, are subject to recovery.

NYS controls changes to the MMIS system through the use of "Evolution Projects". The term "Evolution Projects" (EP) is used to describe an established project management protocol that coordinates all changes to the MMIS billing and data production to ensure Medicaid eligible individuals are receiving the correct services and that Medicaid Providers bill Medicaid correctly. An EP is a "blue print" to assure that all waiver billing activities follow and meet standard requirements and necessary computer changes related to Medicaid billing occur across relevant systems.

Each EP is assigned a number for tracking purposes. All EPs are monitored by the Evolution Control Board (ECB) that is chaired by the State Medicaid Director. The ECB meets every other month to review projects design, testing, performance and implementation.

An Evolution Project is a management tool used to assure that appropriate edit logic is applied to each project component revision through successful completion. It is a dynamic, consistent systemic approach to support, guide and improve project performance, outcomes and Medicaid billing accuracy.

The focus is to define, refine and manage Medicaid billing system developments or change, increase accountability, timeliness and quality, conserve resources and eliminate error or project failure.

The purpose of EPs is to bring all projects partners/pieces together to:

- *review/analyze and assess federal and state legislation that may impact Medicaid recipients, programs and billing accuracy*
- *share information*
- *identify issues/make adjustments or corrections*
- *accommodate any changes*
- *assure deliverables*
- *monitor quality*

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 §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

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

○ ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***

◉ ***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:

For services delivered prior to 4/1/14, the following applies:
a) All payments for services are ultimately adjudicated through NYS MMIS (referred to as eMedNY. However, for services provided by the OPWDD or through its OHCDS, claims are first submitted to the Medicaid Agency (New York State Department of Health - DOH) for payment of service on the Standard State Agency Claim Form (DOH-4103). Any discrepancies between payment and adjudication are reconciled with the Medicaid Agency (see I-2b and I-2d).
b) The Medicaid Agency makes the payments to OPWDD. All paid claims are ultimately processed and adjudicated through the eMedNY. Any claims ultimately denied or which have payment adjusted will also be processed through eMedNY.
c) For all payments made outside eMedNY, service information is validated by staff and inputted into OPWDDs tracking and billing system (TABS). TABS includes all information necessary to generate a claim for payment (the individual, the HCBS Waiver service, date of service and all necessary Medicaid identifiers). Based on service recording information in TABS, a claim for payment is prepared and submitted to DOH. The same information is used to transmit service information to eMedNY for adjudication. The DOH claim is ultimately reconciled against eMedNY adjudication. All service recording information in TABS is subject to the fiscal audit program described in I-1. All claim data history is available in the eMedNY Data Warehouse for up to five years.
d) The basis for the draw of Federal funds is the service information which is entered into TABS and subject to fiscal audit. OPWDD completes a DOH-4103 for submission to DOH. All claim expenditures are subsequently reported by DOH on the CMS-64.
For all waiver services with a service date of 4/1/2014 or thereafter the following applies:
The State (OPWDD) will process and adjudicate all claims for services provided by public providers, claims for services provided by its OHCDS, and for any services provided by private providers, through the State's MMIS prior to any claiming for Federal Financial Participation. Only valid adjudicated paid claims will be claimed on the quarterly expenditure CMS-64 reports.
For the months of April and May 2014 only, the State may draw the federal financial participation amount for waiver service claims with dates of service in April and May 2014 based on information from their TABS system prior to being adjudicated through the States MMIS under the following conditions:
1. The draw amount for April 2014 and May 2014, will only include claims for services provided by public providers and OHCDS providers.
2. The computation of the dollar amount of the draw will be based on the revised waiver service rates which will be retroactive to April 1, 2013 using the reimbursement methodology changes in NY waiver amendment NY.0238.R04.06, and based on the units of service for April and May 2014.
3. Prior to the draw for April and May 2014, the State shall submit to the CMS Regional Office, in reasonable detail, the computation of the draw amounts for April and May. CMS will review the draw amounts for reasonableness and use of the revised rates.
4. The State within 60 days following each month end of April and May 2014, will submit all claims associated with the draw amounts for these two months through the States MMIS for claim adjudication. The State will not duplicate the draw of FFP for these claims when submitted through the MMIS.
5. The State (OPWDD) will by the 30th of each month following May 1, 2014, submit to the CMS Regional Office a reconciliation of the draw amounts, including the amount of the draw less adjudicated claims for April and May 2014, with supporting documentation of MMIS claims adjudication for actual payments with dates of service in the months of April and May 2014. The format of the reconciliation shall be approved by CMS.
6. If there is any remaining balance of drawn amounts of Federal Financial Participation less fully adjudicated claims processed and paid though the States MMIS for services in the months of April and May 2014 on September 30, 2014, that balance shall reduce the subsequent draw amount no later than November 1, 2014.
7. If the State does not comply with all of the above conditions, CMS will immediately recover any balance related to the drawn amounts for April and/or May 2014.

○ ***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:

○ ***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:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

☐ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☒ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☐ ***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:

☐ ***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.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

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:*

○ ***No. The state does not make supplemental or enhanced payments for waiver services.***

◉ ***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; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. 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.

Prior to the implementation of rate reform 7/1/14, waiver services include payments to pay health care enhancements allowing agencies to increase health care coverage and benefits for employees. We have been advised by CMS that effective with the 4/1/13 amendment to this waiver, such payments are considered supplemental payments. All enhanced or supplemental payments for private providers are included in the rates in the attached Addenda A.1-A.7.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

- ○ ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*
- ◉ ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

HCBS Waiver services are provided directly by OPWDD through its Regional Offices. There are also a small number of local governments and a public university which are authorized as waiver providers. The following services are furnished by these providers: Residential Habilitation, Day Habilitation, Prevocational Services, Supported Employment, Respite, Family Education and Training and Plan of Care Support Services. In addition, OPWDD is the provider of Environmental Modifications and Adaptive Technology services.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

- ○ ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ○ ***The amount paid to state or local government 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.***
- ◉ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government 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:

For state-provided HCBS waiver services with rate-based reimbursement, the cost of service provision is compare to the actual reimbursement as described below. When the Consolidated Fiscal Report (CFR) is completed, the State will calculate a final rate using the CFR applicable to the rate period for each waiver service using the rate methodology above. The same CFR lines which identify costs used to establish Interim Rates will be used to calculate the Final Rate; since the CFR used for the final rate will be the rate period CFR, trending or adjustments for differences in fringe benefits will not be used for the final rate.
The final average rate for each service will be multiplied by the adjudicated paid Medicaid service units for services provided in the rate period to determine the allowable Medicaid cost. The final allowable Medicaid cost for each service will be compared to all interim payments, plus any other payments received and expected to be received under this section. If total payments for all waiver service exceed the final allowable Medicaid costs for such rate period, the State will treat any overage as an overpayment to the federal share of which shall be refunded on the next calendar quarter CMS-64 expenditure report. If the total payments received and expected to be received under this section for all Waiver Services are less than allowable Medicaid costs for such rate period, the State shall be entitled to claim the federal share of such difference.

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

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:*

- (●) ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ( ) ***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.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

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

- (●) ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***
- ( ) ***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.

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

- ( ) ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.***
- (●) ***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:

a) OPWDD operates as an OHCDS [see 42 CFR 447.10]. OPWDD qualifies as an OHCDS because it also provides direct waiver services with its own employees. The following services are available through OHCDS:
Residential Habilitation, Supervised and Supportive IRA; Day Habilitation; Respite Services; Supported Employment; Pre Vocational Services; Community Habilitation

b) Under its OHCDS, OPWDD contracts with other providers to furnish HCBS waiver services. OPWDD only contracts with providers that are also HCBS Waiver providers outside the OHCDS. Qualified waiver providers may opt to provide waiver services directly or within the OHCDS.

Provider agencies that deliver services under this waiver are not required to contract with the designated OHCDS. Whether a non-profit organization contracts with the designated OHCDS or not, they are required to complete a waiver enrollment application which must be reviewed by OPWDD and ultimately approved by the single state Medicaid agency (New York State Department of Health).

c) Waiver participants may choose to receive waiver services through an OHCDS or directly from a qualified provider (see B-7a, regarding freedom of choice).

d) As previously noted, providers must go through the process of becoming an HCBS Waiver provider prior to delivering waiver services via the OHCDS contract. Because subcontractors under OPWDD's OHCDS are also separately qualified as HCBS waiver providers, these subcontractors are subject to OPWDD and DOH reviews and quality measures regarding qualified providers (see Appendix c-2). Providers that contract with the OHCDS are required to maintain service documentation that captures all required documentation elements.

e) OHCDS contracts between OPWDD and subcontracting entities are subject to New York State contracting requirements, and are reviewed and approved by the New York State Office of the Comptroller prior to payment to the subcontractor and Medicaid claiming. These OHCDS services are subject to audit by the Office of the State Comptroller, in addition to the Medicaid audit activities of OPWDD, DOH, and the OMIG. Contracts that OPWDD has with contractors under the OHCDS define the OHCDS as being in accordance with applicable federal rules at 42 C.F.R. 434 and 45 CFR.

f) In order to ensure the financial accountability of OHCDS payments, OPWDD has developed an electronic system for service reporting that interfaces with contract information and service authorization information. Effective with services delivered on or after 4/1/13, the rate methodology for OHCDS services will be one statewide rate, and adjustments to the rate will be made based on final audit findings or review, and subject to the methodology described in Addendum A.

SERVICE REPORTING
For each type of waiver service included in an OHCDS contract, OPWDD establishes a unique program in its Tracking and Billing System (TABS). This TABS program identifies the subcontractor agency, the type of waiver service, the open (or close) date of the program, the eMedNY identifier used for claiming, and the contract identifier (used for registering contracts with Office of the State Comptroller). People whom the Regional Office authorizes to receive a particular OHCDS service, are then "added" to the TABS Program by Regional Office staff.

PAYMENT TO THE SUBCONTRACTOR
The contract payment amount the subcontractor is paid for each unit of the OHCDS service provided is maintained in TABS by Central Office staff. The amount the sub-contractor is paid is established using a budget methodology which is initially compared to the subcontractor's historical cost data, comparative costs of similar services in the region, and the level of need of the person being served. The contract, including the contract payment amount, is reviewed and approved by Office of the State Comptroller and the New York State Attorney General prior to the contract payment amount being input into TABS.

After verifying service delivery, the subcontractor agency inputs OHCDS service information directly into a web-based application that interfaces with TABS (i.e., subcontractor inputs the units of a particular service that are provided to a particular person, on a given date, under the identified contract). A subcontractor is

only able to enter services in the web-based application if the Regional Office has authorized the service for a particular person, and the person has been added to the TABS program by the Regional Office. Based on the subcontractor service information and the contract payment information in TABS, an electronic file is created and transmitted to the New York State Office of the State Comptroller, which then issues payment to the subcontractor. Payment is made with 100% state funds.

MEDICAID PAYMENT PROCESSING
On a regularly scheduled basis the services provided by the OHCDS subcontractor are billed by OPWDD for Medicaid payment through eMedNY. In order to simplify and streamline Medicaid claiming, the amount claimed to Medicaid for OHCDS services utilizes an Agency Statewide prospective rate setting methodology that is established using the same components as are used when establishing provider-specific rates (see I-2). In developing the OHCDS prospective rate setting methodology, historical reimbursement and OHCDS proposals/budgets for all non-profit providers were analyzed. The resulting methodology uses averages derived from the analysis as the basis for the Medicaid rate. The methodology's use of averaging historical reimbursement and OHCDS proposals/budgets results in an overall equity in the Medicaid reimbursement. Effective with the 4/1/13 amendment the methdology for reimbursement of OHCDS services is described in Addendum A.

Payment processing of OHCDS services follows the same procedure as is used for HCBS Waiver services delivered by OPWDD staff (see I-3 a). OPWDD submits a claim form (Form 4103) to DOH for payment by service type. At the same time, OPWDD forwards a billing file to eMedNY for adjudication. The DOH claim is ultimately reconciled against eMedNY adjudication.

All OHCDS service recording information in TABS is subject to the fiscal audit program described in I-1. All claim data history is available in the eMedNY Data Warehouse for up to five years.

Beginning 4/1/2013, NYS has modified its OHCDS requirements to include the following activities:
1. The State shall identify provider cost in accordance with Generally Accepted Accounting Principles (GAAP).

2. The State shall annually report cost using a complete Consolidated Fiscal Report (CFR). The CFR annual cost report shall be audited by an Independent Certified Public Accountant (CPA), or the State may use the Compliance Review identified in the New York State Consolidated Fiscal Reporting and Claiming Manual as of April 1, 2013, in lieu of an audit; and the CPA shall render an opinion on the reported cost regarding reasonableness, compliance with GAAP, and that the CFR reported costs were determined in accordance with the cost principles described in the Medicare Provider Reimbursement Manual (HIM-15). Each Waiver service will be reported using a separate column of the CFR; in addition each waiver service provided by and OHCDS will also be reported using a separate column of the CFR.

3. Federal Financial Participation (FFP) will be based on the final reimbursable cost which will be limited to the lower of the actual amount paid to the Voluntary Providers, or the sum of each Voluntary Provider's OHCDS units multiplied by the Voluntary Provider's non-OHCDS waiver service rate for the applicable service.

iii. Contracts with MCOs, PIHPs or PAHPs.

○ ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***

◉ ***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 voluntarily elect to receive waiver 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.

The Fully Integrated Duals Advantage Plan (FIDA-IDD) is a voluntary, comprehensive Managed Care Plan that coordinated HCBS Waiver Services and a full array of Medicaid and Medicare services for individuals who select this option. The plan began operations in April 2016. There is one plan authorized under the State-Federal Medicaid-Medicare demonstration, Partners Health Plan (PHP). PHP operates in the seven county Downstate area made up of Long Island, New York City, Westchester and Rockland counties. All HCBS waiver services are available as part of the benefit package. PHP receives a monthly Medicaid capitation payment. The Medicaid capitation rate that is established by the NYS actuaries under contract with NYS Department Of Health and approved by CMS.

○ ***This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver 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.***

○ ***This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

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. Select at least one:*

☒ ***Appropriation of State Tax Revenues to the State Medicaid agency***

☒ ***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 state 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 state agencies as CPEs, as indicated in Item I-2-c:

For services delivered by provider agencies, the source of funds for the State share is tax revenues appropriated to OPWDD. When provider agencies bill eMedNY for payment, the Department of Health covers the non-federal share expenditures in the first instance. Throughout the state fiscal year, such expenditures are applied against OPWDD appropriations by the transfer of funds from OPWDD to DOH.

State tax revenues are the source of funds for the state share for HCBS Waiver services delivered by NYS Office of People With Developmental Disabilities (OPWDD) and providers contracted by OPWDD under its Organized Health Care Delivery System. The non-federal share is appropriated to the DOH and paid to OPWDD along with the federal share.

☐ ***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 state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government 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. Select One:*

○ ***Not Applicable****. There are no local government level sources of funds utilized as the non-federal share.*

◉ ***Applicable***

Check each that applies:

☒ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government 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 local government agencies as CPEs, as specified in Item I-2-c:

Local government cost sharing is a part of the financing of provider agency payments. IGTs from counties are part of the non-federal matching funds for provider agency payments made through the NYS Medicaid payment system. Payments are funded with 50% of federal funding and the balance funded through State funding or a combination of state and local funding.

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government 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 local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

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: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

◉ ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***

○ ***The following source(s) are used***

Check each that applies:

☐ ***Health care-related taxes or fees***

☐ ***Provider-related donations***

☐ ***Federal funds***

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

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

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

- ○ ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***
- ◉ ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

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:*

When budgeting total costs for operating certified residences, room and board costs are isolated and excluded from budgeted costs associated with service delivery. The budgeted costs associated with service delivery are used to determine the payment rate for the residential habilitation services.

Appendix I: Financial Accountability

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:*

- ○ ***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.***
- ◉ ***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.***

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:

OPWDD's Regional Office staff conduct a fair market appraisal for the monthly rent of the apartment to be leased by the service recipient, noting actual bedrooms vs. needed bedrooms and whether the lease is a related party transaction. The district office staff determines what if any, other benefits such as HUD subsidy, HEAP or food stamps the service recipient may be eligible to receive. These benefits are deducted from the household costs for rent, food and utilities prior to calculating costs associated with the live-in caregiver as follows:

The lesser of the actual rent or fair market rent is divided by the actual number of bedrooms to determine the portion of monthly rent associated with the live-in caregiver. Annual food and utility costs are estimated for the household, reviewed for reasonableness by district office staff, and divided by, the number of persons residing in the household times twelve months, to determine the amount associated with the live-in caregiver.

If the lease is a related party transaction, total payment for the portion of rent attributable to the live-in caregiver is further limited to the landlord's actual cost of ownership.

If the service recipient owns their own home and is making mortgage payments, the aforementioned process shall be used, substituting the annual interest paid on the mortgage in lieu of the rental amount. If there is no mortgage, reimbursement associated with the live-in caregiver will be limited to the pro rated share of utilities and food only.

Until 10/1/14, access to Live-in Caregiver services is restricted to individuals enrolled in the Consolidated Supports and Services self-direction program, who do not live in certified residences. Further, the person's CSS budget/plan must list the live-in caregiver as self-hired staff and describe the live-in caregiver's role.

The Fiscal Intermediary pays allowable Live-In Care Giver expenses as follows:
- *Payment of the total calculated monthly amount may be made directly to the service recipient each month.*
- *Payment of rent and utilities is made to the landlord or utility company*
- *Payment may not be made directly to the Live-In caregiver.*
- *The total service cost for Live-In Caregiver in and of itself does not include any administrative charges by a provider.*

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

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

- (●) ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ( ) ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- [ ] ***Nominal deductible***
- [ ] ***Coinsurance***
- [ ] ***Co-Payment***
- [ ] ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

- (●) ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***
- ( ) ***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; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

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

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: ICF/IID

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 (Col 7 less Column4)
1	68200.13	12180.00	80380.13	184618.00	7418.00	192036.00	111655.87
2	69760.02	12496.00	82256.02	199152.00	7611.00	206763.00	124506.98
3	69728.21	12876.00	82604.21	204235.00	7842.00	212077.00	129472.79
4	72771.50	13268.00	86039.50	219985.00	8081.00	228066.00	142026.50
5	73337.57	13671.00	87008.57	294136.00	8327.00	302463.00	215454.43

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

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 Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		ICF/IID	
Year 1	75483		75483
Year 2	79972		79972
Year 3	82203		82203
Year 4	84811		84811
Year 5	91000		91000

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

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-a.*

The average length of stay is calculated by applying the phase-in factor to all new unduplicated recipients. That amount is added to the unduplicated count of recipients at the beginning of each waiver year. That total is divided by the total unduplicated recipient count, and then multiplied by the annual days in the waiver year. This result is also adjusted by the termination factor to account for any recipient who leaves the waiver during each year.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

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 and methodology for these estimates is as follows:*

For Year 1 of the waiver (2014-15), Factor D was based on the historical data from the Medicaid Payment System. This established a base year level from which we applied the components of a 5 year agency comprehensive development plan.

The development plan lists the opportunities available to the existing waiver recipients as well as the new people who will be enrolled in the waiver. For each year, the new opportunities in each service were added to the base year level of unduplicated recipients. The new opportunities were phased in at 50%. This percentage was used for most services unless the service was expected to begin later in the waiver year. For example, a 25% phase was assumed as it relates to individuals transitioning from institutional programs to community-based HCBS Waiver services. A termination factor was also applied for people who will exit the waiver. These factors were compiled to determine the average units per user per service.

The average cost per unit was determined from historical payment data for 14/15 and trended forward by the appropriate trend factors based on the NYS fiscal plan. These trend factors are .2% for 2016/17, 2.5% for 2017/2018 and 2018/19. The total cost was determined by multiplying the number of users by the average units per user by the average cost per unit.

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:*

The estimate is based on Medicaid payment data for Year 1 (14/15) trended forward by the Medicaid trend factor that is also used in non-waiver rates. These consist of 2.6% to trend forward, then 3.04% (which is the five year average trend factor) for years 3 through 5.

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:*

The estimate is based on the actual ICF rates that were billed for Voluntary Operated ICFs and the reimbursement that will be billed for the State Operated ICFs/DCs (Year 1). Years 2 through 5 were adjusted based on the planned census decline in both Voluntary and State Operated ICFs as individuals transitioned into waiver services. This includes development in other non-residential waiver services particularly in Year 5.

Column 5 was determined using the 2013-14 revised DC rate and State Operated Community based ICF rates approved using SPA 12-03. Adjustments were made for each year of the Waiver to reflect the planned census decline in state-operated ICFs. Years 2 through 5 were trended forward. Year 2 was trended by a 2.6% to trend, then 3.04% (which is the five year average trend factor) for years 3 through 5.

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:*

The estimate is based on Medicaid payment data for Year 1 (14/15) trended forward by the Medicaid trend factor that is also used in non-waiver rates. These consist of 2.6% to trend forward, then 3.04% (which is the five year average trend factor) for years 3 through 5.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Day Habilitation	
Live-in Caregiver (42 CFR §441.303(f)(8))	
Prevocational Services	
Residential Habilitation	

Waiver Services	
Respite	
Supported Employment (SEMP)	
Community Transition Services	
Fiscal Intermediary (FI)	
Individual Directed Goods and Services	
Support Brokerage	
Assistive Technology - Adaptive Devices	
Community Habilitation	
Environmental Modifications (Home Accessibility)	
Family Education and Training	
Intensive Behavioral Services	
Pathway to Employment	
Plan of Care Support Services	
Vehicle Modifications	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:							**1248150578.27**
Day Habilitation - Individual (2014-2015 only) - Fee-For-Service (FFS)	☐	Hourly	378	269.31	41.26	**4200234.17**	
Day Habilitation - Individual (2014-2015 only) - Managed Care (MC)	☒	Hourly	0	269.31	41.26	**0.00**	
Day Habilitation - Group - FFS	☐	Daily	43102	183.51	157.27	**1243950344.11**	

GRAND TOTAL:	**5147950349.08**
Total: Services included in capitation:	0.00
Total: Services not included in capitation:	5147950349.08
Total Estimated Unduplicated Participants:	**75483**
Factor D (Divide total by number of participants):	**68200.13**
Services included in capitation:	0.00
Services not included in capitation:	68200.13
Average Length of Stay on the Waiver:	355

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation - Group - MC	☒	Daily	0	183.51	157.27	0.00	
Live-in Caregiver (42 CFR §441.303(f)(8)) Total:							412408.77
Live-in Caregiver - FFS	☐	Monthly	73	7.12	793.46	412408.77	
Live-in Caregiver - MC	☒	Monthly	0	7.12	793.46	0.00	
Prevocational Services Total:							133841577.67
Prevocational Services - Site Based - FFS	☐	Daily	9227	152.15	92.61	130014072.31	
Prevocational Services - Site Based - MC	☒	Daily	0	152.15	92.61	0.00	
Prevocational Services - Community Based - FFS	☐	Hourly	1237	132.57	23.34	3827505.36	
Prevocational Services - Community Based - MC	☒	Hourly	0	132.57	23.34	0.00	
Residential Habilitation Total:							3316455678.18
Certified Prog. Intensive Res. Hab. - FFS	☐	Daily	28444	344.09	324.34	3174411571.67	
Certified Prog. Intensive Res. Hab. - MC	☒	Daily	0	344.09	324.34	0.00	
Certified Prog. Supportive Res. Hab. - FFS	☐	Monthly	2409	10.93	3800.24	100061725.29	
Certified Prog. Supportive Res. Hab. - MC	☒	Monthly	0	10.93	3800.24	0.00	
Family Care - FFS	☐	Daily	1939	147.12	69.39	19794585.54	
Family Care - MC	☒	Daily	0	147.12	69.39	0.00	
Family Care -	☐					22187795.69	

GRAND TOTAL:	5147950349.08
Total: Services included in capitation:	0.00
Total: Services not included in capitation:	5147950349.08
Total Estimated Unduplicated Participants:	75483
Factor D (Divide total by number of participants):	68200.13
Services included in capitation:	0.00
Services not included in capitation:	68200.13
Average Length of Stay on the Waiver:	355

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
FFS - Monthly (10/1/14-6/30/15)		Monthly	1518	8.54	1711.53		
Family Care - MC - Monthly (10/1/14-6/30/15)	☒	Monthly	0	8.54	1711.53	0.00	
Respite Total:							111270738.41
Respite - Self-Directed - FFS	☐	Hourly	1165	123.25	19.83	2847315.34	
Respite - Self-Directed - MC	☒	Hourly	0	123.25	19.83	0.00	
Respite - Hourly - FFS	☐	Hourly	17025	276.65	23.02	108423423.08	
Respite - Hourly - MC	☒	Hourly	0	276.65	23.02	0.00	
Supported Employment (SEMP) Total:							48125268.24
SEMP - Hourly - FFS	☐	Hourly	7448	23.22	51.35	8880600.46	
SEMP - Hourly - MC	☒	Hourly	0	23.22	51.35	0.00	
SEMP - Self-Directed - FFS	☐	Hourly	469	164.97	26.26	2031760.62	
SEMP - Self-Directed - MC	☒	Hourly	0	164.97	26.26	0.00	
SEMP - Monthly - FFS	☐	Monthly	8437	7.75	569.12	37212907.16	
SEMP - Monthly - MC	☒	Monthly	0	7.75	569.12	0.00	
Community Transition Services Total:							51819.00
Community Transition Services - FFS	☐	$10 Units	23	225.30	10.00	51819.00	
Community Transition Services - MC	☒	$10 Units	0	225.30	10.00	0.00	
Fiscal Intermediary (FI) Total:							14049665.55
Fiscal Intermediary - FFS	☐	Unit (3 Levels)	3314	8.37	506.51	14049665.55	
Fiscal Intermediary -	☒	Unit (3 Levels)	0	8.37	506.51	0.00	

GRAND TOTAL:	5147950349.08
Total: Services included in capitation:	0.00
Total: Services not included in capitation:	5147950349.08
Total Estimated Unduplicated Participants:	75483
Factor D (Divide total by number of participants):	68200.13
Services included in capitation:	0.00
Services not included in capitation:	68200.13
Average Length of Stay on the Waiver:	355

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
MC							
Individual Directed Goods and Services Total:							**6167612.00**
Individual Goods and Services - FFS	☐	$10 Units	2420	254.86	10.00	**6167612.00**	
Individual Goods and Services - MC	☒	$10 Units	0	254.86	10.00	**0.00**	
Support Brokerage Total:							**2594847.42**
Support Brokerage - FFS	☐	Hourly	3267	21.04	37.75	**2594847.42**	
Support Brokerage - MC	☒	Hourly	0	21.04	37.75	**0.00**	
Assistive Technology - Adaptive Devices Total:							**144808.04**
Adaptive Technologies- FFS	☐	Other	52	1.00	2784.77	**144808.04**	
Adaptive Technologies- MC	☒	Other	0	1.00	0.01	**0.00**	
Community Habilitation Total:							**262781494.94**
Community Hab - Self-Direction - FFS	☐	Hourly	4609	626.10	24.36	**70295527.76**	
Community Hab - Self-Direction - MC	☒	Hourly	0	626.10	24.36	**0.00**	
Community Hab - Hourly - FFS	☐	Hourly	15218	336.13	37.63	**192485967.17**	
Community Hab - Hourly - MC	☒	Hourly	0	336.13	37.63	**0.00**	
Environmental Modifications (Home Accessibility) Total:							**476726.06**
Environmental Modifications - FFS	☐	Other	46	1.00	10363.61	**476726.06**	
Environmental Modifications	☒					**0.00**	

GRAND TOTAL:	**5147950349.08**
Total: Services included in capitation:	0.00
Total: Services not included in capitation:	5147950349.08
Total Estimated Unduplicated Participants:	**75483**
Factor D (Divide total by number of participants):	**68200.13**
Services included in capitation:	0.00
Services not included in capitation:	68200.13
Average Length of Stay on the Waiver:	355

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
- MC		Other	0	0.01	0.01		
Family Education and Training Total:							**104056.73**
Family Education and Training - FFS	☐	Other	1229	1.14	74.27	**104056.73**	
Intensive Behavioral Services Total:							**208336.12**
Intensive Behavioral Services - Plan Fee - FFS	☐	Other	68	1.00	1664.89	**113212.52**	
Intensive Behavioral Services - Plan Fee - MC	☒	Other	0	1.00	1664.89	**0.00**	
Intensive Behavioral Services - Service Hours - FFS	☐	Hourly	107	13.02	68.28	**95123.60**	
Intensive Behavioral Services - Service Hours - MC	☒	Hourly	0	13.02	68.28	**0.00**	
Pathway to Employment Total:							**1719944.13**
Pathway to Employment - FFS	☐	Hourly	659	68.18	38.28	**1719944.13**	
Pathway to Employment - MC	☒	Hourly	0	68.18	38.28	**0.00**	
Plan of Care Support Services Total:							**1394789.55**
Plan of Care Support Services - FFS (10/1/14-6/30/18 only)	☐	Semi-Annual	2722	2.11	242.85	**1394789.55**	
Vehicle Modifications Total:							**0.00**
Vehicle Modifications (Effective 8/1/2017) - FFS	☐	Other	0	0.01	0.01	**0.00**	

GRAND TOTAL:	**5147950349.08**
Total: Services included in capitation:	0.00
Total: Services not included in capitation:	5147950349.08
Total Estimated Unduplicated Participants:	**75483**
Factor D (Divide total by number of participants):	**68200.13**
Services included in capitation:	0.00
Services not included in capitation:	68200.13
Average Length of Stay on the Waiver:	355

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Vehicle Modifications - MC	☒	Other	0	0.01	0.01	0.00	

GRAND TOTAL:	5147950349.08
Total: Services included in capitation:	0.00
Total: Services not included in capitation:	5147950349.08
Total Estimated Unduplicated Participants:	75483
Factor D (Divide total by number of participants):	68200.13
Services included in capitation:	0.00
Services not included in capitation:	68200.13
Average Length of Stay on the Waiver:	355

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:							1289037863.50
Day Habilitation - Individual (2014-2015 only) - Fee-For-Service (FFS)	☐	Hourly	0	0.00	1.00	0.00	
Day Habilitation - Individual (2014-2015 only) - Managed Care (MC)	☒	Hourly	0	0.00	1.00	0.00	
Day Habilitation - Group - FFS	☐	Daily	45800	178.00	157.55	1284410620.00	
Day Habilitation - Group - MC	☒	Daily	165	178.00	157.55	4627243.50	
Live-in Caregiver (42 CFR §441.303(f)(8)) Total:							628800.48

GRAND TOTAL:	5578848013.03
Total: Services included in capitation:	20011521.63
Total: Services not included in capitation:	5558836491.41
Total Estimated Unduplicated Participants:	79972
Factor D (Divide total by number of participants):	69760.02
Services included in capitation:	250.23
Services not included in capitation:	69509.78
Average Length of Stay on the Waiver:	355

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Live-in Caregiver - FFS	☐	monthly	88	9.00	793.94	628800.48	
Live-in Caregiver - MC	☒	monthly	0	9.00	793.94	0.00	
Prevocational Services Total:							137765900.46
Prevocational Services - Site Based - FFS	☐	daily	9182	158.00	93.34	135413565.04	
Prevocational Services - Site Based - MC	☒	daily	36	158.00	93.34	530917.92	
Prevocational Services - Community Based - FFS	☐	hourly	2022	37.00	24.25	1814239.50	
Prevocational Services - Community Based - MC	☒	hourly	8	37.00	24.25	7178.00	
Residential Habilitation Total:							3585656417.44
Certified Prog. Intensive Res. Hab. - FFS	☐	day	29545	356.00	325.64	3425088032.80	
Certified Prog. Intensive Res. Hab. - MC	☒	daily	114	356.00	325.64	13215773.76	
Certified Prog. Supportive Res. Hab. - FFS	☐	monthly	2367	12.00	3873.96	110035959.84	
Certified Prog. Supportive Res. Hab. - MC	☒	monthly	9	12.00	3873.96	418387.68	
Family Care - FFS	☐	Daily	1945	272.00	69.46	36747118.40	
Family Care - MC	☒	Daily	8	272.00	69.46	151144.96	
Family Care - FFS - Monthly (10/1/14-6/30/15)	☐	Monthly	0	0.00	1.00	0.00	
Family Care - MC - Monthly (10/1/14-6/30/15)	☒	Monthly	0	0.00	1.00	0.00	

GRAND TOTAL:	5578848013.03
Total: Services included in capitation:	20011521.63
Total: Services not included in capitation:	5558836491.41
Total Estimated Unduplicated Participants:	79972
Factor D (Divide total by number of participants):	69760.02
Services included in capitation:	250.23
Services not included in capitation:	69509.78
Average Length of Stay on the Waiver:	355

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:							**133366206.43**
Respite - Self-Directed - FFS	☐	hourly	1411	666.25	19.95	**18754571.06**	
Respite - Self-Directed - MC	☒	Hourly	3	666.25	19.95	**39875.06**	
Respite - Hourly - FFS	☐	Hourly	17415	284.50	23.09	**114400963.58**	
Respite - Hourly - MC	☒	Hourly	26	284.50	23.09	**170796.73**	
Supported Employment (SEMP) Total:							**47029983.16**
SEMP - Hourly - FFS	☐	hourly	7555	85.75	52.05	**33720137.06**	
SEMP - Hourly - MC	☒	Hourly	34	85.75	52.05	**151751.78**	
SEMP - Self-Directed - FFS	☐	Hourly	527	939.00	26.34	**13034428.02**	
SEMP - Self-Directed - MC	☒	Hourly	5	939.00	26.34	**123666.30**	
SEMP - Monthly - FFS	☐	Monthly	0	0.01	0.01	**0.00**	
SEMP - Monthly - MC	☒	Monthly	0	0.00	0.01	**0.00**	
Community Transition Services Total:							**66920.00**
Community Transition Services - FFS	☐	$10 Units	28	239.00	10.00	**66920.00**	
Community Transition Services - MC	☒	$10 Units	0	239.00	10.00	**0.00**	
Fiscal Intermediary (FI) Total:							**18094200.00**
Fiscal Intermediary - FFS	☐	Unit (3 Levels)	3411	10.00	530.00	**18078300.00**	
Fiscal Intermediary - MC	☒	Unit (3 Levels)	3	10.00	530.00	**15900.00**	
Individual Directed Goods and Services Total:							**6166350.00**
Individual Goods and	☐	$10 Units	2892	213.00	10.00	**6159960.00**	

GRAND TOTAL:	**5578848013.03**
Total: Services included in capitation:	20011521.63
Total: Services not included in capitation:	5558836491.41
Total Estimated Unduplicated Participants:	**79972**
Factor D (Divide total by number of participants):	**69760.02**
Services included in capitation:	250.23
Services not included in capitation:	69509.78
Average Length of Stay on the Waiver:	355

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Services - FFS							
Individual Goods and Services - MC	☒	$10 Units	3	213.00	10.00	6390.00	
Support Brokerage Total:							2921095.00
Support Brokerage - FFS	☐	hourly	3865	20.00	37.75	2918075.00	
Support Brokerage - MC	☒	Hourly	4	20.00	37.75	3020.00	
Assistive Technology - Adaptive Devices Total:							556954.00
Adaptive Technologies-FFS	☐	unit	200	1.00	2784.77	556954.00	
Adaptive Technologies-MC	☒	unit	0	1.00	2784.77	0.00	
Community Habilitation Total:							316684708.40
Community Hab - Self-Direction - FFS	☐	hourly	4723	1141.00	24.40	131490209.20	
Community Hab - Self-Direction - MC	☒	Hourly	7	1141.00	24.40	194882.80	
Community Hab - Hourly - FFS	☐	Hourly	15431	318.00	37.63	184652592.54	
Community Hab - Hourly - MC	☒	Hourly	29	318.00	37.63	347023.86	
Environmental Modifications (Home Accessibility) Total:							34492500.00
Environmental Modifications - FFS	☐	unit	2628	1.00	13125.00	34492500.00	
Environmental Modifications - MC	☒	Other	0	1.00	0.01	0.00	
Family Education and Training Total:							94991.33
Family Education and Training -	☐	semi-annual	1279	1.00	74.27	94991.33	

GRAND TOTAL:	5578848013.03
Total: Services included in capitation:	20011521.63
Total: Services not included in capitation:	5558836491.41
Total Estimated Unduplicated Participants:	79972
Factor D (Divide total by number of participants):	69760.02
Services included in capitation:	250.23
Services not included in capitation:	69509.78
Average Length of Stay on the Waiver:	355

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
FFS							
Intensive Behavioral Services Total:							**550152.18**
Intensive Behavioral Services - Plan Fee - FFS	☐	other	60	1.10	1664.89	**109882.74**	
Intensive Behavioral Services - Plan Fee - MC	☒	Other	0	1.10	1664.89	**0.00**	
Intensive Behavioral Services - Service Hours - FFS	☐	Hourly	400	16.00	68.28	**436992.00**	
Intensive Behavioral Services - Service Hours - MC	☒	Hourly	3	16.00	68.28	**3277.44**	
Pathway to Employment Total:							**4042913.28**
Pathway to Employment - FFS	☐	hourly	941	112.00	38.32	**4038621.44**	
Pathway to Employment - MC	☒	Hourly	1	112.00	38.32	**4291.84**	
Plan of Care Support Services Total:							**1692057.38**
Plan of Care Support Services - FFS (10/1/14-6/30/18 only)	☐	Semi-Annual	2787	2.50	242.85	**1692057.38**	
Vehicle Modifications Total:							**0.00**
Vehicle Modifications (Effective 8/1/2017) - FFS	☐	Other	0	0.01	0.01	**0.00**	
Vehicle Modifications - MC	☒	Other	0	0.01	0.01	**0.00**	

GRAND TOTAL:	**5578848013.03**
Total: Services included in capitation:	20011521.63
Total: Services not included in capitation:	5558836491.41
Total Estimated Unduplicated Participants:	**79972**
Factor D (Divide total by number of participants):	**69760.02**
Services included in capitation:	250.23
Services not included in capitation:	69509.78
Average Length of Stay on the Waiver:	355

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:							1340332314.00
Day Habilitation - Individual (2014-2015 only) - Fee-For-Service (FFS)	☐	Hourly	0	0.00	1.00	0.00	
Day Habilitation - Individual (2014-2015 only) - Managed Care (MC)	☒	Hourly	0	0.00	1.00	0.00	
Day Habilitation - Group - FFS	☐	Daily	44883	184.00	158.65	1310206582.80	
Day Habilitation - Group - MC	☒	Daily	1032	184.00	158.65	30125731.20	
Live-in Caregiver (42 CFR §441.303(f)(8)) Total:							724205.07
Live-in Caregiver - FFS	☐	monthly	109	9.00	724.93	711156.33	
Live-in Caregiver - MC	☒	monthly	2	9.00	724.93	13048.74	
Prevocational Services Total:							121337200.31
Prevocational Services - Site Based - FFS	☐	daily	5881	153.50	99.95	90228213.32	
Prevocational Services - Site Based - MC	☒	daily	212	153.50	99.95	3252572.90	
Prevocational Services - Community Based - FFS	☐	hourly	2812	404.00	23.76	26992500.48	
Prevocational Services -	☒					863913.60	

GRAND TOTAL:	5731868088.15
Total: Services included in capitation:	122468410.32
Total: Services not included in capitation:	5609399677.84
Total Estimated Unduplicated Participants:	82203
Factor D (Divide total by number of participants):	69728.21
Services included in capitation:	1489.83
Services not included in capitation:	68238.38
Average Length of Stay on the Waiver:	355

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Based - MC		hourly	90	404.00	23.76		
Residential Habilitation Total:							**3618914708.73**
Certified Prog. Intensive Res. Hab. - FFS	☐	day	29783	341.00	333.79	**3389972241.37**	
Certified Prog. Intensive Res. Hab. - MC	☒	day	698	341.00	333.79	**79448028.22**	
Certified Prog. Supportive Res. Hab. - FFS	☐	monthly	2363	11.00	3602.62	**93642901.66**	
Certified Prog. Supportive Res. Hab. - MC	☒	monthly	54	11.00	3602.62	**2139956.28**	
Family Care - FFS	☐	Daily	1833	327.00	87.37	**52368791.67**	
Family Care - MC	☒	Daily	47	327.00	87.37	**1342789.53**	
Family Care - FFS - Monthly (10/1/14-6/30/15)	☐	Monthly	0	0.00	1.00	**0.00**	
Family Care - MC - Monthly (10/1/14-6/30/15)	☒	Monthly	0	0.00	1.00	**0.00**	
Respite Total:							**131176242.20**
Respite - Self-Directed - FFS	☐	hourly	2223	244.00	19.40	**10522792.80**	
Respite - Self-Directed - MC	☒	Hourly	4	244.00	19.40	**18934.40**	
Respite - Hourly - FFS	☐	Hourly	18150	285.00	23.13	**119645707.50**	
Respite - Hourly - MC	☒	Hourly	150	285.00	23.13	**988807.50**	
Supported Employment (SEMP) Total:							**57791305.50**
SEMP - Hourly - FFS	☐	hourly	9196	114.00	50.73	**53182491.12**	
SEMP - Hourly - MC	☒	Hourly	207	114.00	50.73	**1197126.54**	

GRAND TOTAL:	**5731868088.15**
Total: Services included in capitation:	122468410.32
Total: Services not included in capitation:	5609399677.84
Total Estimated Unduplicated Participants:	**82203**
Factor D (Divide total by number of participants):	**69728.21**
Services included in capitation:	1489.83
Services not included in capitation:	68238.38
Average Length of Stay on the Waiver:	355

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
SEMP - Self-Directed - FFS	☐	Hourly	589	191.00	29.92	3365970.08	
SEMP - Self-Directed - MC	☒	Hourly	8	191.00	29.92	45717.76	
SEMP - Monthly - FFS	☐	Monthly	0	0.00	0.01	0.00	
SEMP - Monthly - MC	☒	Monthly	0	0.00	0.01	0.00	
Community Transition Services Total:							151630.00
Community Transition Services - FFS	☐	unit	59	257.00	10.00	151630.00	
Community Transition Services - MC	☒	unit	0	257.00	10.00	0.00	
Fiscal Intermediary (FI) Total:							36581112.00
Fiscal Intermediary - FFS	☐	monthly	8292	9.00	489.00	36493092.00	
Fiscal Intermediary - MC	☒	monthly	20	9.00	489.00	88020.00	
Individual Directed Goods and Services Total:							17418000.00
Individual Goods and Services - FFS	☐	unit	5785	300.00	10.00	17355000.00	
Individual Goods and Services - MC	☒	unit	21	300.00	10.00	63000.00	
Support Brokerage Total:							8672355.72
Support Brokerage - FFS	☐	hourly	8164	27.50	38.51	8645880.10	
Support Brokerage - MC	☒	Hourly	25	27.50	38.51	26475.62	
Assistive Technology - Adaptive Devices Total:							671129.57
Adaptive Technologies-FFS	☐	unit	240	1.00	2784.77	668344.80	
Adaptive Technologies-	☒	unit				2784.77	

GRAND TOTAL:	5731868088.15
Total: Services included in capitation:	122468410.32
Total: Services not included in capitation:	5609399677.84
Total Estimated Unduplicated Participants:	82203
Factor D (Divide total by number of participants):	69728.21
Services included in capitation:	1489.83
Services not included in capitation:	68238.38
Average Length of Stay on the Waiver:	355

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
MC			1	1.00	2784.77		
Community Habilitation Total:							**383828262.27**
Community Hab - Self-Direction - FFS	☐	hourly	9573	642.50	25.77	**158502314.92**	
Community Hab - Self-Direction - MC	☒	Hourly	41	642.50	25.77	**678846.22**	
Community Hab - Hourly - FFS	☐	Hourly	17653	331.50	38.02	**222491880.39**	
Community Hab - Hourly - MC	☒	Hourly	171	331.50	38.02	**2155220.73**	
Environmental Modifications (Home Accessibility) Total:							**3976875.00**
Environmental Modifications - FFS	☐	unit	303	1.00	13125.00	**3976875.00**	
Environmental Modifications - MC	☒	unit	0	1.00	0.01	**0.00**	
Family Education and Training Total:							**115807.92**
Family Education and Training - FFS	☐	semi-annual	967	1.50	79.84	**115807.92**	
Intensive Behavioral Services Total:							**245249.07**
Intensive Behavioral Services - Plan Fee - FFS	☐	Other	87	1.00	1751.86	**152411.82**	
Intensive Behavioral Services - Plan Fee - MC	☒	Other	0	1.00	1751.86	**0.00**	
Intensive Behavioral Services - Service Hours - FFS	☐	Hourly	119	11.00	69.75	**91302.75**	
Intensive Behavioral	☒					**1534.50**	

GRAND TOTAL:	**5731868088.15**
Total: Services included in capitation:	122468410.32
Total: Services not included in capitation:	5609399677.84
Total Estimated Unduplicated Participants:	**82203**
Factor D (Divide total by number of participants):	**69728.21**
Services included in capitation:	1489.83
Services not included in capitation:	68238.38
Average Length of Stay on the Waiver:	355

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Services - Service Hours - MC		Hourly	2	11.00	69.75		
Pathway to Employment Total:							**6408425.40**
Pathway to Employment - FFS	☐	hourly	1608	85.00	46.77	**6392523.60**	
Pathway to Employment - MC	☒	Hourly	4	85.00	46.77	**15901.80**	
Plan of Care Support Services Total:							**1617265.84**
Plan of Care Support Services - FFS (10/1/14-6/30/18 only)	☐	Semi-Annual	2907	2.25	247.26	**1617265.84**	
Vehicle Modifications Total:							**1905999.55**
Vehicle Modifications (Effective 8/1/2017) - FFS	☐	Other	91	1.00	20945.05	**1905999.55**	
Vehicle Modifications - MC	☒	Other	0	1.00	20945.05	**0.00**	

GRAND TOTAL:	**5731868088.15**
Total: Services included in capitation:	122468410.32
Total: Services not included in capitation:	5609399677.84
Total Estimated Unduplicated Participants:	**82203**
Factor D (Divide total by number of participants):	**69728.21**
Services included in capitation:	1489.83
Services not included in capitation:	68238.38
Average Length of Stay on the Waiver:	355

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:							**1412936305.44**
Day Habilitation - Individual (2014-2015 only) - Fee-For-Service (FFS)	☐	Hourly	0	0.00	0.01	**0.00**	
Day Habilitation - Individual (2014-2015 only) - Managed Care (MC)	☒	Hourly	0	0.00	0.01	**0.00**	
Day Habilitation - Group - FFS	☐	Daily	45532	184.00	161.67	**1354453152.96**	
Day Habilitation - Group - MC	☒	Daily	1966	184.00	161.67	**58483152.48**	
Live-in Caregiver (42 CFR §441.303(f)(8)) Total:							**848661.60**
Live-in Caregiver - FFS	☐	monthly	117	9.50	744.44	**827445.06**	
Live-in Caregiver - MC	☒	monthly	3	9.50	744.44	**21216.54**	
Prevocational Services Total:							**115281569.21**
Prevocational Services - Site Based - FFS	☐	daily	4785	137.00	107.17	**70254757.65**	
Prevocational Services - Site Based - MC	☒	daily	389	137.00	107.17	**5711410.81**	
Prevocational Services - Community Based - FFS	☐	hourly	3411	421.00	25.07	**36001297.17**	
Prevocational Services - Community Based - MC	☒	hourly	314	421.00	25.07	**3314103.58**	
Residential Habilitation Total:							**3845366883.82**
Certified Prog. Intensive Res. Hab. - FFS	☐	day	29963	344.00	343.38	**3539311059.36**	
Certified Prog.	☒					**158638812.96**	

GRAND TOTAL:	**6171823314.16**
Total: Services included in capitation:	243830883.67
Total: Services not included in capitation:	5927992430.49
Total Estimated Unduplicated Participants:	**84811**
Factor D (Divide total by number of participants):	**72771.50**
Services included in capitation:	2874.99
Services not included in capitation:	69896.50
Average Length of Stay on the Waiver:	355

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Intensive Res. Hab. - MC		day	1343	344.00	343.38		
Certified Prog. Supportive Res. Hab. - FFS	☐	monthly	2325	11.00	3595.16	91946217.00	
Certified Prog. Supportive Res. Hab. - MC	☒	monthly	100	11.00	3595.16	3954676.00	
Family Care - FFS	☐	Daily	1690	330.00	87.85	48993945.00	
Family Care - MC	☒	Daily	87	330.00	87.85	2522173.50	
Family Care - FFS - Monthly (10/1/14-6/30/15)	☐	Monthly	0	0.00	0.01	0.00	
Family Care - MC - Monthly (10/1/14-6/30/15)	☒	Monthly	0	0.00	0.01	0.00	
Respite Total:							145053250.80
Respite - Self-Directed - FFS	☐	hourly	2469	320.00	20.06	15849004.80	
Respite - Self-Directed - MC	☒	Hourly	9	320.00	20.06	57772.80	
Respite - Hourly - FFS	☐	Hourly	18827	285.00	23.71	127220628.45	
Respite - Hourly - MC	☒	Hourly	285	285.00	23.71	1925844.75	
Supported Employment (SEMP) Total:							75538769.60
SEMP - Hourly - FFS	☐	monthly	9492	120.00	60.42	68820796.80	
SEMP - Hourly - MC	☒	Hourly	396	120.00	60.42	2871158.40	
SEMP - Self-Directed - FFS	☐	Hourly	545	195.50	35.20	3750472.00	
SEMP - Self-Directed - MC	☒	Hourly	14	195.50	35.20	96342.40	
SEMP - Monthly - FFS	☐	Monthly	0	0.01	0.01	0.00	
SEMP - Monthly - MC	☒	Monthly	0	0.01	0.01	0.00	

GRAND TOTAL:	6171823314.16
Total: Services included in capitation:	243830883.67
Total: Services not included in capitation:	5927992430.49
Total Estimated Unduplicated Participants:	84811
Factor D (Divide total by number of participants):	72771.50
Services included in capitation:	2874.99
Services not included in capitation:	69896.50
Average Length of Stay on the Waiver:	355

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Transition Services Total:							**98910.00**
Community Transition Services - FFS	☐	unit	42	235.50	10.00	**98910.00**	
Community Transition Services - MC	☒	unit	0	0.01	0.01	**0.00**	
Fiscal Intermediary (FI) Total:							**55976216.54**
Fiscal Intermediary - FFS	☐	monthly	11200	9.50	524.36	**55791904.00**	
Fiscal Intermediary - MC	☒	monthly	37	9.50	524.36	**184312.54**	
Individual Directed Goods and Services Total:							**27106090.00**
Individual Goods and Services - FFS	☐	unit	7906	341.00	10.00	**26959460.00**	
Individual Goods and Services - MC	☒	unit	43	341.00	10.00	**146630.00**	
Support Brokerage Total:							**11852280.72**
Support Brokerage - FFS	☐	hourly	11021	27.00	39.64	**11795555.88**	
Support Brokerage - MC	☒	Hourly	53	27.00	39.64	**56724.84**	
Assistive Technology - Adaptive Devices Total:							**718470.66**
Adaptive Technologies-FFS	☐	unit	255	1.00	2784.77	**710116.35**	
Adaptive Technologies-MC	☒	unit	3	1.00	2784.77	**8354.31**	
Community Habilitation Total:							**468163244.20**
Community Hab - Self-Direction - FFS	☐	hourly	11764	690.00	26.60	**215916456.00**	
Community Hab - Self-Direction -	☒	Hourly	77	690.00	26.60	**1413258.00**	

GRAND TOTAL:	**6171823314.16**
Total: Services included in capitation:	243830883.67
Total: Services not included in capitation:	5927992430.49
Total Estimated Unduplicated Participants:	**84811**
Factor D (Divide total by number of participants):	**72771.50**
Services included in capitation:	2874.99
Services not included in capitation:	69896.50
Average Length of Stay on the Waiver:	355

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
MC							
Community Hab - Hourly - FFS	☐	Hourly	18258	341.00	39.59	246486469.02	
Community Hab - Hourly - MC	☒	Hourly	322	341.00	39.59	4347061.18	
Environmental Modifications (Home Accessibility) Total:							3727500.00
Environmental Modifications - FFS	☐	unit	283	1.00	13125.00	3714375.00	
Environmental Modifications - MC	☒	unit	1	1.00	13125.00	13125.00	
Family Education and Training Total:							93147.16
Family Education and Training - FFS	☐	semi-annual	747	1.50	83.13	93147.16	
Intensive Behavioral Services Total:							279508.11
Intensive Behavioral Services - Plan Fee - FFS	☐	Other	93	1.00	1789.19	166394.67	
Intensive Behavioral Services - Plan Fee - MC	☒	Other	0	1.00	0.01	0.00	
Intensive Behavioral Services - Service Hours - FFS	☐	Hourly	141	11.00	71.41	110756.91	
Intensive Behavioral Services - Service Hours - MC	☒	Hourly	3	11.00	71.41	2356.53	
Pathway to Employment Total:							5546277.60
Pathway to Employment - FFS	☐	hourly	1328	86.00	48.20	5504825.60	
Pathway to Employment - MC	☒	Hourly	10	86.00	48.20	41452.00	

GRAND TOTAL:	6171823314.16
Total: Services included in capitation:	243830883.67
Total: Services not included in capitation:	5927992430.49
Total Estimated Unduplicated Participants:	84811
Factor D (Divide total by number of participants):	72771.50
Services included in capitation:	2874.99
Services not included in capitation:	69896.50
Average Length of Stay on the Waiver:	355

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Plan of Care Support Services Total:							**1330229.14**
Plan of Care Support Services - FFS (10/1/14-6/30/18 only)	☐	Semi-Annual	2699	2.00	246.43	**1330229.14**	
Vehicle Modifications Total:							**1905999.55**
Vehicle Modifications (Effective 8/1/2017) - FFS	☐	Other	90	1.00	20945.05	**1885054.50**	
Vehicle Modifications - MC	☒	Other	1	1.00	20945.05	**20945.05**	

GRAND TOTAL:	**6171823314.16**
Total: Services included in capitation:	243830883.67
Total: Services not included in capitation:	5927992430.49
Total Estimated Unduplicated Participants:	**84811**
Factor D (Divide total by number of participants):	**72771.50**
Services included in capitation:	2874.99
Services not included in capitation:	69896.50
Average Length of Stay on the Waiver:	355

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:							**1454650197.00**
Day Habilitation - Individual (2014-2015 only) - Fee-For-Service (FFS)	☐	Hourly	0	0.01	0.01	**0.00**	

GRAND TOTAL:	**6673718466.53**
Total: Services included in capitation:	343737930.77
Total: Services not included in capitation:	6329980535.76
Total Estimated Unduplicated Participants:	**91000**
Factor D (Divide total by number of participants):	**73337.57**
Services included in capitation:	3777.34
Services not included in capitation:	69560.23
Average Length of Stay on the Waiver:	355

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation - Individual (2014-2015 only) - Managed Care (MC)	☒	Hourly	0	0.01	0.01	0.00	
Day Habilitation - Group - FFS	☐	Daily	46365	182.00	162.55	1371666796.50	
Day Habilitation - Group - MC	☒	Daily	2805	182.00	162.55	82983400.50	
Live-in Caregiver (42 CFR §441.303(f)(8)) Total:							1034839.20
Live-in Caregiver - FFS	☐	monthly	137	10.00	728.76	998401.20	
Live-in Caregiver - MC	☒	monthly	5	10.00	728.76	36438.00	
Prevocational Services Total:							162312529.78
Prevocational Services - Site Based - FFS	☐	daily	3847	132.00	113.23	57498646.92	
Prevocational Services - Site Based - MC	☒	daily	526	132.00	113.23	7861785.36	
Prevocational Services - Community Based - FFS	☐	hourly	4844	710.00	25.75	88560430.00	
Prevocational Services - Community Based - MC	☒	hourly	459	710.00	25.75	8391667.50	
Residential Habilitation Total:							4037087475.87
Certified Prog. Intensive Res. Hab. - FFS	☐	day	30463	344.00	349.77	3665334967.44	
Certified Prog. Intensive Res. Hab. - MC	☒	day	1815	344.00	349.77	218382397.20	
Certified Prog. Supportive Res. Hab. - FFS	☐	monthly	2297	11.00	3545.95	89595518.65	
Certified Prog.	☒					5694795.70	

GRAND TOTAL:	6673718466.53
Total: Services included in capitation:	343737930.77
Total: Services not included in capitation:	6329980535.76
Total Estimated Unduplicated Participants:	91000
Factor D (Divide total by number of participants):	73337.57
Services included in capitation:	3777.34
Services not included in capitation:	69560.23
Average Length of Stay on the Waiver:	355

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supportive Res. Hab. - MC		monthly	146	11.00	3545.95		
Family Care - FFS	☐	Daily	1585	469.00	72.76	54087237.40	
Family Care - MC	☒	Daily	117	469.00	72.76	3992559.48	
Family Care - FFS - Monthly (10/1/14-6/30/15)	☐	Monthly	0	0.00	0.01	0.00	
Family Care - MC - Monthly (10/1/14-6/30/15)	☒	Monthly	0	0.00	0.01	0.00	
Respite Total:							167721434.10
Respite - Self-Directed - FFS	☐	hourly	3211	462.00	20.33	30159189.06	
Respite - Self-Directed - MC	☒	Hourly	14	462.00	20.33	131494.44	
Respite - Hourly - FFS	☐	Hourly	19447	285.00	24.31	134735622.45	
Respite - Hourly - MC	☒	Hourly	389	285.00	24.31	2695128.15	
Supported Employment (SEMP) Total:							91919969.54
SEMP - Hourly - FFS	☐	hourly	9720	127.00	66.88	82559347.20	
SEMP - Hourly - MC	☒	Hourly	539	127.00	66.88	4578136.64	
SEMP - Self-Directed - FFS	☐	Hourly	573	206.00	39.15	4621187.70	
SEMP - Self-Directed - MC	☒	Hourly	20	206.00	39.15	161298.00	
SEMP - Monthly - FFS	☐	Monthly	0	0.01	0.01	0.00	
SEMP - Monthly - MC	☒	Monthly	0	0.01	0.01	0.00	
Community Transition Services Total:							133000.00
Community Transition Services - FFS	☐	unit	56	237.50	10.00	133000.00	
Community Transition	☒	unit	0	0.01	0.01	0.00	

GRAND TOTAL:	6673718466.53
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Average Length of Stay on the Waiver:	355

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Services - MC							
Fiscal Intermediary (FI) Total:							**89317763.00**
Fiscal Intermediary - FFS	☐	monthly	16740	10.00	531.97	**89051778.00**	
Fiscal Intermediary - MC	☒	monthly	50	10.00	531.97	**265985.00**	
Individual Directed Goods and Services Total:							**44203060.00**
Individual Goods and Services - FFS	☐	unit	11750	374.00	10.00	**43945000.00**	
Individual Goods and Services - MC	☒	unit	69	374.00	10.00	**258060.00**	
Support Brokerage Total:							**20029089.90**
Support Brokerage - FFS	☐	hourly	16499	30.00	40.27	**19932441.90**	
Support Brokerage - MC	☒	Hourly	80	30.00	40.27	**96648.00**	
Assistive Technology - Adaptive Devices Total:							**698977.27**
Adaptive Technologies-FFS	☐	unit	248	1.00	2784.77	**690622.96**	
Adaptive Technologies-MC	☒	unit	3	1.00	2784.77	**8354.31**	
Community Habilitation Total:							**589790189.03**
Community Hab - Self-Direction - FFS	☐	hourly	15828	721.00	27.46	**313373190.48**	
Community Hab - Self-Direction - MC	☒	Hourly	104	721.00	27.46	**2059060.64**	
Community Hab - Hourly - FFS	☐	Hourly	19417	343.00	40.29	**268332648.99**	
Community Hab - Hourly - MC	☒	Hourly	436	343.00	40.29	**6025288.92**	

GRAND TOTAL:	**6673718466.53**
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Total: Services not included in capitation:	6329980535.76
Total Estimated Unduplicated Participants:	**91000**
Factor D (Divide total by number of participants):	**73337.57**
Services included in capitation:	3777.34
Services not included in capitation:	69560.23
Average Length of Stay on the Waiver:	355

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Environmental Modifications (Home Accessibility) Total:							**3556875.00**
Environmental Modifications - FFS	☐	unit	270	1.00	13125.00	**3543750.00**	
Environmental Modifications - MC	☒	unit	1	1.00	13125.00	**13125.00**	
Family Education and Training Total:							**81834.39**
Family Education and Training - FFS	☐	semi-annual	631	1.50	86.46	**81834.39**	
Intensive Behavioral Services Total:							**300949.50**
Intensive Behavioral Services - Plan Fee - FFS	☐	other	101	1.00	1831.50	**184981.50**	
Intensive Behavioral Services - Plan Fee - MC	☒	Other	0	0.00	0.01	**0.00**	
Intensive Behavioral Services - Service Hours - FFS	☐	Hourly	156	10.00	72.48	**113068.80**	
Intensive Behavioral Services - Service Hours - MC	☒	Hourly	4	10.00	72.48	**2899.20**	
Pathway to Employment Total:							**8974283.40**
Pathway to Employment - FFS	☐	hourly	1814	94.00	52.17	**8895819.72**	
Pathway to Employment - MC	☒	Hourly	16	94.00	52.17	**78463.68**	
Plan of Care Support Services Total:							**0.00**
Plan of Care Support Services - FFS (10/1/14-	☐	Semi-Annual	0	0.00	0.01	**0.00**	

GRAND TOTAL:	**6673718466.53**
Total: Services included in capitation:	343737930.77
Total: Services not included in capitation:	6329980535.76
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Factor D (Divide total by number of participants):	**73337.57**
Services included in capitation:	3777.34
Services not included in capitation:	69560.23
Average Length of Stay on the Waiver:	355

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
6/30/18 only)							
Vehicle Modifications Total:							**1905999.55**
Vehicle Modifications (Effective 8/1/2017) - FFS	☐	Other	90	1.00	20945.05	**1885054.50**	
Vehicle Modifications - MC	☒	Other	1	1.00	20945.05	**20945.05**	

GRAND TOTAL:	**6673718466.53**
Total: Services included in capitation:	343737930.77
Total: Services not included in capitation:	6329980535.76
Total Estimated Unduplicated Participants:	**91000**
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Services included in capitation:	3777.34
Services not included in capitation:	69560.23
Average Length of Stay on the Waiver:	355

NY Waiver – NY.0238.R05.05
Addendum A – Supplemental Rate Language

Provider Reimbursement for Waiver Services

Effective July 1, 2019, provider reimbursement for all Waiver Services will be governed by Part (A) of this Appendix I-2; and the associated supporting addenda. This Appendix describes the reimbursement for State Operated Providers, Non-State Government Providers, and Voluntary Providers.

Waiver services

The Waiver services include: Support Brokerage, Supported Employment, Family Education and Training, Intensive Behavioral Services, Pre-vocational, Community Habilitation, Community Transition Services, Day Habilitation, Fiscal Intermediary, Environmental Modifications, Respite, Residential Habitation, Adaptive Technology, Vehicle Modifications, Live-in Caregiver, Pathways to Employment, and Individual Directed Goods and Services.

I. Definitions Applicable to this Section

a. **Acuity Factor –** Factor developed through a regression analysis utilizing components of the Developmental Disabilities Profile-2 (DDP-2) scores, average residential bed size, Willowbrook class indicators and historical utilization data to predict direct care hours needed to serve individuals. Factors are available on: http://www.health.ny.gov/health_care/medicaid/rates/mental_hygiene/

b. **Allowable Capital Costs –** All necessary and proper capital costs that are appropriate and helpful in developing and maintaining the provision of HCBS waiver services to beneficiaries determined in accordance with the cost principles described in the Medicare Provider Reimbursement Manual (Publication-15) except as further defined below. This shall include, where appropriate, allowable lease/rental and ancillary costs; amortization of leasehold improvements and depreciation of real property; financing expenditures associated with the purchase of real property and related expenditures, and leasehold improvements.

   i. With the exception of Live-In Caregiver services, allowable capital costs shall not include the costs of room.

   ii. The capital component of a provider's rate will not include the costs identified in paragraph iii below.

   iii. Capital Costs of depreciation, and lease/ rental, of equipment and vehicles (annual lease, depreciation and interest). Annual capital reimbursement identified in this paragraph will be included in the operating component of the provider's rate.

c. **Ancillary Costs** – Those costs identified in a lease in addition to monthly rent. These include, but are not limited to: special assessments, taxes, co-op or condo maintenance fees, utility payments assessed on the lessee by the lessor pursuant to the terms of the lease, and lessor-financed renovations billed as additional rent.

d. **Authorized Rate Period Units** – units approved by OPWDD Budget Office to deliver Day Habilitation Services. OPWDD Budget Office adjusts the units based on addition or subtraction of individuals as well as addition or subtraction of sites. These units are tracked on an ongoing basis and reported to DOH on a semi-annual basis (January and July). Based on the unit update the operating portion of the final target rate will not change. The capital portion will be adjusted by the change in units, which will change the overall Day Habilitation rate.

e. **Base Period CFR** –The Consolidated Fiscal Report (CFR) used to update methodologies.

f. **Budget Neutrality Adjustment** – Factor applied to the end of the methodology, by service, to ensure the total annual target reimbursement is equivalent to the total annual base reimbursement. The factors can be found on: **http://www.health.ny.gov/health_care/medicaid/rates/mental_hygiene/**

g. **Capital Costs** – Costs that are related to the acquisition, lease and/or long-term use of land, buildings and construction equipment, leasehold improvements and vehicles.

h. **Consolidated Fiscal Report (CFR)** –The reporting tool utilized by all government and non-government providers to communicate annual costs incurred as a result of operating OPWDD programs and services, along with related patient utilization and staffing statistics. The CFR is the report and associated instructions as of April 1, 2013, identified by the New York State Education Department, and found at: http://www.oms.nysed.gov/rsu/Manuals_Forms/

i. **Department of Health (DOH) Regions -** Regions as defined by the Department of Health, assigned to providers based upon the geographic location of the provider's headquarters, as reported on the consolidated fiscal report. Such regions are as follows:

- Downstate: 5 boroughs of New York City, and counties of Nassau, Suffolk and Westchester;
- Hudson Valley: Counties of Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster;

- Upstate Metro: Counties of Albany, Erie, Fulton, Genesee, Madison, Monroe, Montgomery, Niagara, Onondaga, Orleans, Rensselaer, Saratoga, Schenectady, Warren, Washington, Wyoming;

- Upstate Non-Metro: Any counties not included in other regions.

j. **Depreciation** –The allowable cost based on historical costs and useful life of buildings, equipment, capital improvements and/or acquisition of real property. The useful life shall be based on "The Estimated Useful Life of Depreciable Hospital Assets (2008 edition) "except that the useful life for day habilitation buildings will be 25 years. The depreciation method used shall be straight-line method.

k. **Developmental Disabilities Profile (DDP)** –The Confidential Needs Identification (DDP – 4 form) is used by the NYS Office For People With Developmental Disabilities (OPWDD) to help identify service needs for persons with developmental disabilities, whether the person is receiving services from OPWDD or not. The DDP-4 form provides information to OPWDD which is used for planning. A copy of the form and the guide for completion is available at the OPWDD website: http://www.opwdd.ny.gov/opwdd_resources/opwdd_ forms/home.

l. **Evacuation Score (E-Score)** – The score for a supervised community residence and/or individual residential alternative that is certified under Chapters 32 or 33 of the Residential Board and Care Occupancies of the NFPA 101 Life Safety Code (2000 edition) that is provided to the Department by OPWDD once a year. The factors can be found on: http://www.health.ny.gov/health_care/medicaid/rates/mental_hygiene/

m. **Facility** – the site or physical building where actual services are provided.

n. **Final Average Rate** - The final average rate is the reimbursement amount per unit of service for each waiver service, determined for those waiver services subject to annual reconciliation. The final average rate is determined using the final rate year reimbursable cost divided by the final rate year total units of service regardless of payer.

o. **Financing Expenditures** – Interest expense and fees charged for financing of costs related to the purchase/acquisition, alteration, construction, rehabilitation and/or renovation of real property, vehicles and equipment.

p. **Individual** – A person who is receiving a waiver service.

q. **Initial Period** – For Non-State Government and Voluntary Providers the first 12 months of the two-year rate cycle. For Public Providers the initial period will be the first 12 months of the three-year rate cycle for rate

periods 4/1/13 through 3/31/16. All rate periods thereafter, the initial period will be the first 12 months of the two-year rate cycle.

r. **Lease/Rental and Ancillary Payments** – A facility's annual rental payments for real property and ancillary outlays associated with the property such as utilities and maintenance.

s. **Occupancy Adjustment** – An adjustment to the calculated daily rate of a Voluntary Agency which provides Supervised Residential Habilitation to account for days when Medicaid billing cannot occur because an individual has passed away or has moved to another site.

   i. For the rate periods beginning July 1, 2019 and thereafter; Voluntary Providers will receive an occupancy adjustment to the operating component of their rate for vacancy days. The occupancy adjustment percentage is calculated by dividing the sum of the agency's rate period reported retainer days, service days and the therapy days by 100% of the agency's certified capacity. The certified capacity is calculated taking into account capacity changes throughout the year, multiplied by 100% of the year's days. This adjustment will begin on July 1, 2019 and be recalculated on an annual basis based on the most current and complete twelve months of experience.

t. **Operating Costs** - All necessary and proper costs that are appropriate and helpful in developing and maintaining the provision of HCBS waiver services. Necessary and proper costs are costs that are common and accepted occurrences in the field of HCBS waiver services. These costs shall be determined in accordance with the cost principles described in the Medicare Provider Reimbursement Manual (Publication-15). This shall include allowable: program administration, direct care, support, clinical, fringe benefits, contracted personal service and non-personal service.

u. **OPWDD Region -** Regions as defined by OPWDD. Such regions are as follows:

   - Region 1: 5 boroughs of New York City;
   - Region 2: Counties of Suffolk, Nassau, Rockland, Westchester, Putnam;
   - Region 3: Remaining counties in New York State not included in Region 1 or 2.

Effective July 1, 2019 OPWDD Regions for Community Habilitation services are defined as follows:

- Downstate: 5 boroughs of New York City and Nassau, Suffolk, Westchester, Rockland, Putnam, Dutchess, Orange, Sullivan and Ulster counties;
- Upstate: All remaining counties.

v. **Rate** – A reimbursement amount based on a computation using annual provider reimbursable cost divided by the applicable annual units of service.

w. **Rate Period** – The annual time period that rates are effective. For Public Providers the time period is April 1st through March 31st and for Voluntary Providers the time period July 1st through June 30th.

x. **Rate Period Capacity** – The Certified Capacity on the last day of the base rate period which includes any adjustments plus or minus made to the Operating Certificate as certified by OPWDD Division of Quality Improvement, which adjusts the Certified Capacity from the base rate period to the rate period.

y. **Rebasing** – updating cost data in the methodology, using an available and complete CFR.

z. **Reimbursable Cost** – The final allowable operating and capital costs of the rate year after all audit and /or other adjustments are made. Reimbursable cost will also be reduced by any applicable third-party revenue or payments made by or on behalf of individuals receiving services. For Public Providers reimbursable cost for each Waiver service will be used to determine a final average rate per service.

aa. **Residential Room and Board** – Room means hotel or shelter type expenses including all property related costs such as rental or depreciation related to the purchase of real estate and furnishings; maintenance, utilities and related administrative services. Board means three meals a day or any other full nutritional regimen.

bb. **Retainer days** – are days of Medical leave or an associated day where any other institutional or in-patient Medicaid payment is made for providing services to the beneficiary. A provider is limited to being paid 14 Retainer days per rate year, multiplied by certified capacity.

cc. **Service days** – A day when paid Supervised IRA staff deliver residential habilitation to a person who is either resident in the Supervised IRA or is absent from the IRA and receives residential habilitation services from paid Supervised IRA staff, and these services are of the same scope, frequency and duration as the services provided when the person is resident in the Supervised IRA.

dd. **Start-Up Costs –** Those costs associated with the opening of a new program. Start-up costs include pre-operational rent, utilities, staffing, staff

training, advertising for staff, travel, security services, furniture, equipment and supplies.

ee. **Target Rate** – The rate in effect at the end of the transition period for each waiver service determined using the base year reimbursable cost for each respective provider for each respective service divided by the applicable annual units of service for all individuals, regardless of payer.

ff. **Therapy Day** – A therapy day is a day when the individual is away from the supervised residence and is not receiving services from paid Residential Habilitation staff and the absence is for the purpose of a visiting with family or friends, or a vacation. The therapy day must be described in the person's plan of care to be eligible for payment and the person may not receive another Medicaid-funded residential or in-patient service on that day.

gg. **Trend Factor** – A percentage applied to all applicable operating costs that represent inflations in the costs of goods and services as described in paragraph d of section III.

hh. **Units of Service** – The unit of measure varies by the type of service, i.e., hourly, daily, monthly, or one-time occurrence. The unit of measure used for the following waiver services are:

- Supervised Residential Habilitation IRA –Day
- Supportive Residential Habilitation IRA – Month
- Day Habilitation – Day
- Pre-vocational - Site-based – Day
- Pre-vocational fee – Community based - Hour
- Residential Habilitation – Family Care Day
- Respite – Hour
- Supported Employment Fee – Hour
- Community Habilitation Fee – Hour
- Pathway to Employment Fee – Hour
- Community Transition Services – One-time occurrence
- Intensive Behavioral Service
  Product Fee – One-time occurrence
  Hourly Fee – Hour
- Family Education and Training – Unit (up to 2 hours) – Max 2 Per Year

ii. **Utilization Statistics** – For those waiver services which require an annual reconciliation, OPWDD will record and maintain total utilization units, and will report these units on the annual CFR. Unless specifically noted elsewhere, the Medicaid utilization units will be paid Medicaid units reported and adjudicated through the State's MMIS.

jj. **Vacancy days** – Is an unoccupied period of time (a day) that a provider agency is unable to bill a residential habilitation daily rate, due to an

individual or individuals under the care of a provider agency no longer maintaining a residence, and no other individual occupies the residential bed for any reason. Vacancy days would result from an individual moving, or from death; they would not include an unoccupied period of time where individuals are absent due to paid Therapy days or reported Retainer days**.**

i. Vacancy days will be reimbursed through an occupancy adjustment as defined in paragraph s. The adjustment will be made prospectively at the beginning of the rate year and is based on twelve months of experience. The reduced occupancy shall only be based on the number of Vacancy days which are described in paragraph jj above and based on the most current and complete twelve months of experience. The Occupancy adjustment calculation will be agency specific and will be the higher of the agency's actual occupancy percent or at 95 percent occupancy. The occupancy percentage will be used to adjust the operating component of the rate for the rate year.

kk. **Wage Equalization –** Is the sum of the provider average direct care hourly rate multiplied by seventy-five hundredths from the base period CFR and the applicable regional average direct care hourly rate multiplied by twenty-five hundredths from the base period CFR.

II. State Operated Providers, Non-State Government Providers and Voluntary Providers Annual Reporting Requirements

a. State Operated Providers

i. The State shall identify provider cost in accordance with Generally Accepted Accounting Principles (GAAP)

ii. The State shall annually report cost using a complete Consolidated Fiscal Report (CFR). The CFR annual cost report shall be audited by an Independent Certified Public Accountant (CPA), or the State may use the Compliance Examination identified in the New York State Consolidated Fiscal Reporting and Claiming Manual as of April 1, 2013, in lieu of an audit; and the CPA shall render an opinion on the reported cost regarding reasonableness, compliance with GAAP, and that the CFR reported costs were determined in accordance with the cost principles described in the Medicare Provider Reimbursement Manual (Publication-15). Each Waiver service will be reported using a separate column of the CFR.

iii. The CFR schedules to be completed annually by Public Providers are:

CFR – i Agency Identification and Certification Statement

CFR – ii / CFR- iiA – Accountant's Report (The State will use the CFR iiA as modified by the independent CPA firm to meet professional reporting standards.)
CFR 1 – Program/Site data
CFR 2 – Agency Fiscal Summary
CFR 3 – Agency Administration
CFR 4 – Personal Services
CFR 4 A – Contracted Direct Care and Clinical Personal Services
CFR 5 – Transactions with Related Organizations/Individuals
CFR 6 – Governing Board and Compensation Summary
DMH 1 – Program Fiscal Summary
DMH 2 – ATL/Direct Contract Summary
DMH 3 – ATL & Direct Contracts Program Funding Source Summary OPWDD 1 – ICF/DD Schedule of Service
OPWDD 2 – ICF/DD Medical Supplies

b. Non-State Government Providers and Voluntary / Private Providers

i. The Non-State Government Providers and Voluntary Providers shall identify provider cost in accordance with Generally Accepted Accounting Principles (GAAP)

ii. The state will contract with an independent auditing entity for annual reviews of private provider (not-for-profit) HCBS cost reporting.. OPWDD will implement the audits of cost reports for all years that are the basis of rate development activities as described in paragraph I. subparagraph f. The sample used for these audits will cover all waiver services and a statistically valid sample of providers. If the State/OPWDD changes their reimbursement practice of rebasing every two years, the auditing of cost reports will occur every other year regardless of when rebasing occurs.

iii. The CFR schedules to be completed annually by Non-State Government Providers and Voluntary / Private Providers are:

CFR – i Agency Identification and Certification statement
CFR – ii / CFR- iiA – Accountant's Report
CFR 1 – Program/Site data
CFR 2 – Agency Fiscal Summary
CFR 3 – Agency Administration
CFR 4 – Personal Services
CFR 4 A – Contracted Direct Care and Clinical Personal Services
CFR 5 – Transactions with Related Organizations/Individuals
CFR 6 – Governing Board and Compensation Summary
DMH 1 – Program Fiscal Summary
DMH 2 – ATL/Direct Contract Summary

DMH 3 – ATL & Direct Contracts Program Funding Source Summary
OPWDD 1 – ICF/DD Schedule of Service
OPWDD 2 – ICF/DD Medical Supplies
OPWDD 3 – HUD Revenues and Expenses
OPWDD 4 – Fringe Benefit Expense and Program Administration
OPWDD 5 – Capital Schedule

III. Rate Setting for Public Providers

a. There shall be one State-wide rate for each waiver service for State Operated Providers.

b. New York State will make an adjustment(s) to the rate resulting from any final audit findings or reviews.

c. Interim Rates Calculations

   i. The interim rate will be computed based on the most recent cost reconciliation as described below and adjusted in accordance with the trend factor as described in paragraph d of section III..

   ii. The interim fee will be computed based on the most recent cost reconciliation as described below.

   iii. The State will set rates using this interim methodology for the following six (6) Waiver services:

      (a) Day Habilitation
      (b) Residential Habilitation – IRA (Supervised Certified Site)
      (c) Residential Habilitation – IRA (Supportive Certified Site)
      (d) Residential Habilitation – Family Care
      (e) Respite Services
      (f) Pre Vocational - Site-based

d. Trend Factors

   i. The trend factor used will be the applicable years from the Medical Care Services Index for the period April to April of each year from www.BLS.gov/cpi; Table 1 Consumer Price Index for All Urban Consumers (CPI-U); U.S. city average, by expenditure category and commodity and service group.

   ii. Generally, actual index values will be used for all intervening years between the base period and the rate period. However, because the index value for the last year immediately preceding the current rate period will not be available when the current rate is calculated, an

average of the previous five years actual known indexes will be calculated and used as a proxy for that one year.

iii. A compounded trend factor will be calculated in order to bring base period costs to the appropriate rate period.

e. Cost Reconciliation using Final Rates/Fees

i. When the CFR is completed, the State will calculate a final rate/fee using the CFR applicable to the rate period for each waiver service using the following rate methodology:

(a) The calculation of reconciled rates and fees is described below.

1. Residential Habilitation Services (Supervised and Supportive)

a. Total Operating Costs from CFR1 line 64
b. Plus Agency Administration Allocation from CFR1 line 65
c. Less/Plus Adjustments from CFR1 line 66
d. Less Room and Board Components calculation as described below.

i. Room and Board Components are the result of CFR1 lines 21, 22, 23, 26, 28, 37, 38, Allocation Group Maintenance and Utilities line 40 costs from the CFR Other Detail, Direct Maintenance Titles from CFR4, and Allocation Group Maintenance and Utilities from CFR4. Fringe associated with the Direct Maintenance Titles and Allocation Group Maintenance and Utilities from CFR4 should also be included.

e. The result of a, b, c and d is divided by the Units of Service reported on CFR1 line 13.

2. All Other Waiver Rates and Fees

a. Total Operating Costs from CFR1 line 64
b. Plus Agency Administration Allocation from CFR1 line 65
c. Less/Plus Adjustments from CFR1 line 66
d. The result of a, b, and c plus CFR1 Property and Equipment lines 48 and 63 is divided by the Units of Service reported on CFR1 line 13

i. The State will set fees for the following four Waiver Services:

(a) Pathway to Employment

(b) Supported Employment (Intensive and Extended)
(c) Community Prevocational
(d) Community Habilitation

ii. The final average rate/fee for each service will be multiplied by the adjudicated paid Medicaid service units for services provided in the rate period to determine the allowable Medicaid reimbursement. The final allowable Medicaid reimbursement for each service subject to annual reconciliation will be compared to reconciled rate payments for each service, including those processed through eMedNY, for the applicable rate year. If such total payments for any Waiver Service, subject to the annual reconciliation, exceed the final allowable Medicaid reimbursement for such rate period, the State will treat any overage as an overpayment of the federal share. The final rate as approved through reconciliation will be adjudicated through the NYS Medicaid system upon receipt and, any overpayment shall be returned to CMS on the next calendar quarter CMS-64 expenditure report. If the total payments for a Waiver Service, subject to annual reconciliation, are less than the allowable Medicaid reimbursement for such rate period, the State shall treat the difference as an under payment of the federal share and be entitled to submit a claim by adjudicating the final rate through the NYS Medicaid Payment System. Additional funds will be reported on the next quarters CMS-64.

iii. The State will complete a full CFR and cost reconciliation for each waiver service and will submit these reconciliations to CMS for review and approval within 18 months of the end of each rate period.

IV. Rate Setting for Non-State Governmental Providers and Voluntary Providers for Waiver Services.

a. The State will set rates for Services delivered to individuals with Developmental Disabilities as described below for the following three services; effective July 1, 2019.

i. Residential Habilitation - Supervised IRA (Certified Site)
ii. Residential Habilitation – Supportive IRA (Certified Site)
iii. Day Habilitation – Group and Supplemental Group

b. Residential Habilitation – Supervised IRA

i. Target Rate Operating Cost Components

(a) Regional Average Direct Care Hourly Wage = From the CFR for the base year, divide Salaried Direct Care dollars (CFR4, Title Code 200s), totaled by DOH Region, for all Residential Habilitation–Supervised IRA, Residential Habilitation–Supportive

IRA, Day Habilitation–Group and Supplemental Group, and Intermediate Care Facility for the Developmentally Disabled programs by Salaried Direct Care hours (CFR4, Title Code 200s), totaled by DOH Region, for Residential Habilitation–Supervised IRA, Residential Habilitation–Supportive IRA, Day Habilitation–Group and Supplemental Group, and Intermediate Care Facility for the Developmentally Disabled programs.

(b) Target Rate Regional Average Employee-Related Hourly Component = From the CFR for the base year, add Vacation Leave Accruals (CFR1 line 17) and Total Fringe Benefits (CFR1 line 20), totaled by DOH Region. Divide by Salaried Direct Care dollars (CFR4, Title Code 200s), totaled by DOH Region. Multiply by the applicable Regional Average Direct Care Hourly Wage as computed in subparagraph (a) of this paragraph.

(c) Target Rate Regional Average Program Support Hourly Component = From the CFR for the base year, add Transportation Related-Participant (CFR1 line 24), Staff Travel (CFR1 line 25), Participant Incidentals (CFR1 line 26), Expensed Adaptive Equipment (CFR1 line 27), Sub-Contract Raw Materials (CFR1 line 29), Participant Wages-Non-Contract (CFR1 line 30), Participant Wages-Contract (CFR1 line 31), Participant Fringe Benefits (CFR1 line 32), Staff Development (CFR1 line 34), Supplies and Materials-Non-Household (CFR1 line 36), Other-OTPS (CFR1 line 40), Lease/Rental Vehicle (CFR1 line 42), Depreciation-Vehicle (CFR1 line 44), Interest-Vehicle (CFR1 line 46), Other-Equipment (CFR1 line 47), Other Than To/From Transportation Allocation (CFR1 line 68a), Salaried Support dollars (CFR4 Title Code 100s, excluding Housekeeping and Maintenance Staff Title 102) and Salaried Program Administration dollars (CFR4 Title 500s), totaled by DOH Region. Divide by Salaried Direct Care dollars (CFR4, Title Code 200s), totaled by DOH Region. Multiply by the applicable Regional Average Direct Care Hourly Wage as computed in subparagraph (a) of this paragraph.

(d) Target Rate Regional Average Direct Care Hourly Rate-Excluding General and Administrative = Add applicable Regional Average Direct Care Hourly Wage as computed in subparagraph (a) of this paragraph, applicable Regional Average Employee-Related Hourly Component as computed in subparagraph (b) of this paragraph, and applicable Regional Average Program Support

Hourly Component as computed in subparagraph (c) of this paragraph.

(e) Target Rate Regional Average General and Administrative Hourly Component = From the CFR for the base year, add Insurance-General (CFR1 line 39) and Agency Administration Allocation (CFR1 line 65), totaled by DOH Region. Divide by the sum of Total Program/Site Costs (CFR1 line 67) and Other Than To/From Transportation Allocation (CFR1 line 68a), minus the sum of Food (CFR line 21), Repairs and Maintenance (CFR1 line 22), Utilities (CFR1 line 23), Expensed Equipment (CFR1 line 28), Household Supplies (CFR1 line 37), Telephone (CFR1 line 38), Lease/Rental Equipment (CFR1 line 43), Depreciation Equipment (CFR1 line 45), Total Property-Provider Paid (CFR1 line 63), Housekeeping and Maintenance Staff (CFR4 Title 102), Salaried Clinical dollars (CFR4 Title Code 300s), and Contracted Clinical dollars (CFR4A Title Code 300s) totaled by DOH Region, to calculate the General and Administrative quotient. Divide the Regional Average Direct Care Hourly Rate-Excluding General and Administrative, as computed in subparagraph (d) of this paragraph, by 1 minus the applicable Regional Average General and Administrative quotient, as computed previously in this subparagraph. From this total subtract the applicable Regional Average Direct Care Wage Hourly Rate-Excluding General and Administrative, as computed in subparagraph (d) of this paragraph.

(f) Target Rate Regional Average Direct Care Hourly Rate = Add applicable Regional Average Direct Care Hourly Wage, as computed in subparagraph (a) of this paragraph, applicable Regional Average Employee-Related Hourly Component as computed in subparagraph (b) of this paragraph, applicable Regional Average Program Support Hourly Component as computed in subparagraph (c) of this paragraph, and applicable Regional General and Administrative Hourly Component as computed in subparagraph (e) of this paragraph.

(g) Target Rate Provider Average Direct Care Wage = From the CFR for the base year, divide Salaried Direct Care dollars (CFR4, Title Code 200s), totaled by provider by Salaried Direct Care hours (CFR4, Title Code 200s), totaled by provider.

(h) Target Rate Provider Average Employee-Related Hourly Component = From the CFR for the base year, add Vacation Leave Accruals (CFR1 line 17) and Total Fringe Benefits (CFR1 line 20), totaled by provider. Divide by Salaried Direct Care dollars (CFR4, Title Code 200s), totaled by provider. Multiply by the Provider Average Direct Care Wage as computed in subparagraph (g) of this paragraph.

(i) Target Rate Provider Average Program Support Hourly Component = From the CFR for the base year, add Transportation Related-Participant (CFR1 line 24), Staff Travel (CFR1 line 25), Participant Incidentals (CFR1 line 26), Expensed Adaptive Equipment (CFR1 line 27), Sub-Contract Raw Materials (CFR1 line 29), Participant Wages-Non-Contract (CFR1 line 30), Participant Wages-Contract (CFR1 line 31), Participant Fringe Benefits (CFR1 line 32), Staff Development (CFR1 line 34), Supplies and Materials-Non-Household (CFR1 line 36), Other-OTPS (CFR1 line 40), Lease/Rental Vehicle (CFR1 line 42), Depreciation-Vehicle (CFR1 line 44), Interest-Vehicle (CFR1 line 46), Other-Equipment (CFR1 line 47), Other Than To/From Transportation Allocation (CFR1 line 68a), Salaried Support dollars (CFR4 Title Code 100s, excluding Housekeeping and Maintenance Staff Title 102) and Salaried Program Administration dollars (CFR4 Title 500s), totaled by provider. Divide by Salaried Direct Care dollars (CFR4, Title Code 200s), totaled by provider. Multiply by the Provider Average Direct Care Wage as computed in subparagraph (g) of this paragraph.

(j) Target Rate Provider Average Direct Care Hourly Rate-Excluding General and Administrative= Add Provider Average Direct Care Wage as computed in subparagraph (g) of this paragraph, Provider Average Employee-Related Hourly Component as computed in subparagraph (h) of this paragraph, and Provider Average Program Support Hourly Component as computed in subparagraph (i) of this paragraph.

(k) Target Rate Provider Average General and Administrative Hourly Component = From the CFR for the base year, add Insurance-General (CFR1 line 39) and Agency Administration Allocation (CFR1 line 65), totaled by provider. Divide by the sum of Total Program/Site Costs (CFR1 line 67) and Other Than To/From Transportation Allocation (CFR1 line 68a), minus the sum of Food (CFR line 21), Repairs and Maintenance (CFR1 line 22), Utilities (CFR1 line 23), Expensed Equipment (CFR1 line 28), Household Supplies (CFR1 line 37), Telephone (CFR1 line 38), Lease/Rental Equipment (CFR1 line 43), Depreciation Equipment (CFR1 line 45), Total Property-Provider Paid (CFR1 line 63), Housekeeping and Maintenance Staff (CFR4 Title 102), Salaried Clinical dollars (CFR4 Title Code 300s), and Contracted Clinical dollars (CFR4A Title Code 300s), totaled by provider, to calculate the General and Administrative quotient. Divide the Provider Average Direct Care Hourly Rate-Excluding General and Administrative as computed in subparagraph (d) of this paragraph, by 1 minus the applicable Provider Average General and Administrative quotient, as computed previously in this subparagraph. From this total subtract the Provider Average Direct Care Wage Hourly Rate-

Excluding General and Administrative, as computed in subparagraph (j) of this paragraph.

(l) Target Rate Provider Average Direct Care Hourly Rate = Add Provider Average Direct Care Wage, as computed in subparagraph (g) of this paragraph, Provider Average Employee-Related Hourly Component as computed in subparagraph (h) of this paragraph, Provider Average Program Support Hourly Component as computed in subparagraph (i) of this paragraph, and Provider General and Administrative Hourly Component as computed in subparagraph (k) of this paragraph.

(m) Statewide Average Direct Care Hours Per Person = From the CFR for the base year, divide Total Salaried and Contracted Direct Care Hours (CFR4 and CFR4-A, Title 200s) by the sum of the capacities for all Voluntary Provider rate sheets for the base year (pro-rated for partial year sites).

(n) Statewide Average Direct Hours Per Provider = Multiply Statewide Average Direct Care Hours Per Person, by the applicable provider acuity factor, the applicable provider E-Score factor, and the provider Rate Sheet capacity for the base year (pro-rated for partial year sites).

(o) Statewide Budget Neutrality Adjustment Factor for Hours = From the CFR for the base year, divide Total Salaried and Contracted Direct Care Hours (CFR4 and CFR4-A, Title 200s) by the Statewide Average Direct Hours Per Provider totaled for all providers.

(p) Calculated Direct Care Hours = Multiply Statewide Average Direct Care Hours Per Provider, as computed in subparagraph (n) of this paragraph by the Statewide Budget Neutrality Adjustment Factor for Hours, as computed in subparagraph (o) of this paragraph. Divide by the Rate Sheet capacity for the base year (pro-rated for partial year sites). Multiply by Rate Period capacity for the Initial period.

(q) Regional Average Clinical Hourly Wage = From the CFR for the base year, divide Salaried Clinical dollars (CFR4, Title Code 300s), totaled by DOH Region, by Salaried Clinical hours (CFR4, Title Code 300s), totaled by DOH Region.

(r) Provider Average Clinical Hourly Wage = From the CFR for the base year, divide Salaried Clinical dollars (CFR4, Title Code 300s), totaled by provider, by Salaried Clinical hours (CFR4, Title Code 300s), totaled by provider.

(s) Provider Salaried Clinical Hours = From the CFR for the base year, divide Salaried Clinical hours (CFR4, Title 300s), totaled by provider, by Rate Sheet capacity for the base year (pro-rated for partial year sites). Multiply by Rate Period capacity for the Initial Period.

(t) Regional Average Contracted Clinical Hourly Wage = From the CFR for the base year, divide Contracted Clinical dollars (CFR4A, Title Code 300s) totaled by DOH Region by Contracted Clinical hours (CFR4A, Title Code 300s), totaled by DOH Region.

(u) Provider Contracted Clinical Hours = From the CFR for the base year, divide Contracted Clinical hours (CFR4A, Title 300s), totaled by provider, by Rate Sheet capacity for the base year (pro-rated for partial year sites). Multiply by Rate Period capacity for the Initial Period.

(v) Provider Direct Care Hourly Rate- Adjusted for Wage Equalization = multiply applicable Provider Average Direct Care Hourly Rate, as computed in subparagraph (l) of this paragraph, by .75. Multiply applicable Regional Average Direct Care Hourly Rate, as computed in subparagraph (f) of this paragraph, by .25. Add results together.

(w) Provider Clinical Hourly Wage – Adjusted for Wage Equalization = multiply applicable Provider Average Clinical Hourly Wage by .75. Multiply applicable Regional Average Clinical Hourly Wage, by .25. Add results together.

(x) Provider Reimbursement from Direct Care Hourly Rate = multiply applicable Calculated Direct Care Hours, by applicable Provider Direct Care Hourly Rate-Adjusted for Wage Equalization.

(y) Provider Reimbursement from Clinical Hourly Wage = multiply applicable Provider Salaried Clinical hours, as computed in subparagraph (s) of this paragraph, by applicable Provider Clinical Hourly Wage-Adjusted for Wage Equalization.

(z) Provider Reimbursement from Contracted Clinical Hourly Wage = multiply applicable Provider Contracted Clinical hours, as computed in subparagraph (u) of this paragraph, by applicable Regional Average Contracted Clinical Hourly Wage.

(aa) Provider Operating Revenue = Add applicable Provider Reimbursement from Direct Care Hourly Rate, applicable Provider Reimbursement from Clinical Hourly Wage, and applicable Provider Reimbursement from Contracted Clinical Hourly Wage.

(bb) Statewide Budget Neutrality Adjustment Factor for Operating Dollars = Divide the sum of Operating Revenue from all provider Rate Sheets in effect on 6/30/14, by the sum of all Provider Operating Revenue as calculated in (aa).

(cc) Total Provider Operating Revenue- Adjusted = multiply applicable Provider Operating Revenue, by Statewide Budget Neutrality Adjustment Factor for Operating Dollars.

(dd) Initial Target Daily Operating Rate = Divide the sum of applicable Total Provider Operating Revenue - Adjusted as computed in (cc) and applicable Adjustments as computed in subdivision VII, by the applicable Rate Period capacity for the Initial Period. Divide such quotient by 365, or in the case of a leap year 366. To this result apply the occupancy adjustment, as specified in paragraph s of Section I.

ii. Alternative Operating Cost Hourly Component – For providers that did not submit a cost report for Residential Habilitation – Supervised IRA services for the base year, the target daily operating rate shall be a regional daily operating rate, computed as follows:

(a) Reimbursement from Regional Direct Care Hourly Rate = from the base year, divide the Salaried and Contracted Direct Care Hours (CFR4 and CFR4-A, Title 200s), totaled by DOH region, by Rate Sheet capacity for the base year (pro-rated for partial year sites), totaled by DOH region. Multiply by the applicable Regional Average Direct Care Hourly Rate, as computed in subparagraph (f) of paragraph i, and by Rate Period capacity for the Initial Period.

(b) Reimbursement from Regional Clinical Hourly Wage = from the base year, divide the Salaried and Contracted Clinical Hours (CFR4 and CFR4-A, Title 300s), totaled by DOH region, by Rate Sheet capacity for the base year (pro-rated for partial year sites), totaled by DOH region. Multiply by the applicable Regional Average Clinical Hourly Wage, as computed in subparagraph (q) of this paragraph, and by Rate Period capacity for the Initial Period.

(c) Provider Operating Revenue = Add applicable Reimbursement from Regional Direct Care Hourly Rate, as computed in subparagraph (a) of this paragraph, and applicable Reimbursement from Regional Clinical Hourly Wage, as computed in subparagraph (b) of this paragraph.

(d) Total Provider Operating Revenue – Adjusted = Multiply applicable Provider Operating Revenue, as computed in

subparagraph (c) of this paragraph, by Statewide Budget Neutrality Adjustment Factor for Operating Dollars, as computed in subparagraph (bb) of paragraph i.

(e) Target Regional Daily Operating Rate = Divide the sum of applicable Total Provider Operating Revenue-Adjusted, as computed in subparagraph (d) of this paragraph and applicable Adjustments as computed in subdivision VII, by the applicable Rate Period capacity for the Initial Period. Divide such quotient by365, or in the case of a leap year 366. This rate will be in effect until such time that the provider has submitted a cost report for a base year which will be used in the calculation of a subsequent rate period. If a provider fails to file a cost report by the due date (including one 30-day extension, if granted by OPWDD), OPWDD will impose a penalty of 2% on the provider's Medicaid reimbursement. For cost reporting periods ending December 31, 2014 and later, if a provider fails to file a cost report by the due date (including one 30-day extension, if granted by OPWDD), OPWDD will impose a penalty of 2% on the provider's Medicaid reimbursement, effective the first day of the sixth month following the end of the cost reporting period. However, OPWDD will not impose such a penalty if it determines that there were unforeseeable circumstances beyond the provider's control (such as a natural disaster) that prevented the provider from filing the cost report by the due date.

If a Non-State (NS) provider has not filed a complete and compliant annual Consolidated Fiscal Report (CFR) for any CFR reporting period ending between January 1, 2013 and January 1, 2015, the NS provider will be considered delinquent. The State shall give notice to delinquent providers that to avoid the loss of Federal Financial Participation (FFP) effective April 1, 2016, a complete and compliant CFR must be submitted by October 1, 2015. The State will not claim FFP for any Waiver Service provided by the delinquent NS provider after April 1, 2016.

For the CFR cost reporting periods July 1, 2014 through June 30, 2015 and January 1, 2015 through December 31, 2015, NS providers are required to file an annual CFR to the State within 120 days (150 with a requested extension) following the end of the provider's fiscal reporting period. For CFR cost reporting periods beginning July 1, 2015 and thereafter, NS providers are required to file an annual CFR to the State by June 1st for providers reporting on the January 1st through December 31st period or December 1st for providers reporting on the July 1st through June 30th period. If a NS provider fails to file a complete and compliant CFR by the first day of the second month

following the imposition of the 2% penalty, the State must provide timely notice to the delinquent provider that FFP will end on the first day of the eighth month following the imposition of the 2% penalty; and the State will not claim FFP for any Waiver service provided by the NS provider with a date of service after the first day of the eighth month. If the completed CFR is not submitted by either June 1st for providers reporting on the January 1st through December 31st period or December 1st for providers reporting on the July 1st through June 30th period, a 2% penalty will be imposed.

c. Residential Habilitation – Supportive IRA

i. Target Rate Operating Cost Hourly Components

(a) Regional Average Direct Care Hourly Wage = From the CFR for the base year, divide Salaried Direct Care dollars (CFR4, Title Code 200s), totaled by DOH Region, for all Residential Habilitation–Supervised IRA, Residential Habilitation–Supportive IRA, Day Habilitation–Group and Supplemental Group, and Intermediate Care Facility for the Developmentally Disabled programs by Salaried Direct Care hours (CFR4, Title Code 200s), totaled by DOH Region, for Residential Habilitation–Supervised IRA, Residential Habilitation–Supportive IRA, Day Habilitation - Group and Supplemental Group, and Intermediate Care Facility for the Developmentally Disabled programs.

(b) Regional Average Employee-Related Hourly Component = From the CFR for the base year, add Vacation Leave Accruals (CFR1 line 17) and Total Fringe Benefits (CFR1 line 20), totaled by DOH Region. Divide by Salaried Direct Care dollars (CFR4, Title Code 200s), totaled by DOH Region. Multiply by the applicable Regional Average Direct Care Hourly Wage as computed in subparagraph (a) of this paragraph.

(c) Regional Average Program Support Hourly Component = From the CFR for the base year, add Transportation Related-Participant (CFR1 line 24), Staff Travel (CFR1 line 25), Participant Incidentals (CFR1 line 26), Expensed Adaptive Equipment (CFR1 line 27), Sub-Contract Raw Materials (CFR1 line 29), Participant Wages-Non-Contract (CFR1 line 30), Participant Wages-Contract (CFR1 line 31), Participant Fringe Benefits (CFR1 line 32), Staff Development (CFR1 line 34), Supplies and Materials-Non-Household (CFR1 line 36), Other-OTPS (CFR1 line 40), Lease/Rental Vehicle (CFR1 line 42), Depreciation-Vehicle (CFR1 line 44), Interest-Vehicle (CFR1 line 46), Other-Equipment (CFR1 line 47), Other Than To/From Transportation Allocation (CFR1 line 68a), Salaried Support dollars (CFR4 Title Code 100s,

excluding Housekeeping and Maintenance Staff Title 102) and Salaried Program Administration dollars (CFR4 Title 500s), totaled by DOH Region. Divide by Salaried Direct Care dollars (CFR4, Title Code 200s), totaled by DOH Region. Multiply by the applicable Regional Average Direct Care Hourly Wage as computed in subparagraph (a) of this paragraph.

(d) Regional Average Direct Care Hourly Rate-Excluding General and Administrative = Add applicable Regional Average Direct Care Hourly Wage as computed in subparagraph (a) of this paragraph, applicable Regional Average Employee-Related Hourly Component as computed in subparagraph (b) of this paragraph, and applicable Regional Average Program Support Hourly Component as computed in subparagraph (c) of this paragraph.

(e) Regional Average General and Administrative Hourly Component = From the CFR for the base year, add Insurance-General (CFR1 line 39) and Agency Administration Allocation (CFR1 line 65), totaled by DOH Region. Divide by the sum of Total Program/Site Costs (CFR1 line 67) and Other Than To/From Transportation Allocation (CFR1 line 68a), minus the sum of Food (CFR line 21), Repairs and Maintenance (CFR1 line 22), Utilities (CFR1 line 23), Expensed Equipment (CFR1 line 28), Household Supplies (CFR1 line 37), Telephone (CFR1 line 38), Lease/Rental Equipment (CFR1 line 43), Depreciation Equipment (CFR1 line 45), Total Property-Provider Paid (CFR1 line 63), Housekeeping and Maintenance Staff (CFR4 Title 102), Salaried Clinical dollars (CFR4 Title Code 300s), and Contracted Clinical dollars (CFR4A Title Code 300s), totaled by DOH Region, to calculate the General and Administrative quotient. Divide the Regional Average Direct Care Hourly Rate-Excluding General and Administrative, as computed in subparagraph (d) of this paragraph, by 1 minus the applicable Regional Average General and Administrative quotient, as computed previously in this subparagraph. From this total subtract the applicable Regional Average Direct Care Wage Hourly Rate-Excluding General and Administrative, as computed in subparagraph (d) of this paragraph.

(f) Regional Average Direct Care Hourly Rate = Add applicable Regional Average Direct Care Hourly Wage, as computed in subparagraph (a) of this paragraph, applicable Regional Average Employee-Related Hourly Component as computed in subparagraph (b) of this paragraph, applicable Regional Average Program Support Hourly Component as computed in subparagraph (c) of this paragraph, and applicable Regional General and Administrative Hourly Component as computed in subparagraph (e) of this paragraph.

(g) Provider Average Direct Care Wage = From the CFR for the base year, divide Salaried Direct Care dollars (CFR4, Title Code 200s), totaled by provider by Salaried Direct Care hours (CFR4, Title Code 200s), totaled by provider.

(h) Provider Average Employee-Related Hourly Component = From the CFR for the base year, add Vacation Leave Accruals (CFR1 line 17) and Total Fringe Benefits (CFR1 line 20), totaled by provider. Divide by Salaried Direct Care dollars (CFR4, Title Code 200s), totaled by provider. Multiply by the Provider Average Direct Care Wage as computed in subparagraph (g) of this paragraph.

(i) Provider Average Program Support Hourly Component = From the CFR for the base year, add Transportation Related-Participant (CFR1 line 24), Staff Travel (CFR1 line 25), Participant Incidentals (CFR1 line 26), Expensed Adaptive Equipment (CFR1 line 27), Sub-Contract Raw Materials (CFR1 line 29), Participant Wages-Non-Contract (CFR1 line 30), Participant Wages-Contract (CFR1 line 31), Participant Fringe Benefits (CFR1 line 32), Staff Development (CFR1 line 34), Supplies and Materials-Non-Household (CFR1 line 36), Other-OTPS (CFR1 line 40), Lease/Rental Vehicle (CFR1 line 42), Depreciation-Vehicle (CFR1 line 44), Interest-Vehicle (CFR1 line 46), Other-Equipment (CFR1 line 47), Other Than To/From Transportation Allocation (CFR1 line 68a), Salaried Support dollars (CFR4 Title Code 100s, excluding Housekeeping and Maintenance Staff Title 102) and Salaried Program Administration dollars (CFR4 Title 500s), totaled by provider. Divide by Salaried Direct Care dollars (CFR4, Title Code 200s), totaled by provider. Multiply by the Provider Average Direct Care Wage as computed in subparagraph (g) of this paragraph.

(j) Provider Average Direct Care Hourly Rate-Excluding General and Administrative= Add Provider Average Direct Care Wage as computed in subparagraph (g) of this paragraph, Provider Average Employee-Related Hourly Component as computed in subparagraph (h) of this paragraph, and Provider Average Program Support Hourly Component as computed in subparagraph (i) of this paragraph.

(k) Provider Average General and Administrative Hourly Component = From the CFR for the base year, add Insurance-General (CFR1 line 39) and Agency Administration Allocation (CFR1 line 65), totaled by provider. Divide by the sum of Total Program/Site Costs (CFR1 line 67) and Other Than To/From Transportation Allocation (CFR1 line 68a), minus the sum of Food (CFR line 21),

Repairs and Maintenance (CFR1 line 22), Utilities (CFR1 line 23), Expensed Equipment (CFR1 line 28), Household Supplies (CFR1 line 37), Telephone (CFR1 line 38), Lease/Rental Equipment (CFR1 line 43), Depreciation Equipment (CFR1 line 45), Total Property-Provider Paid (CFR1 line 63), Housekeeping and Maintenance Staff (CFR4 Title 102), Salaried Clinical dollars (CFR4 Title Code 300s), and Contracted Clinical dollars (CFR4A Title Code 300s), totaled by provider, to calculate the General and Administrative quotient. Divide the Provider Average Direct Care Hourly Rate-Excluding General and Administrative, as computed in subparagraph (d) of this paragraph, by 1 minus the applicable Provider Average General and Administrative quotient, as computed previously in this subparagraph. From this total subtract the Provider Average Direct Care Wage Hourly Rate-Excluding General and Administrative, as computed in subparagraph (j) of this paragraph.

(l) Provider Average Direct Care Hourly Rate = Add Provider Average Direct Care Wage, as computed in subparagraph (g) of this paragraph, Provider Average Employee-Related Hourly Component as computed in subparagraph (h) of this paragraph, Provider Average Program Support Hourly Component as computed in subparagraph (i) of this paragraph, and Provider General and Administrative Hourly Component as computed in subparagraph (k) of this paragraph.

(m) Statewide Average Direct Care Hours Per Person = From the CFR for the base year, divide Total Salaried and Contracted Direct Care Hours (CFR4 and CFR4-A, Title 200s) by total capacity from the Rate Sheets for the base year (pro-rated for partial year sites).

(n) Statewide Average Direct Hours Per Provider = Multiply Statewide Average Direct Care Hours Per Person, as computed in subparagraph (m) of this paragraph, by the applicable provider acuity factor, and by the provider Rate Sheet capacity for the base year (pro-rated for partial year sites).

(o) Statewide Budget Neutrality Adjustment Factor for Hours = From the CFR from all Providers for the base year, divide Total Salaried and Contracted Direct Care Hours (CFR4 and CFR4-A, Title 200s) by the total of Statewide Average Direct Hours per Provider for all providers, as computed in subparagraph (n) of this paragraph.

(p) Calculated Direct Care Hours = Multiply Statewide Average Direct Care Hours Per Provider, as computed in subparagraph (n) of this paragraph, by the Statewide Budget Neutrality Adjustment Factor for Hours, as computed in subparagraph (o) of this

paragraph. Divide by the Rate Sheet capacity for the base year (pro-rated for partial year sites). Multiply by Rate Period capacity for the Initial period.

(q) Regional Average Clinical Hourly Wage = From the CFR for the base year, divide Salaried Clinical dollars (CFR4, Title Code 300s), totaled by DOH Region, by Salaried Clinical hours (CFR4, Title Code 300s), totaled by DOH Region.

(r) Provider Average Clinical Hourly Wage = From the CFR for the base year, divide Salaried Clinical dollars (CFR4, Title Code 300s), totaled by provider, by Salaried Clinical hours (CFR4, Title Code 300s), totaled by provider.

(s) Provider Salaried Clinical Hours = From the CFR for the base year, divide Salaried Clinical hours (CFR4, Title 300s), totaled by provider, by Rate Sheet capacity for the base year (pro-rated for partial year sites). Multiply by Rate Period capacity for the Initial Period.

(t) Regional Average Contracted Clinical Hourly Wage = From the CFR for the base year, divide Contracted Clinical dollars (CFR4A, Title Code 300s) totaled by DOH Region by Contracted Clinical hours (CFR4A, Title Code 300s), totaled by DOH Region.

(u) Provider Contracted Clinical Hours = From the CFR for the base year, for each provider, divide Contracted Clinical hours (CFR4A, Title 300s) by Rate Sheet capacity for the base year (pro-rated for partial year sites). Multiply by Rate Period capacity for the Initial Period.

(v) Provider Direct Care Hourly Rate-Adjusted for Wage Equalization = Multiply applicable Provider Average Direct Care Hourly Rate, as computed in subparagraph (l) of this paragraph, by .75. Multiply applicable Regional Average Direct Care Hourly Rate, as computed in subparagraph (f) of this paragraph, by .25. Add results together.

(w) Provider Clinical Hourly Wage – Adjusted for Wage Equalization = Multiply applicable Provider Average Clinical Hourly Wage, as computed in subparagraph (r) of this paragraph, by .75. Multiply applicable Regional Average Clinical Hourly Wage, as computed in subparagraph (q) of this paragraph, by .25. Add results together.

(x) Provider Reimbursement from Direct Care Hourly Rate = Multiply applicable Calculated Direct Care Hours, as computed in subparagraph (p) of this paragraph, by applicable Provider Direct

Care Hourly Rate-Adjusted for Wage Equalization, as computed in subparagraph (v) of this paragraph.

(y) Provider Reimbursement from Clinical Hourly Wage = Multiply applicable Provider Salaried Clinical hours, as computed in subparagraph (s) of this paragraph, by applicable Provider Clinical Hourly Wage-Adjusted for Wage Equalization, as computed in subparagraph (w) of this paragraph.

(z) Provider Reimbursement from Contracted Clinical Hourly Wage = Multiply applicable Provider Contracted Clinical hours, as computed in subparagraph (u) of this paragraph, by applicable Regional Average Contracted Clinical Hourly Wage, as computed in subparagraph (t) of this paragraph.

(aa) Provider Operating Revenue = Add applicable Provider Reimbursement from Direct Care Hourly Rate, as computed in subparagraph (x) of this paragraph, applicable Provider Reimbursement from Clinical Hourly Wage, as computed in subparagraph (y) of this paragraph, and applicable Provider Reimbursement from Contracted Clinical Hourly Wage, computed in subparagraph (z) of this paragraph.

(bb) Statewide Budget Neutrality Adjustment Factor for Operating Dollars = Divide Operating Revenue from all provider Rate Sheets for the Initial Period, by Provider Operating Revenue for all providers, as computed in subparagraph (aa) of this paragraph.

(cc) Total Provider Operating Revenue - Adjusted = Multiply applicable Provider Operating Revenue, as computed in subparagraph (aa) of this paragraph, by Statewide Budget Neutrality Adjustment Factor for Operating Dollars, as computed in subparagraph (bb) of this paragraph.

(dd) Target Monthly Operating Rate = Divide the sum of applicable Total Provider Operating Revenue - Adjusted as computed in (cc) and applicable Adjustments as computed in subdivision VII, by the applicable Rate Period capacity for the Initial Period. Divide such quotient by twelve.

ii. Alternative Operating Cost Hourly Component – For providers that did not submit a cost report for Residential Habilitation – Supportive IRA services for the base year, the target monthly operating rate shall be a regional daily operating rate, calculated as follows:

(a) Reimbursement from Regional Direct Care Hourly Rate = From the base year, divide the Salaried and Contracted Direct Care

Hours (CFR4 and CFR4-A, Title 200s), totaled by DOH region, by Rate Sheet capacity for the base year (pro-rated for partial year sites), totaled by DOH region. Multiply by the applicable Regional Average Direct Care Hourly Rate, as computed in subparagraph (f) of paragraph i, and by Rate Period capacity for the Initial Period.

(b) Reimbursement from Regional Clinical Hourly Wage = From the base year, divide the Salaried and Contracted Clinical Hours (CFR4 and CFR4-A, Title 300s), totaled by DOH region, by Rate Sheet capacity for the base year (pro-rated for partial year sites), totaled by DOH region. Multiply by the applicable Regional Average Clinical Hourly Wage, as computed in subparagraph (q) of paragraph i, and by Rate Period capacity for the Initial Period.

(c) Provider Operating Revenue = Add applicable Reimbursement from Regional Direct Care Hourly Rate, as computed in subparagraph (a) of this paragraph, and applicable Reimbursement from Regional Clinical Hourly Wage, as computed in subparagraph (b) of this paragraph.

(d) Total Provider Operating Revenue – Adjusted = Multiply applicable Provider Operating Revenue, as computed in subparagraph (c) of this paragraph, by Statewide Budget Neutrality Adjustment Factor for Operating Dollars, as computed in subparagraph (bb) of paragraph i.

(e) Target Regional Monthly Operating Rate = Divide the sum of applicable Total Provider Operating Revenue-Adjusted, as computed in subparagraph (d) of this paragraph and applicable Adjustments as computed in subdivision VII, by the applicable Rate Period capacity for the Initial Period. Divide such quotient by twelve. This rate will be in effect until such time that the provider has submitted a cost report for a base year which will be used in the calculation of a subsequent rate period. If a provider fails to file a cost report by the due date (including one 30-day extension, if granted by OPWDD), OPWDD will impose a penalty of 2% on the provider's Medicaid reimbursement. For cost reporting periods ending December 31, 2014 and later, if a provider fails to file a cost report by the due date (including one 30-day extension, if granted by OPWDD), OPWDD will impose a penalty of 2% on the provider's Medicaid reimbursement, effective the first day of the sixth month following the end of the cost reporting period. However, OPWDD will not impose such a penalty if it determines that there were unforeseeable circumstances beyond the provider's control (such as a natural disaster) that prevented the provider from filing the cost report by the due date.

If a Non-State (NS) provider has not filed a complete and compliant annual Consolidated Fiscal Report (CFR) for any CFR reporting period ending between January 1, 2013 and January 1, 2015, the NS provider will be considered delinquent. The State shall give notice to delinquent providers that to avoid the loss of FFP effective April 1, 2016, a complete and compliant CFR must be submitted by October 1, 2015. The State will not claim FFP for any Waiver Service provided by the delinquent NS provider after April 1, 2016.

For the CFR cost reporting periods July 1, 2014 through June 30, 2015 and January 1, 2015 through December 31, 2015, NS providers are required to file an annual CFR to the State within 120 days (150 with a requested extension) following the end of the provider's fiscal reporting period. For CFR cost reporting periods beginning July 1, 2015 and thereafter, NS providers are required to file an annual CFR to the State by June 1st for providers reporting on the January 1st through December 31st period or December 1st for providers reporting on the July 1st through June 30th period. If a NS provider fails to file a complete and compliant CFR by the first day of the second month following the imposition of the 2% penalty, the State must provide timely notice to the delinquent provider that FFP will end on the first day of the eighth month following the imposition of the 2% penalty; and the State will not claim FFP for any Waiver service provided by the NS provider with a date of service after the first day of the eighth month. If the completed CFR is not submitted by either June 1st for providers reporting on the January 1st through December 31st period or December 1st for providers reporting on the July 1st through June 30th period, a 2% penalty will be imposed.

d. Day Habilitation – Group and Supplemental Group

i. Target rate Operating Cost Hourly Components

(a) Regional Average Direct Care Hourly Wage = From the CFR for the base year, divide Salaried Direct Care dollars (CFR4, Title Code 200s), totaled by DOH Region, for all Residential Habilitation–Supervised IRA, Residential Habilitation–Supportive IRA, Day Habilitation -Group and Supplemental Group, and Intermediate Care Facility for the Developmentally Disabled programs by Salaried Direct Care hours (CFR4, Title Code 200s), totaled by DOH Region, for Residential Habilitation–Supervised IRA, Residential Habilitation–Supportive IRA, Day Habilitation - Group and Supplemental Group, and Intermediate Care Facility for the Developmentally Disabled programs.

(b) Regional Average Employee-Related Hourly Component = From the CFR for the base year, add Vacation Leave Accruals (CFR1 line 17) and Total Fringe Benefits (CFR1 line 20), totaled by DOH Region. Divide by Salaried Direct Care dollars (CFR4, Title Code 200s), totaled by DOH Region. Multiply by the applicable Regional Average Direct Care Hourly Wage as computed in subparagraph (a) of this paragraph.

(c) Regional Average Program Support Hourly Component = From the CFR for the base year, add Transportation Related-Participant (CFR1 line 24), Staff Travel (CFR1 line 25), Participant Incidentals (CFR1 line 26), Expensed Adaptive Equipment (CFR1 line 27), Staff Development (CFR1 line 34), Supplies and Materials-Non-Household (CFR1 line 36), Other-OTPS (CFR1 line 40), Lease/Rental Vehicle (CFR1 line 42), Depreciation-Vehicle (CFR1 line 44), Interest-Vehicle (CFR1 line 46), Other-Equipment (CFR1 line 47), Other Than To/From Transportation Allocation (CFR1 line 68a), Salaried Support dollars (CFR4 Title Code 100s, excluding Housekeeping and Maintenance Staff Title 102) and Salaried Program Administration dollars (CFR4 Title 500s), totaled by DOH Region. Divide by Salaried Direct Care dollars (CFR4, Title Code 200s), totaled by DOH Region. Multiply by the applicable Regional Average Direct Care Hourly Wage as computed in subparagraph (a) of this paragraph.

(d) Regional Average Direct Care Hourly Rate-Excluding General and Administrative = Add applicable Regional Average Direct Care Hourly Wage as computed in subparagraph (a) of this paragraph, applicable Regional Average Employee-Related Hourly Component as computed in subparagraph (b) of this paragraph, and applicable Regional Average Program Support Hourly Component as computed in subparagraph (c) of this paragraph.

(e) Regional Average General and Administrative Hourly Component = From the CFR for the base year, add Insurance-General (CFR1 line 39) and Agency Administration Allocation (CFR1 line 65), totaled by DOH Region. Divide by the sum of Total Program/Site Costs (CFR1 line 67) and Other Than To/From Transportation Allocation (CFR1 line 68a), minus the sum of Food (CFR line 21), Repairs and Maintenance (CFR1 line 22), Utilities (CFR1 line 23), Expensed Equipment (CFR1 line 28), Household Supplies (CFR1 line 37), Telephone (CFR1 line 38), Lease/Rental Equipment (CFR1 line 43), Depreciation Equipment (CFR1 line 45), Total Property-Provider Paid (CFR1 line 63), Housekeeping and Maintenance Staff (CFR4 Title 102), Salaried Clinical dollars (CFR4 Title Code 300s), and Contracted Clinical dollars (CFR4A Title Code 300s), totaled by DOH Region, to calculate the General and Administrative quotient. Divide the Regional

Average Direct Care Hourly Rate-Excluding General and Administrative, as computed in subparagraph (d) of this paragraph, by 1 minus the applicable Regional Average General and Administrative quotient, as computed previously in this subparagraph. From this total subtract the applicable Regional Average Direct Care Wage Hourly Rate-Excluding General and Administrative, as computed in subparagraph (d) of this paragraph.

(f) Regional Average Direct Care Hourly Rate = Add applicable Regional Average Direct Care Hourly Wage, as computed in subparagraph (a) of this paragraph, applicable Regional Average Employee-Related Hourly Component as computed in subparagraph (b) of this paragraph, applicable Regional Average Program Support Hourly Component as computed in subparagraph (c) of this paragraph, and applicable Regional General and Administrative Hourly Component as computed in subparagraph (e) of this paragraph.

(g) Provider Average Direct Care Wage = From the CFR for the base year, divide Salaried Direct Care dollars (CFR4, Title Code 200s), totaled by provider by Salaried Direct Care hours (CFR4, Title Code 200s), totaled by provider.

(h) Provider Average Employee-Related Hourly Component = From the CFR for the base year, add Vacation Leave Accruals (CFR1 line 17) and Total Fringe Benefits (CFR1 line 20), totaled by provider. Divide by Salaried Direct Care dollars (CFR4, Title Code 200s), totaled by provider. Multiply by the Provider Average Direct Care Wage as computed in subparagraph (g) of this paragraph.

(i) Provider Average Program Support Hourly Component = From the CFR for the base year, add Transportation Related-Participant (CFR1 line 24), Staff Travel (CFR1 line 25), Participant Incidentals (CFR1 line 26), Expensed Adaptive Equipment (CFR1 line 27), Staff Development (CFR1 line 34), Supplies and Materials-Non-Household (CFR1 line 36), Other-OTPS (CFR1 line 40), Lease/Rental Vehicle (CFR1 line 42), Depreciation-Vehicle (CFR1 line 44), Interest-Vehicle (CFR1 line 46), Other-Equipment (CFR1 line 47), Other Than To/From Transportation Allocation (CFR1 line 68a), Salaried Support dollars (CFR4 Title Code 100s, excluding Housekeeping and Maintenance Staff Title 102) and Salaried Program Administration dollars (CFR4 Title 500s), totaled by provider. Divide by Salaried Direct Care dollars (CFR4, Title Code 200s), totaled by provider. Multiply by the Provider Average Direct Care Wage as computed in subparagraph (g) of this paragraph.

(j) Provider Average Direct Care Hourly Rate-Excluding General and Administrative= Add Provider Average Direct Care Wage as computed in subparagraph (g) of this paragraph, Provider Average Employee-Related Hourly Component as computed in subparagraph (h) of this paragraph, and Provider Average Program Support Hourly Component as computed in subparagraph (i) of this paragraph.

(k) Provider Average General and Administrative Hourly Component = From the CFR for the base year, add Insurance-General (CFR1 line 39) and Agency Administration Allocation (CFR1 line 65), totaled by provider. Divide by the sum of Total Program/Site Costs (CFR1 line 67) and Other Than To/From Transportation Allocation (CFR1 line 68a), minus the sum of Food (CFR line 21), Repairs and Maintenance (CFR1 line 22), Utilities (CFR1 line 23), Expensed Equipment (CFR1 line 28), Household Supplies (CFR1 line 37), Telephone (CFR1 line 38), Lease/Rental Equipment

(CFR1 line 43), Depreciation Equipment (CFR1 line 45), Total Property-Provider Paid (CFR1 line 63), Housekeeping and Maintenance Staff (CFR4 Title 102), Salaried Clinical dollars (CFR4 Title Code 300s), and Contracted Clinical dollars (CFR4A Title Code 300s), totaled by provider, to calculate the General and Administrative quotient. Divide the Provider Average Direct Care Hourly Rate-Excluding General and Administrative, as computed in subparagraph (d) of this paragraph, by 1 minus the applicable Provider Average General and Administrative quotient, as computed previously in this subparagraph. From this total subtract the Provider Average Direct Care Wage Hourly Rate-Excluding General and Administrative, as computed in subparagraph (j) of this paragraph.

(l) Provider Average Direct Care Hourly Rate = Add Provider Average Direct Care Wage, as computed in subparagraph (g) of this paragraph, Provider Average Employee-Related Hourly Component as computed in subparagraph (h) of this paragraph, Provider Average Program Support Hourly Component as computed in subparagraph (i) of this paragraph, and Provider General and Administrative Hourly Component as computed in subparagraph (k) of this paragraph.

(m) Provider Direct Care Hours = From the CFR for the base year, add Salaried and Contracted Direct Care hours (CFR4 and CFR4A, Title 200s), by provider. Divide by provider billed units for the base year. Multiply by Rate Period authorized units for the Initial Period.

(n) Regional Average Clinical Hourly Wage = From the CFR for the base year, divide Salaried Clinical dollars (CFR4, Title Code 300s), totaled by DOH Region, by Salaried Clinical hours (CFR4, Title Code 300s), totaled by DOH Region.

(o) Provider Average Clinical Hourly Wage = From the CFR for the base year, divide Salaried Clinical dollars (CFR4, Title Code 300s), totaled by provider, by Salaried Clinical hours (CFR4, Title Code 300s), totaled by provider

(p) Provider Salaried Clinical Hours = From the CFR for the base year, divide Salaried Clinical hours (CFR4, Title 300s), totaled by provider, by provider billed units for the base year. Multiply by Rate Period authorized units for the Initial Period.

(q) Regional Average Contracted Clinical Hourly Wage = From the CFR for the base year, divide Contracted Clinical dollars (CFR4A, Title Code 300s) totaled by DOH Region by Contracted Clinical hours (CFR4A, Title Code 300s), totaled by DOH Region.

(r) Provider Contracted Clinical Hours = From the CFR for the base year, divide Contracted Clinical hours (CFR4A, Title 300s), totaled by provider, by provider billed units for the base year. Multiply by Rate Period authorized units for the Initial Period.

(s) Provider Direct Care Hourly Rate- Adjusted for Wage Equalization = Multiply applicable Provider Average Direct Care Hourly Rate, as computed in subparagraph (l) of this paragraph, by .75. Multiply applicable Regional Average Direct Care Hourly Rate, as computed in subparagraph (f) of this paragraph, by .25. Add results together.

(t) Provider Clinical Hourly Wage – Adjusted for Wage Equalization = Multiply applicable Provider Average Clinical Hourly Wage, as computed in subparagraph (o) of this paragraph, by .75. Multiply applicable Regional Average Clinical Hourly Wage, as computed in subparagraph (n) of this paragraph, by .25. Add results together.

(u) Provider Reimbursement from Direct Care Hourly Rate = Multiply applicable Provider Direct Care Hours, as computed in subparagraph (m) of this paragraph, by applicable Provider Direct Care Hourly Rate-Adjusted for Wage Equalization, as computed in subparagraph (s) of this paragraph.

(v) Provider Reimbursement from Clinical Hourly Wage = Multiply applicable Provider Salaried Clinical Hours, as computed in subparagraph (p) of this paragraph, by applicable Provider

Clinical Hourly Wage-Adjusted for Wage Equalization, as computed in subparagraph (t) of this paragraph.

(w) Provider Reimbursement from Contracted Clinical Hourly Wage = Multiply applicable Provider Contracted Clinical Hours, as computed in subparagraph (r) of this paragraph, by applicable Regional Average Contracted Clinical Hourly Wage, as computed in subparagraph (q) of this paragraph.

(x) Provider Facility Reimbursement – From the CFR for the base year, add Food (CFR line 21), Repairs and Maintenance (CFR1 line 22), Utilities (CFR1 line 23), Expensed Equipment (CFR1 line 28), Household Supplies (CFR1 line 37), Telephone (CFR1 line 38), Lease/Rental Equipment (CFR1 line 43), Depreciation of Equipment (CFR1 line 45), Insurance – Property and Casualty (CFR1 line 55), Housekeeping and Maintenance Staff (CFR4 Title 102), and Program Administration Property (OPWDD4 line 24), totaled by provider. Divide by the provider billed units for the base year. Multiply by Rate Period authorized units for the Initial Period.

(y) Provider To/From Transportation Reimbursement – Effective July 1, 2018 and only for the rate period July 1, 2018 through June 30, 2019, all providers will receive a survey requesting prospective reimbursement data for Provider To/From transportation. Only those providers having a signed and negotiated multi-year transportation contract inclusive of the period January 1, 2017 through December 31, 2017 for calendar year filers and July 1, 2017 through June 30, 2018 for fiscal year filers will need to submit the completed survey to DOH. The budgets will be reviewed and compared to the most current and available cost report. A determination of appropriate reimbursement will be made by DOH and that result will be included in the July 1, 2018 rates. A reconciliation of this funding will be performed with a reimbursement adjustment made in the rate period July 1, 2019 through June 30, 2020 utilizing the July 1, 2017 through June 30, 20188 and January 1, 2017 through December 31, 2017 CFRs. In subsequent rate periods, To/From transportation will be updated on an annual basis by utilizing the most current available CFR. Divide To/From Transportation Allocation (CFR1 line 68b) by applicable provider billed units. Multiply by rate period authorized units.

(z) Provider Operating Revenue = Add applicable Provider Reimbursement from Direct Care Hourly Rate, as computed in subparagraph (u) of this paragraph, applicable Provider Reimbursement from Clinical Hourly Wage, as computed in subparagraph (v) of this paragraph, applicable Provider

Reimbursement from Contracted Clinical Hourly Wage, as computed in subparagraph (w) of this paragraph, applicable Provider Facility Reimbursement, as computed in subparagraph (x) of this paragraph, and Provider To/From Transportation Reimbursement, as computed in subparagraph (y) of this paragraph.

(aa) Statewide Budget Neutrality Adjustment Factor for Operating Dollars = Divide Operating Revenue from all provider Rate Sheets in effect on 06/30/14, by Provider Operating Revenue for all providers, as computed in subparagraph (z) of this paragraph.

(bb) Total Provider Operating Revenue- Adjusted = Multiply applicable Provider Operating Revenue, as computed in subparagraph (z) of this paragraph, by Statewide Budget Neutrality Adjustment Factor for Operating Dollars, as computed in subparagraph (aa) of this paragraph.

(cc) Total Capital Reimbursement = Capital reimbursement shall be computed as described in subparagraph ii. of this paragraph

(dd) Target Daily Rate = Add applicable Total Provider Operating Revenue-Adjusted, as computed in subparagraph (bb) of paragraph I, adjustments as computed in subdivision VII and Total Capital Reimbursement, as computed in paragraph ii. Divide sum by applicable provider Rate Period authorized units for the Initial Period.

ii. Total Capital Reimbursement = Capital reimbursement shall be computed as follows:

(a) For Capital Assets Approved by OPWDD on Prior Property Approvals (PPA) prior to July 1, 2014. OPWDD regulations under 14 NYCRR Subpart 635-6 establish standards and criteria that describes the Capital acquisition and lease of real property assets which require approval by OPWDD.

1. Reimbursement rates will include actual straight-line depreciation, amortization, Interest expense, financing expenses, and lease costs.

2. OPWDD will never approve lease or acquisition costs in excess of the lower of fair market value (as determined by an independent appraisal) or the provider's actual cost. However, OPWDD may limit the approved costs to a lower amount based on a review of the reasonableness of the transaction and price and a comparison of costs to those of similar facilities with the same characteristics. For example,

if a provider purchases or leases a property in an area in which real estate costs are considerably higher than those in the surrounding areas, and an equally suitable property in the surrounding area was available to the provider for purchase or lease at a lower cost, OPWDD may limit the allowable costs to those of properties in the surrounding area.

3. In no case will the total capital reimbursement associated with the capital asset exceed the total acquisition or renovation cost associated with a capital asset.

4. The State will identify each asset by provider and provide a schedule of these assets identifying: total actual cost, reimbursable cost and useful life, determined by the prior property approval, total financing cost, allowable depreciation and allowable interest for the remaining useful life as determined by the prior approval, and the allowable reimbursement for each year of the remaining useful lives.

5. Notification to Providers. Each provider will receive supporting documentation detailing all real property to be included in the capital component of the provider's reimbursement rate.

(b) Capital rate for capital assets approved by OPWDD on Prior Property Approvals on or after July 1, 2014. OPWDD regulations under 14 NYCRR Subpart 635-6 establish standards and criteria that describes the Capital acquisition and lease of real property assets which require approval by OPWDD.

1. Reimbursement rates will include actual straight-line depreciation, Interest expense, financing expenses, and lease cost established using generally accepted accounting principles, comply with CMS Publication – 15 (Medicare cost and cost allocation principles) and establish useful lives using the American Hospital Association (AHA) Estimated Useful Lives of Depreciable Hospital Assets Revised 2008 Edition.

2. OPWDD will never approve lease or acquisition costs in excess of the lower of fair market value (as determined by an independent appraisal) or the provider's actual cost. However, OPWDD may limit the approved costs to a lower amount based on a review of the reasonableness of the transaction and price and a comparison of costs to those of similar facilities with the same characteristics. For example, if a provider purchases or leases a property in an area in which real estate costs are considerably higher than those in

the surrounding areas, and an equally suitable property in the surrounding area was available to the provider for purchase or lease at a lower cost, OPWDD may limit the allowable costs to those of properties in the surrounding area.

3. In no case will the total capital reimbursement associated with the capital asset exceed the total acquisition, renovation and financing cost associated with a capital asset.

4. The State will identify each asset by provider and provide a schedule of these assets identifying: total actual cost, reimbursable cost and useful life, determined by the prior

   property approval, total financing cost, allowable depreciation and allowable interest for the remaining useful life as determined by the prior approval, and the allowable reimbursement for each year of the remaining useful lives.

5. Notification to Providers. Each provider will receive supporting documentation detailing all real property to be included in the capital component of the provider's reimbursement rate.

6. The rate shall include applicable annual interest, depreciation and/or amortization of the approved appraised costs of an acquisition, or fair market value of a lease, and estimated costs for renovations, interest, soft costs and start-up expenses. For real property associated with day habilitation facilities, the useful life will be 25 years. Such costs shall be included in the rate as of the date of certification of the site, continuing until such time as actual costs are submitted to the State.

   Estimated costs shall be submitted in lieu of actual costs for a period no greater than two years. If actual costs are not submitted to the State within two years from the date of site certification, the amount of capital costs included in the rate shall be zero for each period in which actual costs are not submitted. DOH will retroactively adjust the capital component; and will return FFP to CMS on the next quarterly expenditure report (CMS-64) following the two-year period. Once the final cost reconciliation has been received by the Department of Health, the rate will be retroactively adjusted to include reconciled costs.

7. DOH will verify and reconcile the costs submitted on a PPA by requiring the provider to submit to the State supporting

documentation of actual costs. Actual costs shall be verified by the State reviewing the supporting documentation of such costs. A provider submitting such actual costs shall certify that the reimbursement requested reflects allowable capital costs and that such costs were actually expended by such provider. Under no circumstances shall the amount included in the rate under this subparagraph exceed the amount authorized in the approval process. Capital costs shall be amortized over a 25-year period for acquisition of properties or the life of the lease for leased sites. Capital improvements shall be depreciated over the life of the asset, or the revised useful life of the asset as a result of the capital improvements, whichever is greater. The amortization of interest shall not exceed the life of the loan taken. Amortization or depreciation shall begin upon certification by the provider of such costs. Start-up costs shall be amortized over a one-year period beginning with certification of the site. If actual costs are not submitted to the State within two years from the date of site certification, the amount of capital costs included in the rate shall be zero for each period in which actual costs are not submitted.

The Department will retroactively adjust capital reimbursement based on the actual cost verification process as described.

8. DOH will annually update Capital reimbursement for existing proprieties these changes will occur in, January for providers filing a CFR on a calendar year and July for providers filing a CFR on a fiscal year cycle. Also, DOH will update capital to include all newly approved PPAs twice a year (in January and July). The second update may require the Department to annualize the PPA, which could include more than 12 months of costs in the first year.

(c) CFR Reporting for Capital Assets

1. Expenses relating to Equipment are reported in two sections of CFR-1. Expensed equipment is included under the Other Than Personal Services (OTPS) section of CFR-1 and is included in the operating portion of the rate reimbursement (Lines 27 & 28). Depreciable equipment expenses are included under the Equipment section of CFR-1 and all items in this section are included in the operating portion of the rate reimbursement (Lines 42-47).

2. Capital expenses related to real property are included under the Property section of the CFR-1 (Lines 49-62). With the

exception of Insurance-Property or Casualty, which is reported on CFR-1, Line 55, Lines 49-62 are not included in the rates. Alternatively, providers are reimbursed for Capital in accordance with the capital schedule (IV as identified below) and the Insurance-Property or Casualty reported on CFR-1, Line 55.

3. All expenses reported on CFR-1 are to be reported in accordance with Appendix X – Adjustments to Reported Costs, dated January 1, 2014, which details expenses that are considered to be non-allowable. CFR instructions for reporting depreciation and amortization are included in Appendix O of the January 1, 2014 CFR Manual, which can be found at: http://www.oms.nysed.gov/rsu/Manuals_Forms/Manuals/CFRManual/home.html

4. Capital Schedule. Beginning with the cost reporting period ending December thirty-first, two thousand fourteen, each provider shall submit to OPWDD, as part of the annual cost report, a Capital Schedule.

   This schedule will specifically identify the differences, by capital reimbursement item, between the amounts reported on the certified cost report, and the reimbursable items, including depreciation, interest and lease cost from the schedule of approved reimbursable costs.
   The provider's independent auditor will apply procedures to verify the accuracy and completeness of the capital schedule.

5. If a provider fails to file a cost report (including the capital reimbursement reconciliation schedule) by the due date (including one 30-day extension, if granted by OPWDD), OPWDD will impose a penalty of 2% on the provider's Medicaid reimbursement. For cost reporting periods ending December 31, 2014 and later, if a provider fails to file a cost report (including the capital schedule) by the due date (including one 30-day extension, if granted by OPWDD), OPWDD will impose a penalty of 2% on the provider's Medicaid reimbursement, effective the first day of the sixth month following the end of the cost reporting period. However, OPWDD will not impose such a penalty if it determines that there were unforeseeable circumstances beyond the provider's control (such as a natural disaster) that prevented the provider from filing the cost report by the due date.

If a Non-State (NS) provider has not filed a complete and compliant annual Consolidated Fiscal Report (CFR) for any CFR reporting period ending between January 1, 2013 and January 1, 2015, the NS provider will be considered delinquent. The State shall give notice to delinquent providers that to avoid the loss of FFP effective April 1, 2016, a complete and compliant CFR must be submitted by October 1, 2015. The State will not claim FFP for any Waiver Service provided by the delinquent NS provider after April 1, 2016.

For the CFR cost reporting periods July 1, 2014 through June 30, 2015 and January 1, 2015 through December 31, 2015, NS providers are required to file an annual CFR to the State within 120 days (150 with a requested extension) following the end of the provider's fiscal reporting period. For CFR cost reporting periods beginning July 1, 2015 and thereafter, NS providers are required to file an annual CFR to the State by June 1st for providers reporting on the January 1st through December 31st period or December 1st for providers reporting on the July 1st through June 30th period. If a NS provider fails to file a complete and compliant CFR by the first day of the second month following the imposition of the 2% penalty, the State must provide timely notice to the delinquent provider that FFP will end on the first day of the eighth month following the imposition of the 2% penalty; and the State will not claim FFP for any Waiver service provided by the NS provider with a date of service after the first day of the eighth month. If the completed CFR is not submitted by either June 1st for providers reporting on the January 1st through December 31st period or December 1st for providers reporting on the July 1st through June 30th period, a 2% penalty will be imposed.

iii. Alternative Operating Cost Component – For providers that did not submit a cost report for Day Habilitation – Group and Supplemental Group services for the base year, the target daily operating rate shall be a regional daily operating rate, calculated as follows:

(a) Reimbursement from Regional Direct Care Hourly Rate = From the base year, divide the Salaried and Contracted Direct Care Hours (CFR4 and CFR4-A, Title 200s), totaled by DOH region, by billed units for the base year (pro-rated for partial year sites), totaled by DOH region. Multiply by the applicable Regional Average Direct Care Hourly Rate, as computed in subparagraph (f) of paragraph i, and by Rate Period authorized units for the Initial Period.

(b) Reimbursement from Regional Clinical Hourly Wage = From the base year, divide the Salaried and Contracted Clinical Hours (CFR4 and CFR4-A, Title 300s), totaled by DOH region, by billed units for the base year (pro-rated for partial year sites), totaled by DOH region. Multiply by the applicable Regional Average Clinical Hourly Wage, as computed in subparagraph (n) of paragraph i, and by Rate Period authorized units for the Initial Period.

(c) Provider Operating Revenue = Add applicable Reimbursement from Regional Direct Care Hourly Rate, as computed in subparagraph (a) of this paragraph, and applicable Reimbursement from Regional Clinical Hourly Wage, as computed in subparagraph (b) of this paragraph.

(d) Total Provider Operating Revenue – Adjusted = Multiply applicable Provider Operating Revenue, as computed in subparagraph (c) of this paragraph, by Statewide Budget Neutrality Adjustment Factor for Operating Dollars, as computed in subparagraph (bb) of paragraph i.

(e) Total Capital Reimbursement = Capital reimbursement shall be computed as described in paragraph ii.

(f) Target Regional Daily Operating Rate = Add applicable Total Provider Operating Revenue-Adjusted, as computed in subparagraph (d) of this paragraph and Total Capital Reimbursement, as computed in subparagraph (e) of this paragraph. Divide sum by applicable provider Rate Period authorized units for the Initial Period. This rate will be in effect until such time that the provider has submitted a cost report for a base year which will be used in the calculation of a subsequent rate period. If a provider fails to file a cost report by the due date (including one 30-day extension, if granted by OPWDD), OPWDD will impose a penalty of 2% on the provider's Medicaid reimbursement. For cost reporting periods ending December 31, 2014 and later, if a provider fails to file a cost report by the due date (including one 30-day extension, if granted by OPWDD), OPWDD will impose a penalty of 2% on the provider's Medicaid reimbursement, effective the first day of the sixth month following the end of the cost reporting period. However, OPWDD will not impose such a penalty if it determines that there were unforeseeable circumstances beyond the provider's control (such as a natural disaster) that prevented the provider from filing the cost report by the due date.

If a Non-State (NS) provider has not filed a complete and compliant annual Consolidated Fiscal Report (CFR) for any CFR

reporting period ending between January 1, 2013 and January 1, 2015, the NS provider will be considered delinquent. The State shall give notice to delinquent providers that to avoid the loss of FFP effective April 1, 2016, a complete and compliant CFR must be submitted by October 1, 2015. The State will not claim FFP for any Waiver Service provided by the delinquent NS provider after April 1, 2016.

For the CFR cost reporting periods July 1, 2014 through June 30, 2015 and January 1, 2015 through December 31, 2015, NS providers are required to file an annual CFR to the State within 120 days (150 with a requested extension) following the end of the provider's fiscal reporting period. For CFR cost reporting periods beginning July 1, 2015 and thereafter, NS providers are required to file an annual CFR to the State by June 1st for providers reporting on the January 1st through December 31st period or December 1st for providers reporting on the July 1st through June 30th period. If a NS provider fails to file a complete and compliant CFR by the first day of the second month following the imposition of the 2% penalty, the State must provide timely notice to the delinquent provider that FFP will end on the first day of the eighth month following the imposition of the 2% penalty; and the State will not claim FFP for any Waiver service provided by the NS provider with a date of service after the first day of the eighth month. If the completed CFR is not submitted by either June 1st for providers reporting on the January 1st through December 31st period or December 1st for providers reporting on the July 1st through June 30th period, a 2% penalty will be imposed.

e. Subsequent Rate Periods

   i. Beginning one year after the initial period the methodology will rebase the costs used in the methodology described in this section using the 1/1 – 12/31 and 7/1 – 6/30 CFR one and one half and two years prior to the rate period respectively. Thereafter, the Department will follow a two-year rate cycle utilizing the CFR one and one half and two years prior to the rate year respectively.
   For years in which the Department of Health does not update the base year the Department will update to-from transportation from the CFR and update property as described above.

f. Transition period
   i. Beginning July 1, 2015 all edits will be operational in the eMedNY system as follows:

      a. Limit to the reimbursement of retainer payments to the approved retainer days as defined in Section I.bb.

b. Vacancy days will be reimbursed through an occupancy adjustment as defined in section I.jj.i. The adjustment will be made prospectively at the beginning of the rate year and is based on twelve months of experience. The reduced occupancy shall only be based on the number of Vacancy days which are described in the definition section and based on the most current and complete twelve months of experience. The Occupancy adjustment calculation will be Agency specific and will be the higher of the Agencies actual occupancy percentage or at 95% occupancy. The occupancy percentage will be used to adjust the operating component of the rate for the rate year.

The State will set rates for Services delivered to individuals with Developmental Disabilities as described below for the following services; as of July 1, 2015:

-Pre Vocational Services – Site Based

g. Pre Vocational Services – Site Based

i. Target rate Operating Cost Hourly Components

(a) Regional Average Direct Care Hourly Wage = From the CFR for the base year, divide Salaried Direct Care dollars (CFR4, Title Code 200s) for Pre Vocational services, totaled by DOH Region, by Salaried Direct Care hours (CFR4, Title Code 200s) for Pre Vocational services, totaled by DOH Region.

(b) Regional Average Employee-Related Hourly Component = From the CFR for the base year, add Vacation Leave Accruals (CFR1 line 17) and Total Fringe Benefits (CFR1 line 20), totaled by DOH Region. Divide by Salaried Direct Care dollars (CFR4, Title Code 200s), totaled by DOH Region. Multiply by the applicable Regional Average Direct Care Hourly Wage as computed in subparagraph (a) of this paragraph.

(c) Regional Average Program Support Hourly Component = From the CFR for the base year, add Transportation Related-Participant (CFR1 line 24), Staff Travel (CFR1 line 25), Participant Incidentals (CFR1 line 26), Expensed Adaptive Equipment (CFR1 line 27), Staff Development (CFR1 line 34), Supplies and Materials-Non-Household (CFR1 line 36), Other-OTPS (CFR1 line 40), Lease/Rental Vehicle (CFR1 line 42), Depreciation-Vehicle (CFR1 line 44), Interest-Vehicle (CFR1 line 46), Other-Equipment (CFR1 line 47), Other Than To/From Transportation Allocation (CFR1 line 68a), Salaried Support dollars (CFR4 Title Code 100s, excluding Housekeeping and Maintenance Staff Title

102) and Salaried Program Administration dollars (CFR4 Title 500s), totaled by DOH Region. Divide by Salaried Direct Care dollars (CFR4, Title Code 200s), totaled by DOH Region. Multiply by the applicable Regional Average Direct Care Hourly Wage as computed in subparagraph (a) of this paragraph.

(d) Regional Average Direct Care Hourly Rate-Excluding General and Administrative = Add applicable Regional Average Direct Care Hourly Wage as computed in subparagraph (a) of this paragraph, applicable Regional Average Employee-Related Hourly Component as computed in subparagraph (b) of this paragraph, and applicable Regional Average Program Support Hourly Component as computed in subparagraph (c) of this paragraph.

(e) Regional Average General and Administrative Hourly Component = From the CFR for the base year, add Insurance-General (CFR1 line 39) and Agency Administration Allocation (CFR1 line 65), totaled by DOH Region. Divide by the sum of Total Program/Site Costs (CFR1 line 67) and Other Than To/From Transportation Allocation (CFR1 line 68a), minus the sum of Food (CFR line 21), Repairs and Maintenance (CFR1 line 22), Utilities (CFR1 line 23), Expensed Equipment (CFR1 line 28), Household Supplies (CFR1 line 37), Telephone (CFR1 line 38), Lease/Rental Equipment (CFR1 line 43), Depreciation Equipment (CFR1 line 45), Total Property-Provider Paid (CFR1 line 63), Housekeeping and Maintenance Staff (CFR4 Title 102), Salaried Clinical dollars (CFR4 Title Code 300s), and Contracted Clinical dollars (CFR4A Title Code 300s), totaled by DOH Region, to calculate the General and Administrative quotient. Divide the Regional Average Direct Care Hourly Rate-Excluding General and Administrative, as computed in subparagraph (d) of this paragraph, by 1 minus the applicable Regional Average General and Administrative quotient, as computed previously in this subparagraph. From this total subtract the applicable Regional Average Direct Care Wage Hourly Rate-Excluding General and Administrative, as computed in subparagraph (d) of this paragraph.

(f) Regional Average Direct Care Hourly Rate = Add applicable Regional Average Direct Care Hourly Wage, as computed in subparagraph (a) of this paragraph, applicable Regional Average Employee-Related Hourly Component as computed in subparagraph (b) of this paragraph, applicable Regional Average Program Support Hourly Component as computed in subparagraph (c) of this paragraph, and applicable Regional General and Administrative Hourly Component as computed in subparagraph (e) of this paragraph.

(g) Provider Average Direct Care Wage = From the CFR for the base year, divide Salaried Direct Care dollars (CFR4, Title Code 200s), totaled by provider by Salaried Direct Care hours (CFR4, Title Code 200s), totaled by provider.

(h) Provider Average Employee-Related Hourly Component = From the CFR for the base year, add Vacation Leave Accruals (CFR1 line 17) and Total Fringe Benefits (CFR1 line 20), totaled by provider. Divide by Salaried Direct Care dollars (CFR4, Title Code 200s), totaled by provider. Multiply by the Provider Average Direct Care Wage as computed in subparagraph (g) of this paragraph.

(i) Provider Average Program Support Hourly Component = From the CFR for the base year, add Transportation Related-Participant (CFR1 line 24), Staff Travel (CFR1 line 25), Participant Incidentals (CFR1 line 26), Expensed Adaptive Equipment (CFR1 line 27), Staff Development (CFR1 line 34), Supplies and Materials-Non-Household (CFR1 line 36), Other-OTPS (CFR1 line 40), Lease/Rental Vehicle (CFR1 line 42), Depreciation-Vehicle (CFR1 line 44), Interest-Vehicle (CFR1 line 46), Other-Equipment (CFR1 line 47), Other Than To/From Transportation Allocation (CFR1 line 68a), Salaried Support dollars (CFR4 Title Code 100s, excluding Housekeeping and Maintenance Staff Title 102) and Salaried Program Administration dollars (CFR4 Title 500s), totaled by provider. Divide by Salaried Direct Care dollars (CFR4, Title Code 200s), totaled by provider. Multiply by the Provider Average Direct Care Wage as computed in subparagraph (g) of this paragraph.

(j) Provider Average Direct Care Hourly Rate-Excluding General and Administrative= Add Provider Average Direct Care Wage as computed in subparagraph (g) of this paragraph, Provider Average Employee-Related Hourly Component as computed in subparagraph (h) of this paragraph, and Provider Average Program Support Hourly Component as computed in subparagraph (i) of this paragraph.

(k) Provider Average General and Administrative Hourly Component = From the CFR for the base year, add Insurance-General (CFR1 line 39) and Agency Administration Allocation (CFR1 line 65), totaled by provider. Divide by the sum of Total Program/Site Costs (CFR1 line 67) and Other Than To/From Transportation Allocation (CFR1 line 68a), minus the sum of Food (CFR line 21), Repairs and Maintenance (CFR1 line 22), Utilities (CFR1 line 23), Expensed Equipment (CFR1 line 28), Household Supplies (CFR1 line 37), Telephone (CFR1 line 38), Lease/Rental Equipment (CFR1 line 43), Depreciation Equipment (CFR1 line 45), Total

Property-Provider Paid (CFR1 line 63), Housekeeping and Maintenance Staff (CFR4 Title 102), Salaried Clinical dollars (CFR4 Title Code 300s), and Contracted Clinical dollars (CFR4A Title Code 300s), totaled by provider, to calculate the General and Administrative quotient. Divide the Provider Average Direct Care Hourly Rate-Excluding General and Administrative, as computed in subparagraph (d) of this paragraph, by 1 minus the applicable Provider Average General and Administrative quotient, as computed previously in this subparagraph. From this total subtract the Provider Average Direct Care Wage Hourly Rate-Excluding General and Administrative, as computed in subparagraph (j) of this paragraph.

(l) Provider Average Direct Care Hourly Rate = Add Provider Average Direct Care Wage, as computed in subparagraph (g) of this paragraph, Provider Average Employee-Related Hourly Component as computed in subparagraph (h) of this paragraph, Provider Average Program Support Hourly Component as computed in subparagraph (i) of this paragraph, and Provider General and Administrative Hourly Component as computed in subparagraph (k) of this paragraph.

(m) Provider Direct Care Hours = From the CFR for the base year, add Salaried and Contracted Direct Care hours (CFR4 and CFR4A, Title 200s), by provider. Divide by provider billed units for the base year. Multiply by Rate Period authorized units for the Initial Period.

(n) Regional Average Clinical Hourly Wage = From the CFR for the base year, divide Salaried Clinical dollars (CFR4, Title Code 300s), totaled by DOH Region, by Salaried Clinical hours (CFR4, Title Code 300s), totaled by DOH Region.

(o) Provider Average Clinical Hourly Wage = From the CFR for the base year, divide Salaried Clinical dollars (CFR4, Title Code 300s), totaled by provider, by Salaried Clinical hours (CFR4, Title Code 300s), totaled by provider

(p) Provider Salaried Clinical Hours = From the CFR for the base year, divide Salaried Clinical hours (CFR4, Title 300s), totaled by provider, by provider billed units for the base year. Multiply by Rate Period authorized units for the Initial Period.

(q) Regional Average Contracted Clinical Hourly Wage = From the CFR for the base year, divide Contracted Clinical dollars (CFR4A, Title Code 300s) totaled by DOH Region by Contracted Clinical hours (CFR4A, Title Code 300s), totaled by DOH Region.

(r) Provider Contracted Clinical Hours = From the CFR for the base year, divide Contracted Clinical hours (CFR4A, Title 300s), totaled by provider, by provider billed units for the base year. Multiply by Rate Period authorized units for the Initial Period.

(s) Provider Direct Care Hourly Rate- Adjusted for Wage Equalization = Multiply applicable Provider Average Direct Care Hourly Rate, as computed in subparagraph (l) of this paragraph, by .75. Multiply applicable Regional Average Direct Care Hourly Rate, as computed in subparagraph (f) of this paragraph, by .25. Add results together.

(t) Provider Clinical Hourly Wage – Adjusted for Wage Equalization = Multiply applicable Provider Average Clinical Hourly Wage, as computed in subparagraph (o) of this paragraph, by .75. Multiply applicable Regional Average Clinical Hourly Wage, as computed in subparagraph (n) of this paragraph, by .25. Add results together.

(u) Provider Reimbursement from Direct Care Hourly Rate = Multiply applicable Provider Direct Care Hours, as computed in subparagraph (m) of this paragraph, by applicable Provider Direct Care Hourly Rate-Adjusted for Wage Equalization, as computed in subparagraph (s) of this paragraph.

(v) Provider Reimbursement from Clinical Hourly Wage = Multiply applicable Provider Salaried Clinical Hours, as computed in subparagraph (p) of this paragraph, by applicable Provider Clinical Hourly Wage-Adjusted for Wage Equalization, as computed in subparagraph (t) of this paragraph.

(w) Provider Reimbursement from Contracted Clinical Hourly Wage = Multiply applicable Provider Contracted Clinical Hours, as computed in subparagraph (r) of this paragraph, by applicable Regional Average Contracted Clinical Hourly Wage, as computed in subparagraph (q) of this paragraph.

(x) Provider Facility Reimbursement – From the CFR for the base year, add Food (CFR line 21), Repairs and Maintenance (CFR1 line 22), Utilities (CFR1 line 23), Expensed Equipment (CFR1 line 28), Household Supplies (CFR1 line 37), Telephone (CFR1 line 38), Lease/Rental Equipment (CFR1 line 43), Depreciation Equipment (CFR1 line 45), Insurance – Property and Casualty (CFR1 line 55), Housekeeping and Maintenance Staff (CFR4 Title 102), and Program Administration Property (OPWDD4 line 24), totaled by provider. Divide by the provider billed units for the base year. Multiply by Rate Period authorized units for the Initial Period.

(y) Provider To/From Transportation Reimbursement – Effective July 1, 2018 and only for the rate period July 1, 2018 through June 30, 2019, all providers will receive a survey requesting prospective reimbursement data for Provider To/From transportation. Only those providers having a signed and negotiated multi-year transportation contract inclusive of the period January 1, 2017 through December 31, 2017 for calendar year filers and July 1, 2017 through June 30, 2018 for fiscal year filers will need to submit the completed survey to DOH. The budgets will be reviewed and compared to the most current and available cost report. A determination of appropriate reimbursement will be made by DOH and that result will be included in the July 1, 2018 rates. A reconciliation of this funding will be performed with a reimbursement adjustment made in the rate period July 1, 2019 through June 30, 2020 utilizing the July 1, 2017 through June 30, 2018 and January 1, 2017 through December 31, 2017 CFRs. In subsequent rate periods, To/From Transportation will be updated on an annual basis by utilizing the most current available CFR. Divide To/From Transportation Allocation (CFR1 line 68b) by applicable provider billed units. Multiply by rate period authorized units.

(z) Provider Operating Revenue = Add applicable Provider Reimbursement from Direct Care Hourly Rate, as computed in subparagraph (u) of this paragraph, applicable Provider Reimbursement from Clinical Hourly Wage, as computed in subparagraph (v) of this paragraph, applicable Provider Reimbursement from Contracted Clinical Hourly Wage, as computed in subparagraph (w) of this paragraph, applicable Provider Facility Reimbursement, as computed in subparagraph (x) of this paragraph, and Provider To/From Transportation Reimbursement, as computed in subparagraph (y) of this paragraph.

(aa) Statewide Budget Neutrality Adjustment Factor for Operating Dollars = Divide Operating Revenue from all provider Rate

Sheets in effect 06/30/15, by Provider Operating Revenue for all providers, as computed in subparagraph (z) of this paragraph.

(bb) Total Provider Operating Revenue- Adjusted = Multiply applicable Provider Operating Revenue, as computed in subparagraph (z) of this paragraph, by Statewide Budget Neutrality Adjustment Factor for Operating Dollars, as computed in subparagraph (aa) of this paragraph.

(cc) Total Capital Reimbursement = Capital reimbursement shall be computed as described in subparagraph (ii) of this paragraph.

(dd) Target Daily Rate = Add applicable Total Provider Operating Revenue-Adjusted, as computed in subparagraph (bb) of this paragraph and Total Capital Reimbursement, as computed in subparagraph (cc) of this paragraph. Divide sum by applicable provider Rate Period authorized units for the Initial Period.

ii. Total Capital Reimbursement = Capital reimbursement shall be computed as follows:

(a) For Capital Assets Approved by OPWDD on Prior Property Approvals Prior to July 1, 2014. OPWDD regulations under 14 NYCRR Subpart 635-6 establish standards and criteria that describes the Capital acquisition and lease of real property assets which require approval by OPWDD.

1. Reimbursement rates will include actual straight-line depreciation, amortization, Interest expense, financing expenses, and lease costs.

2. OPWDD will never approve lease or acquisition costs in excess of the lower of fair market value (as determined by an independent appraisal) or the provider's actual cost. However, OPWDD may limit the approved costs to a lower amount based on a review of the reasonableness of the transaction and price and a comparison of costs to those of similar facilities with the same characteristics. For example, if a provider purchases or leases a property in an area in which real estate costs are considerably higher than those in the surrounding areas, and an equally suitable property in the surrounding area was available to the provider for purchase or lease at a lower cost, OPWDD may limit the allowable costs to those of properties in the surrounding area.

3. In no case will the total capital reimbursement associated with the capital asset exceed the total acquisition or renovation cost associated with a capital asset.

4. The State will identify each asset by provider and provide a schedule of these assets identifying: total actual cost, reimbursable cost and useful life, determined by the prior property approval, total financing cost, allowable depreciation and allowable interest for the remaining useful life as

determined by the prior approval, and the allowable reimbursement for each year of the remaining useful lives.

5. Notification to Providers. Each provider will receive supporting documentation detailing all real property to be included in the capital component of the provider's reimbursement rate.

(b) Capital rate for capital assets approved by OPWDD on Prior Property Approvals on or after July 1, 2014. OPWDD regulations under 14 NYCRR Subpart 635-6 establish standards and criteria that describes the Capital acquisition and lease of real property assets which require approval by OPWDD.

1. Reimbursement rates will include actual straight-line depreciation, Interest expense, financing expenses, and lease cost established using generally accepted accounting principles, comply with CMS Publication – 15 (Medicare cost and cost allocation principles) and establish useful lives using the American Hospital Association (AHA) Estimated Useful Lives of Depreciable Hospital Assets Revised 2008 Edition.

2. OPWDD will never approve lease or acquisition costs in excess of the lower of fair market value (as determined by an independent appraisal) or the provider's actual cost. However, OPWDD may limit the approved costs to a lower amount based on a review of the reasonableness of the transaction and price and a comparison of costs to those of similar facilities with the same characteristics. For example, if a provider purchases or leases a property in an area in which real estate costs are considerably higher than those in the surrounding areas, and an equally suitable property in the surrounding area was available to the provider for purchase or lease at a lower cost, OPWDD may limit the allowable costs to those of properties in the surrounding area.

3. In no case will the total capital reimbursement associated with the capital asset exceed the total acquisition, renovation and financing cost associated with a capital asset.

4. The State will identify each asset by provider and provide a schedule of these assets identifying: total actual cost, reimbursable cost and useful life, determined by the prior property approval, total financing cost, allowable depreciation and allowable interest for the remaining useful life as determined by the prior approval, and the allowable reimbursement for each year of the remaining useful lives.

5. Notification to Providers. Each provider will receive supporting documentation detailing all real property to be included in the capital component of the provider's reimbursement rate.

6. The rate shall include applicable annual interest, depreciation and/or amortization of the approved appraised costs of an acquisition for a useful life consistent with AHA guidelines, or fair market value of a lease, and estimated costs for renovations, interest, soft costs and start-up expenses. Such costs shall be included in the rate as of the date, continuing until such time as actual costs are submitted to the State. Estimated costs shall be submitted in lieu of actual costs for a period no greater than two years. If actual costs are not submitted to the State within two years from the date, the amount of capital costs included in the rate shall be zero for each period in which actual costs are not submitted. DOH will retroactively adjust the capital component; and will return FFP to CMS on the next quarterly expenditure report (CMS-64) following the two-year period. Once the final cost reconciliation has been received by the Department of Health, the rate will be retroactively adjusted to include reconciled costs.

7. The provider shall submit to the State supporting documentation of actual costs. Actual costs shall be verified by the State reviewing the supporting documentation of such costs. A provider submitting such actual costs shall certify that the reimbursement requested reflects allowable capital costs and that such costs were actually expended by such provider. Under no circumstances shall the amount included in the rate under this subparagraph exceed the amount authorized in the approval process. Capital costs shall be amortized according to AHA guidelines for the acquisition of properties or the life of the lease for leased sites. Capital improvements shall be depreciated over the life of the asset, or the revised useful life of the asset as a result of the capital improvements, whichever is greater. The amortization of interest shall not exceed the life of the loan taken. Amortization or depreciation shall begin upon certification by the provider of such costs. Start-up costs shall be amortized over a one-year period beginning with certification of the site. If actual costs are not submitted to the State within two years from the date of site certification, the amount of capital costs included in the rate shall be zero for each period in which actual costs are not submitted.

The Department will retroactively adjust capital reimbursement based on the actual cost verification process as described in subparagraph II of this paragraph.

(c) CFR reporting for Capital assets:

1. Expenses relating to Equipment are reported in two sections of CFR-1. Expensed equipment is included under the Other Than Personal Services (OTPS) section of CFR-1 and is included in the operating portion of the rate reimbursement (Lines 27 & 28). Depreciable equipment expenses are included under the Equipment section of CFR-1 and all items in this section are included in the operating portion of the rate reimbursement (Lines 42-47).

2. Capital expenses related to real property are included under the Property section of the CFR-1 (Lines 49-62). With the exception of Insurance-Property or Casualty, which is reported on CFR-1, Line 55, Lines 49-62 are not included in the rates. Alternatively, providers are reimbursed for Capital in accordance with the capital schedule (as identified in 1. iv and 2. iv of this paragraph) and the Insurance-Property or Casualty reported on CFR-1, Line 55.

3. All expenses reported on CFR-1 are to be reported in accordance with Appendix X – Adjustments to Reported Costs, dated January 1, 2014, which details expenses that are considered to be non-allowable. CFR instructions for reporting depreciation and amortization are included in Appendix O of the January 1, 2014 CFR Manual, which can be found at:
   http://www.oms.nysed.gov/rsu/Manuals_Forms/Manuals/CFRManual/home.html

4. Capital Schedule. Beginning with the cost reporting period ending December thirty-first, two thousand fourteen, each provider shall submit to OPWDD, as part of the annual cost report, a Capital Schedule. This schedule will specifically identify the differences, by capital reimbursement item, between the amounts reported on the certified cost report, and the reimbursable items, including depreciation, interest and lease cost from the schedule of approved reimbursable costs. The provider's independent auditor will apply procedures to verify the accuracy and completeness of the capital schedule.

5. If a provider fails to file a cost report (including the capital reimbursement reconciliation schedule) by the due date (including one 30-day extension, if granted by OPWDD), OPWDD will impose a penalty of 2% on the provider's Medicaid reimbursement. For cost reporting periods ending December 31, 2014 and later, if a provider fails to file a cost report (including the capital schedule) by the due date (including one 30-day extension, if granted by OPWDD), OPWDD will impose a penalty of 2% on the provider's Medicaid reimbursement, effective the first day of the sixth month following the end of the cost reporting period. However, OPWDD will not impose such a penalty if it determines that there were unforeseeable circumstances beyond the provider's control (such as a natural disaster) that prevented the provider from filing the cost report by the due date.

   If a Non-State (NS) provider has not filed a complete and compliant annual Consolidated Fiscal Report (CFR) for any CFR reporting period ending between January 1, 2013 and January 1, 2015, the NS provider will be considered delinquent. The State shall give notice to delinquent providers that to avoid the loss of FFP effective April 1, 2016, a complete and compliant CFR must be submitted by October 1, 2015. The State will not claim FFP for any Waiver Service provided by the delinquent NS provider after April 1, 2016.

   For the CFR cost reporting periods July 1, 2014 through June 30, 2015 and January 1, 2015 through December 31, 2015, NS providers are required to file an annual CFR to the State within 120 days (150 with a requested extension) following the end of the provider's fiscal reporting period. For CFR cost reporting periods beginning July 1, 2015 and thereafter,

   NS providers are required to file an annual CFR to the State by June 1st for providers reporting on the January 1st through December 31st period or December 1st for providers reporting on the July 1st through June 30th period. If a NS provider fails to file a complete and compliant CFR by the first day of the second month following the imposition of the 2% penalty, the State must provide timely notice to the delinquent provider that FFP will end on the first day of the eighth month following the imposition of the 2% penalty; and the State will not claim FFP for any Waiver service provided by the NS provider with a date of service after the first day of the eighth month. If the completed CFR is not submitted by either June 1st for providers reporting on the January 1st through December 31st period or December 1st

for providers reporting on the July 1st through June 30th period, a 2% penalty will be imposed.

iii. Alternative Operating Cost Component – For providers that did not submit a cost report for Pre Vocational Site Based services for the base year, the target daily operating rate shall be a regional daily operating rate, calculated as follows:

(a) Reimbursement from Regional Direct Care Hourly Rate = from the base year, divide the Salaried and Contracted Direct Care Hours (CFR4 and CFR4-A, Title 200s), totaled by DOH region, by billed units for the base year (pro-rated for partial year sites), totaled by DOH region. Multiply by the applicable Regional Average Direct Care Hourly Rate, as computed in subparagraph (f) of paragraph i, and by Rate Period authorized units for the Initial Period.

(b) Reimbursement from Regional Clinical Hourly Wage = from the base year, divide the Salaried and Contracted Clinical Hours (CFR4 and CFR4-A, Title 300s), totaled by DOH region, by billed units for the base year (pro-rated for partial year sites), totaled by DOH region. Multiply by the applicable Regional Average Clinical Hourly Wage, as computed in subparagraph (n) of paragraph i, and by Rate Period authorized units for the Initial Period.

(c) Provider Operating Revenue = Add applicable Reimbursement from Regional Direct Care Hourly Rate, as computed in subparagraph (a) of this paragraph, and applicable Reimbursement from Regional Clinical Hourly Wage, as computed in subparagraph (b) of this paragraph.

(d) Total Provider Operating Revenue – Adjusted = Multiply applicable Provider Operating Revenue, as computed in subparagraph (c) of this paragraph, by Statewide Budget Neutrality Adjustment Factor for Operating Dollars, as computed in subparagraph (bb) of paragraph i.

(e) Total Capital Reimbursement = Capital reimbursement shall be computed as described in subparagraph (cc) of paragraph i.

(f) Target Regional Daily Rate = Add applicable Total Provider Operating Revenue-Adjusted, as computed in subparagraph (d) of this paragraph and Total Capital Reimbursement, as computed in subparagraph (e) of this paragraph. Divide sum by applicable provider Rate Period authorized units for the Initial Period This rate will be in effect until such time that the provider has submitted a cost report for a base year which will be used in the

calculation of a subsequent rate period. If a provider fails to file a cost report by the due date (including one 30-day extension, if granted by OPWDD), OPWDD will impose a penalty of 2% on the provider's Medicaid reimbursement. For cost reporting periods ending December 31, 2014 and later, if a provider fails to file a cost report by the due date (including one 30-day extension, if granted by OPWDD), OPWDD will impose a penalty of 2% on the provider's Medicaid reimbursement, effective the first day of the sixth month following the end of the cost reporting period. However, OPWDD will not impose such a penalty if it determines that there were unforeseeable circumstances beyond the provider's control (such as a natural disaster) that prevented the provider from filing the cost report by the due date.

If a Non-State (NS) provider has not filed a complete and compliant annual Consolidated Fiscal Report (CFR) for any CFR reporting period ending between January 1, 2013 and January 1, 2015, the NS provider will be considered delinquent. The State shall give notice to delinquent providers that to avoid the loss of FFP effective April 1, 2016, a complete and compliant CFR must be submitted by October 1, 2015. The State will not claim FFP for any Waiver Service provided by the delinquent NS provider after April 1, 2016.

For the CFR cost reporting periods July 1, 2014 through June 30, 2015 and January 1, 2015 through December 31, 2015, NS providers are required to file an annual CFR to the State within 120 days (150 with a requested extension) following the end of the provider's fiscal reporting period. For CFR cost reporting periods beginning July 1, 2015 and thereafter, NS providers are required to file an annual CFR to the State by June 1st for providers reporting on the January 1st through December 31st period or December 1st for providers reporting on the July 1st through June 30th period. If a NS provider fails to file a complete and compliant CFR by the first day of the second month following the imposition of the 2% penalty, the State must provide timely notice to the delinquent provider that FFP will end on the first day of the eighth month following the imposition of the 2% penalty; and the State will not claim FFP for any Waiver service provided by the NS provider with a date of service after the first day of the eighth month. If the completed CFR is not submitted by either June 1st for providers reporting on the January 1st through December 31st period or December 1st for providers reporting on the July 1st through June 30th period, a 2% penalty will be imposed.

h. Subsequent Rate Periods for Pre Vocational Services:

i. The Department will follow a two-year rate cycle utilizing the CFR two years prior to the rate year.

i. **Changes in Ownership and Control** - The following will be effective beginning August 1, 2017.

Where a non-state governmental provider or voluntary provider ceases some or all of its operations due to:

i. a limitation, suspension, revocation, or surrender of that provider's operating certificate;
ii. bankruptcy or other financial or operational distress; or
iii. dissolution of the provider under State Law;

and there arises an emergency situation of a loss of services to individuals, OPWDD will transfer all of the affected provider's services to another voluntary provider at a temporarily enhanced reimbursement rate as described below.

In those emergency situations, the voluntary provider assuming the transferred services will be reimbursed at a rate which is the higher of the two providers' rates, as those rates are calculated in accordance with NY.0238 (hereafter "higher of rate"). The higher of rate will be in effect until a full year's cost of providing services to the individual(s) impacted by the transfer of services is reflected in the assuming provider's base year CFR.

In situations where a non-state governmental provider or voluntary provider ceases some or all of its operations due to circumstances other than those specified in subparagraphs (i), (ii) or (iii) of this paragraph, or there is no emergency situation of a loss of services to individuals, any provider assuming the operation of those services will not be eligible for a temporarily enhanced reimbursement rate. The assuming provider will use their rate as calculated for all of the individuals they are taking over services for.

j. The following services will be reimbursed based on the fee schedules found using the link below as of 07/01/2019. These fees reflect the adjustments as described in Section VII.

i. Community Habilitation
ii. Intensive Behavioral Services
iii. Family Education and Training
iv. Supported Employment Services (SEMP)
v. Pathway to Employment
vi. Prevocational (Community Based)
vii. Residential Habilitation
viii. Respite

ix. Higher Needs Funding

https://www.health.ny.gov/health_care/medicaid/rates/mental_hygiene/index.htm

(a) The Respite fee schedule will be used to compute a 24-hour per day reimbursement for no more than 42 days in a 180-day period per beneficiary. For days in excess of the 42 days, the maximum amount for any 24-hour period, per individual beneficiary, that may be paid under this waiver is limited to the Regional Rate – Daily using the link above.

(b) Higher Needs Funding - Effective July 1, 2017 through June 30, 2021, the State will set a Higher Needs rate for Services delivered to individuals with Developmental Disabilities, who are not currently being served in one of the following services or individuals who are currently being served but have experienced a significant change in their status as described below. Eligibility for the Higher Needs rate will be based upon an evaluation of the person's needs for additional direct care and/or clinical support hours that are eligible for funding as part of a Residential or Day Habilitation rate.

This method applies to individuals who are approved for one or more of the following services on and after July 1, 2017:

- Residential Habilitation – Supervised IRA
- Residential Habilitation – Supportive IRA
- Day Habilitation

1. "Significant change" is a decline in a person's status that has occurred within the previous six months and:

   (i) Will not normally resolve itself without intervention by staff and i.e. it is not "self-remitting;"
   (ii) Impacts more than one area of the person's health and/or behavioral status;
   (iii) Requires professional review and/or revision of the care plan; and
   (iv) Results in the newly identified staffing need for enhanced or increased oversight supervision.

2. OPWDD will conduct a clinical determination of the level of direct care and/or clinical support needs of an individual at the time he or she requests one of the above-referenced services. The clinical determination will be conducted for the purpose of establishing the level of direct care and/or clinical supports necessary to provide the individual with the appropriate level of services to ensure his or her health, safety and welfare. This will be done on a service-specific basis.

3. The level of direct care and/or clinical supports determined in subparagraph 2 of this paragraph will be evaluated against a set of threshold levels established by OPWDD.

4. If the direct care and/or clinical supports determined in subparagraph 2 of this paragraph meet the threshold levels established by OPWDD then a Higher Needs rate will be set. The Higher Needs rate will be provider-specific and will be based upon the inclusion of direct support and/or clinical hours as described below. These hours will be added to the agency's approved direct care and/or clinical hours as described in Section IV. Once added to current reimbursable hours, an agency specific fee will be calculated.

5. The need for an Higher Needs rate will be subject to review on a six-month basis until such time as the support hours can be integrated into the provider's existing Residential or Day Habilitation Rate or until the cost of providing service(s) to this individual for a full year is reflected in the service provider's base year CFR applicable to the requested service and are included in the rebase of the methodology, at which time the Higher Needs funding for the individual will sunset.

6. Based on the clinical determination conducted by OPWDD, an individual will receive additional hours of direct care and/or clinical supports as delineated in the following tables:

HIGHER NEEDS FUNDING - RESIDENTIAL Effective 7/1/17 – 3/31/18	
Tier	Additional Hours Per Individual
1	1000
2	2000
3	See Fee Tables

HIGHER NEEDS FUNDING - DAY HABILITATION Effective 7/1/17 – 3/31/18	
Tier	Additional Hours Per Unit
1	0.95
2	1.89
3	See Fee Tables

7. Effective 4/1/18, based on the clinical determination conducted by OPWDD, an individual will receive additional hours of direct care and/or clinical supports as delineated in the following tables. Additional hours will not exceed those shown in these tables.

HIGHER NEEDS FUNDING - RESIDENTIAL Effective 4/1/18 – 6/30/21	
Tier	Additional Hours Per Individual
1	1000
2	2000
3	Greater than 2000

HIGHER NEEDS FUNDING - DAY HABILITATION Effective 7/1/17 – 6/30/21	
Tier	Additional Hours Per Unit
1	0.95
2	1.89
3	Greater than 1.89

8. Effective 7/1/17, the Special Populations Funding will be replaced by Higher Needs Funding. Individuals approved for Special Populations funding prior to 7/1/17 will be grandfathered into the Higher Needs Tier equivalent to the funding level for which he or she was approved as shown in the Higher Needs Funding tables found using the following link: https://www.health.ny.gov/health_care/medicaid/rates/mental_hygiene/index.htm

   Daily reimbursement will not exceed these fees. Individuals approved for Higher Needs funding on or after 7/1/17 will receive a daily fee not to exceed these fees.
9. Effective 4/1/18, there will not be a limit on the daily fee for individuals that meet the criteria set forth in Subsection (b) of this Section.

10. Intermediate Care Facility for the Developmentally Disabled (ICF/IID) Conversions - Effective July first, two thousand seventeen, the State will establish higher needs funding for services delivered to individuals with Developmental Disabilities who are transitioning from an Intermediate Care Facility for the Developmentally Disabled (ICF/IID) to one of the following services:
    - Residential Habilitation – Supervised IRA
    - Residential Habilitation – Supportive IRA

    (i) The higher needs funding will be based upon a review of the average direct care and/or clinical support hours provided in the entire ICF/IID program from which the individual is transitioning.

(ii) The average salaried direct care, contracted direct care, salaried clinical and contracted clinical hours identified in subparagraph (i) of this paragraph will be compared to the Calculated Direct Care Hours, Provider Salaried Clinical Hours and/or Provider Contracted Clinical Hours per individual that the agency currently receives in accordance with the respective methodology described in NY Waiver – NY.0238.

(iii) If the average direct care and/or clinical support hours identified in subparagraph (i) of this paragraph are higher than the Calculated Direct Care Hours, Provider Salaried Clinical Hours and/or Provider Contracted Clinical Hours per individual currently being served by the proposed service provider based on the reimbursement methodology as described in NY .0238, then a higher needs funding per individual will be set. The only difference between the higher needs funding and the provider's rate calculated in accordance with the methodology described in NY.0238 is the additional needed direct care and/or clinical support hours. The higher needs funding rate will replace direct care and/or clinical support hours in the rate established in accordance with NY.0238 with the hours identified in accordance with subparagraph (i) of this paragraph.

(iv) There will be no change to the other cost components associated with delivering the requested service(s); the only change will be the number of direct care and/or clinical support hours available to appropriately support the individual(s) in one or more of the community service options described above.

11. Higher Needs Funding will sunset June 30, 2021; after which time OPWDD will utilize the Coordinated Assessment System (CAS) to determine individuals' complex needs. OPWDD will submit an amendment to this waiver to address any proposed new or amended reimbursement.

V. Self-Direction Services

a. Consolidated Supports and Services (CSS)

Consolidated Supports and Services (CSS) prices are established for each individual based on a comprehensive process of evaluating and determining individual specific needs and relating the individual's needs to the Personal Resource Allocation (PRA), effective with prices established on or after April 1, 2013 all prices will be within PRA (see attached table Addendum A.10) or will be separately identified in this supplement to the waiver application. The CSS rates in effect prior to 10/1/14 are included in Addenda A.4 and A.7.

Consolidated Support Services (CSS) identified in this waiver as a service, and for the purposes of this waiver, will sunset on September 30, 2014. NY (OPWDD) will not bill or claim FFP for CSS services with a date of service of October 1, 2014 or thereafter. The individual waiver services identified in Appendix C, other than CSS, may be individually billed and claimed for FFP, if they are provided in accordance with the terms and conditions of this waiver.

Annual Reconciliation - A provider must submit an annual reconciliation to OPWDD no later than 150 days following the end of the rate year or rate period. Once the annual reconciliation is received OPWDD will return any FFP that is not supported on the next quarterly expenditure report – CMS 64. If a provider fails to submit the annual reconciliation by the required time, OPWDD will return all FFP associated with the rate period on the next quarterly expenditure report – CMS 64. After CSS sunsets, the reconciliation is no longer required as each service is billed directly to Medicaid.

b. Agency with Choice/Financial Management Service AWC/FMS

Through 9/30/14, FMS provider agencies are compensated at 17 ½ percent of the service budget for performing the fiscal intermediary duties on behalf of an individual. Effective 10/01/14, OPWDD will implement a fee structure that will replace the current percentage-based methodology for all individuals opting for self-direction with the assistance of a fiscal intermediary.

c. Fiscal Intermediary Services

Effective 10/1/14 Fiscal Intermediary Services will be reimbursed at the following fee schedule based on the level of service provided as described in Appendix C of this HCBS Agreement.

Fiscal Intermediary Level	Statewide Monthly Fee
1	$125
2	$225
3	$550

Effective 8/1/2017, Fiscal Intermediary Services will be reimbursed at the following fee schedule based on the level of service provided as described in Appendix C of this HCBS Agreement.

Fiscal Intermediary Level	Statewide Monthly Fee
1	$125
2	$225
3 PRA below $60,000 PRA $60,000 and above	 $500 $650

d. Individual Directed Goods and Services (IDGS)

The claiming limits and allowable goods and services that can be purchased using IDGS is described in Addendum A.11 to this HCBS Waiver Agreement.

e. Live-in Caregiver

Access to Live-in Caregiver services is restricted to individuals who are enrolled in the Consolidated Supports and Services or after 10/1/14 people who self-direct their services with budget authority and do not live in certified residences. Further, the person's CSS budget/plan must list the live-in caregiver as self-hired staff and describe the live-in caregiver's role. The FMS/AWC (through 9/30/14) and the fiscal intermediary agency (after 10/1/14) pays allowable Live in Care Giver expenses as follows:

- Payment of rent and utilities is made to the landlord or utility company
- Payment for food is reimbursement after presentation of a receipt approved by the CSS participant/designee.

The payment is based on the proportion of these costs that can be attributed to the Live in Care Giver. For example, if the person and Live in Care Giver are the only two people living in an apartment, then a maximum of 50% of the above costs would be attributed to the Caregiver.

At the end of the calendar year, the FMS agency follows procedures for reconciliation of Medicaid receipts against payments from participant accounts. The total service cost for Live-in Caregiver in and of itself does not include any administrative charges by a provider.

f. Support Brokerage

Support Brokerage is reimbursed by the FMS/AWC (through 9/30/14) and by the fiscal intermediary (after 10/1/14) provider at an hourly rate of payment not to exceed as follows:

Support Broker who has completed the necessary training but has had no experience as a Support Broker and may require mentoring	$20
Support Broker with limited experience and has brokered one approved OPWDD CSS Plan/Budget for at least six months.	$25
Support Broker who has brokered two approved OPWDD CSS Plan/Budgets for at least six months	$30
Support Broker who has brokered three or more approved CSS Plan/Budgets for at least six months	$35 -$40

g. "Self-Hired" Staffing for Community Habilitation, Supported Employment and Respite Services

For Self-Directed Services delivered prior to 10/1/14: Annual Reconciliation

– A provider must submit an annual reconciliation to OPWDD no later than 150 days following the end of the rate year or rate period. Once the annual reconciliation is received OPWDD will return any FFP that is not supported on the next quarterly expenditure report – CMS 64. If a provider fails to submit the annual reconciliation by the required time, OPWDD will return all FFP associated with the rate period on the next quarterly expenditure report – CMS 64. The reconciliation is not needed after 9/30/14 service dates since the billing to Medicaid will be based on actual utilization/expenditure and not on a monthly budgeted price as existed prior to 10/1/14. As of 10/1/14, individuals who select and hire staff using a Fiscal Intermediary may pay the staff delivering the self-directed services an hourly rate that does not exceed the following levels:

Self-Hired Service	-Hourly Rate effective 7/1/15
Community Habilitation	Regional Fee for Provider-Delivered Community Habilitation Region 1: $ 38.51 (1-to-1); $ 24.07 (Group) Region 2: $ 39.91 (1-to-1); $ 24.95 (Group) Region 3: $ 39.00 (1-to-1); $ 24.37 (Group)
Respite	Average Regional Rate for Non-State Government Providers and Voluntary Providers Delivered Respite Services as follows: Region 1: $21.36 Region 2: $20.08Region 3: $19.60 Region 4: $19.44
Supported Employment	Region 1: $ 69.97 (1-to-1); $27.99 (Group) Region 2: $ 63.95 (1-to-1); $25.58 (Group) Region 3: $ 56.50 (1-to-1); $22.60 (Group)

Effective 7/1/17, individuals who select and hire Respite staff using a Fiscal Intermediary may pay the Respite staff delivering the self-directed services an hourly rate that does not exceed the calculated fee for In-Home Respite, as specified in the appropriate fee schedule for the service as identified in subdivision IV.

VI. Services paid using a Contract Amount

As of August 1, 2017, the limitations in the HCBS Waiver are being modified for Community Transition Services. In addition, through July 31, 2017, Vehicle Modifications are a component of the Adaptive Technology HCBS Waiver service. Effective August 1, 2017, Vehicle Modifications will be added as a separate new HCBS Waiver service.

a. Environmental Modifications

NYS is the provider of record for environmental modifications for billing purposes. The work is done by a contractor who is selected through a standard bid process, following the rules established by the Office of the State Comptroller. The e-mod is only billed to Medicaid once the contract work is verified as complete and the amount billed is equal to the contract value. Environmental Modifications are limited to individual or family owned or controlled homes.

Effective with claims submitted to eMedNY on or after April 1, 2013 the maximum expenditure for Environmental Modifications for the benefit of an individual Medicaid beneficiary may not exceed $60,000 in any consecutive five year period. If an individual requires an expenditure which exceeds the maximum expenditure amount, the Single State Medicaid Agency may submit and seek approval of an amendment to the waiver; the Single State Medicaid Agency shall provide supporting documentation as deemed necessary by CMS to support approval of the amendment. Any exceptions will be noted in the supplemental language included as part of the Comprehensive HCBS Waiver agreement.

b. Adaptive Technology

Effective with claims submitted to eMedNY on or after April 1, 2013 the maximum expenditure for adaptive technology services for the benefit of an individual Medicaid beneficiary may not exceed $35,000 in any consecutive two years period. If an individual requires an expenditure which exceeds the maximum expenditure amount, the Single State Medicaid Agency may submit and seek approval of an amendment to the waiver; the Single State Medicaid Agency shall provide supporting documentation as deemed necessary by CMS to support approval of the amendment. Any exceptions will be noted in the supplemental language included as part of the Comprehensive HCBS Waiver agreement.

c. Vehicle Modifications

Effective August 1, 2017, Vehicle Modifications will be added as a new HCBS Waiver service. The maximum expenditure for Vehicle Modifications for the benefit of an individual Medicaid beneficiary will be reimbursed at $35,000 in a 5 year period. Previously Vehicle Modifications were a component of the adaptive technology Waiver service. Contracts for vehicle modifications are limited to the primary vehicle of the recipient.

NYS is the provider of record for Vehicle Modifications for billing purposes. The work is done by a contractor who is selected through a standard bid process, following the rules established by the Office of the State Comptroller.

d. Community Transition Services

This service is a one-time reimbursement. The one-time payment will be no more than $3,000 per person. This service may not be used to pay for furnishing living arrangements that are owned or leased by a waiver provider where the provision of these items and services are inherent to the service they are already providing.

Through July 31, 2017 this service is a one-payment of actual expenses which may not exceed $3,000. Effective August 1, 2017, this service is a one-time payment of actual expenses which may not exceed $5,000.

VI. Adjustments

a. Increases to Compensation these increases will be displayed as a separate line and calculated as stated below.

i. Applicability. On or after January 1, 2015, rates of reimbursement for providers that operate eligible programs as defined in this section will be revised to incorporate funding for compensation increases to their direct support professional employees. Such rate increases will be effective January 1, 2015. The compensation increase funding will be included in the provider's rate issued for January 1, 2015 and in a subsequent rate with the inclusion of funding in the amount necessary to achieve the same funding impact as if the rate had been issued on January 1, 2015. The compensation increase funding will be inclusive of associated fringe benefits. The inclusion of this provision will be included until the use of the January 1, 2015 through December 31, 2015 CFR (Upstate) and the July 1, 2014 through June 30, 2015 CFR (Downstate) as a base at which time the adjustment will be included in the CFR and no longer necessary. The July 1, 2014 through June 30, 2015 Downstate CFR data will be adjusted to annualize the six-month increase.

ii. Definitions. As used in this section, the following terms shall have the following meanings:

(a) Direct support professionals are those defined as Direct Care and Support per Consolidated Fiscal Report (CFR) Appendix R and reported on the CFR under the Position Title code identifiers of 100 or 200. Contracted staff salary information will not be utilized.

(b) Clinical staff are those defined as Clinical per CFR Appendix R and reported on the CFR under the Position Title code identifier of 300. Contracted staff salary information will not be utilized.

(c) Eligible rate based programs shall mean supervised community residences (including supervised IRAs), supportive community residences (including supportive IRAs), or group day habilitation programs.

iii. January 1, 2015 Increase. Rates for eligible rate based programs will be revised to incorporate funding for compensation increases to direct support professional employees. Such rate increases will be effective January 1, 2015. The compensation increase funding will be included in the provider's rate issued for January 1, 2015, and in a subsequent rate with the inclusion of funding in the amount necessary to achieve the same funding impact as if the rate had been issued on January 1, 2015. The compensation increase funding will be inclusive of associated fringe benefits.

(a) April 1, 2015 Increase. In addition to the compensation funding effective January 1, 2015, providers that operate supervised IRAs, including supervised community residences, supportive IRAs, including supportive community residences, and group day habilitation will receive a compensation increase targeted to direct support professional and clinical employees to be effective April 1, 2015. The compensation increase funding will be inclusive of associated fringe benefits. The April 1, 2015 direct support professionals compensation funding will be the same, on an annualized basis, as that which was calculated for the January 1, 2015 compensation increase and will be an augmentation to the January 1, 2015 increase.

(b) Calculations. The basis for the calculation of provider and regional direct care, support and clinical salary averages and associated fringe benefit percentages will be the data in providers' CFRs for July 1, 2010 through June 30, 2011 for providers reporting on a fiscal year basis or January 1, 2011 through December 31, 2011 for providers reporting on a calendar year basis.

1. The January 1, 2015 and April 1, 2015 Direct Support Professionals compensation increase funding formula will be as follows:

A) The annual impact of a two percent increase to 2010-11 or 2011 salaried direct care dollars, salaried support dollars and associated fringe benefits will be calculated.

B) The annual impact of the two percent increase for salaried direct care dollars, salaried support dollars and associated fringe will be added to the appropriate operating components in the rate methodology. This will result in a recalculation of provider and regional average direct care wages, provider and regional average employee-related components, provider and regional average program support components, and provider and regional average direct care hourly rates.

C) The provider direct care hourly rate – adjusted for wage equalization factor will be recalculated to utilize the provider average direct care hourly rate and regional average direct care hourly rate, as calculated in subparagraph 2) of this paragraph.

D) An identification will be made of the dollar difference between the provider direct care hourly rate – adjusted for wage equalization factor, which is in the rate in effect on December 31, 2014, and the provider direct care hourly rate – adjusted for wage equalization factor, as calculated in subparagraph 3) of this paragraph.

E) The rate difference identified in subparagraph 4) of this paragraph will be multiplied by the calculated direct care hours in the rate in effect on December 31, 2014 to calculate the additional funding generated by the direct care compensation adjustment.

F) The rate add-on for the compensation increase shall be determined by dividing the additional funding, as calculated in subparagraph 5) of this paragraph by the rate sheet units in effect on January 1, 2015.

2. The April 1, 2015 Clinical compensation increase funding formula will be as follows:

A) The annual impact of a two percent increase to 2010-11 or 2011 salaried clinical dollars and associated fringe benefits will be calculated.

B) The annual impact of the two percent increase for salaried clinical dollars and associated fringe will be added to the appropriate operating components in the rate methodology. This will result in a recalculation of provider and regional average employee-related components, provider and regional average clinical hourly wages.

C) The provider clinical hourly wage – adjusted for wage equalization factor will be recalculated to utilize the provider average clinical hourly wage and regional average clinical hourly wage, as calculated in subparagraph 2) of this paragraph.

D) An identification will be made of the dollar difference between the provider clinical hourly wage – adjusted for wage equalization factor, which is in the rate in effect on December 31, 2014, and the provider clinical hourly wage – adjusted for wage equalization factor, as calculated in subparagraph 3) of this paragraph.

E) The rate difference identified in subparagraph 4) of this paragraph will be multiplied by the provider salaried clinical hours in the rate in effect on December 31, 2014 to calculate

the additional funding generated by the clinical compensation adjustment.

F) The rate add-on for the compensation increase shall be determined by dividing the additional funding, as calculated in subparagraph 5) of this paragraph by the rate sheet units in effect on January 1, 2015.

iv. When costs for this adjustment appear in the CFR and are included in the rebase of the methodology, the add-on will sunset.

b. Other adjustments to reimbursement. Adjustments will be displayed as a separate line and calculated as stated below.

i. Applicability. Rates of reimbursement for providers that operate eligible programs as defined in this section will be revised for services and included in the provider's rate for the period as specified. Funding will continue to be included in subsequent rate periods in the amount necessary to achieve the same funding impact. The inclusion of this provision will be included until the use of the CFR for January 1, 2017 through December 31, 2017 , (Upstate) and July 1, 2016 through June 30, 2017, (Downstate) as a base, at which time the adjustment will be included in the CFR and no longer necessary.

ii. January 1, 2016 Increase. Rates for supervised community residences (including supervised IRAs) that submitted billing outside of the rate for clinic nutrition and psychology services during the period of July 1, 2014 through March 31, 2015 will be revised to incorporate the funding for these services. In addition, rates for supportive community residences (including supportive IRAs) that submitted billing outside of the rate for personal care, home health aide and Supplemental Group Day Habilitation services during the period of June 1, 2014 through May 31, 2015 will be revised to incorporate funding for these services. The amount of the funding to be added will be equal to the annualized dollars for the billing periods identified above. The effective date of the adjustments is October 1, 2015, although the funding will be added to the rate as of January 1, 2016.

iii. July 1, 2016 Decrease. Rates for supervised community residences (including supervised IRAs) and group day habilitation programs with clinical hours of direct, hands-on physical therapy, occupational therapy, speech/language pathology, social work and psychology services provided during the period of January 1, 2013 through December 31, 2013 (Upstate) and July 1, 2012 through June 30, 2013 (Downstate) will be revised to remove the funding for these services. The amount of funding to be removed for each provider from each program will be equal to the sum of the direct, hands-on clinical hours identified by the provider multiplied by the Provider Clinical Hourly Wage – Adjusted for

Wage Equalization for the program. The amount of funding to be removed will be documented and attested to by the provider.

iv. Cost of Living Adjustment (COLA). Beginning April 1, 2016, rates of reimbursement for supervised community residences (including supervised IRAs), supportive community residences (including IRAs), group day habilitation programs, prevocational services (site-based), and respite (hourly and free-standing), and fees for prevocational services (community-based), residential habilitation (family care), supported employment, community habilitation, special populations funding, intensive behavioral services, plan of care support services and pathway to employment will be revised to incorporate funding for years in which the New York State Division of Budget approves a COLA. The COLA shall be applied to operating reimbursement and will be determined using the U.S. consumer price index for all urban consumers (CPI-U) published by the United States Department of Labor, Bureau of Labor Statistics for the twelve-month period ending in July of the budget year prior to the fiscal year for the State of New York.

v. Minimum Wage. Beginning January 1, 2017 , rates of reimbursement for providers that operate supervised community residences (including supervised IRAs), supportive community residences (including IRAs), group day habilitation programs, prevocational services (site-based), and respite (hourly and free-standing) will be adjusted to address cost increases resulting from the implementation of Chapter 54 of the Laws of 2016 for New York State, amending section 652 of Labor Law. The minimum wage adjustment will be developed and implemented as follows:

(a) The minimum wage adjustment for 2017 and 2018 will be developed based on provider-attested survey data, or the cost report data, if the survey was not submitted by the provider. In subsequent years, the minimum wage adjustment will be based on the 2018 survey data, or cost report data, if the survey was not submitted by the provider . Once the costs are included in a CFR utilized in a base year, such reimbursement will be excluded from the rate calculation.

(b) The minimum wage adjustment will be incorporated into rates by adding the calculated amounts to the reimbursement. The midpoint of the wage bands, as reported in the provider surveys, will be compared to the minimum wage requirements specified in statute. The minimum wage adjustment amounts will be calculated by multiplying the difference between the midpoint of the applicable wage bands and the specified wage level, by the total number of hours reported within the wage bands. The minimum wage adjustment amounts will be totaled for each

provider and the provider-specific mandated fringe percentage amount, as calculated from the cost report data, will be added.

c. Increases to Compensation - These increases will be displayed as a separate line and calculated as stated below.

i. Applicability. On or after January 1, 2018, rates of reimbursement for providers that operate eligible programs as defined in this section will be revised to incorporate funding for compensation increases to their direct support professional employees. Such rate increases will be effective January 1, 2018. The compensation increase funding will be included in the provider's rate issued for January 1, 2018 and in a subsequent rate with the inclusion of funding in the amount necessary to achieve the same funding impact as if the rate had been issued on January 1, 2018. The compensation increase funding will be inclusive of associated fringe benefits.

ii. Definitions. As described in subparagraph VII.a.ii of this section.

iii. January 1, 2018 Increase. Rates for eligible rate based programs will be revised to incorporate funding for compensation increases to direct support professional employees. Such rate increases will be effective January 1, 2018. The compensation increase funding will be included in the provider's rate issued for January 1, 2018, and in a subsequent rate with the inclusion of funding in the amount necessary to achieve the same funding impact as if the rate had been issued on January 1, 2018. The compensation increase funding will be inclusive of associated fringe benefits. The inclusion of this provision will be included until the use of the January 1, 2018 through December 31, 2018 CFR (Upstate) and the July 1, 2017 through June 30, 2018 CFR (Downstate) as a base at which time the adjustment will be included in the CFR and no longer necessary. The July 1, 2017 through June 30, 2018 Downstate CFR data will be adjusted to annualize the six-month increase.

(a) April 1, 2018 Increase. In addition to the compensation funding effective January 1, 2018, providers that operate supervised IRAs, including supervised community residences, supportive IRAs, including supportive community residences, and group day habilitation will receive a compensation increase targeted to direct support professional and clinical employees to be effective April 1, 2018. The compensation increase funding will be inclusive of associated fringe benefits. The April 1, 2018 direct support professionals' compensation funding will be the same, on an annualized basis, as that which was calculated for the January 1, 2018 compensation increase and will be an augmentation to the January 1, 2018 increase.

(b) Calculations. The basis for the calculation of provider and regional direct care, support and clinical salary averages and associated fringe benefit percentages will be the data in providers' CFRs for July 1, 2014 through June 30, 2015 for providers reporting on a fiscal year basis or January 1, 2015 through December 31, 2015 for providers reporting on a calendar year basis.

1. The January 1, 2018 and April 1, 2018 Direct Support Professionals compensation increase funding formula will be as follows:

A) The annual impact of a three and a quarter percent increase to 2014-15 or 2015 salaried direct care dollars, salaried support dollars and associated fringe benefits will be calculated.

B) The annual impact of the three and a quarter percent increase for salaried direct care dollars, salaried support dollars and associated fringe will be added to the appropriate operating components in the rate methodology. This will result in a recalculation of provider and regional average direct care wages, provider and regional average employee-related components, provider and regional average program support components, and provider and regional average direct care hourly rates.

C) The provider direct care hourly rate – adjusted for wage equalization factor will be recalculated to utilize the provider average direct care hourly rate and regional average direct care hourly rate, as calculated in subparagraph 2) of this paragraph.

D) An identification will be made of the dollar difference between the provider direct care hourly rate – adjusted for wage equalization factor, which is in the rate in effect on December 31, 2017, and the provider direct care hourly rate – adjusted for wage equalization factor, as calculated in subparagraph 3) of this paragraph.

E) The rate difference identified in subparagraph 4) of this paragraph will be multiplied by the calculated direct care hours in the rate in effect on December 31, 2017 to calculate the additional funding generated by the direct care compensation adjustment.

F) The rate add-on for the compensation increase shall be determined by dividing the additional funding, as calculated in subparagraph 5) of this paragraph by the rate sheet units in effect on January 1, 2018.

2. The April 1, 2018 Clinical compensation increase funding formula will be as follows:

    A) The annual impact of a three and a quarter percent increase to 2014-15 or 2015 salaried clinical dollars and associated fringe benefits will be calculated.

    B) The annual impact of the three and a quarter percent increase for salaried clinical dollars and associated fringe will be added to the appropriate operating components in the rate methodology. This will result in a recalculation of provider and regional average employee-related components, provider and regional average clinical hourly wages.

    C) The provider clinical hourly wage – adjusted for wage equalization factor will be recalculated to utilize the provider average clinical hourly wage and regional average clinical hourly wage, as calculated in subparagraph 2) of this paragraph.

    D) An identification will be made of the dollar difference between the provider clinical hourly wage – adjusted for wage equalization factor, which is in the rate in effect on December 31, 2017, and the provider clinical hourly wage – adjusted for wage equalization factor, as calculated in subparagraph 3) of this paragraph.

    E) The rate difference identified in subparagraph 4) of this paragraph will be multiplied by the provider salaried clinical hours in the rate in effect on December 31, 2017 to calculate the additional funding generated by the clinical compensation adjustment.

    F) The rate add-on for the compensation increase shall be determined by dividing the additional funding, as calculated in subparagraph 5) of this paragraph by the rate sheet units in effect on January 1, 2018.

iv. When the costs for this adjustment appear in the CFR and are included in the rebase of the methodology, the add-on will sunset.

Independent Accountant's Compliance Examination Guidance
For use when examining
Office For People With Developmental Disabilities' Consolidated Fiscal Report

Centers for Medicare and Medicaid Services (CMS), NY Office for People With Developmental Disabilities (OPWDD) and Department of Health (DOH) have agreed that the Consolidated Fiscal Report (CFR) with associated instructions is the cost report that will be used to annually report public provider costs for both the Medicaid State Plan and Medicaid Waiver services, beginning with the State Fiscal Year April 1, 2013 thru March 31, 2014. OPWDD has also agreed that they will follow the instructions/procedures defined in the CFR manual as modified with the agreement of both NYS and CMS. All reporting and/or cost allocation(s) not conforming with the requirements stated in the CFR manual, such as OPWDD's required adherence to Medicare Cost and Cost Allocation principles as described in the CMS Medicare Provider Reimbursement Manual (publication-15), require the written approval of CMS. OPWDD which is required to submit a certified CFR to State and/or Federal oversight agencies may use the Compliance Examination in lieu of the accountant's certification which appears on Schedule CFR-ii/CFR-iiA. The Compliance Examination is intended to ensure the reliability of CFR data by subjecting it to generally accepted government auditing standards (GAGAS) as well as the examination guidance specified by and agreed to by State and Federal oversight agencies. The Compliance Examination must include the Document Control Number and the reporting period of the CFR submission that was examined.

The certification must address the following:

- Verification that there is a system in place, as of April 1, 2013, and maintained for recording data in accordance with CFR definitions.

- Verification that source documents are available to support the reported data and are / or will be maintained for review and audit for a minimum of 7 years following the close of the reporting period of the CFR. The data must be fully documented and securely stored.

- Verification that there is a system of internal controls to assure the accuracy of the data collection process and recording system and that reported documents are not altered. Test that documents are reviewed and signed by a supervisor as required.

- Verification that the data collection methods are adequate to support the amounts reported.

- Verification that all amounts reported can be traced to supporting documentation.

- Verification that OPWDD maintained data and prepared cost based on the following:

a. OPWDD shall identify and record provider cost in accordance with Generally Accepted Accounting Principles (GAAP).
b. OPWDD shall annually report cost using a complete Consolidated Fiscal Report (CFR). The CFR annual cost report shall be examined by an Independent Certified Public Accountant (CPA) as of April 1, 2013; in lieu of an audit the CPA shall perform an Attestation Engagement – Examination and render an opinion on the reported cost regarding reasonableness, compliance with GAAP, and that the CFR reported costs were determined in accordance with the cost and cost allocation principles described in the Medicare Provider Reimbursement Manual (Publication-15). Each Waiver service will be reported using a separate column of the CFR; in addition each waiver service provided by and OHCDS will also be reported using a separate column of the CFR. In addition, for State Plan services; each Developmental Center and Over Thirty Bed ICF location should also be reported in a separate column. Any other non-Medicaid services must also be reported in separate columns of the CFR.

- Documentation of the independent practitioner's analytical review of the reported data to provide evidence that the CFR revenues, costs, statistics, and cost allocation methods are reasonable, consistent with prior reporting periods if applicable, and compliant with Medicare cost and cost allocation principles; , or differences are adequately justified, based on the independent practitioner's sufficient knowledge of OPWDD operations.

OPWDD has specified and State and Federal oversight agencies have agreed to a set of procedures for independent practitioners to minimally perform in addition to any others determined necessary in the professional judgment of the practitioner to satisfy GAGAS requirements. Procedures a through j, as listed below, will be performed by the independent practitioner on Schedules: CFR-1, lines 10, 11, 12, 13, 14, 16,17, 20, 41,48, 63, 64 through 67, 69 through 107; CFR-2; CFR-3; CFR-4; CFR 4-A and CFR-5; DMH -1; OPWDD – 3; OPWDD-4; and OMH-1 to satisfy the requirements of CFR Certification.

a. Obtain and review the Consolidated Fiscal Reporting Manual as modified with the agreement of both NYS and CMS, as it relates to the schedules listed above. Ensure that the manual is consistent with GAAP and Publication 15 and any material changes from the prior year, or inconsistency from Medicare Cost and Cost Allocation principles were approved by CMS.

b. The independent practitioner should discuss the procedures (written or informal) with the personnel assigned responsibility of supervising the preparation and maintenance of the CFR to ascertain:

    - The extent to which the OPWDD followed the established procedures on a continuous basis; and

    - The extent to which OPWDD is in compliance with GAAP and Publication-15 cost and cost allocation principles; and

- Whether they believe such procedures are adequate to result in accurate reporting of data required by the CFR

c. Inquire of same person concerning the retention policy that is followed by OPWDD, and any other State or non-State agency or entity, with respect to source documents supporting the CFR.

d. Based on a description of the procedures obtained in items b and c above, identify all the source documents which are to be retained by the OPWDD, or any other State Agency, used in the CFR, for a minimum of seven years. For each type of source document, observe that the document exists for the period.

e. Discuss the system of internal controls with the person responsible for supervising and maintaining the CFR data. Inquire whether personnel independent of the preparer reviews the source documents and data summaries for completeness, accuracy and reasonableness and how often such reviews are performed. Perform tests, as appropriate, to ensure these reviews are performed.

f. Test the mathematical accuracy of the report.

g. Ensure summarization schedules agree to detail schedules, as prescribed by the CFR Manual as modified with the agreement of both NYS and CMS.

h. Obtain the supporting worksheets/reports utilized by the agency to prepare the final data which are transcribed to the CFR. Compare the data included on the worksheets to the amounts reported in the CFR. Test the arithmetical accuracy of the summarizations.

i. Verify that the books and records fully support the total of each amount entered on each line, and column, of the specified CFR schedules. Identify significant reconciling items and conclude on their propriety; and

j. Verify that the total expenditures used to prepare the CFR agree to the Office of the State Comptroller (OSC) data for OPWDD, and report any variance from the OSC data.

The independent practitioner must adequately document the engagement planning, specific procedures followed, personnel interviewed, documents reviewed, tests performed, and conclusions reached in the work papers. The work papers should be available for State and Federal Agencies review for a minimum of seven years following the CFR report year.

The independent practitioner may perform additional procedures which are agreed to by the independent practitioner and the OPWDD, if desired. The independent practitioner should clearly identify the additional procedures performed in a separate attachment to the certification report as procedures that were agreed to by the OPWDD and the independent practitioner.

Addendum A.2 Audit Organization's Report

The following is a sample report on an audit organization's examination of a CFR prepared by OPWDD which has been determined acceptable for CMS purposes. Material omissions in an actual report may result in CMS rejecting the report.

[*Addressee*]

We examined the Consolidated Fiscal Report (CFR) prepared by the New York State Office for People With Developmental Disabilities (OPWDD) for its fiscal year ended March 31, 20XX (Document Control Number ####). OPWDD's management is responsible for implementing and maintaining internal controls that ensure the CFR's conformity with all applicable requirements, including adherence to the New York State Consolidated Fiscal Reporting and Claiming Manual and any exceptions thereto for which approvals of the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) takes precedence. OPWDD management identified for us the following such exceptions as being applicable to the CFR which is the subject of our examination:

1. Agreement between OPWDD and CMS dated [insert date] on [insert topic and brief overview of key matters].

2. State Plan Amendment [insert identifying number] approved by CMS on [insert date] regarding [insert topic and brief overview of key matters].

3. Etc.

Our responsibility is to obtain sufficient, appropriate evidence to express an opinion on whether OPWDD's reported CFR data is complete and in compliance with required criteria in all material respects.

We performed an examination-level attestation engagement conducted in accordance with the standards and guidance contained in Government Auditing Standards issued by the Comptroller General of the United States (2011 revision) which is commonly referred to as generally accepted government auditing standards. These standards require that we design our engagement to provide reasonable assurance of detecting fraud, illegal acts, or violations of provisions of contracts or grant agreements that could have a material effect on OPWDD's CFR.

We obtained an understanding of internal control as it relates to OPWDD's CFR. A deficiency in internal control exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, detect, or correct errors in assertions made by management, on a timely basis. A deficiency in design exists when (1) a control necessary to meet the control objective is missing or (2) an existing control is not properly designed so that, even if the control operates as designed, the control objective is not met. A deficiency in operation exists when a properly designed control does not operate as designed, or when the person performing the control does not possess the necessary authority or qualifications to perform the control effectively. Deficiencies in internal control, if any, are identified in our findings below.

Addendum A.2 Audit Organization's Report

In our opinion, except as noted in our findings below, OPWDD's reported CFR data is complete and in compliance with required criteria in all material respects.

Findings

1.
2.
3.

Recommendations

1.
2.
3.

[*Signature*]
[*Date*]

Addendum A.3

INDIVIDUAL AND COMMUNITY SUPPORTS PERSONAL RESOURCE ACCOUNT (PRA) ANNUAL ALLOCATION

These amounts represent the **OPWDD gross amount** of the total available PRA.

Bernard Fineson, Brooklyn, Metro, Staten Island DDSOs

2	3	4	5	6	7	8	9	10	11	12	13	14
LEVELS	Behavior 1			Behavior 2			Behavior 3			Behavior 4		
	Residential	Day	Total	Residential	Day	Total	Residential	Day	Total	Residential	Day	Total
Direct Care Support - 1	$ 69,185	$ 23,316	$ 92,501	$ 70,578	$ 24,230	$ 94,807	$ 71,801	$ 25,377	$ 97,178	$ 72,919	$ 25,805	$ 98,724
Direct Care Support - 2	$ 78,548	$ 24,612	$ 103,160	$ 79,494	$ 25,377	$ 104,871	$ 80,803	$ 26,727	$ 107,530	$ 81,998	$ 27,939	$ 109,937
Direct Care Support - 3	$ 89,948	$ 28,042	$ 117,990	$ 91,129	$ 28,677	$ 119,806	$ 91,919	$ 29,663	$ 121,582	$ 92,900	$ 30,921	$ 123,821
Direct Care Support - 4	$ 97,422	$ 31,000	$ 128,421	$ 99,209	$ 31,770	$ 130,979	$ 100,858	$ 32,757	$ 133,615	$ 102,084	$ 33,718	$ 135,802
Direct Care Support - 5	$ 107,863	$ 33,686	$ 141,549	$ 110,713	$ 34,559	$ 145,273	$ 112,112	$ 35,318	$ 147,431	$ 113,309	$ 36,439	$ 149,748
Direct Care Support - 6	$ 115,172	$ 36,857	$ 152,029	$ 117,594	$ 37,613	$ 155,207	$ 119,213	$ 38,377	$ 157,590	$ 120,994	$ 39,215	$ 160,209
Direct Care Support - 7	$ 122,788	$ 37,473	$ 160,261	$ 123,895	$ 38,115	$ 162,011	$ 124,923	$ 38,620	$ 163,544	$ 126,703	$ 39,884	$ 166,587
Direct Care Support - 8	$ 129,665	$ 39,915	$ 169,579	$ 131,473	$ 40,842	$ 172,314	$ 132,464	$ 41,981	$ 174,445	$ 133,722	$ 43,348	$ 177,070

Hudson Valley, Long Island DDSOs

LEVELS	Behavior 1			Behavior 2			Behavior 3			Behavior 4		
	Residential	Day	Total	Residential	Day	Total	Residential	Day	Total	Residential	Day	Total
Direct Care Support - 1	$ 63,329	$ 19,946	$ 83,275	$ 64,602	$ 20,650	$ 85,252	$ 65,719	$ 21,354	$ 87,074	$ 66,741	$ 22,058	$ 88,799
Direct Care Support - 2	$ 71,884	$ 22,762	$ 94,647	$ 72,749	$ 23,466	$ 96,216	$ 73,945	$ 24,170	$ 98,116	$ 75,037	$ 24,875	$ 99,912
Direct Care Support - 3	$ 82,301	$ 25,579	$ 107,880	$ 83,380	$ 26,283	$ 109,663	$ 84,102	$ 26,987	$ 111,089	$ 84,999	$ 27,691	$ 112,689
Direct Care Support - 4	$ 89,130	$ 28,395	$ 117,525	$ 90,763	$ 29,099	$ 119,862	$ 92,270	$ 29,803	$ 122,073	$ 93,390	$ 30,507	$ 123,897
Direct Care Support - 5	$ 98,671	$ 31,211	$ 129,882	$ 101,275	$ 31,915	$ 133,190	$ 102,553	$ 32,619	$ 135,172	$ 103,647	$ 33,323	$ 136,970
Direct Care Support - 6	$ 105,349	$ 34,027	$ 139,376	$ 107,563	$ 34,731	$ 142,294	$ 109,042	$ 35,435	$ 144,477	$ 110,669	$ 36,139	$ 146,808
Direct Care Support - 7	$ 112,308	$ 36,843	$ 149,151	$ 113,320	$ 37,547	$ 150,867	$ 114,259	$ 38,251	$ 152,511	$ 115,885	$ 38,955	$ 154,840
Direct Care Support - 8	$ 118,592	$ 39,659	$ 158,251	$ 120,244	$ 40,363	$ 160,607	$ 121,150	$ 41,067	$ 162,217	$ 122,299	$ 42,652	$ 164,951

Broome, Capital District, Central, Finger Lakes, Sunmount, Taconic, Western DDSOs

LEVELS	Behavior 1			Behavior 2			Behavior 3			Behavior 4		
	Residential	Day	Total	Residential	Day	Total	Residential	Day	Total	Residential	Day	Total
Direct Care Support - 1	$ 56,002	$ 17,251	$ 73,252	$ 57,124	$ 17,853	$ 74,977	$ 58,110	$ 18,455	$ 76,565	$ 59,011	$ 19,057	$ 78,068
Direct Care Support - 2	$ 63,546	$ 19,660	$ 83,206	$ 64,309	$ 20,262	$ 84,571	$ 65,364	$ 20,864	$ 86,228	$ 66,327	$ 21,466	$ 87,793
Direct Care Support - 3	$ 72,733	$ 22,069	$ 94,801	$ 73,684	$ 22,671	$ 96,355	$ 74,321	$ 23,273	$ 97,594	$ 75,112	$ 23,875	$ 98,987
Direct Care Support - 4	$ 78,755	$ 24,478	$ 103,233	$ 80,195	$ 25,080	$ 105,275	$ 81,524	$ 25,682	$ 107,206	$ 82,512	$ 26,284	$ 108,796
Direct Care Support - 5	$ 87,169	$ 26,887	$ 114,055	$ 89,466	$ 27,489	$ 116,954	$ 90,593	$ 28,091	$ 118,684	$ 91,557	$ 28,693	$ 120,250
Direct Care Support - 6	$ 93,058	$ 29,296	$ 122,354	$ 95,010	$ 29,898	$ 124,908	$ 96,314	$ 30,500	$ 126,814	$ 97,750	$ 31,102	$ 128,852
Direct Care Support - 7	$ 99,195	$ 31,705	$ 130,900	$ 100,087	$ 32,307	$ 132,394	$ 100,916	$ 32,909	$ 133,825	$ 102,350	$ 33,511	$ 135,861
Direct Care Support - 8	$ 104,737	$ 34,114	$ 138,850	$ 106,193	$ 34,716	$ 140,909	$ 106,992	$ 35,318	$ 142,310	$ 108,006	$ 36,674	$ 144,680

Note: These amounts include Clinic Services and any services billed on the Medicaid card except nursing services. These amounts include State Plan Services, such as Personal Care/Home Health Aide services, Medicaid Service Coordination and clinic services. Any Housing Stipends granted are Net of Countable Income, will be included in the PRA value, thereby reducing the amount available for services. Health Care Enhancements, Transportation and all administration, including Fiscal Management Services payments are included. Persons < 22 years old and receiving services or eligible to receive services through the school district and residing with parents or legal guardian, will receive only 60% of the value of the Residential PRA.

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Addendum A.3

INDIVIDUAL AND COMMUNITY SUPPORTS PERSONAL RESOURCE ACCOUNT (PRA) ANNUAL ALLOCATION

These amounts represent the **OPWDD gross amount** of the total available PRA.

Bernard Fineson, Brooklyn, Metro, Staten Island DDSOs

2	3	4	5	6	7	8	9	10	11	12	13	14
LEVELS	Behavior 1			Behavior 2			Behavior 3			Behavior 4		
	Residential	Day	Total	Residential	Day	Total	Residential	Day	Total	Residential	Day	Total
Direct Care Support - 1	$ 53,192	$ 15,349	$ 68,541	$ 54,340	$ 16,103	$ 70,443	$ 55,350	$ 16,509	$ 71,859	$ 56,271	$ 17,403	$ 73,674
Direct Care Support - 2	$ 60,916	$ 16,419	$ 77,335	$ 61,697	$ 17,049	$ 78,746	$ 62,776	$ 18,169	$ 80,945	$ 63,762	$ 19,163	$ 82,925
Direct Care Support - 3	$ 70,322	$ 19,248	$ 89,570	$ 71,295	$ 19,772	$ 91,067	$ 71,946	$ 20,586	$ 92,532	$ 72,756	$ 21,624	$ 94,380
Direct Care Support - 4	$ 76,487	$ 21,688	$ 98,175	$ 77,962	$ 22,324	$ 100,286	$ 79,322	$ 23,138	$ 102,460	$ 80,332	$ 23,931	$ 104,263
Direct Care Support - 5	$ 85,101	$ 23,904	$ 109,005	$ 87,453	$ 24,625	$ 112,078	$ 88,606	$ 25,251	$ 113,857	$ 89,594	$ 26,175	$ 115,769
Direct Care Support - 6	$ 91,130	$ 26,522	$ 117,652	$ 93,130	$ 27,144	$ 120,274	$ 94,464	$ 27,775	$ 122,239	$ 95,934	$ 28,466	$ 124,400
Direct Care Support - 7	$ 97,414	$ 27,030	$ 124,444	$ 98,327	$ 27,559	$ 125,886	$ 99,175	$ 27,975	$ 127,150	$ 100,643	$ 29,017	$ 129,660
Direct Care Support - 8	$ 103,087	$ 29,043	$ 132,130	$ 104,578	$ 29,808	$ 134,386	$ 105,397	$ 30,748	$ 136,145	$ 106,435	$ 31,876	$ 138,311

Hudson Valley, Long Island DDSOs

LEVELS	Behavior 1			Behavior 2			Behavior 3			Behavior 4		
	Residential	Day	Total	Residential	Day	Total	Residential	Day	Total	Residential	Day	Total
Direct Care Support - 1	$ 48,360	$ 12,569	$ 60,929	$ 49,410	$ 13,150	$ 62,560	$ 50,332	$ 13,731	$ 64,063	$ 51,174	$ 14,312	$ 65,486
Direct Care Support - 2	$ 55,418	$ 14,893	$ 70,311	$ 56,132	$ 15,473	$ 71,605	$ 57,119	$ 16,054	$ 73,173	$ 58,020	$ 16,635	$ 74,655
Direct Care Support - 3	$ 64,012	$ 17,216	$ 81,228	$ 64,902	$ 17,797	$ 82,699	$ 65,497	$ 18,377	$ 83,874	$ 66,237	$ 18,958	$ 85,195
Direct Care Support - 4	$ 69,646	$ 19,539	$ 89,185	$ 70,993	$ 20,120	$ 91,113	$ 72,237	$ 20,701	$ 92,938	$ 73,160	$ 21,281	$ 94,441
Direct Care Support - 5	$ 77,517	$ 21,862	$ 99,379	$ 79,666	$ 22,443	$ 102,109	$ 80,720	$ 23,024	$ 103,744	$ 81,622	$ 23,605	$ 105,227
Direct Care Support - 6	$ 83,027	$ 24,186	$ 107,213	$ 84,853	$ 24,767	$ 109,620	$ 86,073	$ 25,348	$ 111,421	$ 87,416	$ 25,929	$ 113,345
Direct Care Support - 7	$ 88,768	$ 26,509	$ 115,277	$ 89,602	$ 27,090	$ 116,692	$ 90,378	$ 27,671	$ 118,049	$ 91,719	$ 28,252	$ 119,971
Direct Care Support - 8	$ 93,952	$ 28,833	$ 122,785	$ 95,314	$ 29,413	$ 124,727	$ 96,062	$ 29,994	$ 126,056	$ 97,011	$ 31,302	$ 128,313

Broome, Capital District, Central, Finger Lakes, Sunmount, Taconic, Western DDSOs

LEVELS	Behavior 1			Behavior 2			Behavior 3			Behavior 4		
	Residential	Day	Total	Residential	Day	Total	Residential	Day	Total	Residential	Day	Total
Direct Care Support - 1	$ 42,315	$ 10,345	$ 52,660	$ 43,240	$ 10,842	$ 54,082	$ 44,054	$ 11,339	$ 55,393	$ 44,797	$ 11,836	$ 56,633
Direct Care Support - 2	$ 48,539	$ 12,333	$ 60,872	$ 49,169	$ 12,829	$ 61,998	$ 50,038	$ 13,327	$ 63,365	$ 50,833	$ 13,823	$ 64,656
Direct Care Support - 3	$ 56,118	$ 14,320	$ 70,438	$ 56,903	$ 14,817	$ 71,720	$ 57,428	$ 15,314	$ 72,742	$ 58,081	$ 15,811	$ 73,892
Direct Care Support - 4	$ 61,087	$ 16,308	$ 77,395	$ 62,275	$ 16,804	$ 79,079	$ 63,371	$ 17,302	$ 80,673	$ 64,186	$ 17,798	$ 81,984
Direct Care Support - 5	$ 68,028	$ 18,295	$ 86,323	$ 69,923	$ 18,792	$ 88,715	$ 70,852	$ 19,289	$ 90,141	$ 71,649	$ 19,786	$ 91,435
Direct Care Support - 6	$ 72,847	$ 20,282	$ 93,129	$ 74,497	$ 20,779	$ 95,276	$ 75,573	$ 21,276	$ 96,849	$ 76,757	$ 21,773	$ 98,530
Direct Care Support - 7	$ 77,950	$ 22,270	$ 100,220	$ 78,686	$ 22,766	$ 101,452	$ 79,369	$ 23,264	$ 102,633	$ 80,552	$ 23,671	$ 104,223
Direct Care Support - 8	$ 82,521	$ 24,257	$ 106,778	$ 83,723	$ 24,754	$ 108,477	$ 84,382	$ 25,251	$ 109,633	$ 85,218	$ 26,369	$ 111,587

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Addendum A.3

INDIVIDUAL AND COMMUNITY SUPPORTS PERSONAL RESOURCE ACCOUNT (PRA) ANNUAL ALLOCATION

These amounts represent the **OPWDD gross amount** of the total available PRA.

Bernard Fineson, Brooklyn, Metro, Staten Island DDSOs

2	3	4	5	6	7	8	9	10	11	12	13	14
LEVELS	Behavior 1			Behavior 2			Behavior 3			Behavior 4		
	Residential	Day	Total	Residential	Day	Total	Residential	Day	Total	Residential	Day	Total
Direct Care Support - 1	$ 53,708	$ 15,935	$ 69,643	$ 54,861	$ 16,708	$ 71,569	$ 55,876	$ 17,134	$ 73,010	$ 56,803	$ 18,040	$ 74,843
Direct Care Support - 2	$ 61,432	$ 17,005	$ 78,437	$ 62,218	$ 17,654	$ 79,872	$ 63,302	$ 18,794	$ 82,096	$ 64,294	$ 19,800	$ 84,094
Direct Care Support - 3	$ 70,838	$ 19,834	$ 90,672	$ 71,816	$ 20,377	$ 92,193	$ 72,472	$ 21,211	$ 93,683	$ 73,288	$ 22,261	$ 95,549
Direct Care Support - 4	$ 77,003	$ 22,274	$ 99,277	$ 78,483	$ 22,929	$ 101,412	$ 79,848	$ 23,763	$ 103,611	$ 80,864	$ 24,568	$ 105,432
Direct Care Support - 5	$ 85,617	$ 24,490	$ 110,107	$ 87,974	$ 25,230	$ 113,204	$ 89,132	$ 25,876	$ 115,008	$ 90,126	$ 26,812	$ 116,938
Direct Care Support - 6	$ 91,646	$ 27,108	$ 118,754	$ 93,651	$ 27,749	$ 121,400	$ 94,990	$ 28,400	$ 123,390	$ 96,466	$ 29,103	$ 125,569
Direct Care Support - 7	$ 97,930	$ 27,616	$ 125,546	$ 98,848	$ 28,164	$ 127,012	$ 99,701	$ 28,600	$ 128,301	$ 101,175	$ 29,654	$ 130,829
Direct Care Support - 8	$ 103,603	$ 29,629	$ 133,232	$ 105,099	$ 30,413	$ 135,512	$ 105,923	$ 31,324	$ 137,247	$ 106,967	$ 32,513	$ 139,480

Hudson Valley, Long Island DDSOs

LEVELS	Behavior 1			Behavior 2			Behavior 3			Behavior 4		
	Residential	Day	Total	Residential	Day	Total	Residential	Day	Total	Residential	Day	Total
Direct Care Support - 1	$ 48,830	$ 13,145	$ 61,975	$ 49,885	$ 13,744	$ 63,629	$ 50,812	$ 14,344	$ 65,156	$ 51,659	$ 14,938	$ 66,597
Direct Care Support - 2	$ 55,888	$ 15,469	$ 71,357	$ 56,607	$ 16,067	$ 72,674	$ 57,599	$ 16,667	$ 74,266	$ 58,505	$ 17,261	$ 75,766
Direct Care Support - 3	$ 64,482	$ 17,792	$ 82,274	$ 65,377	$ 18,391	$ 83,768	$ 65,977	$ 18,990	$ 84,967	$ 66,722	$ 19,584	$ 86,306
Direct Care Support - 4	$ 70,116	$ 20,115	$ 90,231	$ 71,468	$ 20,714	$ 92,182	$ 72,717	$ 21,314	$ 94,031	$ 73,645	$ 21,907	$ 95,552
Direct Care Support - 5	$ 77,987	$ 22,438	$ 100,425	$ 80,141	$ 23,037	$ 103,178	$ 81,200	$ 23,637	$ 104,837	$ 82,107	$ 24,231	$ 106,338
Direct Care Support - 6	$ 83,497	$ 24,762	$ 108,259	$ 85,328	$ 25,361	$ 110,689	$ 86,553	$ 25,961	$ 112,514	$ 87,901	$ 26,555	$ 114,456
Direct Care Support - 7	$ 89,248	$ 27,085	$ 116,333	$ 90,077	$ 27,684	$ 117,761	$ 90,858	$ 28,284	$ 119,142	$ 92,204	$ 28,878	$ 121,082
Direct Care Support - 8	$ 94,422	$ 29,409	$ 123,831	$ 95,789	$ 30,007	$ 125,796	$ 96,542	$ 30,607	$ 127,149	$ 97,496	$ 31,928	$ 129,424

Broome, Capital District, Central, Finger Lakes, Sunmount, Taconic, Western DDSOs

LEVELS	Behavior 1			Behavior 2			Behavior 3			Behavior 4		
	Residential	Day	Total	Residential	Day	Total	Residential	Day	Total	Residential	Day	Total
Direct Care Support - 1	$ 42,728	$ 10,830	$ 53,558	$ 43,657	$ 11,343	$ 55,000	$ 44,475	$ 11,856	$ 56,331	$ 45,223	$ 12,363	$ 57,586
Direct Care Support - 2	$ 48,952	$ 12,818	$ 61,770	$ 49,586	$ 13,330	$ 62,916	$ 50,459	$ 13,844	$ 64,303	$ 51,259	$ 14,350	$ 65,609
Direct Care Support - 3	$ 56,531	$ 14,805	$ 71,336	$ 57,320	$ 15,318	$ 72,638	$ 57,849	$ 15,831	$ 73,680	$ 58,507	$ 16,338	$ 74,845
Direct Care Support - 4	$ 61,500	$ 16,793	$ 78,293	$ 62,692	$ 17,305	$ 79,997	$ 63,792	$ 17,819	$ 81,611	$ 64,612	$ 18,325	$ 82,937
Direct Care Support - 5	$ 68,441	$ 18,780	$ 87,221	$ 70,340	$ 19,293	$ 89,633	$ 71,273	$ 19,806	$ 91,079	$ 72,075	$ 20,313	$ 92,388
Direct Care Support - 6	$ 73,260	$ 20,767	$ 94,027	$ 74,914	$ 21,280	$ 96,194	$ 75,997	$ 21,793	$ 97,790	$ 77,183	$ 22,300	$ 99,483
Direct Care Support - 7	$ 78,363	$ 22,755	$ 101,118	$ 79,103	$ 23,267	$ 102,370	$ 79,790	$ 23,781	$ 103,571	$ 80,978	$ 24,198	$ 105,176
Direct Care Support - 8	$ 82,934	$ 24,742	$ 107,676	$ 84,140	$ 25,255	$ 109,395	$ 84,803	$ 25,768	$ 110,571	$ 85,644	$ 26,896	$ 112,540

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Addendum A.3

INDIVIDUAL AND COMMUNITY SUPPORTS PERSONAL RESOURCE ACCOUNT (PRA) ANNUAL ALLOCATION

These amounts represent the **OPWDD gross amount** of the total available PRA.

Bernard Fineson, Brooklyn, Metro, Staten Island DDSOs

2	3	4	5	6	7	8	9	10	11	12	13	14
LEVELS	Behavior 1			Behavior 2			Behavior 3			Behavior 4		
	Residential	Day	Total	Residential	Day	Total	Residential	Day	Total	Residential	Day	Total
Direct Care Support - 1	$ 54,224	$ 16,522	$ 70,746	$ 55,383	$ 17,314	$ 72,697	$ 56,403	$ 17,759	$ 74,162	$ 57,335	$ 18,678	$ 76,013
Direct Care Support - 2	$ 61,948	$ 17,592	$ 79,540	$ 62,740	$ 18,260	$ 81,000	$ 63,829	$ 19,419	$ 83,248	$ 64,826	$ 20,438	$ 85,264
Direct Care Support - 3	$ 71,354	$ 20,421	$ 91,775	$ 72,338	$ 20,983	$ 93,321	$ 72,999	$ 21,836	$ 94,835	$ 73,820	$ 22,899	$ 96,719
Direct Care Support - 4	$ 77,519	$ 22,861	$ 100,380	$ 79,005	$ 23,535	$ 102,540	$ 80,375	$ 24,388	$ 104,763	$ 81,396	$ 25,206	$ 106,602
Direct Care Support - 5	$ 86,133	$ 25,077	$ 111,210	$ 88,496	$ 25,836	$ 114,332	$ 89,659	$ 26,501	$ 116,160	$ 90,658	$ 27,450	$ 118,108
Direct Care Support - 6	$ 92,162	$ 27,695	$ 119,857	$ 94,173	$ 28,355	$ 122,528	$ 95,517	$ 29,025	$ 124,542	$ 96,998	$ 29,741	$ 126,739
Direct Care Support - 7	$ 98,446	$ 28,203	$ 126,649	$ 99,370	$ 28,770	$ 128,140	$ 100,228	$ 29,225	$ 129,453	$ 101,707	$ 30,292	$ 131,999
Direct Care Support - 8	$ 104,119	$ 30,216	$ 134,335	$ 105,621	$ 31,019	$ 136,640	$ 106,450	$ 31,900	$ 138,350	$ 107,499	$ 33,151	$ 140,650

Hudson Valley, Long Island DDSOs

LEVELS	Behavior 1			Behavior 2			Behavior 3			Behavior 4		
	Residential	Day	Total	Residential	Day	Total	Residential	Day	Total	Residential	Day	Total
Direct Care Support - 1	$ 49,301	$ 13,721	$ 63,022	$ 50,361	$ 14,339	$ 64,700	$ 51,292	$ 14,958	$ 66,250	$ 52,144	$ 15,564	$ 67,708
Direct Care Support - 2	$ 56,359	$ 16,045	$ 72,404	$ 57,083	$ 16,662	$ 73,745	$ 58,079	$ 17,281	$ 75,360	$ 58,990	$ 17,887	$ 76,877
Direct Care Support - 3	$ 64,953	$ 18,368	$ 83,321	$ 65,853	$ 18,986	$ 84,839	$ 66,457	$ 19,604	$ 86,061	$ 67,207	$ 20,210	$ 87,417
Direct Care Support - 4	$ 70,587	$ 20,691	$ 91,278	$ 71,944	$ 21,309	$ 93,253	$ 73,197	$ 21,928	$ 95,125	$ 74,130	$ 22,533	$ 96,663
Direct Care Support - 5	$ 78,458	$ 23,014	$ 101,472	$ 80,617	$ 23,632	$ 104,249	$ 81,680	$ 24,251	$ 105,931	$ 82,592	$ 24,857	$ 107,449
Direct Care Support - 6	$ 83,968	$ 25,338	$ 109,306	$ 85,804	$ 25,956	$ 111,760	$ 87,033	$ 26,575	$ 113,608	$ 88,386	$ 27,181	$ 115,567
Direct Care Support - 7	$ 89,709	$ 27,661	$ 117,370	$ 90,553	$ 28,279	$ 118,832	$ 91,338	$ 28,898	$ 120,236	$ 92,689	$ 29,504	$ 122,193
Direct Care Support - 8	$ 94,893	$ 29,985	$ 124,878	$ 96,265	$ 30,602	$ 126,867	$ 97,022	$ 31,221	$ 128,243	$ 97,981	$ 32,554	$ 130,535

Broome, Capital District, Central, Finger Lakes, Sunmount, Taconic, Western DDSOs

LEVELS	Behavior 1			Behavior 2			Behavior 3			Behavior 4		
	Residential	Day	Total	Residential	Day	Total	Residential	Day	Total	Residential	Day	Total
Direct Care Support - 1	$ 43,141	$ 11,316	$ 54,457	$ 44,075	$ 11,844	$ 55,919	$ 44,897	$ 12,373	$ 57,270	$ 45,649	$ 12,891	$ 58,540
Direct Care Support - 2	$ 49,365	$ 13,304	$ 62,669	$ 50,004	$ 13,831	$ 63,835	$ 50,881	$ 14,361	$ 65,242	$ 51,685	$ 14,878	$ 66,563
Direct Care Support - 3	$ 56,944	$ 15,291	$ 72,235	$ 57,738	$ 15,819	$ 73,557	$ 58,271	$ 16,348	$ 74,619	$ 58,933	$ 16,866	$ 75,799
Direct Care Support - 4	$ 61,913	$ 17,279	$ 79,192	$ 63,110	$ 17,806	$ 80,916	$ 64,214	$ 18,336	$ 82,550	$ 65,038	$ 18,853	$ 83,891
Direct Care Support - 5	$ 68,854	$ 19,266	$ 88,120	$ 70,758	$ 19,794	$ 90,552	$ 71,695	$ 20,323	$ 92,018	$ 72,501	$ 20,841	$ 93,342
Direct Care Support - 6	$ 73,673	$ 21,253	$ 94,926	$ 75,332	$ 21,781	$ 97,113	$ 76,416	$ 22,310	$ 98,726	$ 77,609	$ 22,828	$ 100,437
Direct Care Support - 7	$ 78,776	$ 23,241	$ 102,017	$ 79,521	$ 23,768	$ 103,289	$ 80,212	$ 24,298	$ 104,510	$ 81,404	$ 24,726	$ 106,130
Direct Care Support - 8	$ 83,347	$ 25,228	$ 108,575	$ 84,558	$ 25,756	$ 110,314	$ 85,225	$ 26,285	$ 111,510	$ 86,070	$ 27,424	$ 113,494

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NEW YORK STATE OF OPPORTUNITY. Office for People With Developmental Disabilities

Addendum A.4

Individual Directed Goods and Services (IDGS) Definitions Chart

TABLE 1: Allowable IDGS Expenses

IDGS Category	Available To Individuals in Certified Residences?	Description	Qualifications	Pricing Parameters
Camp	• No	• Funding may be requested for the cost of summer camp in a self-directed plan for a camp that is able to provide the needed safeguarding supports and supports to achieve the person's valued outcomes. • Camps can be either focused on supporting individuals with disabilities or camps that are available to the general public. • Directly related to a valued outcome.	• For a children's camp, a state, city, or county health department permit to operate legally and must operate in compliance with Subpart 7-2 of the State Sanitary Code requirements. A permit is issued only when the camp is in compliance with the state's health regulations.	• Not to exceed published fees • Annual cap $4000/year.
Community Classes & Publicly Available Training/Coaching	• Yes	• Classes available to the general public in any subject area that relates to a person's valued outcomes (Art, Dance, Exercise, Cooking, Computer Training, Etc.) • Sessions with a private trainer (physical education/exercise) may be covered as long as the service relates to a valued outcome). • Classes must be related to a habilitative need in the individual's person-centered plan and not just for recreational purposes. • Classes must be non-credit bearing; IDGS funding is for non-matriculating students.		• Not to exceed the published fees as outlined in the entity's published course fees.

Coaching/ education for parent(s), spouse and advocates involved in the person's self-directed services	• No	• IDGS funding is for Parent/Spouse/Advocate to attend/participate in educational opportunities (not covered by other public programs) that assist participants and those close to them to achieve goals established in the individual's service plan. • Self-directing individual is over age 18 (Under 18 is through FET). • May Include registration, and conference fees.		• Annual cap $500/year based on Family Education & Training (FET) pricing parameters in 1915(c) HCBS waiver. • Reimbursement is only up to FET reimbursement levels; overnight lodging or travel not allowable.
Clinician Consultants, Independent Contractors – (Non-Direct Service Provision -- Clinical Consultation Specialties)	• Yes, but only related to self-directed services	• Consultants/contractors are clinical specialists who are hired for the following purpose: ▪ Evaluate an individual's habilitation plan ▪ Training self-hired staff in delivering the self-directed plan (NOTE: State Plan clinic services may not be used to train and consult with paid caregivers. To the extent that IDGS Consultation services are being used to train self-hired staff, who might otherwise not have such resources available to them, it will not duplicate State Plan services) ▪ Evaluation of the effectiveness of the self-hired staff in carrying out the services in the self-directed plan • Consultants/contractors services cannot replicate any service available through a third-party insurer, the Medicaid State Plan or the HCBS Waiver Service. • Consultants must provide a written outline of services to be delivered prior to approval; consultants must provide an annual update of progress/provision of service and need to continue.	• A consultant/ contractor who is a member of a profession that is under the jurisdiction of the NYSED Office of the Professions, must meet all licensure or registration requirements as verified at the following site: http://www.op.nysed.gov/opsearches.htm • Discipline authorized under Article 16 clinic regulations (Psychology, OT, PT, SLP, social work, nursing, nutrition/ dietetics, rehabilitation counseling)	The hourly amount paid to the therapist cannot exceed the 90th percentile for the hourly wage for the therapeutic or consultant's professional discipline (i.e., the standard occupational code) published by the Bureau of Labor Statistics (BLS) and is identified in the table below

Clinician (Direct-Provision of Therapies/ Therapeutic Activities Not Otherwise Funded in the State Plan)	• Yes, but only related to self-directed services	<u>Hippo Therapy:</u> A treatment strategy by physical therapists, occupational therapists, and speech language pathologists that is incorporated into the professional's plan of care to achieve functional outcomes. Hippo therapy is a medical treatment, not a recreational program of teaching a progressive riding and horsemanship skill. • Funding may be requested for hippo therapy in a self-directed plan by individuals with cerebral palsy and other neurological disorders that permanently affect body movement and muscle coordination. • Funding may be requested for hippo therapy in a self-directed plan by Individuals with cerebral palsy and other neurological disorders that permanently affect body movement and muscle coordination. <u>Therapeutic Riding & Equine-assisted Activities</u> • <u>Therapeutic Riding</u> and equine-assisted activities address and contribute positively to the cognitive, physical, emotional and social well-being of individuals with special needs. Therapeutic riding and equine-assisted activities are taught by a PATH International Instructor to individuals five (5) years old and older. • The PATH instructor will provide written policies on the eligibility and discharge of individual, written documentation of the initial evaluation of the individual and written progress notes for the individual. The initial evaluation of abilities establishes the appropriate goals and objectives for the individual and the progress notes document the achievements and problem areas. The discharge should be supported by appropriate documentation that shows a baseline for goals and objectives and a recommended course	<u>Hippo Therapy</u> • An individual providing hippo therapy **<u>must</u>** be a NYS licensed Occupational, Physical or Speech Therapist; if he/she is an Assistant in one of those categories (OTA, PTA) then he/she **<u>must</u>** be working under an OT or PT. <u>Therapeutic Riding & Equine Assisted Activities</u> • PATH International Instructor must carry a certification business card with an annual expiration date, and must requalify each year to be certified	The hourly amount paid to the therapist cannot exceed the 90th percentile for the hourly wage for the therapeutic or consultant's professional discipline (i.e., the standard occupational code) published by the Bureau of Labor Statistics (BLS) and is identified in the table below.

Clinician (Direct-Provision of Therapies/ Therapeutic Activities Not Otherwise Funded in the State Plan)	• Yes, but only related to self-directed services	of action when continued participation is no longer appropriate. Instructors communicate with the individual/parents/guardians at the start and at the end of the session (6-8 weeks) to discuss the goals, objectives, accomplishments and the next steps, and best practice includes mid-session meetings and informal discussions each time the individual rode. • Individuals may engage in horseback riding and equine related activity as therapy or through a community class that is available to the general public. When individuals engage in community classes the activity must be in support of a valued outcome and paid based on published class prices. • Riding stables may offer both public classes and equine related therapies. Based on the purpose of the activity the rates and fees must be supported for billing purposes consistent with the guidance defined in this chart and other related guidance. <u>Aquatic, Art, Massage, Music, Play Therapy:</u> • <u>Funding for **massage therapy** may</u> be included in a self-directed plan when the service has been prescribed by the individual's medical doctor to ameliorate a specific medical diagnosis/condition for which massage therapy has recognized efficacy. Funding is not available to support vague goals such as "promote well-being," "reduce stress," or "promote relaxation." There must be a corresponding valued outcome in the individual's plan. • Funding for **music therapy** may be included in a Self Direction Budget only if there is a specific communication or audiological requirement for the service as stated in the plan and justified by the individual's medical doctor or licensed clinician, and a corresponding valued outcome.	<u>Aquatic, Art, Massage, Music, Play Therapy:</u> • A consultant/ contractor who is a member of a profession that is under the jurisdiction of the NYSED Office of the Professions, must meet all licensure or registration requirements as verified at the following site: <u>http://www.op.nysed.gov/opsearches.htm</u>	

Clinician (Direct-Provision of Therapies/ Therapeutic Activities Not Otherwise Funded in the State Plan)	• Yes, but only related to self-directed services	**All Services – Ordering, Treatment Plan & Documentation Requirements** • The request for funding **must** be accompanied by a written prescription from the individual's medical doctor with a goal of treating a specific medical diagnosis/ condition and shall support a specific valued outcome. • The therapist shall conduct an initial assessment, report findings, and propose a treatment plan. These documents are not required as part of the request for funding since these documents are not likely to be developed until after treatment begins. The treatment plan shall outline treatment goals, proposed therapeutic activities, and their anticipated frequency and duration. The treatment plan shall acknowledge the individual's personal goals and support a specific valued outcome(s) described in the ISP. The treatment plan becomes active upon the referring/prescribing medical doctor's review and written approval. • On-going treatment services shall be delivered only in accordance with the approved treatment plan. Each session shall be documented with a brief treatment note outlining the therapeutic services/activities performed, duration, and response to treatment. • The therapist shall provide periodic (at least semi-annual) progress reports to the referring/ prescribing medical doctor. Such report shall review the individual's progress toward goals and the efficacy of services to date; it shall propose any necessary updates/ revisions to the treatment plan. The medical doctor shall review the individual's progress and, if warranted, approve the updated treatment plan and continuation of services in writing.		

Health Club/ Organizational Memberships	• Yes	• Health club memberships; Community membership dues -- Funding for a gym, health club or other community organization membership may be included in the self-directed plan for reasons of health and fitness or community integration in accordance with the participant's valued outcomes. • Membership is for the individual only; no family memberships allowed with IDGS funding. • The club/organization must offer open enrollment to the public, and cannot be a private club with a closed membership where membership is available by invitation only. • An individual may have multiple memberships to health clubs.	• Payment not to exceed the entity's published membership dues/fees specified.	• Annual cap $1500/year.
Household-Related Items and Services	• No	• Item cannot be funded through any other funded program and may include Appliances that assist a person to live more independently (i.e., a microwave oven for someone who cannot safely use a stove or oven) • Appliance must benefit the individual and be related to a valued outcome as well as be related to health and safety. • Household support (cleaning, minor maintenance, snow removal, lawn mowing) only for individuals not living in the family home. • Note: The Community Transition Services (CTS) waiver service and funding cap remains separate from IDGS funding in this category.	• N/A	• Annual cap $1500/year.
Interpretation Services	• Yes, but only related to self-direction services	• Cannot duplicate any Medicaid funded service providers' requirement to communicate with the person, e.g. community habilitation, Medicaid Service Coordination, Hospitalizations • Includes language interpretation, but not translation services.	• Payment may not exceed the entity's established fees • Payment must be to a formal interpretation service	• Published fees cannot be exceeded.

Interpretation Services	• Yes, but only related to self-direction services	• Must be directly related to valued outcomes, safeguards and services identified and approved in the Self Direction Budget. In order to make the determination whether the interpretation is service related, and costs may be reimbursed, the questions to be answered are: 1. What valued outcome/safeguard is this activity in support of? 2. What service was the interpretation related to? 3. What service was actually provided? 4. Who provided the service?		
Paid Neighbor	• No	• Stipend paid to neighbor to be "on-call" to assist a person who lives independently. If the paid neighbor is called upon to provide direct services, he/she is paid an hourly wage for the delivery of self-hired or agency supported community habilitation. • The specific duties are defined in a contract signed by the paid neighbor and the Fiscal Intermediary.	• The paid neighbor staff person cannot be a family member of the person. • Must meet all requirements for background check, and training that would be required of a self-hired staff person.	• Monthly cap $800
Self-Directed Staffing Support	• Yes, but only related to self-directed services	• Assistance with scheduling self-hired staff and with assisting the person to complete staffing related paperwork. • Not to duplicate FI employer responsibilities or Broker services related to development of the person's self-directed plan. • The 'self-hired' staff person providing this support is not a staff person of a NFP agency and is not a person who is active in assisting the person with decision-making regarding his/her self-directed services (not a family-member or a member of the person's freely chosen planning team).	• All staff, volunteers and trainers are screened for criminal background and excluded provider status •	• Not to exceed payment of $20/hour

Transition Programs for Individuals with IDD	• No	• Tuition for non-credit bearing transition programs for individuals with IDD who have already completed their educational program (i.e. 'aged out'). • The coursework must address a person's valued outcomes and address skill building and employment outcomes. • Programs may be provided in non-site based settings, on college campuses, but not in locations certified by OPWDD. • Coursework may include training on personal care skills, and socialization skills, but this training is provided to support vocational outcomes for the person. • To be funded via a person's Self Direction Budget, the program cannot be funded by ACCESS-VR, IDEA or other funding sources. • Services are time-limited and cannot exceed a two year timeframe. • No room and board costs are fundable.	• All staff, volunteers and trainers are screened for criminal background and excluded provider status •	• Published fees cannot be exceeded. • Per class limit for tuition is $350/course. • Where tuition is on a monthly basis, not to exceed $800/month
Transportation	• Yes, only related to self-directed services	• Funding may be requested for the cost of service related transportation that is directly related to valued outcomes, safeguards and services identified and approved in the Self Direction Budget. In order to make the determination whether transportation is service related, and costs may be reimbursed, the questions to be answered are: 5. What valued outcome/safeguard is this activity in support of? 6. What service was this transportation related to? 7. What service was actually provided? 8. Who provided the service? • Transportation costs are not reimbursed through the Self Direction Budget for transportation to and from OPWDD funded services for which transportation costs are included in the price developed and paid for the service.	• Vehicle must be operated by a licensed driver.	• Mileage reimbursement not to exceed standard federal mileage rate: http://www.irs.gov/2014-Standard-Mileage-Rates-for-Business,-Medical-and-Moving-Announced • Reimbursement of public transportation and paratransport limited to published rates. Discounts for individuals with disabilities shall be requested, where available.

Transportation	• Yes, only related to self-directed services	• Mileage may not be reimbursed for medical appointments as this duplicates a State Plan service. • Transportation reimbursement takes several forms: 1. **Reimbursement for service related miles** may be made to: a. *Staff person* who drove his/her personal vehicle to a service related activity, b. *Participant* who drove or was driven in his/her personal vehicle to a service related activity, or c. *Friend or family* member who drove his/her personal vehicle to a service related activity. • Service related mileage may be paid from IDGS for transportation costs required for the individual to access a generic service in the community that is Medicaid reimbursable within the Self Direction Budget (directly related to a valued outcome or safeguard) regardless of whether or not there is a paid staff person present. • Mileage reimbursement covers all operating costs related to the vehicle and included in the IRS standard mileage rate standards, i.e., gas, registration, vehicle inspection, insurance, repairs & maintenance. • **Reimbursement for the cost of public transportation or paratransit**, such as bus passes, bus, taxi and train fares that is directly related to valued outcomes, safeguards and services identified and approved in the Self Direction Budget. Individuals may purchase metro cards under this category for self-hired staff providing habilitation supports as long as the card is kept in the possession of the individual and is only used during the provision of service.	• Vehicle must be operated by a licensed driver.	• Vendor transportation limited to published fees.

TABLE 2: The Following items cannot be funded through IDGS

Academic Tutoring	• Academic tutoring is **not** funded through the IDGS. This service should be pursued through the school district or college setting. Academic tutoring/homework assistance is not an appropriate task for self-hired staff.
Automatic pill dispenser/ medication system	• Available through Assistive Technology, outside the person's Self Direction Budget
Cell Phones/Telephones	• Funding for cell phones is not an allowable IDGS expense. • The SafeLink Wireless program is available to eligible individuals in New York State who receive Supplemental Security Income (SSI). • The SafeLink service in New York State allows for a cell phone and limited free minutes for a person who has a diagnosed developmental disability and receives social security benefits under SSI.
Computer Hardware	• Not allowable in IDGS
Computer Programs/Software	• Computer Software may be available through Assistive Technology, outside the person's Self Direction Budget.
Leased and Purchased Vehicles	• Leased or Purchased Vehicles **are not allowable expenses under IDGS.**
Health-Related Services, Equipment and Supplies	• Health related supplies such as food and beverage thickeners, trachea collars, disposable bed pads, wipes, incontinence products, and supplemental medications are funded through the State Plan only; not through IDGS funding.
Parents' Activity Fees, Expenses, and Meals	• Activity fees, expenses, and meals incurred by parents of individuals **are not** reimbursed with IDGS funds and must be paid by the parents when they accompany an individual to an activity supported by the his/her Self Direction Budget.
Participants' Activity Fees, Expenses, and Meals	• Activity fees, expenses, and meals incurred by individuals **are not** reimbursed with IDGS funds and must be paid by the individual or his/her family.
Personal Monitoring Systems	• Available through State Plan
Staff Activity Fees, Expenses, and Meals	• Activity fees, expenses, and meals incurred by self-hired staff supporting individuals are not reimbursed with IDGS funds, but may be funded through Other Than Personal Services.

Direct Clinician service delivery and Therapies: Physical Therapy, Occupational Therapy, Speech Therapy, Psychology (Medicaid state funded)	• On-going therapies that are provided directly to the person are funded through the individual's State Plan Medicaid Card or, if the individual is school-aged, through the local school district, and are **not** funded under IDGS.
Experimental Therapies	• Experimental therapies are not reimbursable in any clinical category within IDGS and are not a permitted expense in the OTPS payment category.

Table 3: Clinician & Therapy Payment Capitation Levels

Area: New York **Period: May 2013 – Based on 90th Percentile Wages from BLS July 31, 2014**	
Occupation (SOC code)	**Hourly 90th percentile wage**
Social Workers, All Other(211029)	$ 38.21
Dietitians and Nutritionists(291031)	$ 40.14
Occupational Therapists(291122)	$ 51.60
Physical Therapists(291123)includes Equine, Aquatic Therapy**	$ 53.42
Recreational Therapists(291125)	$ 34.60
Speech-Language Pathologists(291127)	$ 61.16
Therapists All Other(291129)	$ 43.00
Registered Nurses(291141)	$ 50.98
Nurse Practitioners(291171)	$ 65.22
Hearing Aid Specialists(292092)	$ 30.33
Occupational Therapy Assistants(312011)	$ 34.09
Occupational Therapy Aides(312012)	$ 25.08
Physical Therapist Assistants(312021)	$ 33.96
Physical Therapist Aides(312022)	$ 18.25
Psychologists, All Other(193039)	57.66
Footnotes: (1) Annual wages have been calculated by multiplying the hourly mean wage by 2080 hours; where an hourly mean wage is not published the annual wage has been directly calculated from the reported survey data.	
SOC code: Standard Occupational Classification code -- see http://www.bls.gov/soc/home.htm	
Data extracted on July 31 2014	

CMS Counterproposal Regarding Clinical Therapies (OT, PT, S/L) Being Included in Residential and Day Habilitation Rates - CMS 64 Claiming/Re-Claiming to Eliminate any Potential Duplicate Payments

Effective July 1, 2014

1. ***Beginning with service dates of July 1, 2014, NYS shall credit to CMS, via the CMS 64, the value of off-site clinic services delivered in Supervised Residential Habilitation and Day Habilitation Sites, or any other waiver rate that might include a service in the state plan.*** This will be accomplished as follows:

   a. The full value of the federal share of all retroactive off-site claims will be credited on a quarterly basis. The voluntary adjustment for the retroactive period will be made on the Quarterly Expenditure Report for July – September 2015.

   b. Prospectively, at the close of each quarter, NYS will calculate the value of off-site services and will continue to refund the federal share value of off-site services until the date when all off-site claims will cease.

2. ***NYS will evaluate Supervised Residential Habilitation and Day Habilitation services to establish where 'hands-on' therapies are provided.***

3. **NYS will reclaim the federal share for the value of any off-site services that meet the following criteria:**

   a. Any off-site services that are determined to be delivered at a day habilitation program, or any other service location that does not include funding in its rate for hands-on therapies.

4. **Following the above "reclaiming process," NYS shall limit the residual value of the repayment of the federal share to the federal share value of off-site services that are delivered at a day habilitation program site that are deemed to include funding for direct, hands-on therapies.**

5. **This process shall continue each quarter until claims run out is complete for off-site services. *All reclaiming is subject to the two-year timely-filing requirements.**

Effective January 1, 2016

1. **The state will submit new, draft State Plan language by 9/30/15 (SPA10-18) to implement changes to the Other Licensed Providers and rehabilitation portions of the State Plan, in order to allow certain off-site Article 16 clinic services and certain therapies provided within HCBS waiver programs to transition to the new State Plan Option effective with service dates of 1/1/16. The SPA will authorize special rates for the provision of the following services when accessed by individuals with IDD and when provided by clinicians experienced in delivering services to the IDD population:**

   a. Occupational Therapy
   b. Physical Therapy
   c. Speech and Language Pathology
   d. Psychology

2. **Also effective with 1/1/16 service dates, funding within Supervised Residential and Day Service rates that are attributable to 'direct – hands on' therapy costs will be removed from waiver rates effective 1/1/16 when the state is able to implement the new State Plan option. Further changes in the Renewal will be necessary to describe the removal of the clinical funding effective 1/1/16.**

The removal of the services have been included in the .07 waiver document effective 07/01/2014; CMS has agreed to acknowledge that the actual payment amount in the State's MMIS system will exclude the associated payment amount effective 1/1/16. During the transition period of 7/1/2014 through 12/31/15, the State will make correcting adjustments when claiming for this time period on the quarterly CMS – 64s. These correcting adjustments will report the value of direct clinic therapy expenses on the appropriate line of the CMS-64, not as an HCBS waiver expense.