



**Office of  
Mental Health**

# 1915c Office of Mental Health (OMH) Serious Emotional Disturbance (SED) Children's Home and Community Based Services (HCBS) Waiver

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*New York State Division of Integrated Community Services  
for Children and Families*

**Program and Billing Manual**

9/1/2017

# 1915C OFFICE OF MENTAL HEALTH SED CHILDREN’S HOME AND COMMUNITY BASED SERVICES (HCBS) WAIVER

NYS OFFICE OF MENTAL HEALTH DIVISION OF INTEGRATED COMMUNITY SERVICES FOR CHILDREN AND FAMILIES

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Contents of this manual are subject to change. Any questions or concerns about this document can be sent to [dcfs@omh.ny.gov](mailto:dcfs@omh.ny.gov).

*Throughout this Manual, the term — “child, adolescent, participant or youth” refers to a HCBS waiver participant from age 5 to 21.*

## Section One: Introduction

### 1. What is the Office of Mental Health SED Children’s Home and Community Based Service Waiver?

Children and adolescents experiencing complex health and mental health conditions require unique considerations when addressing their treatment and service needs. A child with a mental illness needs a system of care that involves a team of professionals who can identify the needs of the child and family, connect them to resources and build a network of support. The first goal of services for youth and their families is for the youth to receive services and supports to function and thrive while living in their home and/or in the community.

The Office of Mental Health (OMH), Division of Children and Families’ Home and Community Based Service (HCBS) Waiver embraces a comprehensive array of home and community based services and supports to provide treatment and to support the functioning of youth with emotional disorders and their families at home, school, work, and in the community. Supporting youth in their homes and in their communities, in the least restrictive home or community setting, the HCBS Waiver program provides opportunities for improving the health, and wellbeing of the children served. The Division also recognizes the complex needs of adolescents and young adults who may have limited community resources and the significance of bridging the gap between children’s mental health needs and the adult service array. Therefore, the HCBS Waiver has increased the service options and enrollment age to account for the unique needs of this population.

The HCBS Waiver utilizes a strength-based, individualized care model to promote wellness, leading to success for the child and family. It ensures effective interventions by implementing a collaborative partnership with the family, treatment provider(s), core waiver services and other natural supports.

### 2. Why is Waiver Changing?

In Chapter 170 of the Laws of 1994 OMH was authorized pursuant to Section 1915(c) of the Federal Social Security Act to provide the HCBS Waiver Program. The general waiver provides Medical Assistance to children and adolescents who meet the eligibility criteria and reimburses several community-based services not previously included in the Medical Assistance program. The children and adolescents whom the HCBS Waiver serves are those who, if not for the HCBS Waiver, would be admitted to institutional levels of care, including long term Residential Treatment Facilities and intermediate psychiatric inpatient care.

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Since 2013, the 1915(c) Waiver has been in a state of renewal as OMH with DOH, worked diligently to meet the requirements set forth by the Centers for Medicaid and Medicare's (CMS). As of August 2017, the 1915(c) Waiver Renewal Application was approved and OMH with HCBS Providers implemented the necessary program and fiscal changes to comply with Federal mandates. Some significant changes include, the unbundling of three services (Individual Care Coordination, Intensive In-Home and Crisis Response), implementation of interim rates and corresponding rate codes, the introduction of three new services (Prevocational, Supported Employment and Youth Peer Advocate Services) and increased enrollment age to 21 years old. When incorporating the required changes, OMH was conscientious of future behavioral health initiatives by aligning the 1915c renewal with expected future requirements.

This program is currently operative in all counties in New York State except for Oneida County which has a separate demonstration project entitled "Kids Oneida".

### 3. Program Values

The following describes major values emphasized by the HCBS Waiver program.

*Accounting for the chronological and developmental age of the youth as well as factoring in the available and appropriateness of family and/ or natural support involvement in the Waiver program specifically for youth that meet the age of legal consent.*

- Children and families are engaged in true partnerships during all phases of service planning and delivery. However, OMH recognizes that Transitional Aged Youth (TAY) and Young Adults (YA) may have limited familial involvement and/or support. OMH believes in working closely with the youth to meet their individual needs and match them with appropriate community and natural supports.
- To ensure that youth's developmental stages and milestones in addition to their chronological age are accounted for when establishing realistic and appropriate service goals.

*Youth and family participation, if applicable, and freedom of choice are essential to planning and strategizing for effective outcomes.*

- The unique strengths and needs of each youth and family direct the design of every service plan.
- Priorities identified by the youth and family guide the development of goals and services to be delivered.
- To ensure youth and families the choice of providers, Waiver ICC agencies are expected to develop a network of providers for the remaining five services.

*Success for youth requires both effective treatment and the services that Waiver provides. Initial and on-going collaboration between providers and natural supports is fundamental to enhancing resiliency, meeting the imperatives of developmental stages, and promoting wellness for each child and their family.*

- Each youth's service plan is integrated with the youth's psychiatric treatment.

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- Both treatment and service providers review and sign each treatment and each service plan.
- Integration of treatment goals and models with Waiver service provision is a requirement and is ensured through collaborative planning and on-going communication between the treatment providers and Waiver program.

*Psychiatric diagnosis alone does not define the youth. The natural, community environment plays a key role in the youth's progress and continued success.*

- Individual Care Coordinators work closely with youth and families during all stages of enrollment to ensure understanding of and continued agreement with the service plan.
- Agreed upon goals and services are mutually worked on to support changes in the home environment that reinforce the child's healthy development.

*All domains of life impact on a youth's level of functioning and overall wellness and must be considered in service planning.*

- Youth and their families are engaged in initial and on-going assessments that examine all domains.
- Information pertaining to domains is integrated in the service plan.
- Medical and dental needs are monitored and addressed throughout Waiver enrollment.

*Safety is a primary concern throughout enrollment.*

- The youth and family engage in developing and implementing safety plans.
- Goals and objectives address identified high risk factors.
- All Waiver services workers are cleared through a criminal history background check and through the Child Abuse Register.

*The least restrictive environment is the environment of choice for a youth and family's success.*

- Services are provided in the home and the community, making full use of natural supports.

*Cultural competence is a crucial building block for effective engagement and intervention.*

- Waiver programs and their subcontractors apply in-depth knowledge of the role of culture (i.e. in forming parenting roles, engagement, family norms, etc.).
- Training in cultural competence is ensured by provider agencies.
- Ethnic demographics are considered in the hiring of Individualized Care Coordinators for the Waiver.

*A skilled workforce enables effective care.*

- OMH maintains training requirements for workers in each of the Waiver services.
- OMH provides training opportunities in all regions of the state and statewide.
- OMH supports and approves curriculum development and utilization.

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- On-going supervision of workers, including assessment of skills, is conducted by the providers.

*Outcome measures provide indicators of program effectiveness.*

- OMH ensures on-going outcome measures such as annual parent and youth satisfaction surveys, expenditure report comparisons, and utilization of services reports.
- OMH utilizes computerized reporting systems to collect outcome indicators and refine the analysis process.
- OMH routinely interfaces with Waiver providers for feedback and to provide technical assistance.

## 4. Goals

The goals of the HCBS Waiver are:

- to serve children with complex and significant mental health needs in their homes and communities,
- to decrease the need for placements in psychiatric inpatient levels of care, including Residential Treatment Facilities (RTF),
- to increase the array of Medicaid reimbursable community-based services available to children and adolescents with serious emotional disturbance and their families,
- to use a culturally sensitive, individualized, strength-based approach to build resiliency, assist in the achievement of age related developmental tasks and promote emotional well-being,
- to provide the services and supports that are specifically needed by each unique family to develop the ability to care for the child in their home in a supportive environment,
- to offer children and families a choice of providers, when possible;
- to provide services that promote better outcomes that are also cost-effective, and
- to demonstrate an integrated model of partnership with the family, treatment provider, core waiver services and other natural supports that are involved with the child and family.

## 5. Funding

Based on the Medicaid claims data, OMH reports to the federal government on service costs and demonstrates that the total statewide Medicaid expenditures are below the federally defined cost of institutionalization. The NYS Division of the Budget imposes a lower cap per enrolled child which recognizes the actual historical costs for waiver children as well as New York State budgetary constraints. There is no local share for Medicaid expenditures for children enrolled in the HCBS Waiver slots that are funded by OMH. The SED Children's Waiver program is covered 50% Federal/50% State. However, in 2005, the NYS Office of Children and Families Services to further extend services purchased HCBS waiver slots utilizing their preventive services funds. Preventive services slots have a 50% Federal, 30.55% OCFS (State) and 19.45% local (county) share.

The OMH transfers funds to the NYS Department of Health (DOH), the State Medicaid Agency, on a quarterly basis to pay for the cost of the enrolled Waiver children based on Medicaid Expenditure reports. (Funds for

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NYS OCFS funded slots are transferred to OMH on a quarterly basis by OCFS based on the percentage of preventive services funded slots. These funds are then transferred by OMH to DOH along with funds for OMH funded slots for enrolled Waiver children.) OMH journal vouchers these funds to the DOH who pays the providers' Medicaid claims through eMedNY (MMIS). The Office of Children and Family Services and the counties participating in the Children's' Waiver are financially responsible for the non-federal share of Waiver participating children, referred by the counties' Preventative Service programs.

The total financial responsibility for OCFS and each County is calculated quarterly using the following formulas:

- OMH calculates the responsibility of the Office of Children and Family Services, the State Agency responsible for the non-Federal share of Medicaid for the Preventative Services' children participating in the Mental Health Waiver.
- Total Claims (including Waiver Services, other MH Services, and Med/Surg Services) multiplied by (the County's Preventative Slots in the Waiver divided by (The County's Total Waiver Slots, including the Preventative Slots) multiplied by 0.5.
- OMH then calculates the County share of the non-Federal share of the Medicaid for these children. Under agreement with OCFS, the counties are responsible for 38.9% of approved non-Federal expenditures for each child. Each county's share is the result of the first formula, multiplied by 38.9%.

The non-Federal Share of Computable Waiver costs are all State general fund monies. The mechanism used is NYS's standard Budget Journal" approved by the Director of the Division of the Budget. The amounts transferred are calculated by OMH accumulating all expenditures for waiver services for all waiver enrollees AND the State Plan services for waiver enrollees who were eligible for Medicaid based exclusively on their enrollment in the waiver and determination of Medicaid eligibility exclusive of any accounting for their parents' income and assets (i.e., "deemed" children).

The State share of HCBS waiver funds is appropriated in NYS's General Fund to OMH for transfer to DOH as the State share of HCBS waiver claims to CMS. All the State share of HCBS waiver funds are General Fund appropriations. All disbursement of Federal Funds received by OMH are disbursed as "Federal Fund" expenditures. These two funds are not interchangeable. No Federal Funds have been applied as the State share of HCBS waiver funds. Federal funds have been used to pay for services like services provided in the HCBS waiver to children NOT enrolled in the waiver. Importantly, these Federal funds have represented either 100% of reimbursement for contracted services or represented the Federal share of approved expenditures where some portion of approved expenditures had to be paid by the State or a local government or non-state provider.

## Section Two: Rights and Responsibilities

### 1. Participant Rights

HCBS is based on core values that seek to establish ethical, competent and recovery-focused services through best-practice. Participants are entitled to the following qualities of care:

- Integrated care
- Coordinated and collaborative care between providers
- Person-Centered
- Recovery-Oriented
- Safety
- Culturally competent
- Flexibility within the least restrictive environment
- Competent service provision
- Quality assurance through data driven practices

In addition to the preceding individual rights as outlined by the program's values, children participating in the HCBS Waiver Program have the right to:

- Be Informed: The participant and family/ caregiver have the right to be informed of the following:
  - Rights and Responsibilities
  - Program background and purpose including values, criteria for enrollment and responsibilities of services providers
  - Be provided with an explanation of all the services offered in the HCBS Waiver Program and other health and community services that may benefit them
  - Grievance/ complaints process and procedures
  - Fair hearing process
  - Incident reporting process and procedures
  - Flex Funds
  - Medicaid due process
- Receive training and support in exercising and maintaining decision-making authority
- Request changes to, assist in the development of, and approve of, their Individualized Service Plan (ISP)
- Select individual service providers and choose to receive waiver services from different agencies or different providers within the same agency, without jeopardizing participation in the program
- Be informed of the name and duties of the individuals providing services within the ICC agency
- Receive contact information for all services providers, their supervisors and The Office of Mental Health
- Refuse services after being fully informed of and understanding the consequences of such actions
- Have grievances/ complaints responded to in a timely fashion

## 2. Participant Responsibilities

Participants are responsible for working with the ICC to develop and/or revise service plans for timely submission as well as, working with services providers as described in the ISP, working with service providers to change or update goals or services, and attend appointments as scheduled and providing notice if an appointment must be cancelled.

## 3. Roles and Expectations of Parent/ Caregiver

Family/ caregiver involvement is essential when they are a source or ongoing contributor to the participant's issues. Even if that is not the case, family members almost always suffer when the child is not doing well and may benefit from guidance and support. Service providers will encourage the family to facilitate, nurture and support desired changes in the participant. Equally important, what parents/ caregivers learn in the process may generalize to other venues, such as enhancing home involvement in school or parent advocacy.

Family engagement is critical to gain a comprehensive contextual picture of needs and strengths of the child and family. Family and participant experiences, goals, and perceptions are used to steer decision making in all aspects of service implementation, operation, and evaluation.

Due to the significance of family involvement the following principles are incorporated into the program to enhance engagement:

- Meetings and service provision happen in culturally and linguistically competent environments where family and participant voices are heard and valued
- Service providers partner with the family and participant by sharing power, resources, authority, responsibility, and control
- Families and participant have access to useful, usable, and understandable information and data, as well as sound professional expertise when making decisions about treatment and services

To ensure best-practice and the best possible service provision outcome, family involvement is not optional\* within the HCBS Waiver Program. Parent/ Caregivers are held to the following expectations:

- Parent/ Caregiver must work with the ICC to develop/ revise service plans for timely submission
- Work with Waiver service providers as described in the service plan
- Work with the ICC and other service providers to change or update goals or services, and attending appointments as scheduled and providing notice if an appointment must be cancelled.
- Follow ICC procedures on incident reporting and safety plan

*\*The HCBS Waiver is inclusive of the differing and unique needs of its participants and as such, recognizes when family involvement may not be a feasible or realistic expectation. In these cases, it is expected that the program will work diligently with the participant to identify natural and community resources to support the individual. Further, the absence of family/ caregiver involvement can only occur when the participant is of the legal age of consent to authorize the delivery of service provision independently.*

## 4. Participant Safeguards

For Waiver programs within *both OMH licensed and non-licensed agencies*: The Waiver program through OMH contract must ensure incidents are reported when one occurs when the client is under the direct care of a waiver funded worker. This includes subcontracted workers. Subcontracted workers who work for an *unlicensed agency* must inform the ICC and the ICC must report the incident. Subcontracted workers who work for a *licensed agency* must themselves directly report the incident and inform the ICC.

Refer to the “Definitions for Incident Types and Severity Ratings (Local Providers)” (below), for specific information on incidents that require reporting and for determining severity.

Incidents are reported into the NYS Incident Management Reporting System (NIMRS) immediately upon discovery of the incident. NIMRS is a web based application that is available on the browser 24 hours a day, 7 days a week. *Call (518) 474-3619 with any questions about reporting an incident.*

### INCIDENT REPORTING

The HCBS Waiver Program is an unlicensed funded program and therefore is not subject to the Justice Center’s jurisdiction. HCBS Waiver incidents need to be reported to The Office of Mental Health (OMH) only, and can be done through the NYS Incident Management Reporting System (NIMRS). These incidents must be reported within one business day of discovery of the incident. [NIMRS is a web based application.](#)

*Please refer to the [How to Report an HCBS Waiver Incident in NIMRS](#) for specific instructions on how to do this.*

#### Reportable Incidents

A Reportable Incident is any situation in which an enrolled child experiences a perceived or actual threat to his/her health and welfare. Reportable incidents fall into six general categories:

- abuse and/ or neglect;
- designation as a missing person;
- criminal involvement, this category includes criminal acts in which the participant is the victim or aggressor;
- death of a participant;
- allegations of sexual assault; and
- other serious incidents involving participants which result in injuries which have an imminent risk for life threatening harm. Incidents which result in admission to a hospital and instances in which police are called as a result of the participant’s actions.

*Please refer to the [HCBS Waiver Definitions for Reportable Types](#) for specific information on incidents that require reporting.*

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### Who Must Report Incidents

As HCBS Lead Agency, the Individualized Care Coordination (ICC) Agency is responsible for incident reporting in an effective and timely manner. To ensure proper protocols and procedures are being maintained, the ICC Agency must maintain the following responsibilities:

- The ICC Agency is responsible for incident reporting after being made aware of an event, either directly (by family, participant, emergency personnel etc.) or by subcontractor personnel, within one business day.
- The ICC Agency must make their subcontractors aware of the ICC Agency's Incident Reporting procedures for the HCBS Waiver Services. HCBS Waiver Service Subcontractors must inform the ICC Agency of all reportable incidents and the ICC Agency must report the incident into NIMRS.
- Parents/caregivers of waiver participants will need to be made aware of the ICC Agency's Incident Reporting Procedures including incidents that constitute as reportable to ensure that they inform the ICC of all reportable incidents.
- If the incident constitutes an emergency, employees must initiate their agencies' emergency procedures and also report the incident in NIMRS.

Please refer to the [How to Report an HCBS Waiver Incident in NIMRS](#) for specific instructions on how to do this.

### *Incident Reporting Follow-up*

The ICC Agency is responsible for providing follow-up regarding unresolved incidents. The ICC Agency should be in contact with the family/ caregiver to find out if there is any new information regarding the incident(s) and report this new information in NIMRS along with any action that has been taken since the initial reporting or the last follow-up, until the incident is resolved. This information should be updated in the Investigation Conclusions area on the Investigation Findings & IRC (Investigation Review Committee) Sub Tab. For example: if a Waiver participant is reported missing, the ICC agency will need to keep in contact with the family and report updates in NIMRS until the child is found. The incident should not just be entered into NIMRS and closed with no follow-up with the family on status of the incident.

### *Oversight*

OMH will monitor all incidents and use the data collected to determine if there are any systemic issues that need to be addressed, OMH reserves the right to review incidents at any time and may request additional information in NIMRS if not updated accordingly.

### *Significant Incidents (SI)*

OMH must report certain significant incidents associated with individuals receiving HCBS Waiver Service to the NYS Department of Health. The following classify as Significant Incidents:

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- Any egregious act that may rise, or believed to rise, to the attention of the media
- Any suspicious or unexpected deaths, such as apparent homicide, suicide, accidental or unexplained death of a person enrolled in waiver.
- Any waiver participant whose whereabouts are not accounted for and who is considered at risk based on age or survival abilities or who may pose a risk to the community.
- Any sexual assault perpetrated by, or against, a participant enrolled in waiver services.
- Any event where the participant is involved in a crime under NYS or Federal law, and is perceived to be a significant danger to the community.
- Any violent or forceful physical attack when a waiver participant is either the victim or the aggressor which results in hospitalization.

Incidents considered to be significant will require the ICC Agency to enter follow up details into NIMRS until the incident involving the HCBS Waiver participant is closed. This information should be updated in the Investigation Conclusions area on the Investigation Findings & IRC tab.

*Please refer to the [HCBS Waiver Definitions for Reportable Types](#) for further information regarding Significant Incidents.*

### *Mandated Reporting*

If an employee of an ICC or subcontractor agency suspects abuse or maltreatment, the employee must immediately report the incident to the Statewide Central Register of Child Abuse and Maltreatment (SCR) at 1-800-342-3720. ICC and subcontractor agencies must cooperate in, and not interfere with, all Child Protective Services (CPS) and law enforcement investigations.

If a report is filed with an ancillary agency, (i.e., Statewide Central Register of Child Abuse and Maltreatment, local law enforcement, etc.) the date the report was filed, the agency, and any additional pertinent information must be clearly indicated in the NIMRS summary.

## 5. Fair Hearings

### **Policy**

#### Right to Appeal

Whenever a child is accepted, denied or terminated from the HCBS Waiver program, written notification of the decision is sent to the child and the child's parents/guardians. If the family feels that the decision made is wrong, e.g., they believe that the child has been wrongfully denied admission into the HCBS Waiver or has been dis-enrolled without just cause; they have the right to appeal that decision.

#### Methods of Appeal

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There are two (2) ways to appeal the decision. A family can utilize one or both of these methods:

- Local Conference, i.e., informal meeting with OMH staff; or
- State Fair Hearing before an Administrative Law Judge.

The **Local Conference** is a less formal proceeding that provides the opportunity for all parties to discuss the basis for the decision and clear up any misunderstandings and/or misinformation. Sometimes a local conference will produce information that will result in a change in the agency's decision or the parent/guardian's decision to contest a decision. It is hoped that most HCBS Waiver disputes can be resolved through local conferences with the ICC, LGU or other OMH staff. However, in the event that the dispute cannot be resolved in this forum, the family is entitled to ask for a *Fair Hearing*. Requests for a local conference are made through the OMH Operations Support Unit (OSU). Contact information is found on the back of the Notice of Decision.

A **Fair Hearing** is presided over and decided by an Administrative Law Judge from the NYS Office of Temporary and Disability Assistance (OTDA). Both sides are entitled to bring representatives (including a lawyer) and/or witnesses who can help explain their position. The claimant (i.e., family) can obtain information from their HCBS Waiver file if needed to prepare/present their position.

### Time Frames for Filing for Fair Hearing

The family has sixty (60) days from the notice date on the Notice of Decision to request a Fair Hearing. They can do this by telephone or in writing. The necessary phone numbers and addresses for Fair Hearings offices are listed on the back of the Notice of Decision.

### Roles/Responsibilities

Following is a list of all the parties connected with the HCBS Waiver who play a role in the appeal process, as well as a brief description of the responsibilities for each group:

- ICC Agency (ICC and/or Director) - ensures OSU is notified as soon as the Agency becomes aware that the Fair Hearing (FH) has been/will be filed; furnishes any required documentation; participates as directed in local conference or Fair Hearing; carries out provisions of Fair Hearing Decision;
- LGU (HCBS Waiver Contact) - same as ICC Agency;
- NYS Department of Health - Office of Medicaid Management - acts as the technical consultants and liaison with State Fair Hearings and LDSS, if necessary;
- OMH Division of Children and Families - arranges and/or conducts local conferences; participates in Fair Hearings, if necessary; ensures that the terms of the decision are carried out;
- OMH Finance (OSU) - Central Office - acts as the primary OMH Fair Hearing contact for State Fair Hearings staff; ensures that all appropriate parties are made aware of all Hearing activity (e.g., receipt of Request, scheduling/rescheduling of Hearing dates, etc.); follows up on receipt of decision and ensures all appropriate parties receive copies.

### Procedures

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Following are the guidelines for handling a request for a Fair Hearing on a HCBS Waiver case:

- Whenever an ICC Agency or the LGU becomes aware that a family intends to request, or has already filed a request for a Fair Hearing, they informally notify OMH Finance-OSU. Official notification is sent to OMH by OTDA.
- As soon as a Fair Hearing request is received from the family, the State Fair Hearings (OTDA) forwards a copy of the Notice of Fair Hearing Request to OSU and the Division of Children and Families.
- OSU and the Division of Children and Families are simultaneously notified by daily electronic correspondence from State Fair Hearings (OTDA). This includes all notices pertaining to a Fair Hearing beyond the initial Notice of Request.
- If the Hearing request requires OMH/ICC/LGU involvement and the issue can be resolved by some action other than a Fair Hearing (e.g., local conference, submittal of additional documentation to the LDSS, etc.), Division of Children and Families consults with the appropriate parties and determines which actions are advisable. Hearings involving Medicaid eligibility issues unrelated to HCBS Waiver clinical status may not require OMH participation in the Hearing.
- If the issue is resolved without a Fair Hearing, Division of Children and Families ensures that the family receives the information needed to request a withdrawal of the Hearing request that was submitted to State Fair Hearings.
- State Fair Hearings (OTDA) sends a copy of the final Fair Hearing Decision to all parties involved, including OSU and Division of Children and Families.
- Division of Children and Families and OSU ensure that proper actions are taken based on final decision of Fair Hearing.

Note: As noted above in the Policy section, families can file for Fair Hearings in several ways: by completing the back side of Notice of Decision and mailing or faxing it to State Fair Hearings; by sending a letter to State Fair Hearings; or by calling State Fair Hearings. If the family uses the Notice of Decision form to request the Hearing, State Fair Hearings should be able to properly identify the case as an OMH/HCBS Waiver case and send the notice to the OMH Fair Hearing contact rather than to a fair hearing contact in a LDSS. However, if the family does not use the form or does not clearly identify the case as an OMH/HCBS Waiver case when they file, it is likely that Fair Hearings will identify the case as belonging to the LDSS and send them the notices of scheduling, etc. This can cause delays and confusion. Whenever this situation occurs, whoever discovers that a HCBS Waiver Fair Hearing is pending notifies OMH Fair Hearings to facilitate correction of the error.

## Section Three: Provider Network

### 1. Individual Care Coordination (ICC) Agencies

To promote efficiency, regional flexibility, and participant choice, OMH enters annual contracts with ICC Agencies across the state to be designated as the coordinating, lead entity. ICCs are mental health child care agencies with demonstrated experience in providing operational and administrative functions at such a level as a Medicaid home and community-based waiver would require.

The philosophy of the HCBS Waiver necessitates that the development of a HCBS Waiver site complement the existing county service system in a manner that fits local culture, including recruitment policies that help meet the cultural and linguistic needs of the program population. This requires a strong collaborative relationship between the Local Government Unit (LGU) and ICC Agency.

In addition, ICC Agency responsibilities include:

- establishment and maintenance of the service provider network by negotiating written contracts for HCBS Waiver services with existing service providers in the community or with new service providers developed specifically for HCBS Waiver service provision. Subcontractor performance must be continually monitored.
- review, approval and documentation of qualifications of ICC Agency Waiver workers, including State Central Registry and fingerprinting clearance. No worker can begin delivering HCBS Waiver services without verification that the individual meets all required qualifications for the respective service;
- completing Service Plans;
- overall monitoring of a child's service plan budget at entry into the HCBS Waiver, at every service plan review, when the individual enters inpatient care for stabilization and when fiscal monitoring reports are received;
- monitoring inpatient stays to ensure that the child continues to meet the level of care of the HCBS Waiver and that status has not changed to warrant termination/discharge;
- hiring (including clearance through State Central Registry and fingerprinting clearance), supervising and training of Waiver workers;
- coordinating all the services the child and family receive under the HCBS Waiver, as well as monitoring the care and costs of other Medicaid reimbursed services for the child;
- functioning as the primary biller of Medicaid HCBS Waiver services as the Organized Health Care Delivery System (OHCDS);
- participating in contract negotiations with the Local DSS and LGU for the foster care population enrolled in HCBS Waiver;
- Incident Reporting and investigating for waiver services and assuring that subcontractors are aware of Incident Reporting policy and procedures\*; (see below)
- informing children (as appropriate) and families of procedures for notifying authorities when abuse, neglect or exploitation is suspected, educating them regarding what constitutes abuse, neglect and exploitation;

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- informing families of the agency's complaint/grievance process and assuring that they have the contact numbers for their regional OMH Parent Advisor and OMH Regional Office;
- completing all program and fiscal reporting requirements;
- overseeing completion of all necessary documentation including the CANS, at prescribed intervals;
- assuring timely, accurate data input of all necessary information into the OMH CAIRS system;
- retain all required original documents including: 1) family request for services, 2) Level of Care and annual recertifications, 3) Freedom of Choice application, 4) Provider Choice forms, 5) CANS, 6) Service Plan, Service Plan Reviews, and Budget, 7) Releases of Information, 8) Progress Notes (including subcontractors' originals)\* and 9) Discharge Summary and After-Care Plan; 10) Result of Screening Letter sent by LGU to family, 11) acceptance letter issued by OSU, 12) termination letter issued by OSU, 13) Safety Alerts Plans and any other significant documentation. (\*The originals of progress notes are retained by the Community or Crisis Residence when the Respite Services are delivered by an OMH-certified Community or Crisis Residence.)
- developing and maintaining written agency [HCBS Waiver Program policies](#) and procedures to include Worker Safety Protocols, Incident Reporting, Complaint and Grievance Procedures, Language Access, Client Satisfaction Surveys and overnight respite;
- attending regional and statewide HCBS Meetings;
- participating in site visit surveys and audits; submitting and completing Corrective Action Plans within prescribed timeframes;
- utilizing Field Coordinators and OMH Central Office for technical assistance;
- assuring compliance with all aspects of the OMH HCBS Waiver Program's policy and procedures and
- assuring that HIPAA requirements are consistently met;
- provision of umbrella liability insurance, or documentation that the individual has their own liability insurance for independent contractors (individuals);
- overseeing the use of individual service dollar expenditures in excess of \$250 (ICC Program Director or Agency equivalent responsibility); approval must be noted in the case record and must relate to goals/objectives in the service plan; rules governing the uses of flexible service dollars are found in each ICC Agency's contract with OMH and in [Section 8](#) of this manual;
- Compliance with Conflict Free Case Management requirements.

\*Incident Reporting: Each ICC agency must follow the [Incident Reporting Policy for HCBS Waiver Programs](#) and the [Definitions for Incident Types and Severity Ratings](#) (Also, see [Appendix I](#)) that correlate with OMH guidelines. These must be maintained by each ICC agency in their Waiver Policy Manual.

## 2. Subcontractor Services

The HCBS Waiver program is held to Freedom of Choice requirements which allows any willing and qualified provider to apply and be considered for service provision. This requirement is intended to provide Waiver participants ample provider choice, when possible. Each ICC agency seeks to provide the most extensive network of service providers to participants. Providers contract with the ICC agency following a selection/approval process which begins with the completion of a Request for Services for Subcontract Agencies. From these, the Local Government Unit makes a formal recommendation which is forwarded to

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OMH for further review and approval. For additional information regarding the subcontractor application process please see [Appendix D](#).

## Section 4: Eligibility Criteria and Referral Process

The Home and Community Based Service (HCBS) Waiver Program is designed to provide community-based services and supports to children at risk of admission to institutional levels of care. This section provides information on eligibility criteria, and the referral process for enrollees.

The enrollment and referral process is designed to meet the Waiver Program's core values of inclusion, coordination, collaboration and integration to best meet the enrollee's needs.

Applicants must meet clinical, Medicaid, and fiscal eligibility criteria to be deemed admission into the HCBS Waiver program. The applicant must be found eligible in all three areas. Ineligibility in one area makes the applicant inadmissible.

Referrals, screening and Level of Care determination should be done in an efficient and timely manner to ensure that families know as quickly as possible. In addition, it is important to make families aware of what services/level of care the SPOA/LGU feels are appropriate/available to the child, e.g. within 30 days of the date a complete referral package is received by the SPOA.

### 1. Criteria

#### A. TARGET POPULATION

The target population for the HCBS Waiver is children and adolescents:

- with serious emotional disturbance, [See Appendix B for SED Definition](#)
- between the ages of 5 and 21 years (prior to 21st birthday),
- who demonstrate complex health and mental health needs,
- who are at imminent risk of admission to a psychiatric institutional level of care or have a need for continued psychiatric hospitalization,
- whose service and support needs cannot be met by just one agency/system,
- who are capable of being cared for in the home and/or community if services are provided,
- who have a viable and consistent living environment with parents/guardians who are able and willing to participate in the HCBS Waiver\*, and
- who can reasonably be expected to be served under the HCBS Waiver at a cost which does not exceed that of psychiatric institutional care.

Additionally, the youth must be eligible for Medicaid under the HCBS Waiver (i.e., are currently enrolled in Medicaid or could be enrolled by meeting federal eligibility standards) in a county with a HCBS Waiver program and be capable of being served in the community at or below the federally approved average yearly cost which is adjusted periodically.

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\* Children in foster care who reside in foster family homes, including approved relative homes, are also eligible for the HCBS Waiver. The following cannot be enrolled in this HCBS Waiver unless they will be discharged and returned home by the enrollment date: children in Residential Treatment Facilities (RTF), Intensive Case Management, Supportive Case Management, Community Residences, Teaching Family Homes, services in other Waiver programs or services in comparable programs in other systems. Additionally, for participants of legal age of consent, parental/ caregiver involvement can be waived if deemed unrealistic when considering the participant's individual circumstances. However, identifying and developing a natural/ community support system continues to be a program expectation.

### B. CLINICAL REQUIREMENTS

To meet the clinical eligibility requirements, a child or adolescent applying for the OMH HCBS Waiver must:

- have a serious emotional disturbance (SED); [See Appendix F for SED Definition](#)
- be between the ages of 5 and 21 on the effective date of enrollment; the child can be served in Waiver until s/he turns 21;
- demonstrate complex health and mental health needs;
- require institutional level of care;
- be at imminent risk of admission to an institutional level of care
- or must have a need for continued psychiatric hospitalization;
- have service and support needs that cannot be met by just one agency/system;
- be capable of being cared for in the home and/or community if Waiver services are provided; *and*
- have a viable and consistent living environment with parents/guardians who are able and willing to participate in the HCBS Waiver and support the child in the home and community. \*

\* For participants of legal age of consent, parental/ caregiver involvement can be waived if deemed unrealistic when considering the participant's individual circumstances. However, identifying and developing a natural and community support system continues to be a program expectation.

Who Determines: Clinical eligibility is determined by the Local Governmental Unit (LGU) representative.

Medicaid Requirements: The requirements for Medicaid eligibility that must be met under the OMH HCBS Waiver are:

- The child/adolescent must meet all federal categorical criteria for eligibility, e.g. the child/adolescent must be a citizen of the US or meet the definition of "qualified alien" to be eligible for Medicaid.
- The child/adolescent's own income and resources, after deducting applicable disregards and exemptions, should be less than the current Medicaid Income Exemption Standard for a family of one. If it is not, effective January 1, 2009, a spend-down process may be initiated.
- Only the child/adolescent's own income and resources are taken into consideration. The parents' income and resources are not counted due to the waiver of parental deeming.
- The child's Medicaid coverage must be in a county which is participating in the OMH HCBS Waiver.

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- In accordance to NYS Department of Health Directive *GIS MA 14/27; December 2014*, all Medicaid applications for individuals in need of waiver services are to be processed by the local district (LDSS/NYC-HRA), and not by means of the New York State of Health (*Health Benefits Exchange*). In most cases, The OMH Operations Support Unit (OSU) will notify Waiver providers that the actions noted below must be taken for an individual that has been found to be in receipt of New York State of Health (*NYSOH*) Medicaid coverage. However, if Waiver program staff discovers NYSOH Medicaid coverage in the early stages of enrollment, the procedures noted below may be proactively executed to maximize the timeliness of the transition from NYSOH to local LDSS/NYC-HRA which is necessary for Waiver enrollment to occur.
- Applications normally submitted to NYC-HRA (*New York City Medicaid*)

Staff must take the following steps regarding application for individuals identified with NYSOH Medicaid coverage:

1. Submit a new completed standard Medicaid application (DOH 4220) used for all new or returning HCBS clients.
2. Attach completed MAP-3084 form (Template provided for assistance) –[MAP form](#) (MAP form and [MAP template](#))
3. Attach completed traditional HCBS Waiver cover letter ([See Appendix I](#))
4. Attach pre-printed cover letter addressed to receiving Medicaid office

- Applications normally submitted to all Upstate Local Department of Social Services (*Upstate LDSS offices*)

Staff must take the following steps regarding application for individuals identified with NYSOH Medicaid coverage:

1. Submit a new completed standard Medicaid application (DOH 4220) used for all new or returning HCBS clients.
2. Attach completed traditional HCBS Waiver cover letter
3. Attach pre-printed cover letter addressed to receiving Medicaid office – Form attached above

### C. FISCAL REQUIREMENTS

To be fiscally eligible for the OMH HCBS Waiver, a child/adolescent must be capable of being served in the community within the federally-approved cost of institutional care and within NYS OMH and Division of the Budget approved caps. A projected annualized budget is included in every service plan for each child.

Who Determines: Fiscal eligibility is determined by the Local Governmental Unit (LGU) representative.

## 2. Referrals

*Referrals* are usually completed by other providers directly to the SPOA; however, families or individuals 18 years or older can "self-refer".

### **Decision to Participate in the Waiver**

The decision to participate in the HCBS Waiver is the individual youth and family's choice. Participation in the HCBS Waiver is voluntary and a family may withdraw at any point in time.

To be screened for eligibility to apply for HCBS Waiver services, the youth/family must go through the Single Point of Access (SPOA) for their county/NYC borough. The SPOA manages the high need community based services in each county/borough. Referrals made to SPOA must include all elements in the OMH [Universal Referral Form](#) (See Appendix I) The ICC agency to which the child is referred incorporates select information from the Referral Form into the [Financial Information Form](#) (See Appendix I), which is ultimately entered into CAIRS and sent to OMH's Operations Support Unit as the "Transmittal 1".

It is important that the referring source be as knowledgeable as possible about the eligibility requirements of the Waiver to ensure: 1) that the referral is appropriate; and 2) that the packet is complete and well-documented.

The county SPOA reviews the referral, completes an assessment and matches the child with the most appropriate services in the county's continuum of care service delivery system.

If the family and/or referral source has supporting documentation relating to any item in the Referral Information/Universal Referral packet, it may be referenced and attached in lieu of completing the questions. The more complete an application, the easier it will be for the persons making the Level of Care Determination to determine need for this level of service.

The package should contain documentation to show that the child meets all of the clinical eligibility requirements outlined in [Section 4.1.B](#). It should also contain as much information as is available at this point to show that the child is also anticipated to meet the Medicaid and Fiscal eligibility requirements of the Waiver ([also in Section 2](#)).

### **Procedures for Forms Completion**

*Universal Referral Form (URF)* (See Appendix C)

Purpose: The purpose of the Universal Referral Form is to:

- identify why the referring staff/persons feel the child would benefit from this proposed level of care;
- provide information related to the child's and family's ability to meet the HCBS Waiver's eligibility criteria;

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- identify the child's and family strengths and informal support structure related to identified needs;
- describe any functional impairments; and
- provide an adequate summarization of historical and current events, treatment, and/or information related to treatment needs.

Completed by: The referral information on the Universal Referral Form is completed by the treating staff, agency, private clinician, and/or the person, as appropriate, making the referral.

When Completed: The Referral Information/Universal Referral Form is completed at the time of referral.

Distribution: Original - ICC Agency.

### 3. Screening

*Screenings* are performed by the SPOA/LGU with input from the ICC Program Director or other ICC agency designee.

Referrals are made to SPOA. The SPOA reviews the referral packet for completeness and screens the child for potential eligibility for the Waiver.

During the screening, it may become apparent that the child will not meet the eligibility requirements for the Waiver. While the SPOA/LGU/ICC cannot refuse an individual's request for screening and Level of Care determination, they can indicate to the individual that it appears unlikely that the SPOA/LGU will be able to make a positive Level of Care (LOC) determination based on the information provided and that pursuit of the application without additional documentation will probably result in denial.

### 4. Level of Care Determination

#### Who Conducts Level of Care Determination

One of the Level of Care signatories must be the LGU or his/her designee. Both Level of Care signatories must meet the following qualifications: The signatory must be a psychiatrist, psychologist, registered nurse or nurse practitioner licensed in NYS, Licensed Master Social Worker, Licensed Mental Health Counselor, Clinical Social Worker or Certified Social Worker with a minimum of three years' experience serving children or adolescents with serious emotional disturbances. Both signatories must meet the above criteria; however, if there are extenuating circumstances whereby one member does not meet the above criteria, the LGU must make a request to OMH central office in writing and an exemption may be granted by OMH. Copies of such exemptions are maintained at the OMH Central Office. An example of a situation which could be approved for exemption would be a social worker with a master's in social work who is not licensed but has the prerequisite years of experience. Another example would be an individual who does not meet the above academic criteria

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but who does have a bachelor's degree in human services and five years serving children or adolescents with serious emotional disturbances.

If signature changes need to be made to the LGU staff designated to sign the LOC and SP forms, please use this [Level of Care Update Form](#).

### *Making the Level of Care Determination*

The SPOA team reviews all information in the referral packet and determines whether the child meets the level of care for Waiver. If it is determined that Waiver is the appropriate level of care, the LGU or his/her designee then completes the Level of Care (LOC) form Level of Care. The recertification date for the level of care is one year from the date on the initial Level of Care. The LOC Recertification is signed by two qualified reviewers including the LGU or his/her designee. Note that each signatory's title/discipline must be clearly indicated.

### *Notifying the Child and Family Regarding the Screening Results*

As soon as the Level of Care form is completed, the LGU representative immediately completes and issues a Result of Screening letter. This letter documents whether the child meets the eligibility criteria to apply for HCBS Waiver services and serves as the official notification to all affected parties of the results of the request for screening. This letter is sent to the child/parent(s) or guardian(s), referral source, and ICC Agency.

The Result of Screening letter must be printed on the LGU's letterhead, or as an attachment to a letter sent on LGU letterhead. The LGU may choose to make minor adjustments to the format of this letter to better suit a specific county's needs, however, the overall content of the form must be retained as is.

In addition to advising of the results of the Level of Care Determination, the letter also outlines next steps:

- If LOC requirements **are met**, the letter states that the ICC Agency will contact the family to set up a meeting and begin the formal application/enrollment process
- If LOC requirements **are not met**, the letter states the referral for the child will be closed **unless** the family contacts the ICC agency within 10 days of receiving the Results of Screening letter and advise that they wish to:
  - appeal the decision by resubmitting their referral packet with additional documentation and requesting a second LOC determination by the LGU; or
  - choose to continue with the application process without providing any updated/additional documentation.

### *Waiver Pursuit When Screening Indicates Ineligibility*

It is important to note that even though the screening process may indicate that a child does not meet the clinical eligibility criteria for the Waiver, if the family insists on pursuing Waiver enrollment, they must be allowed to do so, even though the result may be a denial.

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It should be clearly communicated to the family that the outcome will not likely change unless someone provides documentation that there has been a substantial change from the original information provided through the referral process.

It is also important to note that there are internal county processes to assist families in accessing appropriate services if they are ineligible for the Waiver or choose not to pursue re-screening or Waiver application. A family must *not* be left without any options. Each county has a process in place that encourages the referral source to continue working with the child and family to find services/treatment that meets their needs.

### Procedures for Forms Completion

#### *Level of Care*

**Purpose:** The purpose of the Level of Care form is to document, after review of referral packet and any other information that may subsequently be provided, whether the Level of Care criteria for the HCBS Waiver are met.

**Completed by:** Completed by a team of two individuals, one of whom must be a representative of the LGU and both of whom must be members of approved clinical disciplines. The discipline/title of each reviewer must be clearly noted on the form.

**When Completed:** Complete and send to distributes (see below) within one week of receiving a complete referral packet.

*Note:* After enrollment in the HCBS Waiver, the Level of Care Determination is reviewed and completed every 12 months.

**Distribution:** Original – ICC Agency. Copy – LGU file

#### *Result of Screening Letter*

**Purpose:** The purpose of the Result of Screening letter is to:

- advise the child, his/her parent(s) or guardian(s), and the ICC agency whether the child meets the level of care requirements for participation in the HCBS Waiver;
- apprise the child, his/her parent/guardian what the next steps will be;
- If LOC criteria are met, ICC will contact family to explain meaning of this decision and begin application process; or
- If LOC criteria are not met, referral will be closed unless family indicates intent to submit additional documentation and request re-review of LOC. **Note:** If family requests re-review, must advise intent and submit additional documentation within 10 days of receipt of the Result of Screening form, or referral may be closed.

**Completed by:** LGU representative.

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When Completed/Issued: As soon as Level of Care determination is made, i.e. within one week of the receipt of the referral packet.

Distribution: Original to child/parent(s) or guardian(s); Copies to: referral source, ICC agency, and LGU file.

Supply of form: Word process and/or photocopy. **Note:** Must be printed on LGU letterhead or facsimile.

### Recertification

Each child's clinical eligibility for the HCBS Waiver's level of care and each child's eligibility for Medicaid must be recertified annually. The recertification of the clinical eligibility for the HCBS Waiver is to ensure that the child meets the required level of care so that Waiver resources can be used appropriately to serve and benefit eligible children and adolescents in the community. This is done annually by the local mental health governmental unit (LGU) using the Level of Care (LOC) form. When the child no longer meets the Waiver's level of care, the slot will become available for others to enroll.

The annual recertification of the Medicaid eligibility ensures that the child continues to meet the Medicaid eligibility criteria so that Medicaid will continue to pay for Waiver services.

### **Time Line**

The initial Waiver Notice of Decision (NOD)-Acceptance letter shows the recertification timeframes for both the clinical eligibility for the Waiver level of care and for Medicaid eligibility. **The clinical eligibility recertification of level of care is normally one year from the date of the signing of the initial Level of Care form.** The level of care recertification date is shown on the Waiver Notice of Decision-Acceptance letter in the 2nd paragraph, 1st box which reads: "Current authorization for Waiver eligibility will expire effective \_\_\_\_\_. To continue enrollment in the Waiver program, you will be required to recertify Waiver clinical eligibility at least annually with your local mental health governmental unit (LGU)." (I.E., If the original LOC is signed 3/15/10, it will expire and require re-evaluation of level of care and signing by 3/14/11.)

The Medicaid recertification date is shown on the NOD-Acceptance letter in the 2<sup>nd</sup> paragraph, 2<sup>nd</sup> or 3<sup>rd</sup> box depending on whether the child is eligible for SSI or MA only. If MA only, it is recertified annually and it is the 2<sup>nd</sup> box which reads: "Current Medicaid authorization will expire effective \_\_\_\_\_. You will be notified by your local Department of Social Services when it is time to recertify." If SSI, it is the 3<sup>rd</sup> box and will read: "As long as you remain eligible for a SSI cash payment, separate recertification of Medicaid eligibility is not required." In this case, the MA continues as long as there is SSI.

For children who had Medicaid prior to enrolling in the HCBS Waiver, the Waiver and Medicaid recertification dates will likely be different. For children who are eligible for Medicaid *only* because of their enrollment in the Waiver (i.e. children who qualify because of the parental income deeming waiver), the two recertification dates may be the same. To have the Waiver and Medicaid recertification dates the same, a HCBS Waiver LOC recertification must be completed prior to its annual review. (Note: In such a case, the annual recertification of level of care will be one year from the most recent signing of the LOC.)

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**Required Recertification Actions**

**Medicaid:** The child and family will receive a letter from the local social services district notifying them that their Medicaid is up for recertification. Typically, the letter will state required documentation and what the process is for recertification and instruct the family to call for an appointment. The ICC will not automatically receive a copy of this notice unless arrangements have been made with the local district. Therefore, it is important to remind the family that, when **any** notice is received from the local social services district, their ICC must be informed and shown the paperwork. In some counties, including NYC, Medicaid recertification processes will begin far in advance of the known recertification date. If the case is not re-certified, the counties may terminate MA prior to the current certification (or authorization) end date. This is happening more frequently and can cause billing problems because the Medicaid may be ended two months prior to the recertification date that is listed on the NOD-Acceptance Letter. Therefore, it is important that the ICC be informed and take proactive measures to get the recertification done in a timely manner.

**HCBS Waiver Level of Care:** For recertification, the child and family's current service plan and budget, including any needed documentation to support continued need for this level of care, must be submitted to the LGU for review. The Level of Care form must be signed by the two LGU representatives, returned to the ICC agency and filed in the child's case record. This will serve as continued proof that the child meets HCBS Waiver clinical eligibility requirements. This work must be completed by the child's Waiver recertification date (i.e., one year from the signature date of the initial or prior Level of Care).

## Section 5: Enrollment

All the steps in the process are necessary to ensure that the HCBS Waiver is serving only those children who meet the clinical and Medicaid eligibility criteria for the Waiver; that freedom of choice and admission processing requirements are met; and that enrollment in the Waiver does not exceed the number of authorized slots.

Participation in the OMH HCBS Waiver is voluntary. Therefore, a parent may decide to withdraw his or her child from consideration for admission to the HCBS Waiver. For information on voluntary withdrawal see [Section 11](#).

### 1. Enrollment Considerations

Children in Other Programs: If a child is currently in a Residential Treatment Facility (RTF) and the family wants to have him or her discharged earlier than expected, the child will not be enrolled formally into the HCBS Waiver until the discharge has occurred. Simultaneous enrollment in these two service models is not allowed.

Likewise, children receiving Community Residence, other Waiver programs and comparable programs in other service systems cannot be enrolled in the OMH HCBS Waiver until they have been terminated from such programs.

Please note, however, that the enrollment activities, e.g. Level of Care determination, Medicaid application and eligibility determination, Service Plan/Budget development and approval, may begin prior to discharge from the RTF or another program.

Children in Foster Care: children who reside in certified or approved foster family boarding homes can apply for Waiver enrollment in counties with executed contracts signed by the ICC Agency, LGU, and LDSS regarding this population. OMH HCBS Waiver foster care children must meet all the Waiver eligibility criteria and follow all steps in the enrollment process.

Age Consideration: It is important to note that age should be a consideration during the enrollment process. Best practice and sound clinical judgment are recommended to ensure a child's needs can be met in an appropriate timeframe to ensure a mandatory discharge will not interrupt services (e.g., Waiver services end once a child turns 21 years old).

Children with Developmental Disabilities: Consistent with OMH policy, the HCBS Waiver may serve children whose IQ is 70 and above. OPWDD serves children whose IQ is 50 and below. A local decision is made to determine the best match of services for children whose IQ is 51-69.

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Children Who Are Not United States Citizens: To be eligible for the Medicaid program, an individual must either be a citizen of the United States, or be a lawfully admitted alien who meets the definition of a "qualified alien" established under the welfare reform legislation in OBRA 96. Since the OMH HCBS Waiver is a Medicaid program, the same rules regarding citizenship/"qualified alien" status apply to the Waiver. If there is any question about a child's citizenship and/or status as a qualified alien, please consult with the Operations Support Unit to discuss what is needed to ensure Medicaid eligibility for such a child. **Note:** Individuals who are in the US illegally can never be eligible for Medicaid and therefore cannot be eligible for the Waiver.

## 2. Enrollment Process

To ensure maximum Medicaid reimbursement, all steps in this phase should be completed within 30 days of the date that the Waiver application is signed.

### Paperless Enrollment

OMH utilizes the Child Adult Integrated Reporting System (CAIRS)-based enrollment and disenrollment process that transmits data to Operation Support Unit (OSU) via on-line process which eliminates sending any paper documents to OSU. CAIRS-based enrollment and disenrollment meets OMH security and HIPPA compliance. OSU notifies the provider if the CIN #, date of birth, social security number, county of Medicaid or county of residence was entered incorrectly.

All paper documents: Transmittal 1 (Transmittal 1 Cover Page, Level of Care, Application, and Financial Information form; Transmittal 2 (Transmittal 2 Cover Page, Initial Service Plan and Medicaid Application); and Initial Notice Re Loss of Waiver Eligibility form are no longer sent to OSU but hard copies are retained by the agency. The information on these forms is entered directly into the CAIRS enrollment and dis-enrollment screens.

## A. WAIVER APPLICATION

### **Face-to-Face Meetings with the Child**

The ICC agency contacts the family to schedule a face-to-face meeting as soon as possible after the Results of Screening letter has been issued and they know that a slot will be opening. The purpose of this meeting is to begin the formal application and enrollment process.

### **Completing the Application/Freedom of Choice Form**

During the initial face-to-face meeting, the ICC and family must complete the:

- Application to Participate/Freedom of Choice - This is the formal application to the HCBS Waiver. Completion/signature of this form starts the formal eligibility determination process which ends with the issuance of a formal Notice of Decision/Rights of Appeal.

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The form and its content are required by the federal government as proof that family members are voluntarily choosing the HCBS Waiver as an alternative to institutional level of care. Although it can be word processed and printed on ICC agency letterhead, the content should not be changed. **Note** that a witness of the parent/guardian's and child's signatures is required to attest to the voluntary nature of the signatures.

### Significance of the Date the Application is Signed

The date the family signs the Application to Participate/Freedom of Choice form is significant for the following reasons:

- Once the application form is signed, the Individualized Care Coordination (ICC) agency may start to provide ICC services. **Note:** During the period between the signing of the application and the date the child becomes enrolled in the Waiver only can be billed and reimbursed. The remaining waiver services cannot be billed separately until after the effective date of enrollment has occurred.
- The application date starts the 30/45\* day window, during which time the determination of eligibility for the Waiver should be completed to:
- meet Medicaid statutory requirements; and
- assure that the ICC agency can receive full reimbursement for services provided.

\*30 days for the ICC to complete the required paperwork and 45 days for the LDSS/OSU to issue the applicable Notices of Acceptance. (**Note:** If Determination of Disability is required, the LDSS statutorily has 90 days rather than 45 days to finalize the determination and issue the notice.)

### Continuing the Enrollment Process

#### Procedure for Form Completion

##### Application for Participation/Freedom of Choice

Purpose: The purpose of the Application for Participation/ Freedom of Choice is to:

- provide the family with written confirmation of the clinical eligibility criteria for the Waiver;
- document family's request to apply for participation in the HCBS Waiver;
- ensure that family is aware of their freedom of choice between hospital treatment or participation in the Waiver;
- establish the date that the ICC agency can begin to provide ICC services; and
- start the 30-day enrollment period "clock", i.e. date of enrollment must be effective within 30 days of the date the application is signed if ICC agency is to receive maximum allowable reimbursement.

**Note:** regarding billing for the enrollment period: 1. Child must be enrolled a sufficient number of days and receive required contacts to bill half or full month, or two consecutive half months, respectively.

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**Completed by:** Completed by the child, if over 18 years old, and child's parent(s) or guardian(s) with assistance from the ICC agency.

**Note:** Witness is required for parent/guardian's signature.

**When Completed:** Completed at the face-to-face application meeting with the family, which is scheduled when it is known that there will be a vacant slot in the program which can be filled within the next 45 days.

**Distribution:** Original - Care Coordination (ICC) file.

**Supply of form:** Word process or photocopy [supply of form](#)

**Note:** This form may be printed on ICC letterhead, but the content of the form should not be modified.

## **B. MEDICAID APPLICATION**

The Medicaid Application is usually completed and filed by the ICC Agency, however, the family may file the application themselves. In either case, the family must furnish the necessary information/documentation needed to complete application. Eligibility determined by LDSS. The LDSS has 45 days (90 if disability determination is involved) to issue the Notice of Decision regarding Medicaid eligibility; however, when issued, it should be retroactive to the date the application was filed. Go to [Section 2.C](#) for more details on Medicaid eligibility.

For further information on the completion of the Medicaid Application, please see [Section 14](#).

## **C. HEALTH CARE OPTIONS**

If a child is enrolled in Child Health Plus (CHP) prior to Waiver the family should be advised that they must apply for Medicaid to receive Waiver services, and dis-enroll from Child Health Plus; and upon discharge there may be a gap in coverage between when the Medicaid closes and the CHP starts. There usually is a one month gap in coverage. Also, the family needs to re-apply for CHP and may need to follow-up to ensure that the CHP becomes effective. Each family should be given The Child Health Plus [Re-Enrollment Information Letter](#) within 30 days of enrollment into the Waiver. The ICC is expected to review the letter with the family and respond to their questions. A copy of letter should be kept in Child record, see Client Chart Index [Appendix G](#).

### **Health Care Plans**

#### **Introduction**

The HCBS Waiver initial service plan budget (see [Section 7.3. B](#)) is responsible for monitoring the cost of **all** health care services (medical and psychiatric) that are paid by fee-for-service Medicaid for an enrolled child. This includes not only the HCBS Waiver services but also all medical and psychiatric services covered under New York State's Medicaid State Plan.

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Therefore, if a child being considered for enrollment has high medical costs in addition to his/her psychiatric needs (HCBS Waiver and other State Plan services), the ICC Agency may have difficulty remaining under the program cap, i.e., per slot cap x's number of slots.

If the ICC Agency forecasts the participant's cost being above the program cap, the ICC must notify the Field Office Coordinator to ensure that the participant's Medicaid spending remains below the rate of initialization.

**Private Health Care Insurance**

The child may already have coverage under health insurance plan(s) purchased by his/her parent(s) or by the parent(s)' employers(s). If that is the case, these benefits must be used to the extent possible to meet the child's health expenses. In fact, it is a requirement of the Medicaid program that all Third-Party Insurance coverage be documented by the LDSS; reported in the Welfare Management (WMS) and eMedNY systems; and be billed prior to claims being submitted to Medicaid, i.e., Medicaid is the "payor of last resort".

However, sometimes a family may have access to health insurance coverage (e.g., through an employer) but has opted not to take advantage of it (or is considering canceling it) because of cost. In cases like this, the LDSS sometimes will pay the premiums if they can document the cost effectiveness of maintaining the policy. Each county handles these situations differently so that it is necessary to contact the LDSS Medicaid Unit directly to find out their policy should such a case arise.

### 3. Enrollment Activities (Previously Pre-enrollment or Start-Up)

***Rules for ICC Enrollment Services***

The Enrollment activities or "Enrollment" occur during the time between the signing of the Waiver Application/ Freedom of Choice date and the effective date of Waiver enrollment on the Notice of Decision–Acceptance form (NOD–A) which is issued by OMH's Operations Support Unit (OSU). It provides a set rate for the period before HCBS Waiver enrollment is determined. Enrollment can only be claimed once for each enrollment in the waiver program between the Waiver Application/ Freedom of Choice signature date and the OMH OSU issued enrollment date which is listed on the Notice of Decision–Acceptance form (NOD–A).

All enrollment activities that must occur in order to enroll an individual in the waiver program may be completed in a timely manner that best meets the needs and priorities of the youth and family. To allow for greater flexibility to initiate services quickly and efficiently, the Enrollment rate will be reimbursed for all youth ultimately enrolled in the waiver program, regardless of the timeframe in which enrollment activities were completed. The ICC agency will not be reimbursed for Enrollment periods for those children that sign a Waiver Application but are not ultimately enrolled in the waiver. If a child completes the Enrollment period, but is not ultimately enrolled, Enrollment cannot be billed.

For billing information please see [Section 13 Billing](#).

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Rules regarding enrollment have not changed, OSU will issue the Notification of Decision – Acceptance Letter notifying the ICC Agency of the effective enrollment date. This date will continue to determine Service Plan Review completion and the billing start date for post-enrollment ICC and HCBS Waiver Services. For additional information regarding the enrollment process please see ‘Required Conditions for the Effective Date of Enrollment’ following this subsection.

Enrollment Activities may be conducted prior to an inpatient discharge and/or while a child is residing in the community.

### 4. Transitioning to Waiver

#### Operations Support Unit (OSU)

The OMH Operations Support Unit (OSU) plays a role in monitoring the completion of all enrollment steps and is responsible for:

- establishing the effective date of enrollment for each child who meets all three sets eligibility criteria (i.e. clinical, Medicaid and fiscal) for the waiver;
- issuing the appropriate Notice of Decision (i.e. Acceptance or Denial) to the family re. the outcome of their application to participate in the Waiver;
- monitoring the Welfare Management System (WMS), i.e. the Medicaid computer system, for adequate Medicaid coverage and then making appropriate coding changes in the system to properly identify each new enrollee in the waiver (for claiming purposes and for proper identification in EMEVS). This includes ensuring that the LDSS or HRA has opened the appropriate Medicaid coverage to bill for waiver services; and
- notifying the ICC Agency when they can begin billing for Waiver services.

OSU will issue the Notice of Decision regarding Waiver Enrollment with the effective date of enrollment once all steps of the enrollment process have been completed and the data has been sent to OSU. Note: Post-enrollment and HCBS Service billing information is provided through the HCBS Waiver Effective Billing Date Report accessed through CAIRS Client Reports.

Responsible parties:

- *Service Plan and Budget* – developed by ICC with child, family and other providers and approved by LGU.
- *Medicaid Notice* - issued by LDSS
- *Notice of Enrollment in Waiver* - OSU completes the Notice of Decision and the Waiver agency accesses it through CAIRS.
- *Notification to start billing* (Post-enrollment (ICC) and HCBS Waiver Services) - OSU advises the Waiver Agency through the Effective Billing Date Report in CAIRS and the Waiver agency accesses it through CAIRS.

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### Instructions for Transmittals #1 and #2

To determine the effective date of enrollment and issue the Notice of Acceptance, OSU must receive the dates that the provider agency entered into CAIRS from the following completed/signed/approved/dated documents:

- Waiver Application/Freedom of Choice;
- Financial Information data;
- Level of Care Form (907 MED);
- Medicaid Application (if one is necessary);
- Initial Service Plan (reviewed and signed by LGU); and
- Service Plan Budget (reviewed and signed by LGU).

The dates and information from the above are to be entered into CAIRS. It is anticipated that for most cases the data will be entered in CAIRS and will be sent to OSU in two groups, at different times: See HCBS Waiver Enrollment Process for the New CAIRS Demographics Screen.

#### *Transmittal 1*

Enter required data elements into CAIRS including the date of the Application/Freedom of Choice form and date of the level of care form.

#### *Transmittal 2*

Enter required data elements into CAIRS including the initial Service Plan. The date of the initial Service Plan is the date of the last signature, generally the date signed by the LGU.

**Note:** Please do not delay sending Transmittal 1 to OSU solely because the Medicaid application has not been filed, or there are other Medicaid related hold-ups occurring. Please note that receipt of the information contained within the Transmittal 1 by OSU is the official moment that Operations Support Unit becomes involved with the case, i.e. creates a case file and begins to monitor the enrollment process. Therefore, it is **very important** that Transmittal 1 be sent to OSU as soon as the Application to Participate has been completed.

Completed by:

The ICC agency designates who will input the required data into CAIRS with supervisory review and approval.

### Required Conditions for the Effective Date of Enrollment

**All** the following conditions must be met before an effective date of waiver eligibility can be established:

- Level of Care Determination approved by LGU;
- HCBS Waiver Application Form signed by child, as appropriate, and Parents/Guardians;
- Service Plan must be signed and approved by all participants including all youth over the age of 12. Younger children may also sign the document if indicated. The youth and the family members

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should be the first to sign since the plan begins with them. The ICC and ICC Supervisor may then sign. All signature lines should be complete and filled in prior to obtaining the signature of the LGU. If a child refuses or is unable to sign, this must be indicated with the reason why on the signature line.

- The initial Service Plan and Budget must be approved and signed by the Local Government Unit (LGU).
- Medicaid is Already Active - OR - Medicaid Application is filed with LDSS/HRA; and
- Child is discharged from:
  - Inpatient Status, i.e., Children's Psychiatric Center (CPC), Psychiatric Center (PC), Residential Treatment Facility (RTF), general hospital or private psychiatric facility; or
  - OMH Residential Programs, i.e., State-Operated Community Residence (SOCR), Voluntary-Operated Community Residence (VOCR), Family-Based Treatment (FBT), Teaching Family Home (TFH); or
  - Office of Children and Families Services (OCFS) Residential Programs, i.e., Residential Treatment Center (RTC), Detention Center; or
  - Intensive Case Management (ICM) and Supportive Case Management (SCM)

### How OSU Determines Effective Date of Enrollment

ICC's are required to use CAIRS based electronic transmittals to send notifications to OMH's Operations Support Unit indicating that key forms have been completed, dated and signed by parties involved in the enrollment process. OSU uses the dates on which key documents were signed to determine when the conditions for enrollment have been met. *The effective date of waiver enrollment is determined by the latest date that all the above conditions of enrollment have been met.*

### Children Residing Out of the Home

To participate in the waiver, a child must reside in the community. Even though children in OMH residential programs, residential treatment facilities or psychiatric centers, and recipients of OMH intensive case management services, and residents of OCFS residential treatment centers, can apply for the Waiver, they cannot be enrolled in the waiver while they are still residents/recipients in these programs/facilities.

*Because the effective date of enrollment in the Waiver cannot be established until a child has been discharged and is living within the community, if an ICC wishes to receive maximum allowable reimbursement, it is important that the discharge, like all other conditions of eligibility, take place within 30 days of the date the family applies for the Waiver. It is also important that OSU be apprised of the specific date of discharge/termination from these programs as soon as they occur.*

### Notice of Decision (Acceptance or Denial)

Once OSU has verified that all conditions for enrollment have been met and they have established the effective date of enrollment, they will issue the *OMH HCBS Waiver - Notice of Decision - Acceptance* form. This notification is the family's official notice regarding date of active HCBS Waiver enrollment. Copies of this form are also sent to the ICC, LGU, and LDSS (except NYC).

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If a child is not approved for enrollment into the HCBS Waiver, OSU will issue an *OMH HCBS Waiver - Notice of Decision - Denial* form. The specific reason for the denial and the applicant's appeal (i.e. Fair Hearing) rights will be reflected on this notice.

### When Billing Can Begin

ICC Agencies **must not** begin billing for ICC Enrollment Activities until the youth is formally enrolled in the waiver program. Determining the effective billing date post-enrollment is done electronically in a report through CAIRS via the Program Notes screen. ICC billing staff must wait for notification via this report advising of the enrollment date before initiating post-Enrollment (ICC and HCBS Waiver Services) billing.

**Important Note:** Receipt of the Notice of Decision - Acceptance form is **not** to be interpreted as an instruction to begin billing. *Notification via the Effective Billing Date Report is required before billing may begin.*

## 5. Waitlist

Prioritization is needs-based and is re-evaluated periodically as new children enter the queue or the mental health status of children on the list changes. In addition to meeting all Waiver criteria, the following is weighed in the prioritization process:

### *Priority 1:*

- SPOA and RTF transition coordinator recommends that HCBS Waiver services are needed for a successful transition to a community setting;
- The child is without any services in the community and is in imminent risk of hospitalization if waiver services are not made available
- The child is currently in the hospital and wishes to be diverted to Waiver.

### *Priority 2: (Three of the following must apply)*

- A request from the family/caregiver and PAC Committee for alternative placement in the community rather than RTF or inpatient psychiatric hospital has been made;
- The child is on the RTF wait list;
- The child has utilized multiple intensive alternative community mental health services and requires Waiver services to remain in the community;
- The child requires non-voluntary home tutoring;
- The child is identified as highest need child based on an assessment instrument that identifies the level of need (e.g., Child and Adolescent Needs and Strengths (CANS), Child and Adolescent Level of Care Utilization System (CALOCUS), etc.);
- Multiple hospitalizations or extended hospital stay has occurred within the past six months;
- Multiple emergency presentations with stabilization alternatives within the past six months have occurred.

### *Priority 3: (Three of the following must apply)*

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- The child is on the RTF wait list;
- The child has utilized multiple intensive alternative community mental health services and requires Waiver services to remain in the community;
- Multiple services from other system supports are needed (education, family court, juvenile justice, etc.)
- The child is identified as a high need child based on an assessment instrument that identifies the level of need (e.g., CANS, CALOCUS, etc.)
- Multiple hospitalizations or extended hospital stay within the past year;
- Multiple emergency presentations with stabilization alternatives within the past year.

*Priority 4:*

- Priority 1, 2, and 3 candidates are exhausted.

## Section 6: Partnerships

The HCBS Waiver's success is dependent on the cohesive establishment and maintenance of partnerships with the Local Government Unit (LGU), the Single Point of Access (SPOA), the Individualized Care Coordination (ICC) Agencies (the identified agencies responsible for the Waiver Program in each county), the local Department of Social Services Medicaid Units, the local Department of Social Services Children's Services, the OMH Regional Field Offices and the Office of Children and Families Services (OCFS) Regional Field Offices. Additional stakeholders include the NYS Division of the Budget and the federal Center for Medicare and Medicaid Services.

### 1. Local Government Units (LGU)

#### ROLES AND RESPONSIBILITIES

The Local Government Unit's responsibilities include the:

- Development of the HCBS Waiver primary provider and provider network (ICC Agencies and subcontractors); co-monitoring of network provider performance including attention to the cultural competency of workers; continued recruitment to increase the provider network, thereby providing additional choices to families;
- Completion of initial Level of Care determinations and Result of Screening letter (on LGU letterhead) to parents;
- Annual Level of Care recertification's, as well as any periodic recertification's if a child's ability to remain in the community upon a lengthy inpatient stay is in question;
- Initial Service Plan and Service Plan Budget (UPDATE: LGU, ICC and ICC Supervisor signature required) approval (signature required on both);
- provision of consultation on continued eligibility of children admitted for psychiatric inpatient stays;
- monitoring of ICC Agency performance; making recommendations regarding the Plan of Corrective Action or termination of a contract, if deemed necessary;
- monitoring of ICC Agency fiscal performance through review of financial management reports provided by OMH; pre-approving proposed consumer service dollar (flex fund) expenditures of \$250 and above for Waiver cases in their county;
- monitoring of the subcontractor network performance, including making recommendations to OMH regarding decertification of subcontractors if deemed necessary; all such requests to OMH must be written and include documentation of reasons for recommended action;
- negotiation of the contract between ICC Agency, Local DSS, and LGU for foster care population enrolled in HCBS Waiver;
- notifying OMH Division of Children and Family Services of primary and secondary LOC signatories \*;
- Tracking utilization of care for length of stay and waitlists.

\*See [Section 4 Level of Care Determination](#) for further explanation on LOC signatories qualification requirements.

## 2. SPOA, DSS, OMH Field Offices, OMH Parent Advisors

### ROLES AND RESPONSIBILITIES

#### **Single Point of Access (SPOA)**

The SPOA’s provide initial intake and screening of referrals and determine appropriate service level. They usually complete the initial Child Assessment of Needs and Strengths (CANS) rating instrument for Waiver applicants. The SPOA assures in the absence of Waiver slots, the applicant’s needs are managed through other services until there is an opening.

#### **Local Department of Social Services (LDSS)**

The County Department of Social Services’ Medicaid Unit is responsible for determining Medicaid eligibility through the completion of the [Medicaid Application](#).

#### **Field Coordinators**

Field Coordinators are encouraged to be creative in their efforts to support their regional HCBS Waiver programs. Their responsibilities include:

- functioning as the general liaison between OMH, HCBS Waiver staff and ICC Agency staff on an ongoing basis;
- advocate for county and ICC Agencies to OMH;
- participation in start-up activities of new sites together with the LGU;
- conducting annual program reviews of each ICC Agency through site visits. These must include record reviews, review of program operations, policies and procedures;
- forwarding site visit summary reports within 30 days of the respective site visit to the ICC Agency, LGU, and OMH detailing areas of corrective action using OMH’s [Site Visit Tool Agency](#) and [Site Visit Tool ISP](#)
- reviewing each ICC [Performance Improvement Plan](#), monitoring and following up on its implementation;
- ongoing monitoring of Individualized Care Model in the delivery of HCBS Waiver services and notifying OMH Waiver Program Director of any issues;
- maintaining ongoing contact with the ICC Agency Program Director to troubleshoot any problems that arise or any issues needing attention;
- providing case consultation especially around issues of termination verses continuation of care;

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- providing technical assistance, as needed, to the ICC Agencies and LGU regarding program implementation, administrative issues, case specific clinical issues and discharge planning;
- facilitation of network building by assisting in the recruitment of new service providers;
- scheduling and coordination of training events;
- attendance at statewide ICC Agency meetings;
- scheduling and facilitating regional ICC Agency meetings and
- participation in ICC subcontractor meetings (as applicable).

**Parent (Family) Advisors**

The following list of activities represents roles currently performed by OMH Parent Advisors. Parent Advisors are encouraged to be creative in their efforts to support their local HCBS Waiver programs. Responsibilities include:

- participating in new site start-up activities together with the Field Coordinators;
- advocating for a strong family role in developing policy for the HCBS Waiver sites, preferably through subcontract with local family support programs for services to ICC Agency;
- Aiding ICC Agencies in finding staff/advocates for HCBS Waiver Family Support Service. Providing regular support to staff/advocates (possibly through regular meetings) and involving them in a broader family support arena, including regional meetings;
- providing on-going training, i.e., role of families, family/professional collaboration;
- in collaboration with the ICC Agency, developing a process for coordination of initial contact of family advocate with any child/family applying for HCBS Waiver;
- participating in the annual site visit with specific responsibilities for conducting family satisfaction interviews and supplying relevant information for inclusion in the site visit summary report;
- interfacing with families regarding their concerns or complaints;
- communicating with ICC Agencies, OMH Field Coordinators and/or OMH Waiver Coordinator, as needed;
- assisting in monitoring flex fund expenditures and accessibility to funds to encourage creativity and family self-sufficiency;
- attending Statewide and regional ICC Agency meetings and
- serving as a regional resource to family support staff.

## Section Seven: Service Plans

### 1. Policy

HCBS Waiver Service Plans are designed to document on-going assessment of the child's progress and needs as well as to guide service provision. They are completed by the Individual Care Coordinator (ICC) with input from the child, the child's family, if applicable, treatment provider(s), the child's Waiver service workers and other significant collateral sources. As indicated in the program's core values, Service Plans are family driven, strength-based, individualized, culturally relevant, developmentally framed and correlated with ratings from the [Child and Adolescent Needs and Strengths \(CANS-NY\)](#) assessment tool. Waiver service plans address many areas in the child and family's life including safety, resiliency, developmental tasks and the support of clinical treatment goals. Service plans are to be written in a manner that provides the reader with a clear picture of the child and family's circumstances, dynamics and evolution over time. They must clearly describe the child's progress in achieving each goal and each objective. Service planning meetings are convened by the ICC at prescribed intervals defined later in this section.

A Service Plan also serves as an agreement between an Individual Care Coordination (ICC) Agency and the participant to describe and record the mutually agreed upon specific activities to be undertaken to attain the desired goal(s).

On-going communication between the Waiver Provider and the Treatment Provider inform both Waiver service planning and treatment planning. It is expected that Waiver service planning occur in collaboration with treatment providers. Treatment Providers and ICC Agencies should be familiar with, and have input into, each other's plans. Communication may occur through a variety of venues. However, the ICC is encouraged to attend Treatment Reviews and case conferences for Waiver children and the Waiver child's treatment provider is encouraged to participate in Waiver Service planning meetings.

*PLEASE NOTE: Changes associated with the 1915c application renewal must be incorporated in every active Service Plan by the next scheduled review.*

#### **A. Role of the LGU**

The role of the Local Government Unit (LGU) in the Service Plan includes:

- approving the Initial Service Plan including Budget and
- coordinating with ICC to make remediation, as requested

### **2. Approving the Service Plan**

The Initial Service Plan must be approved and signed by the LGU. The LGU may request adjustments and/or changes to the Service Plan prior to approval. Only services authorized in the Service Plan can be provided and billed. The LGU reviews the Initial Service Plan to determine if:

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- the Service Plan *is* reasonable given the context of the child's stated goals,
- waiver services are being used in an effective manner,
- the services described in the Service Plan support the child's health and welfare,
- informal and non-waiver services are used whenever appropriate, and
- discontinuance is appropriate.

Until the LGU has formally approved any revised Service Plan, the existing Service Plan must stand in effect.

**Note:** effective September 1, 2017, a 30-day Service Plan review will no longer be a program requirement. As such, any changes or revisions requested by the LGU on the Initial Service Plan must be completed immediately and must not wait until the first 90-day review, unless indicated by the LGU.

## **B. Due Dates**

Service planning occurs at predetermined intervals throughout the child's enrollment. The HCBS Waiver requires an Initial Service Plan and Budget shortly after referral to the Waiver agency. A Service Plan review is then due 90 days from the enrollment date issued by OMH's Operations Support Unit. Subsequent Service Plan Reviews are due every 90 days thereafter. Original Initial Service Plans and all subsequent Service Plan reviews must be kept in the child's record.

A revised plan can be made, with revision date and appropriate signatures, at any point in time to accurately incorporate the child's needs and strengths (accompanied by a Progress Note explaining the change) but the original dates will still adhere. At no time, should a service plan be completed, including signatures, more than five business days prior to its due date. All completed service plans, including signatures, after the due date will be considered late. ICC Supervisors will be allowed an extra three business days after the due date if needed, to review and sign the service plan.

On rare occasions, untoward events can prevent timely completion of service plans. Supervisory consideration and approval may be given if a service plan will be late, for extenuating circumstances, but it should not extend more than three business days. If, completion, including signatures, of any service plan is early or delayed, an explanation must be noted on the plan, as well as in a progress note, and the plan must be completed within the extended timeframes prescribed above.

## **C. Service Plan Addendums**

It is understood and expected that youth and family's needs and circumstances may change at any point, outside of the predetermined Service Plan review times. ICCs are responsible for updating Service Plans via addendum to ensure that necessary updates are captured. The Service Plan is the "hub" that informs all HCBS Service Providers of the participant's needs, priorities, and strengths; it is critical that this document reflect any change in the participant's Plan.

If the addendum requires changes to ancillary Service Plan forms (Budget, Safety Plan and/ or Goal and Objectives) the Plan must provide an explanation for these changes. For instance, if a participant is hospitalized and upon discharge it is determined that Respite services will be added to the Plan, the ICC must update the Service Plan to reflect the addition of this service. Additionally, a change in the scope, duration or frequency of

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a service must be reflected in the Budget as well as in the narrative explaining why this change has occurred.

Any change to the Plan regarding the provision of services must be reviewed and authorized by the ICC Supervisor via signature on the Service Plan form. Changes to the Plan must be reviewed and authorized by the participant and/or family at the next scheduled 90-day review, for the except of changes to the Safety Plan. Please see rules regarding Safety Plan completion for further information.

Addendums and/or Service Plan changes do not take the place of routine Service Plan reviews or effect Service Plan due dates.

**D. Team Meetings**

The purpose of a team meeting is to allow for collaboration among the ICC, Waiver Service Providers, the caregiver, when applicable, the youth, collaterals identified in the Plan and anyone else the child/caregiver wishes to have participate in this meeting. The ICC must organize team meetings to review the child's current needs, plan for services and develop/ review the Service Plan. A team meeting does not qualify as a required ICC face-to-face contact with the youth and therefore cannot be used as a substitution for this requirement. Additional information on the role of the ICC and team meetings is provided in [Section 10](#).

Team meetings are permitted but not required for the Initial Service Plan. All subsequent Service Plan reviews require a team meeting.

## 2. Service Plan Components

**A. Service Plan Narrative**

The Service Plan narrative is based on interviews and documentation acquired including the CANS-NY assessment. The Service Plan narrative is a summary of a clinical case, drawing on elements from the participant's medical, psychological and sociological history, and expressed chronologically. The intention of the narrative is to summarize the critical components of the participant's history and precipitating factors to HCBS Waiver enrollment. To ensure effectiveness, the information must be concise and summarize, not synthesize the case.

The Narrative provides the foundation and rationale for the provision of services. It is critical that the Narrative reflect a comprehensive summary of the child and family's strengths, needs and priorities in manner which promotes wellness and empowerment.

**B. Child Adolescent Needs and Strengths (CANS-NY)**

The NYS Office of Mental Health (OMH) and the NYS Office of Children and Families (OCFS) have collaborated with Dr. John Lyons in the development of a comprehensive version of the CANS for New York State, hereafter known as the CANS-NY. The CANS-NY includes a wider range of CANS domains to better identify and address the multi-systems needs of the children served in OMH intensive community-based and

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residential programs and the OCFS Bridges to Health Medicaid Waiver. The CANS-NY serves as a guide in decision making as well as to service planning specifically for children with behavioral needs, medical needs, developmental disabilities, and juvenile justice involvement. Due to its modular design, the tool can be adapted for local applications without jeopardizing its psychometric properties (i.e., a system may select to use certain modules and not others).

**C. Safety Alert and Plan (SAP)**

An additional aspect of the Service Plan is the development with the family and child of a specific plan to address identified safety issues. The HCBS Waiver Safety Alert Plan is used for this purpose. It is essential that the family agree with the components of the plan to better assure compliance. The Safety Alert Plan must be in place for each child and family. All elements on the form must be completed. This must be dated and signed by the child, family member, ICC, ICC supervisor and school representative, if indicated. If a child is unable to sign, the reason is to be stated on the plan. A copy must be given to the family.

Upon referral to the Waiver program, a Safety Alert Plan is developed with the child and family by completion of the Initial Service Plan. Safety Plans are reviewed, signed and updated at each Service Plan Review and as needed. A “child-friendly” contract, [HCBS Waiver and Child Safety Contract](#), may be used in addition to the Safety Alert Plan and this may be adapted to each agency’s needs.

**D. Budget**

The Budget is reviewed at each Service Plan Review meeting and modified as needed. Child costs are monitored to assure that they stay within approved ceilings. Waiver services are reviewed to assure that they are being utilized as noted in the Service Plans and the Budget. Changes to projections are made accordingly.

As part of the planning process, the ICC assists the child and family in identifying which of the remaining Waiver services and providers will be useful in achieving goals. The child and family then complete the Choice of Provider Verification. This form is developed by each ICC Agency and lists their Waiver service providers. This is filed in the child’s record and updated as needed.

**E. Goals, Objectives, Methods**

Writing functional, meaningful and person-centered goals and objectives are essential to not only tracking the child and family’s progress but also in understanding the natural opportunities within everyday routines and activities of the child and family’s life which highlight strengths and promotes competency.

The assessment of the child’s skills and priorities must be conducted in the real-life context of family, culture and community which will lead to functional and relevant goals as opposed to isolated tasks irrelevant to daily life.

The goals and objectives are established after gaining contextually relevant information about the child’s strengths and needs. Part of this process includes the CANS-NY assessment which assists in providing

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perspective to culturally sensitive and individually focused information. All ratings of 2 or 3 must be addressed in the child's Service Plan unless deferred, in which case an explanation for the deferment and a resulting plan to address the concern(s) must be outlined in the Service Plan narrative.

The functionality and fluidity of the goals, objectives and methods determines the availability of progress to the child and family. Goals, objectives and methods are established during the Initial Service Plan as a result of the CANS-NY assessment, observation, family and child input and any additional information gleaned from ancillary resources. These goals, objectives and methods are fluid and change as the strengths, needs and risk factors of the child and family change. Projected use of flex dollars must be specifically noted, when indicated, stating for what they will be used.

For additional assistance please review [Appendix H: Writing Goals, Objectives and Methods](#)

## **F. Discharge Readiness**

Preliminary plans for disenrollment begin during the initial service planning phase. The ICC discusses with the family and child what changes need to occur as well as which services may be needed to support the child in the community after disenrollment. These discussions must continue throughout the child's enrollment and be reflected in the service plans and progress notes.

## **G. Signing the Service Plans**

The child's ICC, the ICC Supervisor and the LGU as well as the family and child, must approve and sign the Initial Service Plan and all parties, except the LGU, must sign each Service Plan Review thereafter. All required signatures and dates must be present. The dated signatures of the ICC and/or ICC supervisor should not be before the dated signatures of the child and family. If a child refuses or is unable to sign, this must be indicated with the reason why on the signature line. For youth over the legal age of consent, parent/ caregiver signature is not required. Please make note of reason in the absence of a parental/ caregiver signature.

# **3. Initial Service Plan**

The Initial Service Plan (ISP) is created upon a child's referral to Waiver soon after the signing of the Application/Freedom of Choice by the child and family. The Service Plan includes a comprehensive description of the child's life domains, child and family strengths, priorities as defined by the child and family, a discharge profile and initial measurable goals, objectives and methods. Risk factors and strengths identified through the CANS-NY are addressed in the plan.

## **A. Initial Assessment: Child Adolescent Needs and Strengths (CANS-NY)**

The [Child and Adolescent Needs and Strengths \(CANS - NY\)](#) is an instrument designed by Dr. John Lyons to assist in assessing children for risks in a number of domains as well as in indicating family strengths. The

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CANS-NY is completed initially when the child is referred for services, usually by the SPOA (if SPOA does not complete, then the ICC does so). *The ICC completes a new CANS-NY at the time of the enrollment if not recently completed by the SPOA and 90 days thereafter to match up with the Service Review.* CANS-NY are filed in the child's record with the associated Service Plan.

The CANS-NY is additionally completed upon disenrollment (unless a SPR was completed with-in 30 days of the discharge) and any time during enrollment when a significant change in identified risk factors or family strengths is observed.

The CANS-NY is useful in assessing risk factors as well as in tracking progress over time. Information from the [Child and Adolescent Needs and Strengths assessment instrument \(CANS-NY\)](#) must be clearly integrated into the service plan narrative. Dimensions with ratings of 2 or 3 in the Risk Factors Domain must be addressed immediately with a corresponding goal and service in the child's plan. In the remaining domains, any dimension that puts a child at risk that is rated 2 or 3 must also be addressed with a goal and service immediately. Other dimensions with rating of 2 or 3 may or may not be immediately addressed. If these are deferred for a later time, the reasons for deferral as well as how each will be addressed in the future must be discussed in the plan's narrative section. This is true also for identified needs that another agency/system is or will be addressing.

[CANS-NY – Coding Definitions](#)

*If the CANS-NY indicates possible changes to the child's eligibility status, the ICC agency must immediately inform the LGU.*

**NOTE: The Health Home Serving Children (HHSC) CANS can be used in lieu of the CANS-NY, at the discretion of the ICC Agency.**

### B. Initial Budget Development

When developing the initial service plan, a budget must be completed by the ICC in coordination with the family and other providers to identify the *anticipated* yearly Medicaid costs associated with the service plan that is developed for the child. All anticipated costs must be identified and annualized, as if the child needed this preliminary package of services for an entire 12-month period. This information is necessary to assist the LGU in determining whether the specific applicant *meets the fiscal eligibility requirements* of the OMH HCBS Waiver program; and to assist the waiver provider in keeping expenditures within both the federal and state prescribed Medicaid caps. The initial budget is modified per actual service delivery as well as anticipated needs with every 90-day service plan review.

The Budget is completed in conjunction with the Service Plan, development of which begins as soon as possible after the Waiver application is signed. **Note:** As the child's needs change and new goals and objectives are created, the service plan and the budget must be revised accordingly.

The budget must be documented on the Individualized Service Plan Budget and must list the type and number of all waiver services indicated in the service plan and estimate the cost for providing these services. The budget

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should also list the type, number and an estimate of the cost of all non-waiver medical and psychiatric services (referred to as "State Plan" services) which are expected to be utilized for the child during the year. Flex fund costs and in-kind are documented in the budget although the flex funds are not included in the budget's total.

It is understood that the initial budget is an estimated budget and that it will change as the service plan changes. **The budget is to be reviewed at each 90-day service plan review and compared to actual services delivered during the prior period as documented in the service plans and progress notes.** The budget must then be adjusted to accurately reflect services that have been provided and are anticipated to be provided during the next 90 days. If additional services, an increase or decrease in any given service, or the removal of a service occurred during the prior period or is anticipated during the upcoming 90 days, this must be shown in the budget and explained in the accompanying 90-day service plan narrative.

### Budget Categories

There are five categories of services broken out on the Individualized Service Plan Budget that must be considered and included in the budget, as applicable. These categories are:

1. **Waiver Services** - ICCs work with the child and family to identify type and amount of waiver services needed and the preferred providers of these services. These are documented on the Budget form.
2. **Non-Waiver Mental Health Services** - These include both outpatient services (i.e. clinic, day treatment and partial hospitalization) and inpatient (i.e. acute, RTF and CPEP). Review with the child and family any mental health services currently being received/sought (outpatient and inpatient). Work with family/others (e.g. school) to determine continued need for these services if child has access to Waiver services. Identify types of services needed and preferred providers and estimate the amount of each service that will be needed. Document them on the Budget form.
3. **Medical Services** - Review the child's past levels of health care service utilization, identify any chronic physical/medical conditions (e.g. asthma, diabetes, HIV, drug or alcohol related problems) and discuss current and future medical needs. Identify types of medical services that will be needed in future and estimate amount of each. Document these on the Budget form. Services that should be included in this category are: pharmacy, physician, medical clinic (hospital based or stand-alone), laboratory, radiology, overnight hospital stays for medical care, dental, optical, drug/alcohol treatment, school-based special education health services (if known at this point), and any transport provided by a Medical enrolled transport provider that is related to getting child to medical appointments.  
**Note:** Since the area on the budget form for medical services is quite small, you will show the total inpatient and outpatient estimated medical costs on the front of the form and use the back of the form to itemize the types and amounts of services.

Please note that if a child is enrolled in a LDSS Medicaid Managed Care plan, the only medical services that you **must** identify individually and include in this section are those medical services that are not covered under the managed care plan contract. These services are billable to Medicaid on a fee for service basis and will be charged back against the Waiver budget. Likewise, if a child is covered under a private health insurance policy (coverage parent has through employment), the only medical services you must identify and determine cost

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for are the medical services/costs that will not be paid by the private health insurance carrier. However, in both situations, it is recommended that you identify **all** expected medical services needed by the child in this section (showing \$0 estimated cost for those items covered by managed care plan or Health Insurance). This way they are known/captured in the event that the child is disenrolled from the Medicaid managed care plan or loses health insurance coverage and the services covered under these plans must be factored back into the budget.

- **Managed Care Premiums** - If the child is enrolled in a Medicaid Managed Care Plan, show the name of the Plan and the amount of the monthly premium that Medicaid pays the Plan in this section.
- **Other** - This section should detail any other needs/expenses that are identified by the child/family and are included in the service plan and are not included in the previous four categories. Flex fund expenditures are entered in this category. For example, a child needs a beeper to communicate with otherwise unreachable parent at work; family needs babysitting money to enable parent to attend parenting skills classes for parents of children with serious emotional disturbance; or child needs to attend a summer camp. Indicate the type and estimated amount needed of each service in this section. Also, use this section to list out any "in-kind" services that the child needs and are included in the service plan but which are being reimbursed through a funding source other than Medicaid, e.g., a summer camp scholarship from YMCA indicate the service and the funding source and show the estimated cost as \$0.00.

### Guidelines for Costing the Budget

All anticipated costs must be identified and must be annualized, as if the child needed this preliminary package of services for an entire 12-month period. Following are guidelines for estimating and annualizing the cost of the service needs identified in the service plan and documented on the service plan budget:

- Cost out each of the Waiver services by determining the number of service units that you expect will be needed during the year and then multiplying the units by your agency's currently approved rate for that service.
- Cost out the amount of mental health outpatient (clinic, day treatment, or partial hospitalization) services by determining the number of each type of visit/service that is expected to be needed during the year for that child and then multiplying the number of visits/services by their respective rates. **Note** that rates may vary across the state.
- Determine the number (if any) of inpatient psychiatric days anticipated on an annual basis at the hospital identified in the service plan. Cost these days out by multiplying them by the hospital's rate, a daily statewide average per diem or by the hospital's actual Medicaid approved psychiatric per diem, if known to you.
- Medical Services must be costed using the best available cost information you can obtain, e.g. past bills, records maintained by the family; contact with actual provider to find out what their Medicaid approved rate is for the service in question; etc. **Note:** private health insurance is available through the family, list all services needed but *only count in the total the costs that* are not covered by the health insurance plan and *will be billed to Medicaid*, e.g. deductibles, coinsurance, non-covered services, etc. If the child is

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enrolled in a Medicaid managed care plan, list all services that are needed but only assign cost to those services that are not covered under the Managed Care Plan contract.

- Calculate the total annualized cost of the managed care plan premium by multiplying the monthly premium by twelve.
- Estimate the cost of the services itemized in the 'Other' section using whatever methods are available, e.g. calling provider/vendor, sale brochures, etc. Involve the family. Assist the participant/ family in prioritizing these needs and where practical encourage them to shop for the lower prices. Also, where needed, assist them in balancing needs with available resources.
- Also, document **flex fund expenditures** on the Budget form but do not count these in the total as these are already accounted for in the ICC rate. Before considering the use of Waiver flex funds, the family must be assisted in exploring other ways to meet their needs.

### Additional Guidelines

If any category threatens to cause the budget to exceed the budget cap, ask and answer such questions as the following (together with all parties involved, i.e. the LGU, ICC program director):

- Will this service be effective for this child?
- Can an alternative to the expensive service (program or provider) be found?
- If inpatient psychiatric days are at issue, are the hospitalizations expected to be short, infrequent, just for "fine-tuning" and can alternatives to hospitalization be found?
- Are the child's needs best met through the Waiver or would they be better served outside the Waiver?

### **Comparing the Estimated Budget to the Cap**

Compare the "Projected Total Cost of Services" figure from the estimated budget to the Federally Approved Average Yearly Cost. If the estimated budget exceeds this figure, then the child does not meet the fiscal requirements for enrollment in the Waiver. If the child's budget cannot be reduced below this figure, then the child's application would be denied on the basis that "child cannot be served in the community at the federally approved average yearly cost".

Next, compare the "Projected Total Cost of Services" figure from the estimated budget to the State defined Program Expenditure Cap. If the projected total cost of services for the child is less than the Program Expenditure Cap, the child meets the fiscal requirements for enrollment.

If the estimated budget is above the Program Expenditure Cap (but below the Federally Approved Average Yearly Cost), examine the service plan and budget to look for ways to reduce the budget, e.g. less costly alternatives. If all costs appear justified and unavoidable, balance this child's budget against those of the other children enrolled in the Waiver. If by including this child in the program, the ICC agency's overall budget average remains at or below the Program Expenditure Cap, there should be no problem admitting the child.

## C. Approval of Service Plan and Budget

The Local Government Unit must review, approve and sign both the *Initial Service Plan and* accompanying Budget following their completion. Once the LGU's dated signature is received on both the initial Service Plan and Budget, the Transmittal 2 must be completed and sent to the OMH Operations Support Unit as soon as possible to prevent delays to the enrollment process

### Timeframe for Approval of the Initial Service Plan/Budget

To ensure that the ICC agency receives maximum Medicaid reimbursement for the services it provides, the Initial Service Plan and initial Budget must be approved within 30 days of the date that the Waiver application is signed. Therefore, it is important that the ICC agency take a very pro-active role in making sure that the 30-day time frame is met. This should include sending the completed service plan and budget to the LGU with enough lead time to ensure that it is reviewed and signed within the 30-day time limit.

## D. Writing Initial Goals

Goals must address scores of 2s and 3s resulting from the CANS-NY assessment as well as encompass the participant and family's priorities. It is understood and expected that flexibility is needed to meet the unique needs and strengths of the participant. Waiver recipients enter the program with various available resources and community involvement. One of the responsibilities of the ICC is to develop and enhance community supports to promote success post-discharge, this involves identifying possible linkages, as needed. To account for the participant's needs as well as the requirement for ICC collateral contacts, initial goals may be written in a general format to account for the flexible nature of contacting numerous entities to identify specific collateral contacts. For instance, if the participant identifies a need for a mental health therapist but currently has no provider, the ICC may write a general goal identifying the need and the ICC's responsibility to identify a clinician in the community. The corresponding objective and method will not identify a specific service provider or agency rather, the steps necessary for locating a clinician will be articulated. Once a provider(s) has been established, the Service Plan must be updated to reflect the entity identified.

## 4. Service Plan Reviews

Service Plan Reviews provide the opportunity for review and discussion of the child's progress and the efficacy of the plan's methods. A narrative summarizing the progress, as well as any significant events and additional information, is developed. Progress in terms of each goal and objective is individually described. Reasons for changing, adding or ending goals or objectives are explained. Modifications, with corresponding status/target dates, may be made to the goals/objectives. Changes in the CANS-NY ratings are integrated into the plan including ratings of 2 and 3. Flex fund expenditures are tracked and adjustments are made to the methods as indicated. In addition, the Budget and Safety Plan are reviewed and/or updated, as applicable. Each form must reflect an updated date and corresponding signature to reflect the review.

## **A. Monitoring the Service Plan and Evaluating the Family's Progress**

Monitoring and evaluation is a continuous process that takes place during each family and service provider contact. In addition to monitoring the family's progress related to completing the tasks outlined on the service plan, every 90 days the Plan should be reviewed to evaluate if it is working or needs to be modified. The following steps are used in the evaluation process:

- Reviewing the Service Plan.
- Collecting information from all service providers regarding the progress toward service plan goals.
- Engaging the child (if age appropriate) and the family in a discussion to review progress in relation to accomplishing the desired results and tasks established in the service agreement.
- Evaluating changes in the conditions and behaviors deemed to be most critical to the assurances of child's safety.
- Collecting information regarding the child's well-being and treatment.
- Considering any changes in family dynamics during the last evaluation period; and
- Documenting the results of the evaluation process in the service plan narrative for reference in future decision making.

The primary purpose of evaluating family progress is to measure what changes have occurred involving the most critical areas of concern identified during the initial child and family assessment. If services are not being provided or used per the Service Plan, find out why, and then support and encourage implementation and/or modify the Plan. In all situations, compliance or lack of compliance with the Service Plan should be communicated to the family, treatment providers, when applicable; the courts (if there is court involvement), and your supervisor.

## **B. Service Plan Organization**

Please see [Appendix G](#) for the outline of Service Plan organization.

## Section Eight: Flex Funds

### 1. Policy

Flex dollars are provided as part of the Individualized Care Coordination (ICC) rate to each agency for each of their allocated slots in the amount of \$1,250 per slot. (One twelfth of \$1,250 is to be billed using the "HCBS Waiver flex fund" rate code). Total annual flex expenditure cannot exceed this figure multiplied by the total number of approved slots per agency. Flex funds can be used either to meet emergency needs or to meet on-going needs of the child and family. ICC Agencies need to have a dedicated process for monitoring, recording and accounting for flex dollars. Flex funds must be linked in writing to the child's goals and objectives in the methods section of the Service Plan. Expenditures must be documented in the Progress Notes. A Flex Fund Spending Log must be used, and made available during site visit reviews.

Individual consumer dollar proposed expenditures of \$250 to \$ 499 must be pre-approved by the Agency Waiver Program Manager and the Local Governmental Unit (LGU). Proposed expenditures of \$500 to \$1,249 must be pre-approved by the Agency Waiver Program Manager, the LGU of that child's county, and the Office of Mental Health (OMH) Regional Field Coordinator. Proposed flex dollar expenditures of \$1,250 and above (for a single use or in aggregate for ongoing needs) must be pre-approved by all the above as well as the OMH Central Office Waiver Program Administrators. The Flex Funds Approval Form is to be used and maintained in the child's case record.

The expenditure of flex funds must be closely and continuously monitored in detail by the Waiver Program Manager and Waiver supervisors. Receipts, sales slips, etc. must be maintained by the ICC Agency. Unspent flex dollars must be maintained by the ICC agency and will be collected by OMH. Flex funds may only be used while a child is enrolled in the Home and Community-Based Services (HCBS) waiver. Flex funds may not be used for post discharge services.

A tax-exempt form can be used by the ICC Agency when spending flexible service funds; however, this cannot be used if family members, themselves, make the purchases. Flex funds cannot be used to pay for a child/family's rent under any circumstances or to purchase a car. Flex funds may not be used for capital improvements for the enhancement of the value of home and property unless such enhancements relate to the safety of the Waiver child. Examples of this include but are not limited to: replacing broken windows or doors; repairing (or replacing if indicated) furnaces, plumbing, electric wiring, septic tanks, roofs, etc. Flex funds cannot be used to pay for staff/worker's meals, entrance fees, etc. when accompanying a child or family member.

Examples of appropriate use of flex funds include activities that clearly support the child's goals and objectives such as: clothing, utilities (not on a routine basis throughout Waiver enrollment), crisis and other specialists, medical, dental and optical care and supplies, transportation, and security deposits not covered under Medicaid or readily available and accessible through other means (e.g. social services). In addition, flex funds can be

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used to further youth development goals, such as memberships, music lessons, art supplies, summer camps, and other activities to further the youth's interests or skill sets. ICCs must make every effort to see if scholarships or other financial assistance is available to the child for any youth development activities before using flex funds.

### Emergencies:

Emergency purchases generally meet unanticipated needs. Funding to meet many of these needs may be available through the Department of Social Services or other community agencies; all efforts should be made to utilize these alternate resources first. For emergency uses, the plan must be developed within 10 days of the emergency. It must clearly state the situation precipitating the use of flex dollars, the types and quantities of goods and services to be purchased with estimated costs, and the anticipated duration of the need. Emergency needs are generally understood as lasting less than one week. If the need goes much beyond this, then a plan for meeting on-going needs must be developed.

### On-Going Needs:

On-going service needs are more long term than emergency needs. Approval of the use of flexible service funds for on-going needs must be given only after a careful review of the circumstances by the Agency ICC Program Director and, as appropriate, the family and child. Any anticipated ongoing expense that exceeds \$1,250 per child must also be pre-approved by the Agency Waiver Program Manager, the LGU of that child's county.

Flex funds **provide temporary assistance** to the child and family. A plan must be developed for how the family will ultimately manage without *flex funds if the need is on-going*. This plan must be documented in the service plan.

For additional information regarding rules for using flex funds, go to [Spending Plan Guidelines: General Provisions](#). Scroll to the bottom of the page and click on "Direct Contract". Follow menu prompts - select for Provider: "Complete Guidelines"; for Contract Number: select "all"; for Year: select the current year. In the next drop-down, select "Aid to Localities Fiscal Contracting Guidelines."

### Letter to Participating Family:

Each family must be given the OMH approved [Family Flex Funds Letter](#) within 30 days of enrollment into the Waiver. The ICC is expected to review the letter with the family and respond to their questions. Please note that if it is an ICC agency's policy to utilize gift cards and/or purchase orders, the sections pertaining to those options may be added to the letter.

### Worker Desk Guide:

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The [Flex Fund Worker Desk Guide](#) is designed to assist Waiver workers in determining appropriateness of requests to use flex dollars as well as a quick review of procedures and required approvals.

## Section Nine: Agency Policies and Protocols

As lead HCBS Waiver Agency, the ICC Agency is responsible for maintaining policies and procedures in line with HCBS Waiver Guidance. The ICC must ensure all applicable staff, including subcontractors, are trained and compliant with Agency policies.

### 1. Required Policies

#### A. Staff Safety Protocols

Each ICC Agency must be committed to providing a safe working environment for all workers, including subcontractor workers. ICC Agencies must establish written safety policy and protocols to be followed by ICC's and other HCBS Waiver services workers when conducting HCBS Services in the home or community. These must be periodically reviewed with all Waiver workers. Such communication must be documented.

##### Required Elements of a Worker Safety Policy

###### *Training*

Training is required for ICCs and other ICC Agency Waiver service and subcontractor staff in how to maintain personal safety in the community (whether with clients or other community members). Employee participation in all training sessions must be documented.

###### *Accountability System*

There must always be a system to account for the location of all ICC's and HCBS Waiver service workers when they are in the field both during usual hours and in after-hours situations. Follow-up must be provided for any reported threatening situation.

###### *Means to Summon Assistance*

ICC's and other Waiver service workers must be provided with means and instructions to readily summon assistance when necessary.

###### *Accompanied Visits*

Protocols must include the provision for accompanied visits when there is a history of assaultive behavior or other significant risk potential.

###### *Risk Analysis*

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The Worker Safety Policy must include methodology and timeframes for analysis of risks and for establishing safety interventions as needed.

*Additional Elements*

The Worker Safety Protocols which follow illustrate requirements and is included as a prototype. ICC Agencies may add to this to address specific concerns.

**B. Progress Notes (ICC, SUBCONTRACTOR, GROUP NOTES)****Policy**

Progress note documentation is a very important function of the Individualized Care Coordinators (ICCs) and HCBS Service Providers. Progress notes are completed when workers provide services to the child, meet with a collateral, or HCBS Service Provider contact or when any significant event occurs during the child's enrollment in the HCBS Waiver. Progress Notes are often reviewed in audits for comparison against Medicaid billing claims, flex dollar usage and relationship to goals and objectives. Each Progress Note must be complete, timely, and must accurately identify and relate to the child's service plan goal and objective(s). Notes must identify areas of need and be written in a strengths-based manner.

All qualifying face-to-face contacts must be recorded via sample ICC Contact Tracker Log to summarize and verify that the appropriate contacts were made to coincide with progress note documentation and billing requirements.

Each ICC Agency must develop and implement quality assurance standards to ensure that **all** individual workers' notes, as well as other documentation, are reviewed periodically by a supervisor. Supervisors must document corrective actions needed, how they will be accomplished and a time frame for completion.

**Purpose of the Progress Note**

Progress Notes provide a narrative history of the child's progress. A Progress Note:

- identifies services, activities, interventions and providing staff;
- identifies relevant goals, objectives which can be measured for progress and specific methods of implementation;
- describes significant events or unusual circumstances that relate to the child's progress toward meeting the goals and objectives of the Service Plan;
- recommends/justifies changes or additions to current goals, objectives and methods/services of the Service Plan;
- describes newly identified strengths, needs, and barriers;
- describes the type of contact, time, duration and service provided and

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- documents use of flex funds, both amount spent and how its use relates to a specific goal and objective(s).

### Progress Note Content

Progress Notes must specify:

- the date the note is being recorded;
- what service was provided;
- to whom the service was provided;
- type of contact
- contact date for the unit of service;
- the duration of the service that was provided (including the time of day as well as hours/minutes);
- amount of flexible service dollars spent and the goal to which expenditure is related;
- progress toward the service plan goals and objectives (citing which specific goal or objective the service provision is related to);
- level of participation of child/family;
- revisions to the service plan, and barriers to timely service plan completion, if any;
- name of person/agency providing the service; and
- name(s) of person(s)/agency with whom services were coordinated.

### Group Progress Notes

Note that for group progress notes, in addition to the above, the type of group (Respite, Skill Building or Family Support Services) and the worker to child ratio must be indicated.

When **Skill Building** groups include the Waiver sibling(s) and/or caregiver(s), the sibling and caregiver **must be noted in the service plan to be billable and their purpose in the group must be directly related to the Waiver child's goals and objectives**. One group progress note must be written for each group. If the group includes Waiver child's siblings or caregivers, this must be indicated in the heading with their name(s). When writing the note, a description must be given of what occurred as it pertains to **each** participant for whom there will be billing. Included must be how the inclusion of siblings/caregivers relates to the specific identified goals and objectives of the Waiver child. It is essential that the progress note be fully completed.

All groups must be clearly identified in the methods section of the Service Plans and must support achieving a specific goal of the child. Progress notes must clearly indicate that the modality was a group, which service provided it, the participant to worker ratio (including any non-Waiver children present or represented in the Group), the Waiver participants as well as all other Medicaid and OMH required elements. In all instances, service plans must clearly support the group composition and the group activities.

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**Subcontract Worker Progress Notes**

For every HCBS Waiver service delivered to an enrolled child or family member, progress notes must be completed by the worker and must comply with all the above criteria. The subcontractor must submit **original** progress notes to the ICC Agency immediately following service delivery except in cases where respite care is provided under the Waiver in an Office of Mental Health Certified Community or Crisis Residence (copies are then sent to the ICC Agency by the subcontractor). The ICC monitors service delivery and coordinates any needed services that arise from other worker contact with the child and family.

**C. Authorization for Release of Information**

For an agency to obtain information from another source outside of Office Mental Health and to share information outside of the Office of Mental Health, an [Authorization for Release of Information \(Español versión PDF\)](#) is required. A One-Time Authorization to Release Information expires when acted upon or 90 days from the date the information is requested, whichever comes first. Consent for release expires within a year or when the individual no longer receives services, whichever comes first. For the HCBS Waiver program wherein children are under the age of 18, only the responsible parent, relative or guardian must sign.

**Elements**

The following elements must be included:

- Identifying information related to participant
- Extent or nature of information to be disclosed
- Purpose or need for information
- Name and address of person/organization/facility/program disclosing the requested information
- Name and address of person/organization/facility/program to which the disclosure is to be made
- Signature and dates signed for authorization of release by a) legally consenting participant or person acting for patient with relationship to patient and b) witness with title,

**Note:** The above signatures are required for refusals to authorize releases of information or cancellations of permission.

- Signature of staff person releasing information, title and **date released**.

A standard Authorization for Release of Information is available through the OMH Central Office Utica Press (Form OMH 11).

**D. Transportation**

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In certain circumstances, children in the HCBS Waiver may be eligible for transportation services through the Local Department of Social Services (LDSS). Each LDSS administers the Transportation Prior Approval procedures for those individuals with Medicaid coverage, including HCBS Waiver recipients. Medicaid providers enrolled with Provider Type 026 (e.g., ICC Agencies) may order transportation services for the HCBS Waiver recipients. It is advisable to establish a working relationship with the LDSS contact person in the county because every county handles the Transportation Program policy differently. It is helpful to indicate that there is no local share for children enrolled in the HCBS Waiver.

## **E. Interpretation and Translation Services**

### *Access to Waiver Services for Limited English Proficiency*

Waiver providers (ICCs) must plan to provide interpretation or translation services for waiver participants who require these services. This may be accomplished through a variety of means, including: employing culturally competent, bi-lingual staff, resources from the community (e.g. local colleges), and contracted interpreters. Non-English speaking waiver participants may bring a translator of their choice with them to meetings with waiver providers. However, waiver applicants or participants are not required to bring their own translator, and waiver applicants or participants cannot be denied access to waiver services based on provider's difficulty in obtaining qualified translators. Waiver providers are required to have a policy in place that outlines procedures facilitating interpretation or translation services. This policy is to be shared with waiver participants and explained in a manner that permits comprehension of their options regarding language access.

OMH Bureau of Cultural Competence is responsible for promoting effective changes in policy, procedure, and practices designed to ensure that diverse cultures are considered in all aspects of service delivery within the behavioral health system for New York State. Our objective is to provide guidance and technical assistance to help facilitate compliance with applicable federal and State laws, regulations, standards, and policies.

#### [Cultural Competence - Regulations](#)

OMH Bureau of Cultural Competence provides a resource list of Interpreter and/or Translator services for providers and agencies to assist them in acquiring Language Access services that meets the consumer and family needs.

#### [Cultural Competence - Translation](#)

## **F. Notification of Significant Program Changes**

The ICC is responsible for providing transparent and consistent service provision. For that reason, the ICC must notify The Office of Mental Health (OMH) in writing when they become aware of significant programmatic changes. For instance, in the event of staff changes, especially administrative staff, the ICC must notify OMH. Notifications must be submitted within a reasonable time frame to ensure program efficacy.

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### G. Conflict of Interest: Conflict Free Case Management

OMH with the assistance of the DOH, was required to implement a transition plan for HCBS Waiver providers to comply with the Centers for Medicaid and Medicare's (CMS) HCBS Conflict of Interest (COI) regulations. Based on guidance from CMS, when the 1915(c) HCBS Waiver transitions to the 1115 waiver and care plans for members receiving HCBS services will be developed by the Health Home Care Management Agencies (HH CMA), the program will be compliant with the federal COI regulation. When Waiver ICC (Individualized Care Coordination) services convert to Health Homes, the HH Care Management Agency (CMA) can, with appropriate administrative firewalls and separate supervisory structures in place, provide care management and HCBS services, and still be compliant with federal conflict of interest requirements.

Therefore, between now and when the 1915(c) Waiver transitions to the 1115, OMH must implement a COI transition plan which requires ICC Agencies to establish administrative firewalls and separate supervisory structures for the provision of care management and HCBS services. This interim conflict free case management (CFCM) structure will enable ICC Agencies to continue to provide both care coordination and the array of HCBS Wavier services, while also providing a choice of provider to children and families for subcontracted HCBS services.

#### COI Transition Compliance

The Transition Compliance Activities that must be implemented, which reflect and interim CFCM structure, include:

- The "ICC bundled rate" will be unbundled fiscally, as well as programmatically, resulting in the individualized care coordinators no longer providing any HCBS services to the clients for whom they provide care coordination.
- ICC Agencies will create administrative firewalls and separate lines of supervision separating care coordination from any/all HCBS Services.
- Due to the increased caseload ratio, under CFCM, ICC Agencies will be able to repurpose any existing care coordinators for the provision of Intensive In-Home Services (IIHS) and Crisis Response (CR) (the two Waiver services previously in the bundled ICC Rate); if they implement the required firewalls and mitigation strategies.
- Where necessary, ICC Agencies, with LGUs, will to work to enhance the availability of subcontracts to increase the array of available HCBS Waiver Service Providers, wherever there are willing and qualified providers, to provide family choice.
- ICC agencies will notify participants of enhanced grievance and appeals process, and provide them with all necessary contact information.

If the ICC Agency plans to provide one or more of the HCBS services, along with their care coordination services, they must implement the necessary firewalls and mitigation strategies to assure compliance with CFCM requirements. Under CFCM requirements, agencies must include a "*separation of entity and provider functions within provider entities,*" for those agencies that provide both care coordination and HCBS services. ICC Agencies must have an OMH approved organizational chart outlining the agency's supervisory

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requirements. The organizational chart must demonstrate a structural and supervisory separation between care coordination and HCBS service provision functions as high up within the agency as possible. If changes must be made to the supervisory chart, the ICC Agency must submit the revisions for approval to OMH prior to implementation.

Separation of services and lines of supervision must reflect the following:

- Individualized Care Coordination services cannot be provided by staff that deliver or supervise HCBS services for the Waiver enrolled youth in the ICC Agency.
- HCBS Waiver services cannot be provided by ICC staff that deliver or supervise care coordination services for the Waiver enrolled youth in the ICC Agency.
- Individualized Care Coordinators (ICCs) and ICC supervisors must report to a program coordinator or director who has no responsibility for any HCBS Waiver services or staff. Wherever possible, the coordinator/director should be a cabinet or executive level manager in the agency.
- Similarly, the HCBS Waiver services staff and HCBS services supervisors must report to a program coordinator or director who has no responsibility for any Care Coordination services or oversight of ICCs. Wherever possible, the coordinator/director should be a cabinet or executive level manager in the agency.

## **H. Retention Requirements**

All OMH Children's SED HCBS Waiver Providers are required to retain participant records in accordance with all applicable State and Federal Laws and Regulations.

Pursuant to Title 18 of New York Code, Rules and Regulations-18NYCRR 517.3 and per 18NYCRR 361.12, records must be kept by the provider for a period of six years from the date the care, services or supplies were furnished or billed or whichever is later. Records of minor participant must be retained for at least six years, and until one year after the minor participant reaches the age of 21 years.

The entire case record must be maintained including:

- Local claiming forms
- Copies of Notice of Decisions
- Service Plans including, but not limited to: budgets, progress notes, assessments, and discharge plans
- Records of eligibility determination and evaluations
- Medical records
- Correspondence, including emails
- And any additional documentation as identified by applicable State and Federal regulations

The records must be maintained by the appropriate agency and must be readily retrievable if requested by the Federal Center for Medicare and Medicaid Services (CMS), The Office of Mental Health (OMH), The Department of Health (DOH) or The Office of the Medicaid Inspector General (OMIG).

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**I. Quality Assurance**

The OMH and DOH Waiver Unit works to continually determine whether the HCBS Waiver Program operates in accordance with its design, meets statutory and regulatory assurances and requirements, achieves desired outcomes and identifies opportunities for improvement. It is the responsibility of the ICC Agency to develop a quality management strategy through the creation of policies and procedures that support continuous program improvement. A quality management strategy explicitly describes the processes and frequency for discovery, remediation and improvement. A strategy must describe the sources and types of information gathered, the analyses used to measure performance and the ICC staff that has key roles and responsibilities in managing program quality.

Quality management strategies must be able to demonstrate whether the children in the HCBS Waiver Program have been able to achieve the outcomes outlined in the Individualized Service Plans and have been successful in avoiding placement in an inpatient setting. These strategies must use a variety of methods to determine stakeholder satisfaction with the quality of services and care provided the child in support of achieving desired outcomes.

The Office of Mental Health is responsible for the design, development, implementation, and oversight of the HCBS Waiver Program. The Regional Field Offices and Central Office Waiver Unit are the key resource for providing the Local Government Unit (LGU), ICC Agencies and Waiver Service Provider entities ongoing program and technical support for the successful implementation and operation of the HCBS Waiver Program. OMH with DOH, performs quality assurance reviews annually to ensure efficacy of the program.

Through ongoing program review and data analysis, OMH will make adjustments and changes to the HCBS Waiver Program's policies and procedures to support the health and welfare of all children. New York State developed a series of Performance Measures to meet specific Federal Centers for Medicare and Medicaid Services (CMS) requirements known as the Home and Community Based Services (HCBS) waiver assurances. The assurances address the unique challenges of assuring the quality of services delivered to vulnerable persons living in their community. The HCBS Performance Measures are the standards that OMH will use to evaluate how well the HCBS Waiver Program is meeting each of the CMS assurances.

**J. Grievance and Complaint**

OMH requires that each ICC Agency develop and implement a policy for responding to grievances and complaints raised by a participant or caregiver. A grievance/complaint may be filed by families at any time regarding the HCBS Waiver Program. This may be done in a written or verbal complaint to any staff person associated with the HCBS Waiver Program. If a verbal complaint, a progress note and agency compliant form must be completed to document the complaint. Grievances or complaints can be filed for a number of reasons such as the type, delivery and frequency of services; problematic issues; and general concerns about the waiver program. This procedure is applicable to both ICC staff and subcontracted staff.

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The HCBS process for grievance/complaints is not intended to replace the Medicaid Fair Hearing process. Participants and families should be made aware that filing a grievance or making a complaint is not a prerequisite or substitute for a Medicaid Fair Hearing.

The ICC agency must inform the family of the grievance and complaint procedure policy and provide them with a copy of a grievance/ complaint reporting form during the enrollment process. The LGU contact information, for the County that the family/participants are receiving services, must be included in the ICC grievance and complaint form. Since the ICC Agency oversees the subcontractors, their Grievance Policy must account for overseeing grievances/ complaints filed to both subcontractor staff and ICC staff. As part of the OMH ICC site visits, OMH reviews the internal policies and procedures of each ICC and service provider agency to aid in monitoring the grievance and complaint process.

When a complaint cannot be resolved by the ICC, the formal grievance process begins and the LGU, Field Office and OMH Central Office are notified. If the ICC is cited in the complaint, OMH determines if there is a conflict of interest and who should conduct the inquiry. The ICC agency is responsible for creating a process and informing the participant and family for addressing verbal or written complaints. This process must include contacting and updating the participant and family within 72 hours of receiving the complaint. All steps within the grievance process cannot exceed 45 days from the receipt of the complaint. Therefore, the ICC Agency's initial response to the complaint must not take more than seven calendar days from the date the complaint was filed. The ICC Agency must follow the below procedures when a complaint cannot be resolved to the satisfaction of the grievant via the ICC internal process:

1. On or before the seventh calendar day from the receipt of the initial complaint, the ICC and the grievant must determine if the grievance has not been addressed to the grievant's satisfaction. If it is not, a representative of the ICC Agency must capture the below information regarding the Grievance/ Complaint:
  - (i) Participant's Name
  - (ii) Participant's Date of Birth
  - (iii) Grievant's Name, contact information and relationship to participant, if not participant
  - (iv) Date of Grievance
  - (v) Name and title of HCBS Waiver representative recording the grievance/ complaint
  - (vi) Type of Grievance/ Complaint (e.g., service availability, service timeliness, service appropriateness, staff action or inaction, service location, cultural/ diversity sensitivity, etc.)
  - (vii) Description of Grievance/ Complaint
  - (viii) What would the Participant like to see changed as a result of the grievance/ complaint
  - (ix) ICC Agency's response/ action in response to grievance/ complaint
2. The Grievance/ Complaint information can be completed by the grievant or, if the grievant prefers, the ICC representative may summarize the concerns. The grievant approves the summary by signing the documentation.
3. The ICC representative then submits the information to the OMH Regional Field Office for further review and determination of action needed, if applicable.

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4. If the ICC Agency and/ or grievant are dissatisfied with the OMH Field Office response, OMH Central Office will be notified.
5. The OMH Central Office decision is final.

At any point in the grievance/complaint process the child/family, ICC agency or LGU may reach out to the appropriate OMH field office for assistance in addressing and resolving a grievance/complaint.

All resolutions must be consistent with the Program's Values and Guidance Document. The ICC Agency copy of the Grievance/ Complaint Form must be retained in the participant's file. Complaints/ grievances are subject to review during the annual Site Review and the data collected may be used to determine if there are any systemic issues that need to be addressed, OMH reserves the right to review grievance/complaints at any time.

**K. Utilization of Non-OMH Forms**

Waiver providers are permitted to use alternative forms or electronic records in place of the current OMH HCBS Waiver forms to support their Medicaid claims and record the care, services and supplies that have been provided.

The following conditions must be met to remain in compliance with program requirements:

- All required elements that are currently on the OMH HCBS Waiver forms must be on the new form. (Sample forms can be found in [Appendix I: Forms](#).)
- The forms must be easily accessible to OMH and any other auditing agency, and are capable of timely reproduction in paper form if requested.
- Also, wherever possible, keeping titles consistent across electronic forms and OMH forms would be appreciated, however; this is not required.

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### Section Ten: Services

HCBS Waiver services are tailored to meet the child's specific needs and are not available through other programs participants may attend. The services in the Waiver Program are as follows:

1. Individualized Care Coordination (ICC)
2. Intensive In-Home (IIH)
3. Crisis Response (CRS)
4. Skill Building (SBS)
5. Respite (RS)
6. Prevocational Services (PS)
7. Supported Employment (SE)
8. Youth Peer Advocacy (YPA)
9. Family Peer Support (FPS)
10. Transitional Case Management (TCM)

#### 1. General Requirements

All services can be provided in the community or in any waiver-eligible setting to the child and other individuals involved with the child including the family/caregiver. The following general requirements apply to all providers of HCBS Waiver services.

##### A. Training Requirements

###### *Mandatory Training*

All Individualized Care Coordinators (ICCs), ICC supervisors and Waiver Service Providers, including staff hired by the ICC Agency to provide HCBS Waiver services, are required to have appropriate training. All mandatory trainings are outlined in each service category.

#### REQUIRED TRAINING

TRAINING	WHO MUST COMPLETE TRAINING
14C.A.R.A.T	ICC, IIH, ICC Supervisors
CANS-NY	ICC, ICC Supervisors
Mandated Reporter	ICC, IIH, Respite, Crisis Response, Family Support, Skill Building, Prevocational, Supported Employment, YPA, ICC Supervisor
Service Specific Curriculum (or substitute) *	Respite, Skill Building, Prevocational, Supported Employment, YPA, Crisis Response

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Partnering for Safety (provided by ICC Agency) or equivalent	ICC, Respite, Skill Building, Family Support, Crisis Response, IIH, Prevocational, Supported Employment, YPA
Parent Empowerment	Family Support
Foundations	Crisis Response, IIH, Skill Building, Respite, Family Support, ICC, Prevocational, Supported Employment, YPA, ICC Supervisors

**\*Please see service descriptions below for supplemental training allowances.**

[Self –Directed Mandated Reporting online training](#)

[Foundations Training](#)  Access

*Recommended Training*

OMH also recommends the below trainings however, these trainings are not mandatory.

RECOMMENDED TRAINING
Family Needs & Strengths (FANS)*
1 <sup>st</sup> Aid Training including Cardio Pulmonary Resuscitation (CPR)

Family Advocates (FPA) that work with families of youth enrolled in the Home and Community Based Waiver use the Family Assessment of Needs and Strengths tool (FANS) to assess the ongoing needs of a family. Much like the CANS-NY, the FANS forms the underpinning from which a support plan is developed between the FPA and the family. This support plan guides the work done together, in order to benefit their child and support ongoing successes.

The Office of Mental Health recommends that the individual who inputs the child’s information into CAIRS also input the FANS into the platform. In doing so, this would allow a provider to determine if there is a correlation between the functioning of the child and the functioning of the family (i.e. as we see improvement in the family’s functioning via the FANS is the child’s functioning via the CANS also improving). The FANS can be accessed via the child’s episode of care within the assessment tab.

**B. Documentation Requirements**

For further details on the following forms, see [Section 7, Individualized Service Plan](#).

*Individualized Service Plan*

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The Individualized Service Plan documents the progress of the child in relation to provided services, justifies the continuation of services, and represents the provider's request for continued approval to provide waiver services. For the LGU to approve/continue a service, the Service Plan must clearly describe how the provision of this service can help maintain the child in the community.

The Service Plan must be completed within 30 days of enrollment into the HCBS Waiver Program and complete an updated Plan every 90 days thereafter, or revised more frequently for the duration of the program.

***Progress Notes***

Progress Notes provide the documentation that captures all contacts, beyond those detailed in the Service Summary, that the ICCs or Waiver Service Providers have on behalf of or with the child and/or family/caregiver, including Team Meetings.

**C. Verification of Credentials**

Workers who deliver HCBS Services may be employed by the Individualized Care Coordinator (ICC) agency or work for a subcontracted provider. Prior to delivering services, each worker must provide professional and/or personal references and a personal history of his/her experience and appropriateness to provide the service, be cleared by the State Child Abuse Register, complete fingerprinting clearance (if hired after April 1, 2005), demonstrate that qualifications are met for the service being provided and complete training requirements. Note that any worker without appropriate documentation of fingerprinting and State Child Abuse Register clearance must not be alone with and must be directly supervised in all contacts with Waiver clients until appropriate documentation is received by the ICC agency. Each worker must be familiar with the service plan and the safety plan for the child with whom they are working and must sign a statement to that effect.

After initial verification, the ICC Agency must annually verify that trainings/certificates and clearances are in good standing. The ICC Agency must verify that qualifications, clearances, training and/or certification of employee(s) and contractors upon hire and annually thereafter. The ICC Agency shall determine that all ICCs and Waiver Service Providers in their employ or under subcontract possess the requisite capacity, skills, competencies and qualifications to effectively support children enrolled in the HCBS Waiver Program.

## 2. Individualized Care Coordination

The Individualized Care Coordinator (ICC) is responsible for engaging the child and family in a partnership of shared decision-making and service plan implementation throughout their enrollment in the HCBS Waiver. The ICC ensures and coordinates a comprehensive set of supports, resources and strategies for each child and family. The ICC works closely with outpatient clinics, day treatment programs and other providers to assure

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that Waiver services and clinical treatment modalities augment each other for optimal outcomes for children and families.

The ICC, the child and family, treatment providers, Waiver subcontractors and natural supports work together on an ongoing basis to develop and periodically review Individual Service Plans and clinical treatment plans to ensure coherence between the two plans; to deliver services as indicated in the Individual Service Plan; to coordinate the development and implementation of a safety plan, and to design and coordinate discharge plans. The ICC is responsible for compliance with Waiver fiscal and program guidelines through all phases of the child's enrollment.

The ICC case ratio limit is 1:9.

### *Service Responsibilities:*

Individualized Care Coordination includes the following components:

- engagement of child and family throughout Waiver enrollment;
- intake and screening- the process of reviewing the referral packet from SPOA;
- initial assessment of strengths and needs- the preliminary process of assessing a child and family's strengths and needs as a precursor to service plan development (this may include completing an initial CANS if not already completed by the SPOA);
- on-going assessment and documentation of the child and family's strengths and needs, progress towards achieving goals, and efficacy of delivered services;
- completion of the Child and Adolescent Needs and Strengths-New York (CANS-NY) every 90 days thereafter, at discharge and as needed;
- on-going consultation with treatment providers to reciprocally inform both clinical treatment and Waiver strategies, with physical health care providers, schools and other relevant collateral sources, with the other waiver service providers who are involved in implementing the service plan;
- development and updating of services plans in partnership with the child and family that are reflective of the child and family's priorities, individualized, strength-based, and related to all life domains, culturally sensitive and relevant, complimentary with any psychiatric treatment received through other providers, focused on developmental tasks, resiliency and wellness, inclusive of safety issues, targeted to address assessment indicators (e.g., CANS), and oriented towards discharge readiness;
- oversight of all documentation in the case record;
- development and updating of a Safety Alert Plan with the child and family in collaboration with the treatment provider;
- coordination and monitoring of Waiver service delivery;
- discharge and after-care planning; linkage and referral to services and supports as specified in the service plan, this encompasses identifying local resources and services for use during both enrollment and discharge planning, sharing information with the child and family concerning relevant resources and service providers, including local family support programs, advisors and advocates; engaging the child and family in making informed choices;
- facilitating connection with selected resources and providers; advocacy which includes the process of helping to empower children and families to initiate and sustain interactions that support their overall

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wellness, interceding on their behalf when necessary to gain access to needed services and supports, and maintenance of the approved HCBS Waiver budget designated for each child.

### *Required Minimum Contacts:*

#### Full Month (21 days): **SIX** Total Required Minimum Contacts

**TWO** minimum required contacts with the family.

- One of the two contacts must include the youth, although the family may be in attendance. The contact with the youth must be a minimum of 30 minutes in duration to ensure meaningful discussion regarding the participant's Service Plan progression and coordination of care. This contact must be face-to-face (FTF).
- The other contact must be with the family/caregiver, as identified in the Service Plan, and may also include the youth. This contact may be face-to-face OR via telephone and must be a minimum of 15 minutes in duration\*.

*Limitation: These two contacts cannot occur in the same day.*

**FOUR** minimum required contacts with collaterals\*\* and HCBS Service Providers.

- Two of the four required contacts must be made with collateral(s).
- Two of the four required contacts must be made with HCBS Service Providers.
- Two of the above four required contacts must be face-to-face. The contacts may be a combination of either collateral(s) and/or HCBS Provider(s) (e.g., 2 FTF with Collaterals or 2 FTF with HCBS Provider or 1 FTF with either entity) to permit flexibility to meet the fluid needs of the family.
- The remaining two required contacts can be telephone contacts.
  - These entities must correlate with a goal in the Service Plan and identified as such in the plan and progress note(s).
  - These contacts must be a minimum of 15 minutes in duration.
  - Team meetings can count as ONE contact with either an HCBS Service Provider or collateral, depending on who is in attendance.
  - Electronic methods of communication do not qualify as a face to face or telephone contact.

The second of two required contacts can be either face-to-face OR via telephone

#### Half Month (11 days): **THREE** Total Required Minimum Contacts

**ONE** minimum required contact with the participant.

- Contact must include the youth, although the family/caregiver may be in attendance. The contact with the youth must be a minimum of 30 minutes in duration to ensure meaningful discussion regarding the participant's Service Plan progression and coordination of care. This contact must be face-to-face (FTF).

**TWO** minimum required contacts with collaterals and HCBS Service Providers.

- One of the two required contacts must be made with collateral(s).
- One of the two required contacts must be made with HCBS Service Provider.
- One of the two required contacts must be face-to-face although these contacts may be a combination of either collateral(s) and/or HCBS Provider(s) (e.g., 1 FTF with Collateral or 1 FTF with HCBS Provider) to permit flexibility to meet the fluid needs of the family.

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- These entities must correlate with a goal in the Service Plan and identified as such in the plan and progress note(s).
- These contacts must be a minimum of 15 minutes in duration.
- Team meetings can count as ONE contact with either an HCBS Service Provider or collateral, depending upon who is in attendance.
- Electronic methods of communication do not qualify as a face to face or telephone contact.
- The second required contact can be either face-to-face OR via telephone

*\*For participants over the legal age of consent in which family involvement is not realistic or appropriate, the second family contact for full month billing may be substituted for a second contact with the participant. The same contact requirements would apply for duration and contact type (face-to-face or telephone). However, it is expected that the ICC will work to develop and/or enhance the natural and community supports in the participant's Plan.*

*\*\*Collaterals contacts are identified as contacts with legal representatives, academic (school), housing, primary care physician, clinical resources (psychiatrist, therapist) Social Services or other people in a child's life who are listed in the service plan as relevant to the goals of the plan for the child. Collateral contacts may also include Natural Supports. "Natural Supports" means personal associations and relationships typically developed in the community that enhance the quality and security of life for individuals, including, but not limited to, family relationships; positive friendships in the neighborhood and the community; and association with fellow students, employees and associations developed through participation in clubs, organizations, and other civic activities.*

### *Collateral Contact Substitution:*

The role and function of an Individualized Care Coordinator is truly to *coordinate care*. The Waiver Program is a system of care that involves a team of professionals who can identify the needs of the child and family, connect them to resources and build a network of support. An ICC will ensure effective interventions by implementing a collaborative partnership with the family, treatment provider(s), core waiver services and other natural supports. To meet the unique needs of the family and provide flexibility for community collateral contacts, collateral contacts can be temporarily substituted by an alternate contact (e.g. WSP, natural supports, child/family) if the ICC has illustrated due diligence by contacting the community collateral prior to the substitution.

The purpose of the collateral contact substitution is not to unnecessarily increase contact with the youth or family, nor minimize treatment provider input to the youth's Service Plan. Rather, it is expected that the ICC will continue to make efforts to coordinate care within the community while also allowing for greater adaptability and flexibility. Therefore, ICCs are expected to outreach to Natural Supports, Waiver Service Providers or other community resources, as identified in the Plan, prior to substituting a collateral contact with the youth or family.

The following elements must be achieved to utilize a collateral contact substitution:

- In the event an ICC is unable to meet the collateral contact requirement, additional face-to-face or telephone contacts with natural supports, waiver service providers, or lastly, the child/family may be substituted to meet the total of six contacts for full-month billing, three for half-month billing.

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- the total of six contacts for full-month billing, three for half-month billing. *The modality of the substitution must match the modality needed with the collateral contact.*
- Progress notes must demonstrate an integrated model of partnership and on-going communication with the family, treatment providers, core waiver services, and other natural supports that are involved with the child and family.
- The progress note must indicate the identified substitute contact and briefly describe efforts made to meet the collateral contact requirements. The remaining progress note content must align with standard HCBS Waiver requirements.
- The contact substitution must tie back to a specific goal and objective in the Service Plan.

For additional information regarding ICC Contacts please see [Section 13](#) regarding billing.

### *Qualifications:*

Each ICC must meet the following qualifications:

- must have completed fingerprinting clearance to ascertain no criminal history;
  - must be cleared through the State Central Child Abuse;
  - Bachelor's degree or a NYS Teacher's Certificate, and two years' experience providing direct services for children in the children's service system with a preference for the mental health field/working with children with SED.
- OR
- a Master's degree and one year experience providing direct services to children, or providing linkage to services, for children, in the children's service system with a preference for the mental health field/working with children with SED.

\*Qualifying experience may be pre- or post- degree. Candidates may qualify by meeting the qualifications for the NYS Intensive Case Manager position.

### *Required Trainings:*

ICC workers are employed by the ICC agency. ICC workers must:

- receive orientation from their ICC Agency to the Waiver Program and the ICC Agency's policy and procedures, including the staff safety protocols, child abuse identification and reporting, and incident reporting;
- participate in technical assistance sessions and agency in-services;
- complete the 14 Collaborative Action Research and Treatment (C.A.R.A.T.) training which incorporates the Individualized Care model as soon after hire as possible;
- Partnering for Safety or equivalent;
- complete CANS-NY training and is certified to use the CANS-NY;

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- complete Mandated Reporting self-directed online training;
- complete OMH online Foundations training when other service specific required trainings are either not offered or scheduled within the first 30 days of employment; and
- complete additional training as mandated.

### 3. Nine (9) HCBS Services

There are nine specific services that comprise the HCBS Waiver. The services are: Transitional Case Management, Intensive In-Home, Crisis Response, Respite, Skill Building, Family Support, Prevocational, Supported Employment and Youth Peer Advocate Services. Each child must have Individual Care Coordination and at least one service, for the exception of Transitional Case Management. The services are selected as indicated by the child, family and ICC to support goals and objectives in the Service Plan.

The following describes the role and primary responsibilities as well as the required qualifications and training, pertaining to workers in each of the nine services. For a complete listing of competencies for workers in each of the nine services, see the website link following each description.

Individualized Care Coordination is a function of the program that is separate and apart from the remaining Waiver services for more information see [Section 9: Conflict of Interest](#). As such, when referencing HCBS Waiver Services, all services for the exception of Care Coordination are included.

#### A. Intensive In-Home (IIH)

The Intensive In-Home (IIH) worker provides services that support the child's social and emotional development and learning. IIH supports the child and family in implementing both the Treatment Plan (from the clinical provider) and the Waiver Service Plan (established by the Waiver program). The IIH worker receives direction from the Individual Care Coordinator who assures the initial and on-going flow of clinical information between the ICC, the treatment provider and the IIH worker. The IIH worker engages the child and family in ways that support the everyday application of treatment methods as described in the child's Treatment Plan and Waiver Service Plan. Specifically, the IIH worker reinforces desired cognitive and behavioral changes to prevent crises and to support the emotional well-being of the family. As each family is unique, strategies are designed to be sensitive to the culture and values of each individual family and may include:

- anger management,
- psycho-education,
- post crisis de-briefing,
- re-enforcing the integration of safety plans in the home,
- parent-child relationship building,
- teaching parenting skills,
- providing support in emotional self-regulation in situational contexts including anger management,

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- encouraging supportive sibling relationships with the Waiver child,
- developing healthy coping mechanisms,
- making healthy choices,
- building self-esteem,
- clarifying identity issues, etc.

IIH Services may be provided in the home or in the community for an individual child and or their family. Intensive In-Home services are provided face-to-face to the child or the child and family. The service is focused on supporting the goals outlined in the child's treatment and service plans. This service is reimbursed based on the duration of service:

- brief-minimum of 30 minutes; full-minimum of 60 minutes or extended-minimum of 90 minutes.
- Limit of up to 4 hours a day per individual not to exceed 24 hours a month per individual.

### *Qualifications:*

Intensive In-Home workers are either employed by the ICC Agency or subcontracted by that ICC agency  
Intensive In-Home workers must:

- must be cleared by the State Child Abuse Registry;
- and complete fingerprinting for a criminal history background clearance;
- have a Master's degree or a NYS Teachers Certificate, and two years' experience providing direct services for children in the children's service system with a preference for the mental health field/working with children with SED.

OR

- a Bachelor's degree or a NYS Teachers Certificate, and four years' experience providing direct services, or providing linkage to services, in the children's service system with a preference for the mental health field/working with children with SED. Qualifying experience may be pre- or post- degree. Candidates may qualify by meeting the qualifications for the NYS Intensive Case Manager position

### *Required Trainings:*

- 14 Collaborative Action, Research and Training C.A.R.A.T. curriculum as soon after hire as possible;
- Partnering for Safety or equivalency;
- complete Mandated Reporting self-directed online training;
- complete OMH online Foundations training when other service specific required trainings are either not offered or scheduled within the first 30 days of employment.

## **B. Crisis Response**

Crisis Response Services Workers perform interventions designed to assist children and families when they are in a crisis. A crisis is an unplanned event that requires a rapid response. A crisis includes instances in which a person cannot manage his/her behavior or psychiatric symptoms without the help of a third party. A crisis may also include situations in which the experience of challenges in daily life have resulted in, or are at risk of creating, an escalation in psychiatric symptoms which cannot be managed without acute crisis intervention.

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These workers provide immediate, short-term interventions until linkages are made to other appropriate services, as needed. This may include de-escalation techniques, assessment, consultation, facilitating the safety plan interventions, and referral when necessary. Crisis response services are to be made available on a 24 hour/7 day a week basis.

Crisis Response may be provided more often initially and become less frequent as the child progresses and stabilizes in the HCBS Waiver Program.

This service is reimbursed based on the duration of service:

- Telephone – Units: 15 minutes (Service Limitation: no more than 2 allowed per day per individual for telephone contact) or Face to Face – Units: 30 minutes, 60 minutes, 90 minutes (Service Limitation: no more than 2 Face-to-Face units allowed per day per individual).

When a child requires a face-to-face crisis intervention service more than the allowable two units per day, the agency should provide the crisis response service. However, to submit the Medicaid, claim for any additional service beyond the limitation, a post-service, pre-authorization from the State is required to bill for the service. Therefore, once the additional face-to-face crisis response service is provided, the agency must submit documentation to the State demonstrating the need for the service for prior authorization before submitting the claim for reimbursement.

### *Qualifications:*

Crisis Response workers are either employed by the ICC Agency or subcontracted by that ICC agency. Crisis Response workers must:

- be cleared by the State Child Abuse Registry;
- complete fingerprinting clearance;
- have a Master's degree or a NYS Teacher's Certificate, and two years' experience providing direct services for children in the children's service system with a preference for the mental health field/working with children with SED

OR

- a Bachelor's or a NYS Teacher's Certificate, and four years' experience providing direct services to children in the children's service system with a preference for the mental health field/working with children with SED. Qualifying experience may be pre- or post- degree. Candidates may qualify by meeting the qualifications for the NYS Intensive Case Manager position.
- be affiliated with an OMH-certified provider;

### *Required Trainings:*

- Partnering for Safety or equivalent;
- Service specific training as provided via OMH – 'Crisis Response One-Day Training'
- have training in mental health diagnosis Diagnostic and Statistical Manual, suicide assessment; psychopharmacology, crisis intervention techniques, and available community resources;

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- complete Mandated Reporting self-direct online training; and
- complete OMH online Foundations training when other service specific required trainings are either not offered or scheduled within the first 30 days of employment.

### **C. Prevocational**

Prevocational services are designed to prepare a youth age 14 or older to engage in paid work, volunteer work, or career exploration. Prevocational services are not job-specific, but rather are geared toward facilitating success in any work environment for children whose disabilities do not permit them access to other prevocational services. The participant's Service Plan will reflect skill development rather than explicit employment objectives.

Prevocational services are structured around teaching concepts based on a specific Plan related to youth with disabilities. Services include activities that are not primarily directed at teaching skills to perform a certain 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 such as:

- facilitating appropriate work habits;
- learning job production requirements;
- 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.

This service may be provided in the community or a worksite (where the waiver participant's work rate is generally less than 50 percent of the minimum wage or the prevailing wage) to introduce the participant to the world of work. Prevocational services do not include vocational services provided in facility based work settings that are not integrated settings in the general community workforce.

Prevocational services should enable each participant to attain the highest level of work in the most integrated setting and with the job matched to the participant's interests, strengths, priorities, abilities, and capabilities, while following applicable federal wage guidelines from the U.S. Department of Labor. This service may be delivered in a one-to-one session or in a group setting of two or three participants.

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### NOTE:

Monitoring of prevocational services will be performed at a minimum every 6 months to assess the participant's progress toward achieving the outcomes identified on the child's ISP related to pre-employment skills enhancement in development and to verify the continued need for prevocational services. The waiver participant can receive up to 12 months of prevocational services. This service may be delivered in a one-to-one session or in a group of two or three participants.

Prevocational service will not be provided to an OMH HCBS Waiver Program participant if:

- (i) Special education and related services that are otherwise available to the individual through a local educational agency, under the provisions of the Individuals with Disabilities Education Act (IDEA).
- (ii) Vocational rehabilitation services are otherwise available to the individual through a program funded under section 110 of the Rehabilitation Act of 1973.

Documentation is required and maintained by the ICC agency that attests that this service is not available to the waiver participant under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.). When applicable, the ICC agency will perform reasonable due diligence to obtain either letter of ineligibility (VR) or discharge letter (SED).

### *Qualifications:*

Pre-Vocational Service workers must:

- Be cleared by the State Child Abuse Registry;
- Complete fingerprinting for a criminal history background clearance;
- Have a valid NYS driver's license (preferred);
- Must be employed by an agency that provides vocational/employment services (Pre-Vocational workers are either employed by the ICC Agency or subcontracted by that ICC agency);
- Have experience working with adolescents and young adults;
- Preferred qualification is to have a Bachelor's degree plus two years' experience. Minimum qualification is an Associate's degree plus two years of related experience;

### *Required Trainings:*

- OMH Foundations;
- complete Mandated Reporting self-direct online training;
- Complete required 3-hr Pre-Vocational/Supported Employment training created and facilitated by the Sidney Albert Training and Research Institute (SATRI).\*
- *\*Please Note: OCFS Bridges to Health (B2H) staff that have completed the B2H Prevocational training would not need to complete the OMH service specific training. However, the ICC Agency must provide an in-service training to familiarize the staff member (or subcontracted entity) with OMH specific documentation requirements and agency policies.*

## **D. Supported Employment**

Supported Employment services are individually designed to prepare individuals with severe disabilities age 14 or older to engage in paid work. Supported Employment provides ongoing supports to participants who, because of their disabilities, need intensive on-going support to obtain and maintain an individual 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, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals.

Supported employment services are individualized and 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;
- 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.

In addition to the need for an appropriate job match that meets the individual's skills and interests, individuals with the most significant disabilities may also need long term employment support to successfully maintain a job due to the ongoing nature of the waiver participant's support needs, changes in life situations, or evolving and changing job responsibilities.

Supported employment service should be reviewed and considered as a component of waiver participant person-centered services and supports plan no less than annually, more frequently as necessary or as requested by the participant. These services and supports should be designed to support successful employment outcomes consistent with the participant's goals.

Supported employment services does not include facility based, or other similar types of vocational services furnished in specialized facilities that are not a part of the general workplace. Supported employment does not include volunteer work. Supported employment services may be provided in a variety of settings, particularly work sites.

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Supported employment will be offered during the times when school is not in session, such as after school, weekends, school vacations and in the summer

Supported Employment service will not be provided to an OMH HCBS Waiver Program participant if:

- (i) Special education and related services that are otherwise available to the individual through a local educational agency, under the provisions of the Individuals with Disabilities Education Act (IDEA).
- (ii) Vocational rehabilitation services that are otherwise available to the individual through a program funded under section 110 of the Rehabilitation Act of 1973.

Documentation is required and maintained by ICC agency that attests that this service is not available to the waiver participant under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.). When applicable, the ICC agency will perform reasonable due diligence to obtain either letter of ineligibility (VR) or discharge letter (SED). During OMH annual site visit reviews, case records are thoroughly reviewed with attention paid to service delivery and required documentation.

### *Qualifications:*

Supported employment providers must:

- be cleared by the State Child Abuse Registry;
- complete fingerprinting for a criminal history background clearance;
- be employed by an agency that provides vocational/employment services (Supported Employment Services workers are either employed by the ICC Agency or subcontracted by that ICC agency);
- have experience working with adolescents and young adults;
- preferred qualification is to have a Bachelor's degree plus two years' experience, minimum qualification is an Associate's degree plus two years of related experience;

### *Required Trainings:*

- Complete required 3-hr Pre-Vocational/Supported Employment training created and facilitated by the Sidney Albert Training and Research Institute (SATRI).\*
- OMH Foundations;
- complete Mandated Reporting self-directed online training.

*\*Please Note: OCFS Bridges to Health (B2H) staff that have completed the B2H Prevocational training would not need to complete the OMH service specific training. However, the ICC Agency must provide an in-service training to familiarize the staff member (or subcontracted entity) with OMH specific documentation requirements and agency policies.;*

## **E. Youth Peer Advocate**

Youth Peer Advocates (YPA) offer positive youth development-centered services for waiver participant with a resiliency/recovery focus. This service will promote skills for coping and managing psychiatric symptoms.

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YPA service will facilitate the use of natural and community resources. In addition, YPA service promotes wellness through modeling and will assist waiver participants with gaining and regaining the ability to make independent choices and playing a proactive role in their own treatment. This service may be delivered in either a one-to-one session or a group setting of 2 or 3 waiver participants.

YPA activities must be intended to develop and achieve the identified goals and/or objectives as set forth in the youth's individualized care plan. Activities provided by the YPA can include problem solving, mentoring, community resources exploration, and life skills support. The structured, scheduled activities provided by this service emphasize the opportunity for the YPA to support participant in the restoration and expansion of the skills and strategies necessary to move forward in meeting their personal, individualized life goals and to support their transition into adulthood.

*Qualifications:*

Youth Peer Advocate workers are either employed by the ICC Agency or subcontracted by that ICC agency. Youth Peer Advocate employees must:

- be cleared by the State Child Abuse Registry;
- complete fingerprinting for a criminal history background clearance;
- have a valid driver's license (preferred);
- be an individual 18 to 28 years old who has self-identified as a consumer of mental health services, special education services or foster care;
- Have a high school diploma, high school equivalency preferred or a State Education Commencement Credential (e.g. SACC or CDOS);
- be supervised by an individual who meets the criteria for a "qualified mental health staff person" found in 14 NYCRR 594 or 14 NYCRR 595. See [Qualified Mental Staff Person](#) for further information.

*Required Trainings:*

- OMH Foundations;
- complete Mandated Reporting self-directed online training;
- YPAs must complete the training developed by The Cornell ACT for Youth Center of Excellence team in collaboration with Youth Power. The YPA training consists of both on-line and in-person components. Training Components includes Role of Youth Peer Advocate in the Waiver System, Peer Mentoring and Support, Small Group Facilitation Skills, Professional Expectations, and Self-care and support.\*

*\*Please Note: YPAs can be hired and begin work after completing all required trainings for the exception of the in-person component of the service-specific training. YPAs will be expected to complete the in-person training within 6-months of employment to continue rendering service. If there are extenuating circumstances, please contact OMH Waiver Unit. OMH recommends increased supervision until all training is complete.*

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**F. REPSITE SERVICES**

Respite Workers temporarily care for the Waiver child, on an emergency or planned basis, providing relief from care-giving responsibilities for the family. Respite Workers supervise the child and engage the child in recreational activities that support his/her constructive interests and abilities. Respite may occur in the child's home, the respite worker's home or in the community with one child or a group, as defined in Waiver Billing Rules.

Respite is a short-term intervention, but also allows for a wide range of flexibility based on family need. This may include on a planned or emergency (crisis) basis, during the day or night (including overnight), and in taking place in the child's home or community. For each of the "types" of respite that are provided, the service must be face to face with a minimum of 30 minutes with billing limitations of 6 hours a day, which allows for flexibility while maintaining it as a short-term service. This allows for children to receive planned respite, such as two hours a week in a group as part of their service plan, or overnight crisis respite in an emergency per their safety alert plan. For respite services that may be crisis or overnight, Federal Financial Participation is not claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

Respite Services in both, Community and Crisis Residences, provides the waiver participant unscheduled and scheduled community activities in the same manner as the individuals not receiving HCBS Waiver services. The setting does not isolate waiver participants from the others in broader community e.g. protocols or practices (visiting). Community and Crisis residences are community based settings and not hospital and/or institutions.

OMH-Certified Community Residence is a single site residence that provides group living for six to eight children and or adolescents. The program provides a supervised, therapeutic environment which seeks to develop the resident's skills and capacity to live in the community and attend school/ work as appropriate.

Crisis Residence is a single site residence designed to provide 24 hours per day supervision, generally for up to 30 days, to adults or children/adolescents experiencing acute symptoms or a temporary disruption in community supports. Services are designed to avoid hospitalization, and return the resident to a stable environment.

HCBS Rules for Respite in Community and Crisis Residences (CR): Community Residences and Crisis Residences cannot use any of their beds for respite. Only an unoccupied bed can be used for respite for a Waiver child, not including an unoccupied bed left by child on leave. The Individualized Care Coordinator must decide as to whether it would be necessary to have an on-call Waiver Respite worker available during waking hours. The vacant bed must be considered "empty" in that it does not have an admitted child; the waiver participant is not able to use an unoccupied bed left by a child on leave and there must exist a commitment and plan to return the child back to the setting prior to the respite or a designated placement after the respite.

*Please note: Must ensure age and gender match the approved population for the CR per their certification.*

OMH State operated facilities have created space to provide Crisis Respite. These are associated with the following facilities: Brooklyn Campus of the NY Children's Center, St. Lawrence, Hutchings, Binghamton, Sagamore and Elmira. They are on the grounds of the psychiatric center but they are an outpatient program base

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service and are open to the community the same as any other outpatient program such as clinic would be. Each of these locations is licensed by the NYS Office of Mental Health and must adhere to all the State and Federal standards of care.

### *Qualifications:*

Respite workers must:

- be staff of an OMH-certified Community Residence, including Crisis Residence, which has an OMH Operating Certificate demonstrating compliance with 14 NYCRR 594;

**or**

- be a respite worker who:
  - is at least 18 years of age for daytime and 21 for overnight services;
  - has experience working with children (preference given to those with experience working with children with special needs);
  - must have high school diploma or G.E.D. and
  - is supervised by an individual who meets the criteria for a ["qualified mental health staff person"](#) found in 14 NYCRR 594 or 14 NYCRR 595; and
  - is cleared by the State Child Abuse Registry; and
  - has completed fingerprinting for a criminal history background clearance (if hired after April 1, 2005).

### *Required Training:*

- Respite workers who have completed one of the following OMH-approved training curriculum: Rest A Bit, Parenting Skills Training, Model Approach to Partnerships and Parenting (MAAP), Therapeutic Crisis Intervention or alternative OMH approved curriculum and the Individualized Care Model prior to January 2008 are not required to complete the OMH Respite Curriculum;
- Respite workers must receive training in safety in the home and community provided through their agency or the ICC agency;
- complete Mandated Reporting self-directed online training;
- OMH Online Foundations training;
- complete Respite Fundamentals training (worker must complete the training when next offered in the agency's region or as reasonable in other regions).

Note: Staff working in an OMH certified community residence or crisis residence program who have met the training requirements for that program are exempt from completing the OMH Respite curriculum. "OCFS licensed/certified Therapeutic Foster Homes" can provide Respite to Home and Community Based Services (HCBS) Waiver children. The training requirements of their certified program will meet the training requirement for Waiver Respite.

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### *Respite and Skill Builders Training Addendum*

It is the responsibility of the ICC agency to approve the qualifications for each sub-contractor staff. For Skill Builders and Respite Workers with degrees including advanced degrees (Master's degree and PhD) in the human services field that may wish to provide Respite or a limited skill set training for a limited number of HCBS Waiver children and youth, the ICC agency may individualize the Respite and the Skill Builders curriculum training and allow individuals with advanced human services degrees, for example, to read all or portions of the curriculum and discuss the material with the approved trainer or review materials learned from training they have completed to meet the competencies of the Respite or Skill Builder position. See Respite Worker and Skill Builder and Respite competencies above.

The ICC agency will need to document any individualized Respite or Skill Builders training other than the approved OMH Foundations and Fundamentals curriculum training with their rationale for approval to be reviewed during annual site visits. Field Coordinators are available for consultation and to ensure that there is consistency across regions in determining any alternate individualized training but the responsibility remains with the HCBS Waiver provider about determining and approving alternate individualized training requirements for Respite Workers and Skill Builders with advanced degree credentials.

## **G. FAMILY SUPPORT SERVICES**

Family Support Services (FSS) are an array of formal and informal services and supports provided to families raising a child who is experiencing social, emotional, developmental and/or behavioral challenges in their home, school, placement, and/or community. FSS activities can consist of engaging the parent/caregiver in activities in the home and community that are designed to address one or more goals on the waiver participant's service plan; assisting parent/caregiver in meeting the needs of the youth through educating, supporting, coaching, modeling and guiding; teaching parent/caregiver how to network/link to community resources and treatment providers; teaching parent/caregiver how to advocate for services and resources to meet the youth's needs; and guiding and supporting linkage to individual, peer/parent support, and self-help groups for parent/caregiver.

Family Support Workers (FSW) are parents who are raising or have raised a child with mental health concerns and are personally familiar with the associated challenges. FSW's offer the integrity of their experience to the families they serve and are often able to connect with waiver families based on a unique understanding of their circumstances. FSW's have first-hand knowledge of the services and supports available in the community. FSW's offer waiver families' activities designed to enhance the family unit, ultimately developing safe, stable, and supportive families who are connected to their communities.

FWSs offer resources, including, but not limited to:

- information on community resources;
- assist families in connecting to community resources and natural supports;
- Strengthen and support the care-giving efforts of families with special emphasis on needs such as: emotional, physical health, parenting, and family interaction;

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- Empower families to make informed choices regarding the nature of supports for themselves and their child by providing an understanding of what resources, services and supports are available and how to access them in their communities.
- Develop a family's capacity to actively participate in all decisions about services and supports for themselves and their child.
- Develop a family's capacity to enhance and improve the overall health and well-being of their child and family.
- Work with the family and their provider team to promote effective collaboration and communication.
- Strengthen and develop a family's skill and feeling of self-efficacy so they can effectively advocate for their child, work collaboratively with service providers and do so with increasing independence over time.
- advocate with the family to access supports, services and activities.

FSW's introduce and connect families to community activities which foster family cohesion. These activities, which may be cultural, educational or recreational, are individualized for each family based on their culture, needs values and preferences and are consistent with the family's income to assure the possibility of continuing the activities post Waiver/ FSW's are also expected to facilitate family/parent support groups. Family Support group activities for parents (i.e., monthly meetings, game night, and annual picnics) are provided as a venue for engaging parents with similar experience as a way of assisting in building natural support systems in their communities.

### *Qualifications*

FSW's may work with an individual parent/guardian or a group of Waiver parents/guardians. Workers must be supervised by an individual who meets the criteria for a "[qualified mental health staff person](#)" \* found in 14 NYCRR 594 or 14 NYCRR 595.

- Must have some high school diploma or G.E.D.;
- be at least 18 years of age;
- have experience working with children (preference given to those with experience working with children with special needs);
- be a parent or caregiver of a child with a history of emotional or behavioral problems (parent or caregiver is defined as a parent, foster parent or other family member with direct responsibility for the care of a child with a diagnosis of emotional disturbance). OMH Parent/Family Advisors at the OMH Regional Offices assist in recruitment of qualified family support workers);
- be cleared by the State Child Abuse Registry; and
- complete fingerprinting for a criminal history background clearance (if hired after April 1, 2005).

### *Training:*

- An FPA must complete Level 1 of PEP training and obtain their provisional credential within 2 months of their hire date. Within 18 months of obtaining their provisional credential an FPA must complete Level 2 of PEP training and obtain their professional FPA credential. Refer to the following link <https://www.ftnys.org/training-credentialing/family-peer-advocate-credential/>

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- complete safety in the home and community training as supplied by the ICC agency and
- complete Mandated Reporting self-directed online training;
- complete OMH online Foundations training when other service specific required trainings are either not offered or scheduled within the first 30 days of employment.

### H. SKILL BUILDING

Skill Builders focus on the developmental stage of the child and work with the child towards achieving age appropriate developmental tasks. In collaboration with the Intensive In-Home provider, they design and provide activities that assist children in developing skills for performing age appropriate tasks needed to live successfully in their homes and communities. Skill Builders help the child to identify current strengths and strategies for acquiring additional desired ones. Activities may support areas such as completing schoolwork, being part of a team, handling money and performing activities of daily living. Skill Builders may work with children or groups of Waiver children on developing specific social skill sets necessary for acceptable social interactions such as how to give and receive compliments, how to start a conversation, how to ask for something, the etiquette of common courtesy, etc. Skill Builders may also work with youth in developing skills for independent living and in accessing vocational skills training. Skill Builders can provide any of their services to an individual child or in a group with other Waiver children. They may also work with the Waiver child's family, including siblings, in teaching them how to best support the child in maintaining the skill sets.

#### *Qualifications:*

- be at least 18 years of age;
- have experience working with children (preference given to those with experience working with children with special needs);
- have a high school diploma or G.E.D.
- be supervised by an individual who meets the criteria for a "[qualified mental health staff person](#)" found in 14 NYCRR 594 or 14 NYCRR 595;
- be cleared by the State Child Abuse Registry; and
- complete fingerprinting for a criminal history background clearance (if hired after April 1, 2005).

#### *Training:*

- successfully complete OMH's Online Foundations training;
- complete Skill Building Fundamentals training (worker must complete the training when next offered in the agency's region or as reasonable in other regions); and
- complete Mandated Reporting self-directed online training.

### I. Transitional Case Management

Transitional Case Management (TCM) is designed to provide coordination and continuity of care by supporting

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youth and family/natural support system in transition from an inpatient or residential setting to a community setting. TCM provides case management to youth enrolled in Waiver that require temporary inpatient care.

TCM coordinators work closely with youth, family/ natural support system and collaborate with all providers to address service plan goals and objectives. TCM coordinators focus on promoting, engaging and empowering youth and family/natural support system to enhance safety and resiliency in all aspects of the youth's life including: behavioral health care, social, education, vocation, and/or community resources and supports. TCM coordinators ensures that the youth and natural support systems' preferences and priorities are addressed through a partnership of shared decision-making and service plan implementation throughout their transition and enrollment into Waiver.

TCM is provided during temporary inpatient stays while the youth is participating in the Waiver Program. By nature of their clinical eligibility for Waiver, it is expected that some youth that are enrolled in Waiver will need short-term psychiatric hospitalization to stabilize in the event of a crisis. Youth may also require medical hospitalization while enrolled in the Waiver. In that case, TCM coordinators will continue to collaborate with a comprehensive set of supports and providers to ensure the participant has the necessary supports, resources, strategies and linkages upon discharge. Ongoing contact with the child and family will be maintained to assure continuity of care and facilitate seamless transition back into the Waiver program. Natural supports will be utilized to assure optimal outcomes for the youth through on-going assessment and documentation to depict the needs and strengths of the participant and family and/or support unit.

Transitional Case Management and HCBS Individualized Care Coordination (ICC) will be provided by the same individual to assure continuity of care. This will provide consistency to the family and participant while allowing for a smooth and efficient transition from inpatient care to the community.

Transitional Case Management includes the following components provided in at least 15-minutes duration:

- Face-to-face or telephonic contacts with the participant to assist preparation for discharge from an institutional setting and adjustment to community life immediately following discharge;
- Face-to-face or telephonic contacts with family members, caregivers, natural supports and/or other collaterals to assist in the planning for returning to the community
- Introducing the participant to other professionals or paraprofessionals involved in the waiver Individualized Service Plan;
- Providing information, education and training for the participant and family, if applicable, regarding:
  - (i) All facets of the Individualized Service Plan including; the assessments, Goals, Objectives and Methods, Safety Plan, Budget and Discharge Plan;
  - (ii) Ancillary behavioral health, educational, vocational community appointments, and provider plans as they relate to the Service Plan, and
  - (iii) Availability and how to access Community resources;
- Assisting with or making arrangements for the coordination of care for the participant while receiving inpatient care in preparation for discharge;
- Participation in Waiver Service Plan development and prescribed Service Plan update meetings.
- Referral and related activities to help a youth and family/natural support system obtain needed services, including activities that help link eligible individuals with medical, social, educational providers or other programs and services that are capable of providing needed services, such as making referrals to

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providers for needed services and scheduling appointments for the individual;

- Communicating with service providers in residential/inpatient setting to assure the continuity of care for effective treatments, interventions and approaches are integrated into the service plan and communicated to community-based service providers.
- Ongoing monitoring and follow-up activities, including activities and contacts that are necessary to ensure the Waiver Individualized Service Plan will be effectively implemented and will adequately address the needs of the eligible individual, and which may be with the individual, family members, providers, or other entities; conducted as frequently as necessary to help determine such matters as:
  - (i) Whether services are arranged to be furnished in accordance with an individual's Individualized Service Plan;
  - (ii) Whether the services in the Individualized Service Plan are adequate for the child and natural supports'/family's needs; and
  - (iii) Whether there are changes in the needs or status of the eligible individual, and if so, making necessary adjustments in the Individualized Service Plan and service arrangements with providers.

TCM and Individualized Care Coordination (ICC) are two separate services. TCM will be documented in the service plan as a TCM service. The visits made to the individual while hospitalized will not count towards the qualifying visit for a full or half month of ICC. If a child is seen while in the hospital, the service would be documented as a TCM service. Once the individual was back in the community, the qualifying contacts for full or half month would start.

### *Qualifications:*

- If hired after 4/1/05 must have completed fingerprinting clearances to ascertain no criminal history;
- Must be cleared through the State Central Child Abuse;
- Bachelor's degree or a NYS Teacher's Certificate, and two years' experience\* providing direct services for children in the children's service system with a preference for the mental health field/working with children with SED.

Or

- Master's degree and one year experience providing direct services to children, or providing linkage to services, for children, in the children's service system with a preference for the mental health field/working with children with SED.

\*Qualifying experience may be pre- or post- degree. Candidates may qualify by meeting the qualifications for the NYS Intensive Case Manager position.

Meet any other certification and training standards defined by the Office of Mental Health.

### *Required Trainings:*

- Meet all New York State Office of Mental Health (NYS OMH) policies and procedures as outlined in the Guidance Document;
- Complete all OMH trainings required for the ICCs
- Receive orientation from their ICC Agency to the Waiver Program and the ICC Agency's policy and

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- procedures, including staff protocols, child abuse identification and reporting, and incident reporting;
- Participate in technical assistance sessions and agency in-services;
  - Complete all required trainings as outlined by NYS OMH.

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Note: A qualified mental health staff person per 14 NYCRR 594 means:

- (i) a physician who is currently licensed as a physician by the New York State Education Department; or
- (ii) a psychologist who is currently licensed as a psychologist by the New York State Education Department; or
- (iii) a social worker who is either currently licensed as a licensed master social worker or as a licensed clinical social worker by the New York State Education Department or has a master's degree in social work from a program approved by the New York State Education Department; or
- (iv) a registered nurse who is currently licensed as a registered professional nurse by the New York State Education Department; or
- (v) an individual having a master's or bachelor's degree in a human service related field; or
- (vi) a creative arts therapist who is currently licensed as a creative arts therapist by the New York State Education Department; or
- (vii) a marriage and family therapist who is currently licensed as a marriage and family therapist by the New York State Education Department; or
- (viii) a mental health counselor who is currently licensed as a mental health counselor by the New York State Education Department; or
- (ix) a psychoanalyst who is currently licensed as a psychoanalyst by the New York State Education Department; or
- (x) a nurse practitioner who is currently certified as a nurse practitioner by the New York State Education Department; or
- (xi) an individual having education, experience and demonstrated competence, as defined below:
  - (a) a master's or bachelor's degree in a human service related field;
  - (b) an associate's degree in a human service related field and three years' experience in human services;
  - (c) a high school degree and five years' experience in human services; or
- (xii) for purposes of a CREDIT program, a registered dietitian who is currently licensed by the New York State Education Department; or
- (xiii) other professional disciplines which receive the written approval of the Office of Mental Health.

## Section 11: Transitions

### 1. Transfers

#### **New County and New Provider, New County and Same Provider, Same County and New Provider**

The following procedures have been developed for handling transfer cases, including allowing a program/county to temporarily exceed capacity when a waiver child moves to their county and they are already at capacity.

#### Procedures

#### **Situation 1: Family/child moves to new county; requires transfer to new provider.**

<b>Who</b>	<b>Action(s)</b>
<b>Family</b>	Notify current (i.e. sending) ICC agency of intent to move and expected timeframes.
<b>Sending ICC Agency</b>	Within 4-6 weeks prior to the expected move date, contact receiving ICC agency to advise that you have a child that will be moving to their county and needs to be transferred to their program. Provide the anticipated move date.
<b>Receiving ICC Agency</b>	<p>Determine if a vacancy will be available at time of anticipated move/transfer.</p> <ul style="list-style-type: none"> <li>• If vacancy is expected and there is no wait list, then earmark vacancy for transfer. There should be no need to go over census in this situation.</li> <li>• If no vacancy is expected at the time of the transfer your program will have to accept the child when s/he transfers and exceed approved capacity until the next vacancy occurs.</li> </ul> <p>Note: When a county is over capacity the expectation is that the ICC caseload ratio of 1:9 will increase to 1:10 or the Supervisor will pick up the additional case until the census returns to the allocated slot capacity.</p>
<b>Sending ICC Agency</b>	Monitor family’s move status. Once move happens: Make a copy of entire case record and complete <i>HCBS Transfer - Case Record Transmittal Cover Memo</i> . Send <b>copy</b> of case record and original of the <i>HCBS Transfer - Case Record Transmittal Cover Memo</i> to the receiving ICC in accordance with HIPAA requirements. Retain original case record and copy of the <i>Case Record Transmittal Cover Memo</i> at your agency. Send copies of the <i>Case Record Transmittal Cover Memo</i> to sending LGU and OSU.

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<b>Receiving ICC Agency</b>	Complete Part 1 of the <i>HCBS Transfer - Exceeding Capacity Turnaround Form</i> . Send original to CO Children and Families (attention: Joyce Billetts), with a copy to ICC file.
<b>CO C&amp;F</b>	Annotate Census Capacity Log.
<b>Receiving ICC</b>	<ul style="list-style-type: none"> <li>Complete the <i>HCBS Transfer - Notification of Transfer Form</i> -ICC check box #1. Send original to OSU, with copies to sending ICC, receiving LGU, sending LDSS, and child/family.</li> <li>Note: Obtain address for former LDSS from the <i>HCBS Transfer - Case Record Transmittal Cover Memo</i> received from the sending ICC.</li> <li>Upon receipt of case record, contact family and make appointment to review child's existing Service Plan and to complete a Medicaid application, if necessary.</li> <li>Meet with family. Review Service Plan and revise if necessary. Complete Medicaid application, if necessary, and gather required documentation.</li> <li>Once Medicaid application is completed, complete the <i>HCBS Transfer - Cover Letter for Medicaid Application</i>.</li> <li>Send/deliver the original cover letter and application package to the receiving LDSS.</li> <li>In the event that the family has already filed a Medicaid application with the new county, send the <i>HCBS Transfer - Letter to LDSS Confirming Clinical Eligibility for Waiver</i> to the new LDSS. Besides confirming the child's clinical and fiscal eligibility for the OMH HCBS Waiver, it reminds the LDSS of the special budgeting rules for the OMH HCBS Waiver.</li> </ul>
<b>OSU</b>	<ul style="list-style-type: none"> <li>Monitor case on WMS to ensure that Medicaid is closed in the old LDSS and opened in the new LDSS in timely manner.</li> <li>Monitor case in WMS to ensure that the proper S/F code is added to the new LDSS case.</li> </ul>
<b>Receiving ICC Agency</b>	As soon as the next vacancy occurs, annotate Part 2 of the copy of the <i>HCBS Transfer - Exceeding Capacity Turnaround Form</i> in the file folder. Send the original to CO C&F (attention: Joyce Billetts) and retain copy in file.
<b>CO C&amp;F</b>	Annotate Census Capacity Log.

Following are the actions that we anticipate that the Local Medicaid Offices (LDSSs) will take in this situation:

<b>Who</b>	<b>Action(s)</b>
<b>LDSS Existing</b>	Upon receipt of the information re. the date of the move, close child's MA case effective the last day of the month following the month of the move.

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	<ul style="list-style-type: none"> <li>Note: In some cases, when sending LDSS closes its case coverage may continue beyond the last day of the month following the month of the move until the receiving county opens their case at which time the system may adjust the sending county's end date (this is known as Continuous Save Date policy.)</li> </ul> <p>Issue <i>Notice of Termination</i> to child/family</p>
<b>LDSS - Receiving</b>	<ul style="list-style-type: none"> <li>Open Medicaid case for child effective the first of the month Receiving of the application is filed with them -or- effective the day the former LDSS's case closed, whichever is later.</li> <li>Add appropriate S/F charge indicator.</li> <li>Issue <i>Notice of Decision</i> to child/family</li> </ul> <p>Note: To ensure that there is no gap in Medicaid coverage that will prevent them from receiving full reimbursement, the receiving ICC is responsible for monitoring Medicaid application process to ensure that the application is filed in a timely manner, i.e. no later than the month that the old LDSS's coverage expires.</p>

### Situation 2: Family/child moves to a new county; remains with same ICC agency.

Who	Action(s)
<b>Family</b>	Notify existing ICC agency of intent to move and expected timeframes.
<b>Existing ICC Agency</b>	Monitor status of move. Once move to the new county occurs, if there is no simultaneous termination taking place, then it is necessary to exceed capacity until the next termination occurs. Note: When a county is over capacity the expectation is that the ICC caseload ratio of 1:9 will increase to 1:10 or the Supervisor will pick up the additional case until the census returns to the allocated slot capacity. Complete Part 1 of the <i>HCBS Transfer - Exceeding Capacity Turnaround Form</i> . Send original to CO Children and Families (attention: Joyce Billetts), with a copy to ICC file.
<b>CO C&amp;F</b>	Annotate Census Capacity Log.
<b>Existing ICC Agency</b>	<ul style="list-style-type: none"> <li>ICC worker in new county contacts family and makes appointment for review/revision of child's existing service plan and completion of a Medicaid application, if necessary.</li> <li>Complete the <i>HCBS Transfer - Notification of Transfer Form</i> -check box #2. Send original of form to OSU, copies to sending LDSS, receiving LGU and child/family.</li> <li>Meet with family. Review service plan and budget; revise if necessary. Complete Medicaid application and gather required documentation, if necessary.</li> </ul>

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	<ul style="list-style-type: none"> <li>Once Medicaid application is completed, complete the <i>HCBS Transfer - Cover Letter for Medicaid Application</i>. Send/deliver the original cover letter and application package to the receiving LDSS. Mail a copy of the application and cover letter to OSU.</li> </ul> <p>If the family has already filed a Medicaid application with the new LDSS, send the <i>HCBS Transfer -Letter to LDSS Confirming Clinical Eligibility for Waiver</i> to the new LDSS. Besides confirming the child's clinical and fiscal eligibility for the OMH HCBS Waiver, it reminds the LDSS of the special budgeting rules for the OMH HCBS Waiver.</p>
<b>OSU</b>	Monitor case on WMS to ensure that Medicaid is closed in the previous LDSS and opened in the new LDSS in timely manner.
<b>Existing ICC Agency</b>	Once the next child is terminated from Waiver, annotate Part 2 of the copy of the <i>HCBS Transfer - Exceeding Capacity Turnaround Form</i> in the file folder. Send the original to CO C&F (attention: Joyce Billetts) and retain copy in file.
<b>CO C&amp;F</b>	Annotate Census Capacity Log.

Following are the actions that we anticipate that the Local Medicaid Offices (LDSSs) will take in this situation:

<b>Who</b>	<b>Action(s)</b>
<b>LDSS Existing</b>	<p>Upon receipt of the information re. the date of the move, close child's MA case effective the last day of the month following the month of the move.</p> <ul style="list-style-type: none"> <li>Note: In some cases, when sending LDSS closes its case coverage may continue beyond the last day of the month following the month of the move until the receiving county opens their case at which time the system may adjust the sending county's end date (this is known as Continuous Save Date policy.)</li> </ul> <p>Issue <i>Notice of Termination</i> to child/family</p>
<b>LDSS - Receiving</b>	<ul style="list-style-type: none"> <li>Open Medicaid case for child effective the first of the month of the application is filed with them -or- effective the day the former LDSS's case closed, whichever is later.</li> <li>Add appropriate S/F charge indicator.</li> <li>Issue <i>Notice of Decision</i> to child/family</li> </ul> <p>Note: To ensure that there is no gap in Medicaid coverage that will prevent them from receiving full reimbursement, the ICC is responsible for monitoring Medicaid application process to ensure that the application is filed in a timely manner, i.e. no later than the month that the old LDSS's coverage expires.</p>

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### Situation 3: Family/child remains in same county; transfers to new ICC Agency.

Note: This can only happen in NYC and in counties where there is more than one ICC Agency in operation, i.e. Erie and Westchester.

Who	Action(s)
Family	Notify existing (i.e. sending) ICC agency of intent to move/transfer and expected timeframes.
Sending ICC Agency	Within 4-6 weeks prior to the expected move/transfer date, contact receiving ICC agency to advise that you have a child that will need to be transferred to their program. Provide the anticipated move date.
Receiving ICC Agency	<p>Determine if a vacancy will be available at time of anticipated move/transfer.</p> <ul style="list-style-type: none"> <li>• If vacancy is expected and there is no wait list, then earmark vacancy for transfer. There should be no need to go over census in this situation.</li> <li>• If no vacancy is expected at the time of the transfer your program must accept the child when s/he transfers and exceed approved capacity until the next vacancy occurs.</li> </ul> <p>Note: When a county is over capacity the expectation is that the ICC caseload ratio of 1:9 will increase to 1:10 or the Supervisor will pick up the additional case until the census returns to the allocated slot capacity.</p>
Sending ICC Agency	<p>Monitor family's move status. Once move happens:</p> <ul style="list-style-type: none"> <li>• Make a copy of entire case record and complete <i>HCBS Transfer - Case Record Transmittal Cover Memo</i>.</li> <li>• Send <b>copy</b> of case record and original of the <i>HCBS Transfer - Case Record Transmittal Cover Memo</i> to the receiving ICC in accordance with HIPAA requirements. Retain original case record and copy of the <i>Case Record Transmittal Cover Memo</i> at your agency.</li> </ul>
Receiving ICC Agency	Complete Part 1 of the <i>HCBS Transfer - Exceeding Capacity Turnaround Form</i> . Send original to CO Children and Families (attention: Joyce Billetts), with a copy to ICC.
CO (C&F)	Annotate Census Capacity Log.
Receiving ICC Agency	<ul style="list-style-type: none"> <li>• Complete the <i>HCBS Transfer - Notification of Transfer Form</i>) - check box #1. Send original of form to OSU, with copies to sending ICC, receiving LGU, and child/family.</li> <li>• Upon receipt of case record, contact family and make appointment to review child's existing Service Plan.</li> <li>• Meet with family. Review Service Plan and revise if necessary.</li> </ul>

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<b>Receiving ICC</b>	Once the next child is terminated from Waiver, annotate part 2 of the copy of the <i>HCBS Transfer - Exceeding Capacity Turnaround Form</i> in the file folder. Send the original to CO C&F (attention: Joyce Billetts) and retain copy in file.
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Note: In Situation 3, there is no activity required on the part of the LDSS since the Medicaid eligibility remains in the same county.

## 2. Hospitalization (In-Patient)

Please refer to billing rules for an inpatient stay in [Section 13](#). Transitional Case Management services may be delivered to the child and the child's family in accordance with the child's service plan goals while a child is hospitalized, no other HCBS Services are billable during an inpatient stay.

### Inpatient Stays for Waiver Enrollees

#### Policy

By nature of their clinical eligibility for the HCBS Waiver, it is expected that some Waiver enrollees will need short-term psychiatric hospitalization to stabilize a crisis. A child may also require medical hospitalization while enrolled in the Waiver. The child's slot may remain active during any inpatient hospitalization for up to 60 days. A longer hospital stay, or if it has been determined at an earlier time that the child will need long term hospitalization, necessitates disenrollment of the child from the HCBS Waiver.

#### Reporting of Inpatient Stays

The Office of Mental Health monitors inpatient service utilization from the financial management reports. However, not all inpatient utilization will be captured through the MMIS claiming process. Some children receiving inpatient services from State Psychiatric Centers may have claims billed to a second Medicaid ID number which OMH may not have. In these cases, expenditures will not appear on the fiscal reports. Also, children with claims paid by other third party health insurers may not show utilization through the fiscal reports.

To capture this information and to offer assistance earlier in the hospitalization period, if needed, OMH requests on-going reporting of data via CAIRS of individual child's admission and discharge dates as well as whether they received services in a State Psychiatric. Information should also be provided regarding whether any psychiatric inpatient services were paid for through Third Party Insurance (TPHI).

## 3. Voluntary Participant Withdrawal

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Participation in the OMH HCBS Waiver is voluntary. Therefore, a youth and/ or parent may decide to withdraw his or her child from consideration for admission to the HCBS Waiver during the period of time when Transmittal I has been sent to OSU in CAIRS but prior to submittal of Transmittal II of the enrollment process. If a parent indicates a desire to withdraw his/her Waiver referral/application, the ICC Agency should draft a letter with the following statement:

"I, the youth and/or parent/guardian of (*child's name*), wish to *voluntarily* withdraw my child from consideration for enrollment in the HCBS Waiver."

The youth, if 18 years old, and/ or parent must sign and date the letter. The original of the letter is retained in the ICC file. If the withdrawal occurs after the Level of Care (LOC) determination has taken place, a copy must be sent to the LGU; and if it occurs after the LOC and Application to Participate (Transmittal 1) have been sent to OSU, then process the case as an Administrative Withdrawal through CAIRS.

In the case of Dis-enrollments, providers must continue to serve the youth and his/her family through 10-day notice period.

## 4. Termination/ Disenrollment

### HCBS Waiver Discharge and Aftercare Plans

*Discharge planning* begins when the child is first enrolled in the HCBS Waiver. The treatment team, child and family discuss what changes would need to occur for the child to be discharged to a less intense level of care. To accomplish this, relevant goals and services are agreed upon. The family and child are engaged in conversations periodically, as well as at service plan reviews, addressing the child's progression and probable services needed after discharge from the Waiver. These are recorded in the Progress Notes and in the 90 Day Service Plan Reviews. When discharge is imminent, the official HCBS Waiver Discharge Plan is completed and necessary signatures are obtained. The ICC is responsible for all documentation and for coordinating aftercare services. The ICC uses the HCBS Waiver Aftercare Follow-Up Plan to document follow-up activities. At a minimum, the ICC agency is required to contact the family to assure that discharge services are operative and to summarize the child and family's status at the first two week and four week intervals. The ICC intervenes as appropriate if problems are noted and continues documenting on the Aftercare Follow-Up Plan.

### *The HCBS Waiver Discharge Plan*

The ICC completes the [HCBS Waiver Discharge Plan](#) prior to the disenrollment which, in the first section, summarizes the movement of the child and family through the Waiver enrollment period and portrays how discharge readiness has been reached. Included in this brief narrative is a description of the services the child and family have received and progression towards specific, identified goals. The second section lists services, with contact names and numbers, to which the child has been discharged. The third section tracks the completion of all required steps and the fourth section documents supervisory review and child/family agreement.

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### *The HCBS Waiver Aftercare Plan*

The [HCBS Waiver Aftercare Plan](#) is used by the ICC to document discharge follow-up to ascertain that discharge services are implemented, and if not, what actions need to be taken. It also gives the ICC the opportunity to assess the effectiveness of the discharge plan and to make changes as indicated. This must be completed two weeks and four weeks after discharge and is reviewed by the ICC Supervisor. Follow-up is initiated and documented as needed thereafter.

### *Termination from the HCBS Waiver*

- Planning for termination begins as early as the application and service planning process.
- The child and family must be included in all decision-making regarding termination from the HCBS Waiver.

### *Reasons and Responsibility for Termination*

It is mainly the responsibility of the ICC for initiating terminations.

Following are the most common and frequent reasons that a child's enrollment in the HCBS Waiver would be terminated:

- the child and family no longer want to receive services through the HCBS Waiver;
- all parties involved concur that the child has met the goals of his/her Individualized Service Plan and no longer requires HCBS Waiver services;
- the child no longer meets the level of care criteria because of one or more of the following reasons:
  - does not meet the definition of seriously emotionally disturbed;
  - does not require, or is not in imminent risk of needing, psychiatric inpatient services for individuals under 21;
  - does not have complex health or mental health needs;
  - has service and support needs that can be met by a single agency/system;
  - is not capable of being cared for in the community if provided access to HCBS Waiver services;
  - or
  - does not have a viable and consistent living environment with parents/guardians who are able and willing to participate in the HCBS Waiver and support him/her in the home and community.
- the child has been or is expected to be a resident of psychiatric inpatient facility for a maximum of 60 consecutive days;
- the child is admitted to another program (Family Based, Teaching Family or Community Residence)
- the child turns age 21;
- the child is deceased;
- the child is no longer eligible for Medicaid;
- the child has moved;
- the child has been hospitalized more than 60 consecutive days;
- the child is incarcerated; or

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- the cost of serving the child in the HCBS Waiver exceeds the annual average cost calculated for psychiatric inpatient level of care

**Note:** Although there may be other reasons for termination, it is anticipated that these would be rare situations and should be handled on a case by case basis.

### *Impact Termination from HCBS Waiver Has on Child's Medicaid Eligibility/Coverage*

As part of the termination process, the ICC assists the family in understanding the ramifications that termination from the HCBS Waiver will have on the child's continued Medicaid coverage post-enrollment and determine whether the family is interested in continuing the child's Medicaid coverage, if possible. Note: If the child had Medicaid prior to enrollment in Waiver then the Medicaid should continue. Waiver enrollment/disenrollment will not have any effect on the Medicaid.

**The family should be advised to contact the LDSS directly regarding changing the Medicaid coverage from HCBS Waiver to non-Waiver status.** In cases where the child's Medicaid coverage will be terminated after leaving the HCBS Waiver, the ICC must advise the family that they should stop using the child's Medicaid card to purchase services as of the date that the child is determined by the ICC/ LGU to no longer be eligible for the HCBS Waiver. (Charges incurred between the date the child becomes ineligible and the date the LDSS closes the case on the WMS system will charge back to the HCBS Waiver.) A separate notice advising the parent/guardian of the actual closure of the Medicaid case will be sent from the LDSS once the case is actually closed on the system.

**Note:** In this context, LDSS means the local Social Services Medicaid Unit for all non-NYC counties and the applicable Medicaid units in the Human Resources Administration (HRA) for all NYC boroughs.

### *Procedures for Terminations*

#### ICC Actions:

**Document Reason for Termination:** ICC documents the reason for termination and initiates completion of the **Notice to LDSS Regarding: Loss of Waiver Eligibility Form.**

**Form Supply:** An ICC can either photocopy the form or use the one on the OMH website. If supplies are photocopied, it is recommended that the agency type its address and phone number taking care to ensure that it does not exceed one page. A copy of this form has been provided to all LDSS Medicaid units as a standardized form.

**Completion of Notice to LDSS Re: Loss of Waiver Eligibility Form:** Complete the Notice to LDSS form as follows:

Check the box indicating the reason why the child is no longer eligible for the HCBS Waiver and enter the date that the child became ineligible. Note: Only box #3 allows more than one selection.

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**Signatures:** The ICC signs and dates the form. If the reason for termination does not involve the LGU, (Level of Care Box #3) the LGU does not need to sign the form. However, if a Level of Care reason #3 is checked, then the LGU signature is required.

The ICC, whenever possible, meets with the family to obtain the parent/guardian's signature and ensures that the date on the form corresponds with the date of the signature. If a face-to-face meeting is not possible, these issues must be discussed over the phone and the parental signature line on the form should be annotated as follows: "Unable to meet, discussed with parent over telephone." The date of the phone conversation is entered in the date field. If the parent/guardian is not cooperating in the termination process, annotate the parent's signature line as follows: "Parent/guardian refuses to sign" and date the form.

**Address Change:** If the address has changed since the child's enrollment date, complete the box at the bottom of the page where the new address is requested. **This updated information is needed by OSU to ensure that the NOD-Termination is sent to the correct address.**

**Distribution of Notice to LDSS re: *Loss of Waiver Eligibility form* (PDF):** ICC distributes the completed "Notice to LDSS re: Loss of Waiver Eligibility form as follows:

Upstate/LI Programs - Original to the LDSS Waiver contact; Photocopy to NYC if termination caused by change in level of care.

NYC Programs - Photocopy to NYC if termination caused by change in level of care.

**Terminating Services and Billing:** The ICC discontinues providing services and billing for HCBS Waiver services effective the date of ineligibility that has been indicated on the "Notice to LDSS re: *Loss of Waiver Eligibility form*".

**LDSS/HRA Actions:**

LDSS/HRA either reevaluates the child's Medicaid eligibility based on the child's current living arrangement using Medicaid standards/methodology applicable to the post-Waiver living arrangements or closes the Medicaid case. Action taken is dependent on whether the family wishes to continue Medicaid coverage and/or whether there is sufficient documentation for reevaluation.

If the child's Medicaid case is closed, the effective date of closure is ten (10) days after the Notice Date (determined by the date the LDSS inputs the closing transaction in the WMS system).

LDSS/HRA notifies the family of the action that has been taken regarding the child's Medicaid and the effective date of this change.

Note: This section pertains to those cases where the child had to apply for Medicaid as part of the waiver enrollment process. If the child had Medicaid prior to waiver the Medicaid should continue, waiver enrollment/disenrollment does not have any effect on the Medicaid in those cases.

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OSU Actions:

Upon receipt of the Transmittal 3 in CAIRS, which contains Loss of Waiver effective date and corresponding reason, OSU terminates the RE Code 23 with the appropriate effective date of termination.

OSU electronically replies to Transmittal 3, and employs reporting features in CAIRS to produce hard copies of "*Waiver Notice of Decision – Termination*". Original copies of the termination letters are sent to Child/Family, LGU, LDSS (Upstate only); and NYC, where applicable. CAIRS reports allow the HCBS Waiver providers to print a copy of the *Waiver Notice of Decision – Termination* immediately following OSU's electronic response to the Transmittal 3 transaction.

Note: This form contains a statement of the child/family's rights to appeal the termination decision and request a Fair Hearing. See [Section 2](#) for Fair Hearing Procedures.

## Section 12: Monitoring and Evaluation

### 1. Overview- Oversight

#### Oversight

The New York State OMH Division of Children and Families and the NYS Department of Health provide oversight, consultation, education, and technical assistance for all aspects of the HCBS Waiver Program. The Division of Children and Families works in close collaboration with various OMH departments including OMH Counsel, Operations Support Unit (OSU), Community Budget, and Finance.

#### Policy

##### ICC Agency HCBS Monitoring and Evaluation Overview

Evaluation and monitoring of the HCBS Waiver Program is mandated by the federal government and the NYS Legislature to examine the efficacy and cost effectiveness of the program. ICC Agencies are required to routinely submit data to the OMH for monitoring and evaluating purposes.

Systematic evaluations focusing on child and family outcomes are completed within prescribed timeframes. Various instruments are utilized for this purpose including annual family and youth satisfaction surveys, the Admission Record, Six-Month Follow-Up and Child Discharge forms.

Another measurement utilized is the *CANS MH Level of Care Rating Form* from which data is compiled to evaluate treatment outcomes. Additionally, specific agency reports are monitored and data may be summarized by OMH to assist in evaluating financial efficiency as well as service utilization and effectiveness.

The wide range of reports and instruments used to evaluate the HCBS Waiver Program look at multiple aspects of the program. The following represents a sampling of areas evaluated:

#### Child and Family Outcomes:

- evidence of strength-based Individualized Care in each life domain;
- child level of recovery and changes in level of care per CANS MH Level of Care Rating Form; services supporting the family and sufficiency of supports;
- precipitating factors for admission into an RTF or inpatient care; and
- gaps in services.

#### Family Satisfaction:

- appropriateness;

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- sensitivity;
- access;
- participation;
- effectiveness;
- and global satisfaction.

## System Factors:

- the number of children and the geographic distribution of those participating in the HCBS Waiver;
- health and mental health profiles;
- utilization and costs of Waiver program services;
- savings achieved by avoiding placement in residential treatment facilities and inpatient facilities operated by OMH;
- the length of time children are enrolled in the HCBS Waiver;
- the utilization of waiting lists for the HCBS Waiver and for services in RTF's, where appropriate;
- patterns of hospitalization and outcomes for children who have been hospitalized;
- flex dollar expenditures;
- follow-up data on children who are disenrolled from the HCBS Waiver, including data on residential program placements; and
- discharge outcomes.

## 2. ICC Agency Site Visit, Agency Corrective Action Plan

### *Provider Clearance Verification*

Annual site visits are conducted at each ICC agency together by OMH Field Coordinators, Parent Advisors and Local Governmental Units (LGUs) using a standardized site visit review protocol that reviews all ICC agency worker background checks and qualifications and the presence of updated agreements with subcontractors. ICC Agencies review approval and documentation of qualifications of ICC Agency Waiver workers, as well as Crisis Response, Intensive In-Home, Family Support, Respite Care, Skill Building Services and the new services, Prevocational service, Supportive Employment and Youth Peer Advocate workers, including State Central Registry and fingerprinting clearance. No worker can begin delivering HCBS Waiver services without verification that the individual meets all required qualifications for the respective service. During the annual site visits, OMH Field Coordinators verify that all providers of waiver services met the required qualifications which include the qualifying education, experience and training requirements as well as the clearance documentation from the State Child Abuse Registry and Fingerprinting. The ICC agencies are responsible for obtaining these clearances and maintaining the documentation. Parent Advisors meet with families during the site visits to ensure that the ICC agencies are following policies and procedures. This is documented on the site visit tool.

### ICC Agency Site Visits

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Starting in 2015, the Office of Mental Health (OMH) and the Department of Health (DOH) combined their ISP reviews into one. OMH provides DOH annually with a list of participants enrolled in the waiver for the respective waiver review year. DOH then runs a query through the NYD Medicaid Data Warehouse to identify all OMH HCBS Waiver participants during the sample time period who are enrolled in the SED Waiver for at least four consecutive months. DOH selects a random statewide sample number, 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 generated a list that includes all waiver services and all waiver service providers and assures that the annual DOH-OMH service plan sample is both statistically valid and representative of all waiver participants. The selected sample is forwarded to OMH at the beginning of the next waiver year and OMH provides the sample list of individuals to the OMH Field Office Coordinators. These are the individuals that are reviewed during their site visit using the *Site Visit Summary Form*. Of these records identified by the statically valid sampling, DOH will annually select a percentage of the ISP's to conduct a desk review. DOH will compare the findings using OMH Site Visit tool with their finding.

A Medicaid billing validation review for a statically valid sample is derived from the larger DOH statically valid sample of ISPs. The FOC will distribute a list of the participants whose records will need to be copied and sent to OMH. DOH conducts this review by comparing the Data Mart Claims Detail Report (CDR) billing to ISP documentation for the specified waiver year. DOH tracks and trends identified deficiencies and monitors to assure that appropriate remediation are completed by OMH and reported to DOH in the agreed upon timeframe. If DOH finds deficient practices, OMH is notified and then they contact the ICC agency requiring them to provide a Performance Improvement Plan (PIP) and proof of reimbursement, as appropriate. OMH reports all corrective actions and proof of reimbursement to DOH.

### Corrective Action Plans

For problems and deficiencies discovered during the OMH annual site visit to each ICC Agency, the Field Coordinators forward copies of the Site Visit Summary Form, with any necessary corrective actions noted to the agency and to the OMH HCBS Waiver Program for review. The ICC Agencies must submit a performance improvement plan to the Regional Field Coordinator within 30 days of receipt of the Site Visit Summary, **using the OMH** approve Performance Improvement Plan form. The field Coordinator forwards a copy of the agency's improvement plan to OMH HCBS Waiver Program with a copy of the Field Coordinator's letter of approval of the plan. The field Coordinator monitors implementation of the improvement plan and provides technical assistance as needed, these individual PIP's will be forwarded to DOH upon request.

### NYS Department of Health (DOH) Desk Reviews

The annual review of a statistically valid, representative sample of individualized service plans (ISPs), previously completed by DOH, will now be conducted by OMH. DOH oversight activities will ensure that OMH is correctly using the agreed upon review tool and that OMH surveyors' ISP reviews are accurate, completed, and executed as per the agreed upon process. OMH will track individual deficiencies identified in this ISP review, monitor 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.

### 3. ICC Agency to OMH Waiver Data Collection and Reports

#### Policy

##### ICC Agency Reports to OMH

Specific data is submitted by the ICC Agencies within prescribed timeframes to OMH to assist in assuring that the HCBS Waiver is being implemented effectively within approved guidelines and to assure timely provision of technical assistance by OMH. These include the following.

##### Annual Administrative Review

This report is completed annually within one month prior to the agency's scheduled annual site visit. As much of the content will remain the same from year to year, each year any changes or **additions are typed in bold and the bolding is removed from any changes made in the previous year**. This is forwarded to the OMH HCBS Waiver Program, Central Office, where it is reviewed and technical assistance is offered as indicated.

##### Outcome Measures Descriptive Data to be entered on CAIRS

- **Admission Record:** This data provides demographic and clinical information about the newly enrolled child. It is due within 30 days of enrollment.
- **Child and Family Status Six Month Follow-Up:** This data is completed at each six-month interval during the child's HCBS enrollment.
- **Child Discharge from HCBS:** Completed upon disenrollment from the waiver program, this data demonstrates change over time and final status at discharge.

##### Semi-Annual Program Report on CAIRS

This report is completed by each agency twice a year on CAIRS. A one month lag is figured into the reporting phases. January through June is due by July 31 and June through December is due January 31.

##### Semi-Annual Waiver Subcontractor Services Summary on CAIRS

This report provides OMH with data on total utilization and expenditures for the five waiver subcontracted services over a six-month period including which subcontractors were used, frequency of services utilized and costs. OMH analyzes these for comparison across the regions as well as statewide. To assure that the information is complete, the Waiver Service Summary is entered on CAIRS in September for the previous January through June and in March of the following year for July through December.

##### Quarterly Program Specific Fiscal Report on CAIRS

This data entry module in CAIRS has four sections which provide the ability to enter the following information:

- **Flexible Service Fund Expenditures:** Data is entered for each child for the amount of flexible service funds used during the quarter, per expenditure category, to show that funds are being used, how they are being used and that expenditures are within prescribed caps.

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- **In-Kind Community Services:** This captures information on “waiver-like” services provided per quarter per child in the community but not specifically billed to Medicaid. Instances of in-kind services may result from the *provision of services similar to the Waiver by the community itself or by the family* through their own means. It is important to account for such differences in service provision when outcomes for enrollees are compared to service utilization.
- **Start-Up ICC:** This section documents the total units of Waiver five services provided to each child per quarter during the Waiver child's Start-Up period through Start-Up ICC case management rates.
- **Inpatient ICC:** This section identifies the units of the Waiver services provided to each child through ICC case management rates while the Waiver enrollee is hospitalized.

### OMH HCBS Waiver Reports

OMH Central Office routinely offers a number of reports which agencies may access through CAIRS. These include:

#### Reports based on agency:

- “Admissions and Discharges” -for all ICC Agencies;
- “Admissions by Gender and Age” - for specific timeframes for three age categories for all ICC agencies;
- “Admissions, Discharges, Census and Length of Stay” - for a specific timeframe by agency;
- “Discharges by Length of Stay” - discharges categorized by length of stay for all ICC agencies with a comparison to quarterly reports for current and past year;
- “Living Situation Prior to Admission for Currently Enrolled Children” – for all ICC agencies;
- “Living Situation Upon Discharge” - for all ICC agencies;
- “Extent to Which Service Goals are Met” - for all ICC agencies by level of accomplishment in five categories;

#### Reports based on region:

- “Admissions, Discharges, Census and LOS” - graph format by region;
- “Discharge by LOS” - graph format of the quarterly comparison of current and past year;
- “Living Situation Prior to Admission” - graph format by region;
- “Extent to Which Service Goals are Met” - graph format by region.

#### Reports based on county:

- “Current Census” - by county;
- “Admissions, Discharges and Average Daily Census” - by county.

#### Client Reports:

- “Child Specific Report” - demographic and clinical information;
- “Current Roster Report” - similar to “Child Specific Report” pertaining to current roster only;

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- “Admissions and Discharges Roster Report” - for specific timeframes;
- “Referral Listing” - provides the names of children referred within specific timeframes;
- “Client Enrolled in Service for a Selected LOS Report” - for specific timeframes;
- “Clients Enrolled for Service for Selected Age Report” - for specific timeframes.

## 4. Medicaid Expenditure Reports

### Policy

#### Medicaid Expenditure Reports by Category

- **Medicaid Expenditure Profile by Child:** gives expenditures by category by month as well as year-to-date totals for the last 24 months for those children enrolled during these years who have not been discharged in the last 6 months. Children with multiple known Medicaid ID numbers will have expenditures reported under their separate ID's. The individual child tables are arranged by recipient Medicaid ID number. Counties will receive reports only for children in their county.
- **Medicaid Expenditure Profile by HCBS Waiver Provider:** gives total expenditures for all enrolled children by category by month for each calendar year of ICC Agency participation in the HCBS Waiver. Also gives number of enrolled children per month, average expenditure per child by month, and year-to-date (YTD) totals with YTD average expenditures based only on months with reported data.
- **Medicaid Expenditure Profile by HCBS Waiver Provider -Average Child Usage:** gives average expenditures over all enrolled children by category by month for each calendar year of ICC Agency participation in the HCBS Waiver.
- **Medicaid Expenditure Profile - Entire State of New York:** gives expenditures by category by month and year-to-date total for each calendar year of HCBS Waiver.
- **Medicaid Expenditure Profile -New York City/Rest of State:** gives expenditures by category by month and year-to-date total for each calendar year of HCBS Waiver.
- **Budgeted vs. Expended Report** -annualizes expenditures and compares them to the budgeted amounts and is given by ICC Agency, region, and NYC/Rest of State. It should be a useful tool in evaluating utilization and expenditures for your enrolled children and families.
  - The report gives total program estimated expenditures and average amount per slot *as budgeted for current calendar year in rate setting worksheets prepared by ICC Agencies.*
  - Actual year-to-date (YTD) expenditures for a specified period are provided. Medicaid billing for this period should be fairly complete.
  - YTD expenditures are annualized for the year.
  - Total annualized YTD program expenditures are compared to total budgeted for all allocated slots. Thus, the percentage includes underspending due to unfilled slots as well as differences due to service utilization.
  - The annualization on a per-slot basis only looks at *children who have Medicaid billings* and therefore is a better representation of what is being spent on the "average" child in the program.

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- The percentages of expended dollars to budgeted dollars depend on how close an ICC Agency has estimated expenditure by category. **These percentages do not, by themselves, tell us whether the levels of service are appropriate or inappropriate.**

### Roster Reports

- **New/Previous Enrollments, Start-up Children, and Current Disenrollments.** This ICC Agency-level report gives roster activity by child for the previous month and includes child's county, Medicaid data consent status, and insurance information as well as a reminder on evaluation forms due.
- **Roster Update.** These reports summarize roster activity for the previous month (previously enrolled children, new enrollments, disenrollments, children in start-up, total including children in start-up, and approved slots) by county for each ICC Agency and by ICC Agency for each region.

### Medicaid Exception Report

- **Waiver Services Billing Exception Report.** Enrollees with waiver services billed outside of their enrollment period (before the enrollment date and on or after the disenrollment date) are identified on this report, and all paid claims falling outside the enrollment period are reported. For purposes of programming, the service dates shown on these reports is one month earlier than what your agency actually used when billing.
- Generally, no claim should show a service date prior to the enrollment date. Claims are allowed on the first of the month after a discharge if the child has not lost Medicaid eligibility in the intervening period. Daily respite may be billed for the actual days of service in the subsequent month. This will be allowed until the daily respite billing instructions are changed. Otherwise, there should be no claims on or after the disenrollment date. If billings were previously corrected by adjustments 12 months after the service date, they may not be reflected in these reports.

### Expenditure Categories

- **Medical/Other** - All other services besides HCBS Waiver services, licensed mental health services, and private mental health practitioner-delivered services:
  - *IP M/S*: Inpatient Medical/Surgical services;
  - *Long Term Care*: Typically nursing home or long term home health care; could include some nursing services;
  - *Emergency*: Emergency room services delivered outside Comprehensive Psychiatric Emergency Program (CPEP); could include psychiatric emergency care;
  - *Physician*: Services billed by physicians, including specialists, but not psychiatrists;
  - *OP Medical*: Outpatient medical or surgical services; could include mental health services delivered in outpatient setting not licensed by the Office of Mental Health;
  - *OP Substance Abuse*: Outpatient alcohol or substance abuse services delivered in settings licensed by the Office of Alcoholism and Substance Abuse;

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- *SSHSP-MH*: Services defined as mental-health related which are delivered through the School Supported Health Services Program for children in special education and billed by local school districts;
- *SSHSP-Other*: Services *not* defined as mental-health related which are delivered through the School Supported Health Services Program for children in special education and billed by local school districts;
- *Pharmacy*: Drugs prescribed and paid for through Medicaid, may be related to mental health diagnoses or not;
- *Transportation*: Transportation services, e.g., ambulance, cab to treatment appointments, paid by Medicaid;
- *Dental*: Dental services;
- *HMO/Managed Care*: Medicaid managed care premiums;
- *FC Medical Per Diem*: Medical per diem paid to voluntary agencies for certain contracted medical expenses for children in foster care and
- *Eye, Ear, DME, Other*: Eye, ear, durable medical equipment, or any other medical/surgical service provided through Medicaid.
- **Outpatient Mental Health** - Services provided by licensed mental health programs, e.g., clinic, day treatment, partial hospitalization, or intensive psychiatric rehabilitation treatment (IPRT) programs or by private mental health practitioners, e.g., psychiatrists, psychologists, social workers:
  - *Clinic - Regular*: Clinic treatment services, including individual, group or crisis services;
  - *Clinic - Collateral*: Clinic treatment services provided to client collateral(s) individually or in groups;
  - *Day Treatment -Regular*: Day treatment, partial hospitalization or IPRT services provided to client;
  - *Day Treatment -Collateral*: Day treatment, partial hospitalization or IPRT services provided to client collateral(s);
  - *Private Practitioner*: Services provided by private mental health practitioners, e.g., psychiatrists, psychologists, social workers;
  - *CPEP*: Services provided in specialized Comprehensive Psychiatric Emergency Program for mental health emergencies and
  - *ICM/SCM*: Intensive or Supportive Case Management services; HCBS Waiver enrollees cannot receive these services during their enrollment periods but may either before or after HCBS Waiver participation.
- **Psychiatric Inpatient/Residential** -Psychiatric services received in an acute general hospitals, private psychiatric hospitals, state-operated psychiatric centers or residential services delivered by programs licensed by the Office of Mental Health:
  - *Acute General Hospital*: Hospitals licensed by the Department of Health; ranges from small rural community hospitals to large metropolitan teaching hospitals. Some hospitals have specialized inpatient psychiatric departments which are licensed by the Office of Mental Health;
  - *Private Psychiatric Hospital*: Hospitals, licensed by the Office of Mental Health, specializing in psychiatric services;

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- *State Psychiatric Center*: Hospitals operated by the Office of Mental Health. Children's Psychiatric Centers only serve children. Psychiatric Centers may have specialized children's units and
- *CR/FBT/TFH*: Community Residences, Family-Based Treatment, and Teaching Family Homes, and all residential programs licensed by the Office of Mental Health. HCBS Waiver enrollees *cannot* receive these services during their enrollment periods but may either before or after HCBS Waiver participation.
- **HCBS Waiver Services** - the HCBS Waiver services

### 5. Items for ICC Agency to Review

As ICC's and the ICC Agency Program Director review the financial management reports, the following items should be addressed, both on a specific child level and systematically over the whole program.

- **CAIRS** - Is the roster on CAIRS current?
- **Missing Data** -Is any known expenditure or expenditure category missing (with no explanation), e.g., transportation? For New York City, are hospitalizations in state-operated psychiatric centers not being captured? If so, perhaps we are missing a second Medicaid ID number for the child.
- **Enrollment/Census Data** -Since many calculations depend on an accurate count of active cases, correct information is critical. Please check to see whether start-up, enrolled or disenrolled children are properly listed on the roster report. Are there enrolled children whose expenditures are not appearing, given a 3-month claim lag? Are disenrolled children's expenditures appearing past the disenrollment date?
- **Higher Expenditures** -Does any category seem larger than expected (compared to the service plan or program rate worksheet budget) with no identifiable reasons?
- **Frequency and Intensity of Other Outpatient Mental Health Services** -Is the frequency or intensity of other outpatient mental health services consistent with care plans and rate worksheet estimate?
- **Service Utilization Patterns** - Are the overall service utilization patterns consistent with expected current levels, e.g., are inpatient psychiatric costs too high, CPEP/ER too high, medical care too low, no needed substance abuse treatment? Are the patterns consistent with levels desired for planned disenrollment?
- **Relative Amounts and Types of Expenditures** -Examine the relative amounts and types of expenditures for each child and the program as a whole. For example, if day treatment is high and alternative packages of HCBS Waiver services or additional work with the schools could allow the child to return to more normalized educational settings, should care plan work toward this, should more outreach efforts be made to teachers and schools so they can understand what the HCBS Waiver can do to help? Or if several CPEP visits have taken place over a short period of time, could more intensive in-home services be put in place to divert/defuse potential crises?
- **Medical Care** -Is the child receiving preventive medical care and attention to chronic physical problems, e.g., physical exams at the appropriate intervals, management of asthma or diabetes? Has the child had an opportunity to be evaluated for possible organic causes of symptoms associated with the mental health diagnosis?
- **Dental, Vision, Hearing** -Has the child's dental, vision, and hearing needs been addressed?

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- **School Supported Health Program Services (SSHPS)** -Is the child receiving SSHPS through his or her school district? How do these services relate to the HCBS Waiver Individualized Care plan? This is an area where we are still trying to gather information to resolve issues of possible coordination/overlap, as well as fiscal responsibility.
- **Unpaid Claims** -Are there billings which do not appear because they have been denied – single occurrences or systematically? Call your Computer Sciences Corp. (CSC) contact or Diana Marek.
- **Inappropriate Claims** -Generally, no claim should show a service date prior to the enrollment date. Claims are allowed on the first of the month after a discharge if the child has not lost Medicaid eligibility in the intervening period. Correct billing of daily respite is complicated by denial of multiple days on a single claim line and some agencies have billed the actual days of service in the subsequent month. This will be allowed until such time as the daily respite billing instructions are changed. Otherwise, there should be no claims on or after the disenrollment date.
- **Overall Comparison** - How does the reported utilization generally compare to the individual child's service plan budget and the program rate worksheet? Look at both Waiver and non-Waiver services. If there are differences, do they indicate reported levels below budgeted amounts because of unmet need, e.g., unavailable respite services? If need is greater than anticipated, e.g., day treatment, frequent hospitalizations, why? Is this something your program can address for an individual child (substitution of another service) or for the program as a whole (look for new avenues to supply subcontract workers)? Is this an issue that your LGU, OMH Field Coordinator, or Parent Advisor might help with (local resources, brainstorming solutions)? Is this an issue that should be brought to OMH Central Office's attention (e.g., services for siblings) or Computer Sciences Corporation (denied claims)? Or, is this an indication that the ICC and child/family should revisit the care plan because the needs originally expressed have changed (either the situation has changed or those involved in the process are better able to articulate those needs)?

### Issues Regarding the Data

- **Data Reliability.** Since there is a lag in the Medicaid adjudicated claims data, we cannot guarantee that all current Medicaid expenditures will be reported, paid, and appear on the reports. There is at least a three-month lag for most mental health outpatient and inpatient billings to be paid. Additionally, we cannot capture data for children until all of their related application and enrollment information has been transmitted to OSU by CAIRS. **It is especially important that ICC Agencies submit claims and resolve denials promptly. Claims paid 12 months after the service date will not be supplied by DOH to OMH or included in the fiscal reports.**
- **COPs.** (Comprehensive Outpatient Program) Outpatient amounts include COPs payments, which are not subject to the budget cap. COPs allow enhanced reimbursement under Medicaid to designated providers who have agreed to certain additional requirements in the provision of outpatient mental health services.
- **Enrolled Children.** The enrollee count by month on the agency-specific profiles is based on calendar days rather than months and half-months, so it may understate ICC Agency capacity. The average expenditure per child per month calculation may be affected by this circumstance.
- **Confidentiality.** Medicaid data released to HCBS Waiver providers, LGU's, and OMH staff are to be maintained under strict rules regarding confidentiality as per HIPAA regulations.

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- These data shall only be used for Medicaid program administration purposes.
- Only staff performing duties specified under the HCBS Waiver Program shall be permitted access to this information.
- All staff having access to recipient-identifiable information shall be instructed in the confidential nature of such data and the limitations relating to its use and handling.
- Medicaid recipient-identifiable data shall be kept in locked areas or secured data base files when not under the direct control of authorized staff members.
- Any Medicaid recipient-identifiable data, including copies and merged databases, shall be returned to the NYS Department of Health (DOH) upon completion of the HCBS Waiver or, with DOH approval, destroyed and written certification of destruction furnished to DOH.
- Information regarding alcoholism or drug abuse services or HIV services are subject to other specific Federal and State laws and regulations.
- DOH reserves the right to monitor and audit usage of these data on-sit

## Section 13: Billing

### 1. Overview

As a Medicaid Waiver program, services provided through the OMH Children's HCBS Waiver are coded and reimbursed through Medicaid. Billing follows general Medicaid rules as well as rules specific to the HCBS Waiver. Compliance with Medicaid requirements, such as following billing rules and careful documentation, will assist providers in avoiding Medicaid disallowances.

To bill for any service, the service, and the purpose of the service in furthering a child's goal, must be clearly identified in the child's service plan. Every service must be connected to one of the objectives for the Waiver child to bill.

#### When Billing Can Begin

ICC Agencies must not begin billing for Waiver services until specifically advised to do so by OSU. The notification of the Effective Billing Date is done electronically in a report through CAIRS via the Program Notes screen. The report is the HCBS-Waiver Date Advised to Bill Notices. ICC billing staff must wait for notification via this report advising of the enrollment date before initiating billing. Important Note: Receipt of the Notice of Decision - Acceptance form is not to be interpreted as an instruction to begin billing. Notification via the Effective Billing Date Report is required before billing may begin.

OMH HCBS Children's Waiver Rate Codes Effective September 1, 2017.

### 1. Billing for Individualized Care Coordination (ICC)

#### Enrollment Activities (Previously: Pre-enrollment or Start-Up)

##### ***Rules for ICC Enrollment Billing***

For information regarding the Enrollment Activities, please see [Section 5: Enrollment Activities](#). Billing may begin following enrollment of an individual in the waiver program. The Enrollment rate is a set rate for activities required between the signing of the Application/ Freedom of Choice and enrollment in the waiver program. The rate can only be claimed once per enrollment. The Enrollment rate code is used for billing the enrollment services.

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The ICC agency will not be reimbursed for Enrollment Activities completed for those children that sign a Waiver application but are not ultimately enrolled in the waiver. If a child completes the Enrollment period, but is not ultimately enrolled, Enrollment cannot be billed.

The Enrollment rate is a set amount regardless of the time and/or amount of contacts needed to complete all Enrollment Activities. The Enrollment rate is billed the last day of the service month.

### ICC Billing Rules After Enrollment

The ICC is reimbursed at a monthly rate. ICC services are billed the last day of the service month. ICC services are provided from the effective date of HCBS Waiver eligibility up to the effective termination date.

To bill, ICC services must be clearly related to the Waiver child's service plan goals and objectives. All qualifying ICC contacts must pertain to an ICC function as defined in [Section 10](#).

### Service Delivery Minimums for ICC

At least one additional HCBS Waiver Service, for the exception of Transitional Case Management (TCM) or Team Meetings, must be scheduled to bill for ICC during full or half month. ICCs are responsible for maintaining the of recording scheduled service appointments via progress note in the participant's case record. If a scheduled appointment is cancelled and/or rescheduled, this must be captured in a progress note to record the originally scheduled appointment date and time.

#### Full Month (21 days): SIX Total Required Minimum Contacts

**TWO** minimum required contacts with the family.

- One of the two contacts must include the youth, although the family may be in attendance. The contact with the youth must be a minimum of 30 minutes in duration to ensure meaningful discussion regarding the participant's Service Plan progression and coordination of care. This contact must be face-to-face (FTF).
- The other contact must be with the family/caregiver, as identified in the Service Plan, and may also include the youth. This contact may be face-to-face OR via telephone and must be a minimum of 15 minutes in duration\*.

*Limitation: These two contacts cannot occur in the same day.*

**FOUR** minimum required contacts with collaterals\*\* and HCBS Service Providers.

- Two of the four required contacts must be made with collateral(s).
- Two of the four required contacts must be made with HCBS Service Providers.
- Two of the above four required contacts must be face-to-face. The contacts may be a combination of either collateral(s) and/or HCBS Provider(s) (e.g., 2 FTF with Collaterals or 2 FTF with HCBS Provider or 1 FTF with either entity) to permit flexibility to meet the fluid needs of the family.
- The remaining two required contacts can be telephone contacts.
  - These entities must correlate with a goal in the Service Plan and identified as such in the plan

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- and progress note(s).
- These contacts must be a minimum of 15 minutes in duration.
- Team meetings can count as ONE contact with either an HCBS Service Provider or collateral, depending on who is in attendance.
- Electronic methods of communication do not qualify as a face to face or telephone contact.

The second of two required contacts can be either face-to-face OR via telephone

### Half Month (11 days): **THREE** Total Required Minimum Contacts

**ONE** minimum required contact with the participant.

- Contact must include the youth, although the family/caregiver may be in attendance. The contact with the youth must be a minimum of 30 minutes in duration to ensure meaningful discussion regarding the participant's Service Plan progression and coordination of care. This contact must be face-to-face (FTF).

**TWO** minimum required contacts with collaterals and HCBS Service Providers.

- One of the two required contacts must be made with collateral(s).
- One of the two required contacts must be made with HCBS Service Provider.
- One of the two required contacts must be face-to-face although these contacts may be a combination of either collateral(s) and/or HCBS Provider(s) (e.g., 1 FTF with Collateral or 1 FTF with HCBS Provider) to permit flexibility to meet the fluid needs of the family.
  - These entities must correlate with a goal in the Service Plan and identified as such in the plan and progress note(s).
  - These contacts must be a minimum of 15 minutes in duration.
  - Team meetings can count as ONE contact with either an HCBS Service Provider or collateral, depending upon who is in attendance.
  - Electronic methods of communication do not qualify as a face to face or telephone contact.
  - The second required contact can be either face-to-face OR via telephone

*\*For participants over the legal age of consent in which family involvement is not realistic or appropriate, the second family contact for full month billing may be substituted for a second contact with the participant. The same contact requirements would apply for duration and contact type (face-to-face or telephone). However, it is expected that the ICC will work to develop and/or enhance the natural\*\*\* and community supports in the participant's Plan.*

*\*\*Collaterals contacts are identified as contacts with legal representatives, academic (school), housing, primary care physician, clinical resources (psychiatrist, therapist) Social Services or other people in a child's life who are listed in the service plan as relevant to the goals of the plan for the child.*

*\*\*\*"Natural Supports" means personal associations and relationships typically developed in the community that enhance the quality and security of life for individuals, including, but not limited to, family relationships; positive friendships in the neighborhood and the community; and association with fellow students, employees and associations developed through participation in clubs, organizations, and other civic activities.*

### Additional Contact Requirements

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- The *two contacts with the youth and the family/caregiver cannot occur in the same day.*
- Each contact must be a minimum of 15 minutes, for the exception of the first face-to-face contact with the participant which must be 30 minutes minimum in duration.
- A Progress Note must be present for each contact.
- Another staff person or the ICC supervisor may substitute for the child's assigned ICC as long as he or she meets all of the ICC qualifications. This arrangement should be discussed with the family and the substitute should be familiar with the child's Service Plan in advance.
- Contacts with providers who can also bill Medicaid are **not** qualifying when those individuals are billing Medicaid at the same time for the contact. This includes but is not limited to staff members of outpatient clinics or any other mental health provider and medical providers billing Medicaid. However, if a Medicaid Provider is identified in the child's Service Plan as a collateral and will not be billing Medicaid at the same time for the contact, then the ICC can bill for a minimum of a 15-minute contact.
- Some billing examples include:
  - A teacher in a public school would not be billing Medicaid and so can be considered qualifying a collateral contact if they are identified in the child's Service Plan.
  - An ICC may meet with the Waiver child's parent for 15 minutes prior to or following the parent meeting with a Medicaid service provider and this would be a billable collateral contact.
  - An ICC or another Waiver service worker could have a qualifying collateral contact with a parent while the child is in Day Treatment.
  - An ICC may meet with the Medicaid provider such as a clinic therapist. If the situation does not justify billing for the Medicaid provider (i.e. youth and family are not present), then the ICC could bill for the service if the Medicaid provider is identified in the child's Service Plan as a collateral.

**It should be noted that billing for Day Treatment Programs occurs in half or full days and not by the individual contact. Therefore, billing for ICC contacts with Day Treatment providers should be carefully coordinated to ensure that duplication does not occur.**

- An ICC may meet with the Medicaid provider such as a Day Treatment Provider. Clarification is necessary to determine how this Medicaid Provider will bill Medicaid. If the contact occurs on a day when the Day Treatment Provider cannot bill such as when the youth is out sick, absent or hospitalized **and** this Medicaid provider is identified in the child's Service Plan as a collateral then the ICC can bill for a minimum of a 15-minute contact. *Please note: If the collateral contact in Day Treatment is not meeting with the waiver participant (e.g., billing Medicaid), the ICC can meet with the collateral contact. It is advised that ICCs meet with only Day Treatment collateral contacts during the Day Treatment program, not the youth to avoid a duplication in Medicaid billing.*

### Jail or Detention

A child may be in jail or detention for up to one month (up to 30 consecutive days) and remain in the Waiver, however, this is done at the discretion of the agency as no billing can occur during this period. A child may be in jail or in detention for only part of a calendar month in which case, an agency may be able to bill.

Appropriate Waiver billing can occur for the balance of the month the child is not in jail or detention. An agency may bill if during that month, the child is home for the minimum of 11 days for half a month billing or

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21 days for a full month billing *and* the minimum ICC contacts have been made. If a child is discharged, it is expected that contact with the juvenile or criminal justice system will be pursued to provide necessary information on the youth's medical and psychiatric needs. Assistance should be provided to the family as part of the aftercare follow-up.

## 2. Billing for the Nine (9) HCBS Services

### Documentation

Planned delivery of service must be authorized and documented in the child's service plan. All services must clearly support the achievement of the Waiver child's identified goals. Services delivered on an emergency basis (unplanned) must be approved by the Individualized Care Coordination agency and documented in the service plan. A Progress Notes must be written for every contact and all fields must be completed.

### Billing, Service Provision and Transportation

Transportation is not a Waiver service. The Waiver services are Respite, Family Support, Skill Building, Intensive In-Home, Crisis Response Services, Youth Peer Advocate, Supported Employment, Pre-Vocational Services and Transitional Case Management. The delivery of these services is not location-specific and could, at times, be delivered to the Waiver child, or other billable family member, in part while that person is being transported. Progress Notes must specifically describe the services performed and how these specifically relate to the child's identified service plan objectives during the billed service time regardless of where the service is provided.

Staff travel time to meet with the client or family is not a Medicaid service and *cannot* be counted in billing.

### Billing Date of Service

Claims should be submitted to Medicaid using the actual date of service for the exception of Transitional Case Management (TCM). For TCM specific guidelines please below.

### Paper Claims and Electronic Billing

The unit's field on the paper UB04 claim is #45. For electronic billing, units are billed as follows: Loop 2400 Segment - SV2 - Institutional Service Line.

Data Element Ref - SV204 Valid Value - UN (for units)

Data Element Ref - SV205 Service unit count (number of units)

## **A. Transitional Case Management (TCM)**

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*Transitional Case Management for Participants enrolled in Waiver*

Transitional Case Management services are limited to a period of 30 days and maximum nine (9) hours (36, 15 minute units) per month.

The service delivery minimum applies while the child is in an inpatient setting if the expectation is that the child will be discharged to the Waiver. The program may not seek reimbursement for any Waiver services outside of TCM during inpatient hospitalization. For TCM contacts with a child while hospitalized to qualify for reimbursement the child must return to the Waiver upon discharge from the hospital.

Discharge may occur after 30 consecutive days in an inpatient setting. However, at the discretion of the ICC Agency, the participant's slot may be maintained for an additional 30 days post the 30-day inpatient period for a total of 60 consecutive days if an inpatient discharge date anticipated and the ICC Agency anticipates the participant's discharge of an inpatient setting to the community and Waiver Program.

The 30 consecutive days post the initial 30 days of the inpatient stay cannot be billed. Billing can resume for all HCBS Waiver Services, including ICC if the child is discharged to Waiver, 24 hours post inpatient discharge.

To bill for TCM services provided while a child is hospitalized, the agency must wait until the child has been discharged and returned to the community and the HCBS Waiver program. Upon return, the agency can submit all claims for TCM services provided during the time the child was in a psychiatric inpatient stay.

*Residential Assessment Program or Substance Abuse Treatment Program*

Children may be placed in a residential assessment program or a substance abuse treatment program for up to 30 days and remain in the Waiver if TCM contacts are made *and* the child returns to home within 30 days. Other than TCM, no other Waiver services may be billed.

*Limitations*

Transitional Case Management services are limited to a period of 30 days. A maximum of nine (9) billable hours (36, 15 minute units) is allowable within the 30-day period. To bill for TCM services provided while a child is hospitalized, the agency must wait until the child has been discharged and returned to the community and the HCBS Waiver program. Upon return, the agency can submit one claim for all units delivered, up to the maximum allowable rendered during the hospitalization. **The day after the date of discharge will be the date of service for billing.**

**B. Intensive In-Home Service**

Intensive In-Home services are provided face-to-face to the child or the child and family. IIH Services may be provided in the home or in the community for an individual child and or their family.

The service is focused on supporting the goals outlined in the child's treatment and service plans. This service is reimbursed based on the duration of service: brief-minimum of 30 minutes; full-minimum of 60 minutes or extended-minimum of 90 minutes.

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### Limitations:

- Only one rate code is to be used per encounter; billing must be limited to durations of 30, 60, or 90 minute increments
- Multiple rate codes can be billed in one day if the encounter\* is unique
- Maximum duration for one encounter is Extended-90 minutes
- Limit of up to 4 hours a day per individual not to exceed 24 hours a month per individual.

*\*Encounter is a unique and distinct meeting involving transportation to the home or community regardless of contact entity or consecutive contact meetings.*

### C. Crisis Response Service

Crisis Response Service is reimbursed based on the duration of service:

- Face-to-face: Brief-minimum of 30 minutes; Full-minimum of 60 minutes or Extended-minimum of 90 minutes
- Telephone: 15 minute units.

### Limitations:

- Contacts: No more than 2 allowed per day per individual for telephone contact or Face to Face – Units: 30 minutes, 60 minutes, 90 minutes (Service Limitation: no more than 2 Face-to-Face units allowed per day per individual). \*
- Only one rate code is to be used per encounter; billing must be limited to durations of 30, 60, or 90 minute increments
- Multiple rate codes can be billed in one day if the encounter\*\* is unique
- Maximum duration for one encounter is Extended-90 minutes

*\* When a child requires a face-to-face crisis intervention service more than the allowable two units per day, the agency should provide the crisis response service. However, to submit the Medicaid claim for any additional service beyond the limitation, a post-service, pre-authorization from the State is required to bill for the service. Therefore, once the additional face-to-face crisis response service is provided, the agency must submit documentation to the State demonstrating the need for the service for prior authorization before submitting the claim for reimbursement.*

*\*\* Encounter is a unique and distinct meeting involving transportation to the home or community regardless of contact entity or consecutive contact meetings.*

### D. Respite, Family Support, Youth Peer Advocate, Supported Employment, Pre-vocational and Skill Building Services

The following rules apply to Respite, Skill Building, Family Support Services, Youth Peer Advocate, Supported Employment & Pre-Vocational Services:

*The following services must be based on face-to-face contacts.*

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### General Group Composition for Youth Peer Advocate, Skill Building, Respite, and Prevocational:

Groups can consist of Waiver children and/or their families (see rules below for each service) as well as non-Waiver children and/or their families. In such instances where both Waiver and non-Waiver participants are represented, billing must be done at the group rate appropriate to the total number of participants. Billing is for Waiver children and/or family members in the group. For example, if there is one Waiver child and two non-Waiver children represented in the group, Waiver services can be billed for the one Waiver child at the 3:1 group rate.

### Billing Rules for Respite Services:

For any "type" \* of respite provided, the service must be face to face with a minimum of 30 minutes with billing limitations of no more than 6 hours a day per individual, which allows for flexibility while maintaining as a short-term service. Services must be documented in the child's service plans and pertain to the child's goal. Service can be done as an individual or in a group. The maximum worker to participant ratio allowed is one worker to three group members, Service plans must clearly support the group composition and the group activities.

*Rules for Respite in Community and Crisis Residences (CR):* Community Residences and Crisis Residences cannot use any of their CR beds for respite. Only a designated respite bed can be used for respite for a Waiver child. There must be a one-on-one Waiver Respite worker with the Waiver child during waking hours. The Individualized Care Coordinator must decide as to whether it would be sufficient to have an on-call Waiver Respite worker available during the time that the Waiver child is sleeping or if this is not necessary per the child's acuity.

To illustrate, if the Waiver child was placed in the CR respite bed at 6:00 p.m. on a Friday, the CR could bill for six (6) hours of respite on Friday (6:00 p.m. to midnight). If the child is returned home from respite on Saturday at 1:00 p.m., the CR could bill for six (6) hours of respite on Saturday.

\*Overnight, day or crisis respite

### Groups: Billing and Participant to Worker Ratios:

Billing is not allowed for groups exceeding the ratios outlined below. The *maximum* worker to participant ratio allowed for billing for both Respite, Prevocational, Youth Peer Advocate and Skill Building is one (1) worker to three (3) group members

Respite groups can consist of Waiver children or non-Waiver children being paid through alternative funding.

### Billing Rules for Skill Building Services:

Service must be based on face-to-face contacts with the Waiver child, sibling, parents or caregivers who have been documented as providing frequent and regular care giving responsibilities. Service must be conducted for a minimum of 30 continuous minutes in a day. Service must be documented in the child's service plans and pertain to the child's goal. Service can be done as an individual or group. Both individual and group must be

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included in the waiver child's service plan if utilized and must clearly support the group composition and the group activities.

Limit of up to 4 hours of Skill Building services a day per individual not to exceed 10 hours of Skill Building services a week per individual (individual and group services both count towards the daily and weekly limits).

**Groups: Billing and Participant to Worker Ratios:**

Skill Building groups can consist of a combination of Waiver children, their parents/guardians, caretakers who have frequent, routine care-giving responsibilities for the Waiver child, the Waiver child's siblings or a non-Waiver child whose service is being paid through alternative funding.

The maximum worker to participant ratio allowed for groups is one worker to three group members. When Skill Building groups include the siblings and caregivers of the participant, they must be noted in the service plan along with their purpose in the group and must be directly related to the participant's goals and objectives.

The Waiver child, the Waiver child's sibling(s) and the Waiver child's parent/primary caregiver may participate in Skill Building groups and billing can occur for each.

*For Skill Building groups consisting of the Waiver child and/or siblings or caregivers, a 1:2 group ratio would be billed for four 15 minute units for each 30-minute group and a 1:3 group ratio would be billed for six 15 minute units for each 30-minute group. When Skill Building groups include the Waiver sibling(s) and/or caregiver(s), the sibling and caregiver must be noted in the service plan to be billable and their purpose in the group must be directly related to the Waiver child's goals and objectives. A Group Progress Note with information pertaining to each billable participant must be present for each Skill Building group.*

**Billing Rules for Family Support Services:**

Family Support can be provided on a one to one basis or in groups of 2, 3, 4 or 5-8. Service must be face-to-face contact with the Waiver child's parents or caregivers who have regular care giving responsibilities for the child. Service must be conducted for a minimum of thirty continuous minutes in a day. Services must be documented in the child's service plans and pertain to the child's goal. The maximum worker to participant ratio allowed for a Family Support group is one Family Support worker for eight group members. Groups consist of a minimum of the parents and/or caretakers who have frequent, routine care-giving responsibilities of at least one Waiver child. Service plan must clearly support the group composition and the group activities.

Limit of up to 4 hours of Family Support services a day per individual not to exceed 10 hours of Family Support services a week per individual (individual and group services both count towards the daily and weekly limits).

**Groups: Billing and Participant to Worker Ratios:**

The worker to participant ratios for Family Support is one (1) Family Support worker for eight (8) group members. If there are multiple workers working with a given group, the total group size may be larger if the maximum ratio for worker to Waiver children, siblings and/or parents is maintained.

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Family Support Services groups consist of a minimum of the parents and/or caretakers who have frequent, routine care-giving responsibilities of at least one Waiver child.

*Billing Rules for Youth Peer Advocate Services:*

This service may be delivered in either a one-to-one session or a group setting of 2 or 3 Waiver participants. The service must be conducted for a minimum of thirty continuous minutes in a day. Services must be documented in the child's service plans and pertain to the child's goal. The service plan must clearly support the group composition and the group activities.

Limit of up to 4 hours of Youth Peer Advocate services a day per individual not to exceed 10 hours of Youth Peer Advocate services a week per individual (individual and group services both count towards the daily and weekly limits).

*Groups: Billing and Participant to Worker Ratios:*

Billing is not allowed for groups exceeding the ratios outlined below. The *maximum* worker to participant ratio allowed for billing for both Respite, Prevocational, Youth Peer Advocate and Skill Building is one (1) worker to three (3) group members

*Billing Rules for Supported Employment:*

Limit of up to 4 hours a day per individual not to exceed 8 hours a week per individual. One billable service a day per individual.

*Billing Rules for Prevocational Services:*

Monitoring of prevocational services will be performed at minimum every 6 months to assess the participant's progress toward achieving the outcomes identified on the child's ISP related to pre-employment skills enhancement in development and to verify the continued need for prevocational services. The waiver participant can receive up to 12 months of prevocational services. This service may be delivered in a one-to-one session or in a group of two or three participants.

Limit of up to 4 hours of Prevocational services a day per individual not to exceed 8 hours of Prevocational services a week per individual (individual and group services both count towards the daily and weekly limits).

*Groups: Billing and Participant to Worker Ratios*

Billing is not allowed for groups exceeding the ratios outlined below. The *maximum* worker to participant ratio allowed for billing for both Respite, Prevocational, Youth Peer Advocate and Skill Building is one (1) worker to three (3) group members.

## Section 14: Medicaid Information

It is expected that a sizable number of children who apply for the Waiver will already be in receipt of Medicaid at the time they apply. The Individualized Care Coordinator (ICC) must verify that the conditions of the child's Medicaid eligibility meet all Waiver requirements. The following deals primarily with those children who, except for the Waiver, would otherwise be ineligible for Medicaid. If a child is enrolled in Child Health Plus (CHP) prior to Waiver the family should be advised that they must apply for Medicaid to receive Waiver services, and dis-enroll from Child Health Plus; and upon discharge there may be a gap in coverage between when the Medicaid closes and the CHP starts. There usually is a one month gap in coverage. Also, the family needs to re-apply for CHP and may need to follow-up to ensure that the CHP becomes effective.

### Introduction

The following focuses on the Medicaid component of Waiver eligibility. It provides information needed to understand how a child qualifies for Medicaid under the Waiver; to know when a Medicaid application is necessary; and how to complete/file the application package. While this contains much information about the Medicaid application process, specific situations may require additional information. The OMH Operations Support Unit (OSU) is available to respond to questions regarding the Medicaid program/eligibility process.

Note: Medicaid Exemption levels, like all federally funded benefits (e.g. SSI, SSA, VA) are usually increased as part of the annual cost of living adjustment (COLA) that takes place January 1st each year. At this time, each Medicaid recipient's eligibility is recalculated using the new standards and any increases in income that may have resulted as a result of the COLA.

Spend Down: Effective January 1, 2009, CMS approved the State's request to allow children to be enrolled in the Waiver whose countable income is in excess of the current MA Income Exemption Standard, IF all other criteria are met and the child's income can be "spent down" to the Medicaid allowable monthly amount. This is accomplished when the child's excess countable income above the allowable monthly Medicaid income is spent on medical expenses that the child incurs or the amount of the monthly excess income is paid directly to the local district of social services. The ICC agency must document how excess income is handled.

### *Operations Support Unit (OSU)*

It is important that all staff involved with inputting required data into CAIRS for enrolling a child in the HCBS Waiver become familiar with the required process. Please note that all pertinent original copies of documents should be maintained by the by ICC agency. See [HCBS Waiver Enrollment Process](#) for a description of the CAIRS Demographics Screen.

OMH OSU is knowledgeable about Medicaid policy and procedures and serves as liaison with the local social services districts (LDSS). ICC's should contact OMH OSU for instances of problems with approval, changing, or terminating a child's regular Medicaid or Waiver Medicaid coverage. OMH OSU should also be the first line of referral for any case specific Waiver Medicaid eligibility/enrollment issues. Questions regarding the

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eligibility/enrollment policies contained in this portion of the Waiver Guidance Document can also be referred to OMH OSU, who can, if needed, forward them to Central Office Finance Management. OMH OSU contact is:

OSU Unit  
Phone: (518) 473-8234  
Fax: (518) 473-2448

## 1. Medicaid Eligibility Requirements

It is the responsibility of the Medicaid Unit in the local social services district (LDSS) to determine whether a child applying for the OMH HCBS Children's Waiver meets the Medicaid requirements for Waiver enrollment.

To participate in the OMH HCBS Waiver, a child must have Medicaid coverage in a county which is participating in the OMH HCBS Waiver.

In the normal situation, a child will reside and be eligible for Medicaid in the same county in which his/her Waiver program operates. However, there are situations where the county responsible for a child's Medicaid coverage may not be the county where a child resides. The most common situation where this occurs is adoption subsidy cases, i.e. hard to place children who receive subsidy support payments and automatic Medicaid from the placing LDSS when they are adopted, sometimes by families from other counties.

If both counties are participants in the Waiver, then it is up to the family and the ICC programs involved to decide which program can best serve the child/family's needs. If the family lives close enough to be served by the program that operates in the county that is responsible for the child's Medicaid, this is the preferred choice but it is not mandatory. For all incidents involving Oneida County, the only non-participating county, contact OSU.

### General Program Categorical Requirements

The child must meet all federal categorical criteria for Medicaid eligibility, including:

**Identity** - It is the responsibility of any applicant for Medicaid to document his/her identity. The preferred proof of identity is a copy of a photo ID card. However, since children do not usually have these documents, a birth certificate is accepted. For other acceptable sources of proof of identity, contact the OMH Operations Support Unit (OSU).

**Residence** - Applicants for Medicaid must provide proof of residence in a county. Contact OSU for acceptable sources of proof of residence.

**Citizenship** - To be eligible for Medicaid, an applicant must be a citizen of the US (i.e. born in the US or someone who has acquired citizenship through the naturalization process) -or- must meet the definition of "qualified alien". The best proofs of citizenship are the birth certificate (for US born) or Certificates of Citizenship/Naturalization (i.e. INS forms N-550, N-560, N-561 and N-570). Qualified Alien (QA) status is

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more difficult to determine/document. Contact OSU for information on all acceptable proofs of citizenship/QA status.

**Note:** We strongly recommend that you contact the Operations Support Unit (OSU) as soon as possible if there is **any question at all** regarding the citizenship status of a child who is applying for the Waiver. OSU staff can assist you in your efforts to determine as quickly as possible whether the child will meet the Medicaid program's citizenship/QA requirements, thereby minimizing the outlay of any expenses for which you may not be able to be reimbursed.

**Age** -Normally, anyone under the age of 21 is considered to be a "minor" for purposes of the Medicaid program. However, for enrollment in the OMH HCBS waiver, an applicant must be over age 5 and under age 21 on the effective date of his/her enrollment. Any child who will be under 5 or over 21 as of the expected date of enrollment cannot be considered for enrollment. A copy of a birth certificate is the preferred proof of birth.

**Note:** A child can be served in Waiver until s/he turns 21; however, s/he **must be enrolled prior to his/her 21st birthday.**

### **Financial Requirements**

Normally when a child who applies for Medicaid resides in his parents' home, both the child's and the parents' income(s) are counted when determining the child's Medicaid eligibility. This is referred to a "parental deeming". However, under the conditions of the OMH Waiver, **parental deeming** has been **waived** and **only the youth's own** income and resources are taken into consideration in determining the Waiver applicant's Medicaid eligibility. Consequently, you only must gather/document the child's income/resource data, not the parent(s)'.

To qualify for the waiver, the child/adolescent's own income and resources, after deducting applicable disregards and exemptions, must be less than the current Medicaid Exemption Standards for a family of one, or a plan for a spend down must be made and accomplished. See the section titled "Assembling the Medicaid Application" for information regarding what kinds of income must be considered as belonging to the youth. Contact Operations Support Unit (OSU) for the current Medicaid Exemption Standards.

### **Category/Budgeting Requirements**

A child applying for the OMH Waiver may be eligible for Medicaid in either of the following categories: **ADC-related** or **SSI-related**. It is expected that most of the Medicaid applications filed for OMH Waiver children will be filed for the child only using the ADC-related category and will be budgeted using the ADC budgeting methodology.

The reason to request that the local social services district (LDSS) budget as ADC-related rather than SSI-related is because the ADC category/budgeting does not require that the child be certified as disabled, which means less paperwork on your part and a quicker eligibility determination by the LDSS.

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The only circumstance in which the LDSS may be asked to determine initial eligibility using the SSI-related category/methodology rather than ADC, is when ADC budgeting necessitates an income spend down, i.e. the child has countable income in excess of the current MA Income Exemption Standard. Because the SSI budgeting methodology allows more income disregards than the ADC methodology (e.g. \$20/mo. unearned income disregard, 1/3 child support disregard), it is possible that the excess income can be reduced to the allowable countable income and the child could qualify under SSI without a spend down, or less of one.

**Example 1:** A child applying for the Waiver on 3/1/07 receives a dependent child benefit from SSA in the amount of \$709/month. Since the 2007 Medicaid Income Exemption is \$700/month, the ADC category/methodology is used this child would have a spend down of \$9/month. However, if SSI budgeting were used, the LDSS would be able to disregard the first \$20 of the SSA benefit as an unearned income disregard, leaving the child with only \$689/month countable income. This compared to the year 2007 \$700/month Medicaid Income Standard makes the child eligible for MA without a spend down.

**Example 2:** A child applying for the Waiver on 3/1/07 receives child support from his father in the amount of \$920/month. Using the ADC budgeting methodology, the child would need a \$220/month spend down to be eligible for the Waiver. However, under SSI budgeting the first 1/3 of child support payment may be disregarded in addition to the \$20 unearned income disregard. Therefore, after disregarding the \$20 unearned income disregard and then \$300 (1/3 of \$900) as the 1/3 child support disregard, the child is left with \$600/month in countable income, or an amount less than the 1/1/07 MA Income Exemption Standard of \$700/month, making him eligible for the Waiver with no need of a spend down.

There are other income disregards that are allowed for both the ADC and SSI categories. However, except for the two disregards mentioned in the examples above, the occurrence of these disregards will most likely be quite rare. Please consult OSU with any question regarding whether a source of income received by a Waiver applicant qualifies for disregard. It should be noted that if the parents wish to apply for Medicaid as a family just for the Waiver applicant), this is allowable. However, when the final determination is made, the case must be fully eligible in a federally participating category of assistance (i.e. ADC-related, SSI-related) in order for the child to meet the requirements for Waiver Medicaid. In the event that the family is found eligible in a non-federally participating category, then the child should be taken out of his family's case and s/he should be rebudgeted in his/her own case to see if s/he meets the eligibility requirements for Waiver Medicaid.

**When is a Medicaid Application Necessary?**

Applicant Not Already in Receipt of Medicaid - A Medicaid application must be completed and filed for any child who is **not already in receipt of Medicaid** at the time s/he applies for the Waiver.

Applicant Already in Receipt of MA in LDSS - If a Waiver applicant is already in receipt of Medicaid in a local social services district (LDSS)1 at the time s/he applies for the Waiver, a Medicaid application for this child will most likely not need to be filed. However, the ICC must verify that the Medicaid case that is open for the child is in a federally participating category (ADC related, SSI related (if case involves other family members).

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If both of these requirements are met, then no MA application is necessary for this child. However, if either of these requirements are not met, the ICC (or OSU) may have to request that the Medicaid Unit in the LDSS take the child out of the existing case (if in a case with other family members) and/or re-budget the child by him/herself using ADC-related or SSI-related budgeting.

OMH OSU automatically performs a look-up on the Welfare Management System (WMS) for each new child who applies for the Waiver to determine existing MA status and see if there is any special action that needs to be taken. This is usually done when the CAIRS Transmittal 1 is received. However, for questions regarding the child's Medicaid status, any time before the application is signed, contact OMH OSU and request their assistance in checking the Medicaid system (WMS).

Applicant Already in Receipt of MA in District 97 - If the child who is applying for the Waiver resides in any of the following residences/ facilities, s/he will most likely be in receipt of Medicaid in District 97 at the time of application: Psychiatric Center (PC) or Community Residence (CR) operated by the NYS Office of Mental Health; or a Residential Treatment Facility, or Teaching Family Community Residence (TFCR), all which are certified but not operated by the OMH.

District 97 Medicaid cases are administered by different units within the OMH Finance Group (i.e. Special Projects Unit (SPU) for RTF, FBT and TFCR cases; and Patient Resource Offices for PC inpatients and residents of state operated community residences.) District 97 Medicaid is only applicable during the period of time that the child resides in the OMH operated or certified facility. As soon as they are notified that the child has been discharged from the PC, CR, RTF or TFCR, OMH staff close the District 97 case.

Therefore, a Medicaid application must be completed and filed for any child who is in receipt of District 97 Medicaid at the time s/he applies for the Waiver. This application must be filed with the LDSS that is fiscally responsible for the child, i.e. usually the county where the child's parent(s) reside.

**Note:** If a Medicaid application has already been filed by the child/family (or someone else on the child's behalf) and is still pending at the time the child applies for the Waiver, it is important that you ensure that the family responds to any requests for missing information/documentation so that the application is not denied due to failure to furnish requested information. In addition, both OSU and the LDSS must be advised regarding the pending Waiver application. The LDSS must budget the case correctly (i.e. apply Waiver rules from the effective date of Waiver enrollment onward and regular Medicaid rules for any period prior to Waiver enrollment) and notify OSU so they can ensure that the case is coded correctly in WMS.

## 2. Medicaid Application

### Assembling the Medicaid Application

#### Who Completes / Signs:

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The Application for Medicaid (LDSS-2921) may be completed and signed either by the parent(s) or by the ICC Agency. If the ICC Agency completes, signs and files the application on behalf of the child/family, the parent(s) must complete the Authorized Representative Consent Form designating the ICC to act as the child's authorized representative.

### Required Contents of the Medicaid Package

All Medicaid Application packages must contain the following materials:

- **Medicaid Application Form** (LDSS- 2921) Fully completed, dated and signed. **Note:** Keep a supply on hand and use the above named form when filing applications for Medicaid for Waiver children. However, some County Medicaid Units may ask that a different version of the Medicaid application form be completed for some cases, i.e. Access NY Health Care.
- **Copies of All Required Documentation/verifications.** These can include but are not limited to proof of the child's:
  - identity
  - age
  - Social Security Number (SSN)
  - legal residence
  - income (including child support paid for the child, Social Security Dependent's benefits)
  - resources (including bank accounts, savings bonds, trust funds)
  - health insurance coverage (carried by parent/guardian)
  - family's shelter and utility costs

### Documentation Requirements

Medicaid will not be approved by the LDSS if they do not receive all required verifications. Every effort should be made to include copies of the required documentation with the initial application package filed with the LDSS. However, in the event that there is a piece(s) of documentation that is taking time to obtain, do not delay filing the application because of the missing documentation. In such a case, simply notate the application to show that you are in process of obtaining the specific piece(s) of documentation and will forward under separate cover. Then be sure that the missing documentation is sent to the LDSS as soon as possible.

Failure to furnish all documentation requested by the LDSS could result in denial of the application. If this happens, the application process may need to be repeated and could result in lost reimbursement. It is important to establish a good system to ensure that all required information/documentation is sent to LDSS and that all requests for additional information are responded to quickly. If the family is the one filing the application and responding to contacts from the LDSS, it is important that the ICC monitor the process closely to ensure that all information is furnished.

- **Cover Letter** - Used to introduce/identify child to the LDSS as an OMH HCBS Waiver applicant and to reiterate the special rules in effect when processing/budgeting OMH Waiver cases.

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*The following materials are optional:*

- **Documentation of Disability** - This information is required **only** if requested by the LDSS to process the application using the SSI-related category/budgeting methodology. If ADC related budgeting is being sought, this information is not necessary. (See section above titled "Category/Budgeting Methodology" for more information).
- **Request to Be Considered for Enrollment in a Medicaid HMO/PCP.** **Note:** This is only included in the application package if the family has decided they wish to enroll in a Medicaid managed care plan. It could also be submitted at a later date.

**Note:** Consult with OSU if you have any questions regarding documentation requirements or if requests for information do not appear to correspond with the procedures outlined in this manual and/or those provided to LDSS's in the "Dear Commissioner Letter" issued by the State DOH.

## **Filing the Application Package**

### Where and When to File

As previously noted, it is the responsibility of the LDSS Medicaid Unit in a specific county to determine whether a child applying for the OMH HCBS Children's Waiver meets the Medicaid requirements for Waiver enrollment. Therefore, for all applicants except those for whom NYC is fiscally responsible for the Medicaid, the application package must be submitted to the Medicaid Unit <sup>2</sup> in the County in which the child resides with his parent(s). For children for whom NYC is fiscally responsible, the application package must be submitted to the HRA's Authorized Representative Unit located at 34th Street, NY, NY for processing.

The date that the LDSS receives a Medicaid application is referred to as the "protective filing date" and it is this date that controls the From Date of the applicant's Medicaid coverage. For Waiver Medicaid cases, because there is no three month retroactive period as with other MA applications, maximum retroactivity is the first of the month in which the LDSS receives the package.

If an ICC agency wishes to be able to claim maximum allowable reimbursement for services provided during the Start-up period, the Medicaid application must be filed with the LDSS no later than the last day of the month following the month in which the Application to Participate in the Waiver is signed. For example, if the family signs the Application to Participate on 7/1, then the Medicaid application must be received by the LDSS no later than 8/31.

It is in the applicant's and the ICC Agency's best interests, to document the "protective filing date" of the application. It is strongly recommended that whenever an application is hand delivered to a LDSS, that the deliverer obtain a signed/dated receipt from whoever accepts the package at the LDSS; and when the application package is mailed to the LDSS, that it be mailed via a method that will guarantee documentation of delivery and acceptance by the LDSS as of a specific date.

## **LDSS Processing**

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Timeframes

By law, the LDSS has 45 days for an ADC related case and 90 days for an SSI disability-related case to complete the eligibility determination process and issue a Notice of Decision regarding Medicaid eligibility. It may take the Districts longer than this to make a final decision, especially if the application package does not contain all of the information/documentation that is needed. However, no matter how long it takes the LDSS to render a decision, if the case is approved, eligibility should be granted retroactive to the first of the month in which the application was received (i.e. "protective filing date" - see "filing the Application Package"). If it is not, please consult with OSU.

**Reminder:** All requests for additional documentation/information made by the LDSS should be responded to promptly to ensure the quickest possible decision and to reduce chances that the application will be denied.

Face-to-Face Interviews

Medicaid statute/regulations require that the Medicaid District conduct a face-to-face interview with each applicant. How district(s) wishes to carry out this requirement and who must/can fulfill this requirement is something that each ICC Agency must discuss with their local county Medicaid contacts during an introductory meeting that should be set up at the time the Waiver is first implemented in a county or a new provider.

Notice of Medicaid Decision

Once the LDSS completes the eligibility determination, they will send a *Medicaid Notice of Decision - Acceptance or Denial (LDSS 3622)* to the child/family to advise the results of the determination. This Notice reflects only the decision regarding the Medicaid component of Waiver eligibility. It is **not** the notice regarding overall acceptance to the Waiver program; that Notice is issued by OSU once they have confirmed that the applicant is fully eligible in all three areas (clinical, Medicaid and fiscal) and have established the effective date of enrollment.

In the unlikely event that the LDSS denies the child's Medicaid application, the notice contains information regarding their Fair Hearing rights. When necessary contact OSU or OMH Central Office Division of Child & Family Services staff to discuss whether appeal should be sought.

LDSS Letter to Commissioner Regarding Start Up

When the Waiver is implemented in a new county, the State Department of Health, Office of Medicaid Management (DOH, OMM) sends the local DSS Commissioner a letter apprising him/her of the start-up of the Waiver in his/her county. Attached to this letter are procedures which provide background regarding the OMH Waiver and provide instructions for LDSS processing. **Note** that there are two different versions of the letter – one for NYC HRA; and one for the remaining county LDSS's.

The Commissioner is also requested to name person(s) within his county who will function as the primary contact(s) for the ICC when filing applications and for OSU in dealing with systems related and policy issues.

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This letter also advises that the contact will be requested to attend an orientation meeting with the ICC Agency and OSU to answer any questions that exist and to work out any local procedures that may be needed.

**Procedures for Forms Completion***Application For Medical Assistance Ldss-2921*

**Purpose:** The *Application for Medical Assistance (LDSS-2921)* must be fully completed, signed and dated in order for the local department of social services (LDSS) to perform a determination of a child's eligibility for Waiver related Medicaid, a key requirement for enrollment in the OMH HCBS Children's waiver. The application package should also contain copies of all required documentation.

**Completed by:** The Application for Medical Assistance may be completed by the parent(s) or by the ICC Agency as the child's authorized representative. If completed by the ICC agency, the child/family must sign the Financial Consent Form.

**When Completed:** Completed/filed as soon as possible after the Waiver application is signed. Application should be received by LDSS MA Unit within 30 days of the date Waiver application is signed to ensure maximum claim coverage.

**Guidelines for Completion:** - See a publication issued by the State Department of Health, titled "How to Complete the Social Services Application".

**Distribution:** Original – To LDSS; Copies – ICC file, child/family

**Note:** The application should be sent to LDSS with copies of all required documentation and the Cover Letter for Medicaid Application.

**Supply of Form:** Order from DSS Forms Unit.

***Authorized Representative Consent Form***

**Purpose:** The purpose of the Authorized Representative Consent Form is to provide documentation that the ICC has been authorized by the child/family to file for Medicaid on the child's behalf and to represent the child/family throughout the Medicaid eligibility determination process.

**Completed by:** Completed either by the ICC or the parent and signed by the parent, if participant is under the age of 18.

**When Completed:** Completed only if the parent wishes the ICC to file the Medicaid application on the child's behalf. If completed, should be done so at the time the Waiver application is signed.

**Guidelines for Completion:** - Enter name of child, parent and ICC Agency in appropriate blanks. Have parent(s) sign and date.

Distribution: Original – ICC file; Copy – child/family

### 3. Medicaid Managed Care Plans

All county LDSS's and the New York City Department of Health contract with managed care organizations to provide managed health care services to their Medicaid recipients. Some Plans cover more services than others, but all Plans covering non-SSI children cover a core group of medical and psychiatric services.

**Note:** Plans covering SSI children cover a core group of medical service; psychiatric services are usually “carved out” of the SSI plans and are paid by Medicaid FFS wraparound coverage.

Medicaid pays the Plan a monthly premium for each Medicaid recipient who is enrolled in the Plan. It is the responsibility of the recipient to obtain all needed services from the Plan and/or the Plan's contractors. It is the responsibility of the Plan to provide or pay for all covered services that the recipient needs. Medicaid Fee for-Service coverage is available to Medicaid managed care enrollees only for Medicaid services not covered under the Plan's contract.

Some categories/groups of Medicaid recipients are required to enroll in a Medicaid managed care plan, i.e., **mandatory** enrollment. The rest of the Medicaid population can choose a managed care plan or choose Medicaid Fee-for-Service, i.e., **voluntary** enrollment, unless in an excluded category.

Until recently, only children eligible for Medicaid in the ADC categories were subject to mandatory enrollment in Medicaid managed care plans in the counties. However, any child identified on the Medicaid system (exception code 94) as having serious emotional disturbance (SED), was exempted (excluded) from mandatory managed care enrollment, but could enroll voluntarily if they wished. Therefore, since SED status is a requirement of the HCBS Waiver program, Waiver enrollees have been able to elect to participate in the county Medicaid managed care plans, or not.

If a HCBS Waiver child is enrolled in a Medicaid managed care plan, only the monthly premium paid to the Plan (plus any non-covered services that are billed Fee-for-Service) will charge back against the HCBS Waiver budget.

#### *Assessment of Need*

When processing the referral/application of a potential enrollee to the HCBS Waiver, the ICC Agency must:

- obtain complete information/documentation about the family's private health insurance entitlements;
- obtain as much information about the child's physical health care needs as possible in order to accurately assess their impact on the HCBS Waiver budget;
- determine whether the purchase of private health insurance and/or enrollment in a Medicaid Managed Care Plan would allow the HCBS Waiver program to remain under the budget cap; and
- ensure that the LDSS and OSU are aware of any private health insurance benefits that cover the child (so that proper entries can be made in the WMS Third Party Resource (TPR) subsystem).

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Once a child who has private health insurance/Medicaid Managed Care coverage is enrolled in the HCBS Waiver, the ICC Agency must ensure, to the extent possible, that the child utilizes covered providers and that insurance/managed care benefits are billed before claims are passed on to Medicaid Fee-for-Service.

### Enrollment in a Medicaid Managed Care Plan

Since the status of managed care implementation differs quite widely from county to county, Individualized Care Coordinators (ICC's) are encouraged to contact the Medicaid Managed Care Coordinator (MCC) in the county to obtain county specific enrollment/program information. In addition to advising the status of implementation of managed care in his/her county (voluntary vs. mandatory), the MCC can also provide information regarding:

- which Medicaid recipients are required to enroll in managed care; which recipients are exempt from mandatory enrollment requirements but eligible to voluntarily enroll; and which recipients are excluded from participation in managed care;
- processes for enrollment and disenrollment, exemption and guaranteed eligibility;
- benefit packages offered by the different Plan providers (SSI recipients vs. non-SSI recipients); and
- mental health, alcohol, and substance abuse treatment services which are available through Medicaid managed care.

**Note:** An HCBS Waiver child may be subject to different enrollment requirements than other family members. For example, some family members may be subject to mandatory enrollment requirements and lock-in provisions, while the HCBS Waiver child may voluntarily enroll in Medicaid managed care and disenroll at any time because of serious emotional disturbance (SED).

### Premiums

Premiums paid to the Managed Care provider are billed directly to Medicaid for months that the child is enrolled in the Medicaid managed care plan. As mentioned previously, for enrollees in the HCBS Waiver, these monthly premiums charge back against the HCBS Waiver budget. They will appear on the fiscal management reports under the Medical/Other category.

### Medicaid Managed Care after Waiver Disenrollment

The family may continue enrollment in Medicaid managed care after the child's HCBS Waiver disenrollment if the child remains Medicaid-eligible. In some plans, there is a guaranteed 6-month enrollment and the managed care plan may not unilaterally disenroll a child until 6 months after enrollment date, even if Medicaid eligibility is lost. The county Medicaid managed care contact person should have information on whether a particular plan has this guarantee.

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1. Does not include individuals who have Medicaid in OMH, i.e. "District 97". See separate paragraph dealing with District 97 cases.
2. The specific person to which the application is delivered/ addressed in the county Medicaid Unit will depend on the arrangements that have been worked out locally between the LDSS and the ICC agency.
3. Unlikely due to the fact that the SPOA/LGU/ICC should have performed preliminary screening of the child's eligibility during the screening/referral phase. Children who are clearly ineligible for MA will most likely have been screened out of the process before a Waiver application is filed.
4. Effective 1/1/07, State DOH began implementing mandatory enrollment of the SSI/SSI-related populations.

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## Appendices

### Appendix A: HCBS Acronyms

ACT	Assertive Community Treatment
AW	Administrative Withdrawal
CAIRS	Child Adult Integrated Reporting System
CANS	Child and Adolescent Needs and Strengths
CARAT	Collaborative Action Research and Treatment
CASSP	Child and Adolescent Service System Program
CDR	Claims Data Report
CHP	Child Health Plus
CMS	Centers for Medicaid/Medicare Services
COLA	Cost of Living Adjustment
COP	Comprehensive Outpatient Program
CR	Community Residence
CRS	Crisis Response Service
CPC	Children's Psychiatric Center
CPEP	Comprehensive Psychiatric Emergency Program
CPI	Consumer Price Index
CSC	Computer Science Corp
DOH	Department of Health
FFP	Federal Financial Participant
FOC	Field Office Coordinator
HCBS	Home and Community Based Services
HRA	Human Resource Administration
ICC	Individualized Care Coordinator
ICF/IID	Intermediate Care Facility for Individuals with Intellectual Disabilities
ICM	Intensive Case Management
IDEA	Individuals with Disabilities Act
IIH	Intensive In-Home
IMD	Institutional Mental Disease
IPRT	Intensive Psychiatric Rehabilitation Treatment
ISP	Individualized Service Plans
LDSS	Local Social Services Districts
LGU	Local Government Unit
LOS	Level of Supervision
MAAP	Model Approach to Partnerships and Parenting
MCC	Medicaid Managed Care
MOU	Memorandum of Understanding

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NIMRS	NYS Incident Management Reporting System
NOD-A	Notice of Decision-Acceptance
OCSF	NYS Office of Children and Family Services
OHCDS	Organized Health Care Delivery System
OMH	NYS Office of Mental Health
OSU	Operational Support Unit
OTDA	NYS Office of Temporary & Disability Assistance
PEP	Parent Empowerment Program
PC	Psychiatric Center
PIP	Performance Improvement Plan
PROS	Personalized Recovery Oriented Services
RS	Respite Service
RTF	Residential Treatment Facility
SATRI	Sidney Albert Training and Research Institute
SCM	Supportive Case Management
SED	Serious Emotional Disturbance
SBS	Skill Building Service
SCM	Supportive Case Management
SOCR	State-Operated Community Residence
SPOA	Single Point Of Access
SPR	Service Plan Review
SPU	Special Projects Unit
SSHSP	School Supported Health Services Program
TCM	Transitional Case Management
TFCR	Teaching Family Community Residence
TFH	Teaching Family Home
TPHI	Third Party Insurance
VOCR	Voluntary-Operated Community Residence
WMS	Welfare Management System
YPA	Youth Peer Advocate

## Appendix B:

# HCBS Eligibility Criteria Definitions- Serious Emotional Disturbance (SED)

### SED Criteria

Serious emotional disturbance means a child or adolescent has a designated mental illness diagnosis according to the most current Diagnostic and Statistical Manual of Mental Disorders (DSM) AND has experienced functional limitations due to emotional disturbance over the past 12 months on a continuous or intermittent basis. The functional limitations must be moderate in at least two of the following areas or severe in at least one of the following areas:

- i. ability to care for self (e.g. personal hygiene; obtaining and eating food; dressing; avoiding injuries); or
- ii. family life (e.g., capacity to live in a family or family like environment; relationships with parents or substitute parents, siblings and other relatives; behavior in family setting); or
- iii. social relationships (e.g. establishing and maintaining friendships; interpersonal interactions with peers, neighbors and other adults; social skills; compliance with social norms; play and appropriate use of leisure time); or
- iv. self-direction/self-control (e.g. ability to sustain focused attention for a long enough period of time to permit completion of age-appropriate tasks; behavioral self-control; appropriate judgment and value systems; decision-making ability); or
- v. ability to learn (e.g. school achievement and attendance; receptive and expressive language; relationships with teachers; behavior in school).

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# Appendix C: Slot Allocation Maps

## WAIVER EXPANSION, SLOT ALLOCATION

- I. [HCBS Children's Waiver County Slot Allocations 2002 Map](#)  shows the counties in the Waiver and the number of slots assigned by county (26 providers; 610 Waiver slots).
- II. [HCBS Children's Waiver County Slot Allocation Map](#)  showing expansion in 2004-5
- III. [HCBS Children's Waiver County Prevention Services Slot Allocations Map](#)  shows the distribution by county of the 202 preventive services slots allocated in 2004-5.
- IV. [HCBS Children's Waiver County Slot Allocations 2005 Map](#)  shows the combined OMH slots (64) and the OCFS Preventive Services slots (202) distributed state-wide for a new total of 876.
- V. [HCBS Children's Waiver 2006-7 County Prevention Services Slot Allocations](#) 
- VI. [HCBS Children's Waiver 2008-9 County Slot Allocations](#) 
- VII. [HCBS Children's Waiver 2009-10 County Slot Allocations](#) 
- VIII. [HCBS Children's Waiver 2009-10 Regional Slot Allocations](#) 
- IX. [HCBS Children's Waiver 2011 County Slot Allocations](#) 
- X. [HCBS Children's Waiver 2012 County Slot Allocations](#) 
- XI. [HCBS Children's Waiver 2013 County Slot Allocations](#) 
- XII. [HCBS Children's Waiver 2014 County Slot Allocations](#) 
- XIII. *See page C.2 for 2017 County Slot Allocations*
- XIV. [Waiver Growth Chart](#) 

[Current Individualized Care Coordination Providers in each of the participating counties.](#)

### Recommending a New ICC Agency or the Expansion of Slots for an Existing ICC Agency

Submit a written recommendation to the Office of Mental Health's Division of Integrated Community Services for Children and Families, outlining which existing ICC Agency should receive additional slots or which provider should be chosen as a new ICC Agency with a description of how the provider best meets the criteria. For new ICC agencies, also include the "HCBS Waiver Qualifications: ICC Provider" application.

OMH will then perform a check on the provider to verify that the agency is administratively competent and has no outstanding practice or financial issues which would impede its ability to be the ICC Agency or receive an expansion in slots. OMH forwards a letter to the county Department of Mental Health stating its approval/disapproval of the choice. If disapproved, the county Department of Mental Health may make another recommendation and follow the same procedures. Once the ICC Agency has been approved, the county Department of Mental Health informs the provider in writing that they have been selected and notifies other providers of the county's choice.

In order to bill Medicaid for waiver services provided through the HCBS Waiver, a new ICC Agency must be enrolled as a Medicaid provider of HCBS Waiver services (category of service 0268). As soon as the selection of the ICC Agency has been approved by OMH, OMH requests that the NYS Department of Health initiate the provider enrollment process by sending an enrollment application package to the ICC Agency. The ICC

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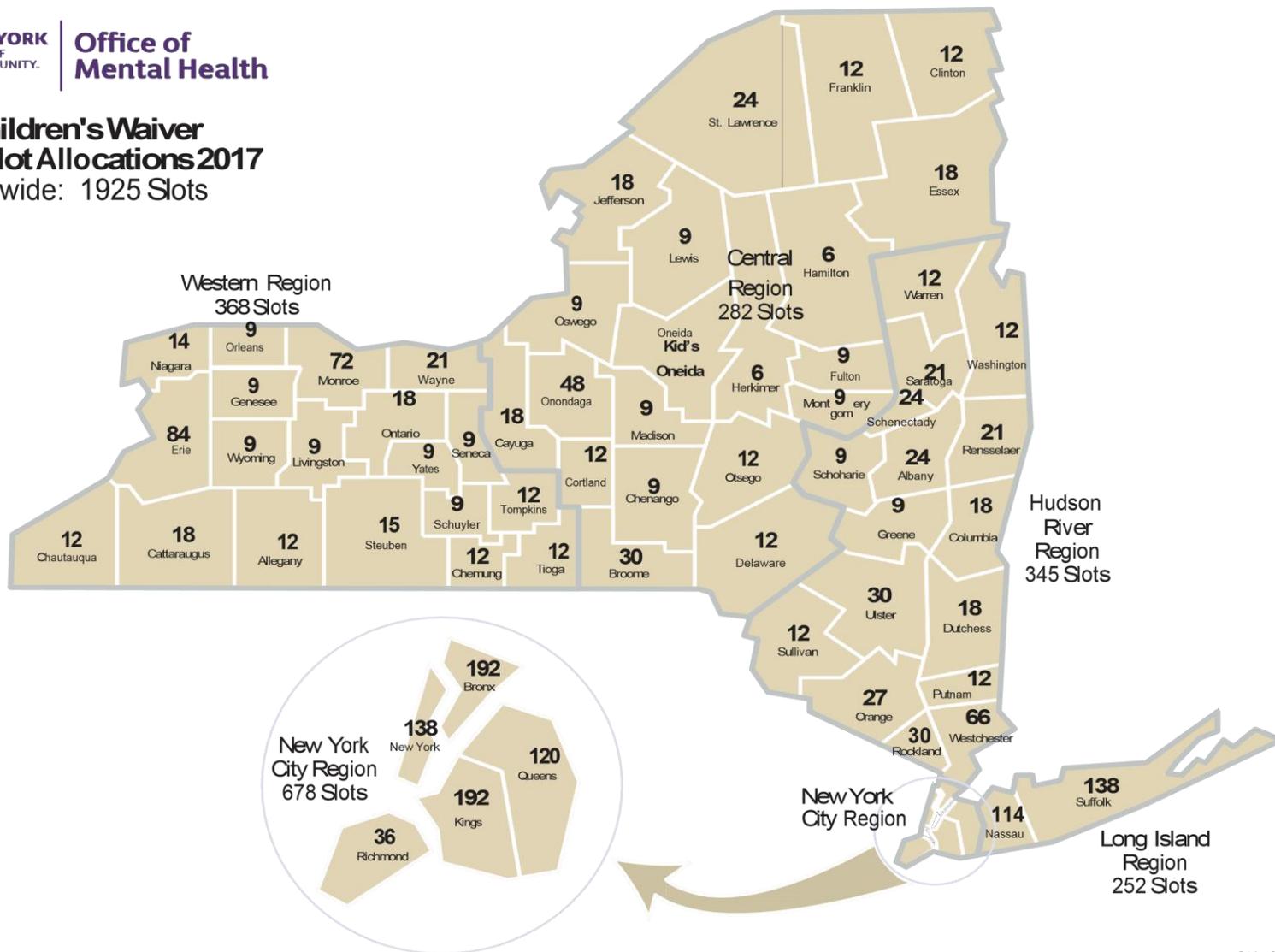
Agency completes the application package and returns it to the Department of Health as soon as possible. The ICC Agency is notified when the enrollment application has been processed. If the ICC Agency has an existing OMH Community Residence, Family-Based Treatment program, PROS or ACT program, that Medicaid provider number will also be used for the HCBS Waiver program. Otherwise, a new Medicaid provider number will be assigned.



Office of Mental Health

# HCBS Children's Waiver County Slot Allocations 2017

Total statewide: 1925 Slots



## Appendix D: Subcontractor Application Process

### A. CRITERIA

The approved providers of the HCBS Waiver services are expected to meet the following general requirements. Specific functions are addressed in the written subcontract with the ICC Agency.

- Workers meet all training, experience, and other requirements and must follow the philosophical values of the Individualized Care Model.
- Workers are available on an "as needed" basis to assure that services will be provided.
- Workers receive on-going supervision including training on service provision, documentation, billing, and appropriate boundaries with children and families.
- Workers maintain on-going contact with the ICC for service planning and exchange of information including timely reporting of cancellations, changed hours, emergency or other unusual occurrences.
- Only those services approved in the service plan and accompanying budget are offered.
- Timely and accurate progress notes and billing records for service hours and/or flexible service expenditures are submitted to the ICC Agency. Records must meet Medicaid standards.
- Any problems identified by child, family, ICC or subcontractor workers are addressed in collaboration with the ICC Agency and/or Local Government Unit.
- All other required OMH reporting documentation is completed.

### B. APPROVAL

The LGU reviews providers' responses and qualifications in conjunction with the local social services district and makes a recommendation in writing to OMH identifying which providers are appropriate to provide one or more of the eight HCBS Waiver services using the Subcontractor Recommendation (200/2B). "The HCBS Waiver Qualifications: Subcontractor" completed application must be attached to this. OMH reviews the recommendations by checking the agency's credentials. This final check ensures that the potential provider agency has no outstanding issues with OMH (performance or financial) that would impede its participation in the HCBS Waiver. OMH then issues a letter to the LGU approving, disapproving or requesting additional information. Once approved, the provider works closely with the ICC Agency to establish a contract, hire any necessary staff and complete training requirements.

*Please note: ICC Agencies can go through this process and be approved to provide any or all of the remaining five HCBS Waiver services, keeping in mind the need to provide choices in providers whenever feasible.*

The HCBS Waiver Subcontractor Recommendation is not required for individuals applying as independent (per diem) subcontractors. The ICC agency can approve their own individual independent subcontractors after ensuring that the individual meets all training, experience, and other requirements for that service and that the philosophical values of the Individualized Care Model are followed. The ICC agency should provide on-going supervision to individual independent subcontractors for training, service provision, documentation, billing and

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appropriate boundaries with child and family. The ICC agency must ensure that appropriate liability insurance (either through an ICC agency's umbrella policy or through independent liability insurance) is in place as well as automobile liability insurance, depending upon the role of the independent subcontractor. During the annual site visits, individual independent subcontractor qualifications are reviewed.

Approval of providers is an ongoing process as localities and families identify providers that are of interest as HCBS Waiver network providers. After the initial RFS to establish new network providers is sent and processed within a county, providers may request approval at any point in time. The same process of LGU review, recommendation and OMH approval is followed.

*Withdrawal of Approval*

A HCBS Waiver provider may lose approval to work with the network if the agency fails to continue meeting the qualifications, if there are serious concerns with performance and ability to maintain requirements of the program, or if the provider does not cooperate with the ICC Agency as the primary coordinator of care for enrollees. Should any of these issues arise in a county, the LGU may recommend withdrawal of approval to OMH. Only the Office of Mental Health has the authority to approve or disapprove a provider.

**C. CONTRACTS**

In order to comply with CMS rules and regulations governing New York's HCBS Waiver, the ICC Agency is required to execute a written contract document with each provider agency. The ICC Agency serves as the Organized Health Care Delivery System (OHCDS) for all waiver services. Although the NYS Department of Health and the Office of Mental Health cannot develop a template, it is recommended that the components of the contract document mirror the elements of the OMH/ICC Agency contract and at a minimum include: 1) philosophy, 2) discussion on reporting incidents, 3) Medicaid billing, 4) qualifications and other standards, 5) record keeping and 6) documentation requirements.

**Timeline for Completion**

Once a provider is approved to provide HCBS Waiver services, a contract must be in place three (3) months from the date of OMH's approval letter to the LGU. This is reviewed during the annual site visits.

**Documentation with ICC Agency**

Each contract document will detail record keeping and documentation requirements, including the requirement that all original Progress Notes are submitted to the ICC Agency. All original records relating to provision of HCBS Waiver services are retained at the ICC Agency.

## Appendix E: NIMRS: Incident Types

### I. DEFINITIONS FOR INCIDENT TYPES AND SEVERITY RATINGS

HCBS Waiver Definitions for Reportable Incident Types  
**MUST reported directly into NIMRS within 24 hours of discovery**

**\* Significant Incident**

**\*\* Significant Incident when Harm or Risk is Level 2 or 3**

#### Abuse & Neglect

Self-Abuse

A participant who self-inflicts injury on themselves not intended to result in death but results in serious injury or harm.

Physical Abuse/Neglect

Non-accidental contact with a participant which causes or potentially causes physical pain or harm and any action, inaction or lack of attention that breaches a custodian's duty and that results in or is likely to result in physical injury or protracted impairment of the physical, mental or emotional condition of a participant.

Sexual Abuse \*

Any sexual contact perpetrated by, or against, a participant enrolled in Waiver services.

Incident with Staff Member\*\*

Staff Involvement Incident

Other

Abuse or neglect to a waiver participant that is not captured elsewhere.

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**Missing Client**

Missing Child \*

A waiver participant whose whereabouts are not accounted for and who is considered at risk based on age or survival abilities or who may pose a risk to the community.

**Crimes**

Assault \*\*

A violent or forceful physical attack in which a participant is either the victim or aggressor, and which results in hospitalization.

Unlawful use/administration of a controlled substance

Any illegal administration, use, or distribution of a controlled substance (e.g. Codeine, OxyContin, Ambien, Cocaine) by a participant or a caregiver.

## Appendix F: Becoming a HCBS Lead Agency

### A. Criteria

In each HCBS Waiver county, an agency, or agencies, must be designated to serve as the coordinating, lead entity. This agency is referred to as the "Individualized Care Coordinating" (ICC) Agency. A county may have more than one ICC Agency. Each ICC Agency may serve more than one county. In order to select a new ICC Agency or allocate additional slots to an existing ICC Agencies, providers must be evaluated using the below criteria:

#### 1. OVERVIEW OF ICC AGENCY QUALIFICATIONS

In order to meet the requirements for becoming an ICC Agency or expanding an existing ICC Agency's Waiver program with additional slots, the agency must demonstrate:

- previous record of administrative competence;
- history of good interagency relationships locally (with schools, DSS, DMH, Probation, Family Court, etc.);
- current Medicaid certification;
- an expressed willingness to be creative and flexible;
- an expressed willingness to establish "parent-professional" partnerships for a team approach;
- consumer participation in the HCBS Waiver program design and internal evaluation process; and
- experience delivering strength-based, community services to children and families, including positive feedback from participating youth and their families.

Existing ICC Agency providers must also have a record of providing quality Waiver services;

- have a history of adhering to Waiver program requirements, evidenced by site reviews and family satisfaction;
- be in good financial standing as an ICC agency and in subcontracts with Waiver service providers; and
- have a history of providing choice of providers for families in all Waiver services when possible.

#### 2. APPROVAL PROCESS

The process of selecting an ICC Agency outlined below must be followed when a county has been allocated 12 or more slots. The process requires the Local Governmental Units (LGUs), i.e., county Departments of Mental Health, to:

- advertise the availability of the program and invite potential and/or current providers to express their desire to become an ICC Agency (see the following template 200/1A) or to receive additional slots;

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- review the written submissions, including justification of how the above listed criteria is met, from each potential new or existing ICC Agency that applies; and
- review and evaluate the responses using a standardized criteria and select the one that best meets the criteria. (Note: If more than one county will be served, the county Departments of Mental Health must jointly select one agency that best serves all counties involved)

## B. Agreements with ICC Agency and OMH Agencies

### *OMH Contracts*

Individualized Care Coordination (ICC) agencies are required to enter into a direct contract each year with the Office of Mental Health before Waiver services can be provided and billed to Medicaid. Information regarding the contract, related OMH fiscal reports, and the fiscal policies that govern the Waiver program are available at the OMH's website: <http://www.omh.ny.gov> Select Information for Service Providers and go to Spending Plan Guidelines. In addition, the OMH Field Offices are available to provide technical assistance to ICC agencies pertaining to contracts and fiscal reports.

Each agency must submit a Consolidated Budget Report (CBR) and a Consolidated Claim Report (CCR) using the Internet-based Consolidated Fiscal Reporting System (see above link). Each ICC agency must submit its contract annually to its respective Field Office for review. Upon review of the contract and approval of the budget, the Field Office forwards the contract to OMH's Central Office for final approval and signature. Changes that occur during the year affecting slot allocations, budget amounts, or other significant areas require a contract amendment.

The OMH has many direct contracts with providers for services that are either partially or fully reimbursed by Medicaid. Unfortunately, not all of these contracts are submitted by providers in a timely manner. In those instances, OMH is left without any contractual agreement with the providers governing the delivery of services or the rights and responsibilities of each party. Therefore, OMH and the NYS Department of Health (DOH) have agreed on and implemented a process whereby OMH instructs DOH to interrupt temporarily the payment of Medicaid associated with overdue contracts.

### *LGU/LDSS Contracts for Children in Foster Homes*

Children who live in foster boarding homes are eligible for Waiver services. Prior to enrollment of a child in foster care into the HCBS Waiver, the ICC Agency executes a contract with the LGU and LDSS of each county it serves. There are two different contracts, one for county operated homes and one for voluntary agency operated homes.

Foster care contracts outline the roles and responsibilities of each party, including that of any voluntary agencies serving the child.

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We expect respondent agencies to justify how they meet the following requirements: previous record of administrative competence; history of good interagency relationships locally (with schools, DSS, DMH, Probation, Family Court, etc.); current Medicaid certification; an expressed willingness to be creative and flexible; expressed willingness to establish "parent-professional" partnerships; consumer participation in program design and internal evaluation process; and experience delivering community-based services in a strength-based manner to children and families including positive feedback from participating consumers and their families.

*See Appendix I for Sample Template for Advertisement in County for ICC Agency*

## Appendix G: Case Record Organization – Table of Contents

### **Case Record Table of Contents:**

#### **Section 1:**

- Chart Index
- Utilization Review Forms

#### **Section 2:**

- Face Sheet with emergency information
- Safety Alerts Plan and updates including medications and medical alerts

#### **Section 3:**

- Screening, Referral and Enrollment Information:
  - Parent/Guardian Request for Screening
  - Screening forms
  - Level of Care and Level of Care Recertifications
  - Screening Results Letter to Family from LGU
  - Application for Waiver Participation/Freedom of Choice form
  - Choice of Waiver Provider Verification
  - Child Health Plus Re-enrollment Information Letter
  - OMH Notice of Decision (Waiver Acceptance or Termination) with enrollment or termination date

#### **Section 4:**

- Including the following labeled subsections:
  - A. Service Plans with corresponding CANS, Service Plan Budget and any Treatment Provider comments
  - B. Flex Funds Tracking forms and receipts

#### **Section 5:**

##### ICC Contact Tracker Log

- Progress Notes divided into the following subsections:
  - A. ICC
  - B. IIH
  - C. CR
  - D. SBS
  - E. FSS
  - F. RS

#### **Section 6:**

- Releases of Information

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- A. Permissions
- B. Statements of understanding

**Section 7:**

- A. Medicaid: Application/Information/Medicaid Correspondence

**Section 8:**

- Assessments (Psychological, Educational, etc.)

**Section 9:**

- A. Correspondence/Miscellaneous

**Section 10:**

- A. Discharge Plans; After-Care Follow-Up; Disenrollment Progress Note

## Appendix H: Writing Goals, Objectives and Methods

### Goals

Goals start with the child and family/ caregiver's priorities, what they consider to be the strengths and the needs most pertinent to their life and the results from the CANS-NY assessment with ratings of 2 or 3. Consider what is working and functioning currently to assist with the implementation of the goal(s). Consider the function areas that need to be addressed, the routine(s) that are impacted, area for child and/or family participation and addressing specific behaviors. Goals are measurable and observable however, not necessarily quantitative, objectives are intended to provide the quantitative data to assess for progress.

Goal setting is a collaborative process, it allows for an important opportunity to partner with the family and include them in the Waiver process. It is critical that goals be written in a realistic and manageable manner. Additionally, all goals should be written in a strength-based tone to remain person-centered. It is important to note that goals, unlike objectives, state the big picture, are less structured and are driven by assessments, team dialogue, and observations. For instance: the parents/ caregiver may have indicated that school attendance is an issue for the child. However, the age and behaviors of the child make it difficult for the child to independently prepare for school and attend in a timely and appropriate fashion and thus, family involvement is critical to achieve this priority. A goal may be, "To increase John's school attendance, parents will fully meet responsibilities with regards to John's education".

### Objectives

Objectives are realistic, measurable, observable, attainable, specific and straightforward. The objective(s) must tie back to the goal and contain specific elements to ensure that progress can be measured. It is important to identify who will be conducting the behavior, what action is taken, when the action will take place and how it will be measured. For instance: "John's parents will take John to school every day, arriving by 8.55am, if the child is unable to attend school, John's parents to contact the school by 8.55am on the day of the absence and inform school staff of the reason for the absence." The measurable aspect of this objective is critical, school attendance, including tardiness, is observable and able to be tracked. This meets the parent's identified priority and by involving the parents, the objective becomes attainable. It is important to note that one goal may require multiple objectives. In this case, the goal is to increase John's attendance and perhaps parental school drop-off is not sufficient to achieve this goal.

### Methods

Methods specifically describe what will be done to achieve the objective, which service(s) will be used (using the approved service codes printed on the Service Plans), and who will do what. The duration and frequency of the service must also be indicated. If the use of flex dollars is anticipated, this must be included in the method. The more realistic or natural the task, the more motivated the child will be and the more applicable it will be to everyday events and situations. Authentic tasks and circumstances reinforce a generalization of application across settings. Additionally, no inferences should be made regarding the child's capabilities, by utilizing the

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CANS-NY assessment, incorporating the priorities and accounts of both child and family and observing the child's natural behavior, the Individual Care Coordinator is able to facilitate the creation of authentic tasks. Five key elements should be included in the methods: who will be conducting the intervention or action, what service will be used, where will the intervention or action take place, when will the action (service) be provided and why is this service being provided. For instance: "IHH will meet with John and parents for one hour at the residence two times a week at school prep time for two weeks to model and assist parents in preparing John for the school day to enhance attendance. ICC will evaluate parent's ability to consistently use this method within one month."

Projected use of flex dollars must be specifically noted, when indicated, stating for what they will be used.

These are revised as need.

