



**Home and Community-Based Services
Medicaid Waiver**

Program Manual

January 2011



New York State Office of Children and Family Services
Division of Child Welfare and Community Services
Bureau of Waiver Management



New York State
Office of
Children &
Family
Services

www.ocfs.state.ny.us

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Governor

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December 5, 2011

Dear HCIA Director:

Effective January 2, 2012, the OCFS Bureau of Waiver Management will implement changes to the following forms and processes for the Bridges to Health (B2H) Waiver Program. These changes will improve efficiencies and streamline operations of the B2H Waiver Program. The forms and accompanying instructions are expected to be posted prior to December 31, 2011. The changes are summarized below:

1. OMRDD 02-02-97 and OCFS-8005B has been eliminated and are replaced with a new form, OPWDD 02-02-97, Revised 11/2011. This form serves as both the initial Level of Care Form and Reauthorization Form for the B2H DD Waiver. Appendix K is replaced with the new instructions.
2. Med F Level of Care Form, OCFS-8005C: Under the section *If child could not be cared for at home he/she would require*: the checkbox for *Other Level of Care* has been eliminated.
3. IHP - the *CANS Scores and Analysis* page has been eliminated. When a new IHP is completed, the most current CANS Score Sheet must be attached. The CANS will continue to require completion within the timeframes outlined in the B2H Program Manual. Data entry of CANS scores into CONNECTIONS will no longer be required.
4. Service Summary Form, OCFS-8018, will be available in both Adobe and Word Format. It also formatted in suggested areas to allow for ease of use. The instructions have been updated and copies clarified.
5. CANS B2H will be replaced with the new CANS-NY. CANS-NY is completed the same way as CANS B2H. CANS NY includes two new domains to address trauma and substance abuse issues.
6. Serious Reportable Incidents (SRIs): must be submitted via email. Due to the volume of SRIs, OCFS can no longer accept SRIs via FAX. SRIs are to be submitted to the following email account:

Email Address: OCFS.SM.B2HSRI@OCFS.STATE.NY.US

Subject Line: HCIA Name space First and Last initials of Child space 8021or
8022 space incident date

Example: CMS MW 8021 01-01-12

If there are questions and/or concerns regarding these changes, we can discuss during the HCIA conference call on December 8 at 11:00AM. If you have any questions, please contact me at 518-408-4064.

As always, I appreciate your cooperation.

Sincerely,

Mimi Weber, Director
OCFS Bureau of Waiver Management



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BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN & FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

Table of Contents

Chapter 1: Introduction

A. Bridges to Health Waiver Program	1-1
1. Health Care Integration Agencies	1-2
2. Health Care Integrators.....	1-2
3. Waiver Service Providers	1-3
4. Medical Consenters	1-3
5. Participation in Decision Making.....	1-3
B. Bridges to Health Waiver Program Enrollment Opportunities	1-4
1. OCFS B2H Medicaid Waiver Program Statewide Implementation	1-5
2. OCFS B2H Medicaid Waiver SED Slot Allocation.....	1-6

Chapter 2: Eligibility, Enrollment, Transitions, Rights and Responsibilities

A. Eligibility	2-1
1. Eligibility Criteria.....	2-1
2. Reasons for Denial for Enrollment.....	2-2
3. Qualifying Diagnoses	2-3
B. Enrollment and Reauthorization.....	2-4
1. Enrollment Steps	2-4
2. Reauthorization Process	2-10
C. Transitions within the Waiver	2-11
1. Changing HCIs	2-12
2. Changing HCIA within the same OCFS B2H Region.....	2-12
3. Changing HCIA between OCFS B2H Regions	2-13
4. Discharge of a Child from Foster Care.....	2-13
5. Reasons for Discontinuance from B2H Waiver Enrollment	2-14
6. Re-Enrollment Opportunity.....	2-15
7. Team Meetings and Agency Conferences prior to Medicaid Fair Hearings	2-15
D. Rights and Responsibilities under the B2H Waiver Program	2-16
1. Individual Rights and Responsibilities upon Application	2-16
2. B2H Participant Rights and Responsibilities.....	2-16
3. Role of Caregiver(s)	2-18

Chapter 3: Becoming a Health Care Integration Agency

A. Policy	3-1
1. Overview of HCIA Qualifications.....	3-1
2. Approval Process.....	3-3
B. Agreements between HCIA and WSP agencies	3-4
C. Waiver Service Provider Review Process	3-5

Chapter 4: LDSS/DJJOY Roles and Responsibilities

A. Background	4-1
B. Specific LDSS Roles and Responsibilities.....	4-2
1. Pre-enrollment Activities.....	4-2
2. LDSS/DJJOY Referral for Waiver Enrollment.....	4-3

BRIDGES TO HEALTH (B2H)

**NEW YORK STATE OFFICE OF CHILDREN & FAMILY SERVICES
HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM**

3. Waiver Enrollment 4-4
4. Determination of Eligibility and Authorization..... 4-7
5. LDSS Notices 4-8
6. Reauthorization 4-9
7. Ongoing Delivery of Services and Monitoring 4-11
8. Documentation of B2H Services in the Family Assessment and Service Plan 4-12
9. Managing Allocation of Waiver Slots 4-12
10. Enrollment Wait Lists..... 4-13
11. Managing the Enrollment Wait Lists 4-14
12. LDSS Participation in Team Meetings..... 4-15
13. Grievances and Complaints 4-16
14. Transfers within the B2H Waiver Program..... 4-16
15. Discharge from Foster Care..... 4-17
16. Discontinuance of B2H Waiver Enrollment..... 4-18
17. Re-Enrollment Opportunity 4-18
18. Aging Out of the B2H Waivers 4-18
19. Managed Care Policy 4-19
20. Recordkeeping and Documentation..... 4-19
21. Reimbursement for B2H Waiver LDSS Administrative Costs 4-20

Chapter 5: Health Care Integration Agencies

A. Oversight of Health Care Integration Services 5-1
B. Pre-Enrollment/Enrollment Activities..... 5-1
 1. Pre-enrollment Responsibilities..... 5-1
 2. Application for Enrollment Packet..... 5-2
 3. Conducting Level of Care Evaluations..... 5-3
 4. The Individualized Health Plan 5-6
C. Ongoing Activities 5-7
 1. Changing an HCI, WSP or HCIA..... 5-7
 2. Reauthorization Activities 5-7
 3. Circumstances Requiring IHP Revisions 5-8
 4. Circumstances Requiring B2H Waiver Program Discontinuance..... 5-8
 5. Transition Planning 5-9
D. Service Development and Network Management..... 5-10
 1. Administrative Policies and Procedures 5-10
 2. Qualified Providers..... 5-10
 3. Training 5-11
 4. Safety Planning..... 5-11
 5. Interpretation and Translation Services..... 5-11
E. Quality Management 5-12
 1. Completing Regular Reviews of Documentation..... 5-12
 2. Reviewing Incidents and Complaints 5-12
 3. Caregiver Satisfaction Survey..... 5-13
 4. Maintaining Proper Documentation 5-13
 5. Reporting to OCFS 5-14
 6. Intake Deferral..... 5-14
 7. Site Visits by Governmental Agencies..... 5-15

BRIDGES TO HEALTH (B2H)

**NEW YORK STATE OFFICE OF CHILDREN & FAMILY SERVICES
HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM**

8. HCI Billing Policies 5-15

Chapter 6: Health Care Integrators

Interaction between the HCI and the Caregiver 6-1

A. Qualifications and Training Requirements 6-2

 1. Qualifications 6-2

 2. Training Requirements 6-3

B. HCI Activities 6-3

 1. Pre-Enrollment Responsibilities 6-3

 2. Preparing Individualized Health Plans 6-4

 3. IHP Revisions/Annual Reauthorizations 6-5

 4. Post-Enrollment Responsibilities 6-6

 5. Facilitating a Change in HCIA, HCI or WSP..... 6-6

 6. Caseload Responsibilities, Management, and Required Contacts 6-7

 7. Documentation Reviews: Detailed Service Plans, Service Summary Forms, & Progress Notes.... 6-7

 8. Leading Team Meetings 6-8

 9. Circumstances Requiring B2H Waiver Program Discontinuance 6-9

 10. Quality Management 6-11

Chapter 7: Waiver Service Providers

A. Becoming a WSP Agency 7-1

B. Waiver Service Provider Staff Qualifications 7-2

C. Ongoing Responsibilities of Waiver Service Providers 7-2

 1. Individualized Health Plans and Detailed Service Plans 7-2

 2. Coordination with the HCI 7-3

 3. Team Meetings 7-3

 4. Service Provision and Documentation Review 7-3

 5. Billing and Documentation 7-4

 6. Incident Reporting and Grievances 7-4

 7. Quality Management 7-4

 8. Interpretation and Translation Services 7-5

Chapter 8: Services

A. General Requirements 8-1

 1. Training Requirements 8-1

 2. Documentation Requirements 8-1

 3. Verification of Credentials 8-3

B. Health Care Integration 8-3

C. Family/Caregiver Supports and Services 8-3

 1. Services 8-3

 2. Provider Qualifications 8-4

 3. Training Requirements 8-4

 4. Documentation Requirements 8-4

 5. Billing Policies 8-4

D. Skill Building 8-5

 1. Services 8-5

 2. Provider Qualifications 8-5

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN & FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

3. Training Requirements	8-5
4. Documentation Requirements	8-6
5. Billing Policies	8-6
E. Day Habilitation	8-6
1. Services	8-6
2. Provider Qualifications.....	8-6
3. Training Requirements	8-7
4. Documentation Requirements	8-7
5. Billing Policies	8-7
F. Special Needs Community Advocacy and Support.....	8-7
1. Services	8-8
2. Provider Qualifications.....	8-8
3. Training Requirements	8-8
4. Documentation Requirements	8-9
5. Billing Policies	8-9
G. Prevocational Services	8-9
1. Services	8-9
2. Provider Qualifications.....	8-10
3. Training Requirements	8-10
4. Documentation Requirements	8-10
5. Billing Policies	8-10
H. Supported Employment.....	8-11
1. Services	8-11
2. Provider Qualifications.....	8-11
3. Training Requirements	8-12
4. Documentation Requirements	8-12
5. Billing Policies	8-12
I. Planned Respite	8-12
1. Services	8-12
2. Provider Qualifications.....	8-13
3. Training Requirements	8-13
4. Documentation Requirements	8-14
5. Billing Policies	8-14
J. Crisis Avoidance, Management, and Training.....	8-14
1. Services	8-14
2. Provider Qualifications.....	8-15
3. Training Requirements	8-15
4. Documentation Requirements	8-15
5. Billing Policies	8-15
K. Immediate Crisis Response Services	8-16
1. Services	8-16
2. Provider Qualifications.....	8-16
3. Training Requirements	8-16
4. Documentation Requirements	8-17
5. Billing Policies	8-17
L. Intensive In-home Supports and Services	8-17
1. Services	8-17

BRIDGES TO HEALTH (B2H)

**NEW YORK STATE OFFICE OF CHILDREN & FAMILY SERVICES
HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM**

2. Provider Qualifications..... 8-18
3. Training Requirements 8-18
4. Documentation Requirements 8-18
5. Billing Policies 8-18
M. Crisis Respite..... 8-19
 1. Services 8-19
 2. Provider Qualifications..... 8-19
 3. Training Requirements 8-20
 4. Documentation Requirements 8-20
 5. Billing Policies 8-20
N. Adaptive and Assistive Equipment 8-20
 Section N-1: Adaptive and Assistive Equipment 8-21
 1. Equipment 8-21
 2. Funding Limits 8-22
 3. Provider Qualifications 8-22
 4. Approval Process for Adaptive and Assistive Equipment for a Home 8-23
 5. Repairs..... 8-24
 6. Reimbursement..... 8-24
 Section N-2: Adaptive and Assistive Equipment and Modification for Vehicles..... 8-25
 1. Equipment and Modifications for Vehicles..... 8-25
 2. Funding Limits 8-26
 3. Used Vehicles 8-27
 4. Used Adaptive and Assistive Equipment for Vehicles..... 8-27
 5. Approval Process for Adaptive/Assistive Equipment for a Vehicle 8-27
 6. Repairs..... 8-28
 7. Reimbursement..... 8-29
O. Accessibility Modifications 8-29
 1. Modifications..... 8-29
 2. Funding Limits 8-30
 3. Provider Qualifications..... 8-31
 4. Approval Process for Accessibility Modifications for a Home..... 8-31
 5. Repairs..... 8-32
 6. Reimbursement..... 8-32
 7. Paying for Accessibility Modifications for a Home 8-33

Chapter 9: The Individualized Health Plan

A. Role of the LDSS/DJJOY 9-1
 1. Approving the IHP 9-1
 2. Coordination Responsibilities 9-2
 3. FASP-IHP Coordination..... 9-2
B. Team Meetings 9-3
C. Contents of the IHP 9-4
D. Four Types of IHPs 9-6
 1. Preliminary IHP 9-6
 2. Initial IHP 9-7
 3. Revised IHP 9-7
 4. Annual Revised IHP 9-8

BRIDGES TO HEALTH (B2H)

**NEW YORK STATE OFFICE OF CHILDREN & FAMILY SERVICES
HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM**

E. Scheduling Services in the IHP 9-8
F. Changing Waiver Service Providers 9-9
G. Recordkeeping and Documentation 9-9
 1. The Detailed Service Plan 9-9
 2. Service Summary Forms 9-10
 3. Progress Notes 9-11

Chapter 10: Providing a High Quality Program

A. Overview 10-1
B. Quality Management Program Components 10-2
C. OCFS Activities 10-12

Chapter 11: Participant Safeguards

A. Critical Event or Incident Reporting 11-1
 1. Serious Reportable Incidents 11-2
 2. Serious Reportable Incident Follow-up 11-4
 3. Recordable Incidents 11-5
B. Formal Grievance Procedures 11-5
C. HCIA Serious Incident Review Committee 11-7
 1. Organization and Membership of the Serious Incident Review Committee 11-7
 2. Responsibilities of the Serious Incident Review Committee 11-7
 3. Documentation of Serious Incident Review Committee Activity 11-8
D. Restraints and Restrictive Interventions 11-8
E. Background Checks 11-9
F. Administering Medication 11-10

Chapter 12: System Links

A. Welfare Management System 12-1
B. eMedNY 12-2
C. CONNECTIONS 12-2

Chapter 13: Billing

A. General Rules for Billing 13-1
 1. Date of Service 13-1
 2. Delivery of Services 13-1
 3. Proper Documentation 13-2
 4. Billing at the Correct Payment Level 13-3
 5. Timely Submission of Bills 13-3
 6. Ensuring Accuracy in Billing 13-3
 7. Fixing Billing Mistakes 13-3
B. Billing Policies for Health Care Integration Services 13-3
 1. Enrollment Month Billing 13-4
 2. Regular Full Month Billing 13-4
 3. Hospitalization Occurrence Billing 13-4
 4. Transfers between HCIAs 13-5
 5. Billing at Discontinuance 13-6

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN & FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

Chapter 14: Training Requirements

A. Mandatory Training	14-1
B. HCIA Sponsored Mandatory Training	14-1
C. OCFS Sponsored Training for Waiver Service Providers and WSP Supervisors	14-2
D. OCFS Sponsored Training for Health Care Integrators and HCI Supervisors.....	14-3
E. Informational Training	14-3
F. Service Providers Training Requirements Chart	14-4

Appendices

Appendix A:	B2H Acronyms
Appendix B:	Terminology Sheet
Appendix B-1:	B2H Case Record
Appendix C:	Consent for Routine Medical Services for Children in Foster Care Chart
Appendix D:	Weekly Schedule of B2H Services
Appendix E:	Forms—Alphabetical List
Appendix F:	Forms—Numerical List (8000–8036)
Appendix G:	Web Links
Appendix H:	HCIA Administrative Separation of Duties Chart
Appendix I:	Transfers within the B2H Waiver Program
Appendix J:	B2H Referral and Enrollment Process
Appendix K:	OPWDD Form OMRDD 02–02–97 (ICF/MR Level of Care Eligibility Determination) and Advisory Guideline–Determining Eligibility for Services: Substantial Handicap and Developmental Disability, dated 8/10/01
Appendix L:	Clarification of Provisions of the August 2001 Eligibility Advisory, dated 12/13/02
Appendix M:	Eligibility for OMRDD Services–Important Facts, dated June 2006
Appendix N:	OMRDD Transmittal for Determination of Developmental Disability
Appendix O:	Interaction of the B2H Waiver program and Child Welfare Training Outline
Appendix P:	B2H Agreement to Accept Services form
Appendix Q:	OCFS Transmittal on B2H Claiming Instructions
Appendix R:	NYC B2H Pre-Referral Process and Request for Services (R4S)
Appendix S:	NYC B2H Initial Level of Care (LOC) process for the DD Waiver type
Appendix T:	OMRDD Administrative Memorandum #2009-05 ICF/MR Level of Care Eligibility Form (LCED) Qualified Mental Retardation Professional (QMRP) authorized to sign annual LCED forms and OMRDD Memorandum dated March 2, 2010 Clarifying Information Administrative Memorandum #2009-05
Appendix U:	B2H Personnel Record Checklists for Health Care Integrators and Waiver Service Providers
Appendix V:	Bridges to Health (B2H) Performance Measures to meet Centers for Medicare and Medicaid Services’ (CMS) Six Assurances

Note: For the most current version of the Bridges to Health (B2H) Program Manual refer to the B2H webpage at www.ocfs.state.ny.us/main/b2h/.

BRIDGES TO HEALTH (B2H)

**NEW YORK STATE OFFICE OF CHILDREN & FAMILY SERVICES
HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM**

B2H Waiver services are available to children (waiver participants from birth to the participant's 21st birthday) who, at the time of enrollment, are placed in the custody of a Local Department of Social Services (LDSS) Commissioner or the custody of the Office of Children and Family Services (OCFS) Commissioner in the Division of Juvenile Justice and Opportunities for Youth (DJJOY). The roles and responsibilities of both LDSS and OCFS DJJOY staff are identical in most instances referenced throughout this Manual. Therefore, when the acronym LDSS is used in this Manual it is to be interpreted as including OCFS DJJOY. Exceptions will be noted.

Throughout this Manual, the term "child" refers to a B2H waiver participant from birth to the participant's 21st birthday.

Chapter 1:

Introduction

Evidence suggests that children who have been placed in foster care, including children placed in the Office of Children and Family Services (OCFS) Division of Juvenile Justice and Opportunities for Youth (DJJOY) residential care, have significantly higher rates of unmet health needs compared to children in the general population.

As demonstrated in the Northwest Foster Care Alumni Study (published by Casey Family Programs, Harvard Medical School, and others), more than half (54%) of children in foster care have one or more mental health disorders, including an incidence of post-traumatic stress disorder that is five times that of the general population. In addition, other studies indicate that 60 percent of children in foster care exhibit developmental delays and at least one chronic medical condition. A quarter of the children have three or more chronic conditions.

The trauma previously experienced by children and youth in out-of-home and residential care frequently creates a set of common needs. Increased numbers of children and youth entering out-of-home and residential care require highly specialized treatment for substance abuse, sexual reactivity, and trauma. Most require ongoing medical services including psychiatric services. A majority need adaptive educational services to either remediate learning deficits or correct academic deficiencies.

A. Bridges to Health Waiver Program

The Bridges to Health (B2H) Waiver Program is designed specifically for these vulnerable children. With approval from the federal government, B2H offers services not otherwise available in the community to children with these complex medical conditions, and does so in the context of their often complicated family and caregiver network. By supporting children in foster care or DJJOY community services supervision in the least-restrictive home or community setting, the B2H Waiver Program provides opportunities for improving the health and well-being of the children served, and supporting permanency planning.

The B2H Home and Community-Based Waiver Program consists of three Waivers—B2H for children with serious emotional disturbances (B2H SED), B2H for children with developmental disabilities (B2H DD), and B2H for medically fragile children (B2H MedF)—designed to provide community-based health care services and supports to children in foster care or DJJOY community services supervision and to those who have been discharged from foster care or DJJOY community services supervision while in one of the three B2H Waivers.

The B2H Waiver Program is designed to recognize that children in foster care or DJJOY community services supervision can have many caregivers involved in their lives. In the program, children are served in the least restrictive, most home-like setting possible, involving those in the caregiver network, whenever appropriate—foster family, birth family, and adoptive family members.

B2H services complement, but do not duplicate, services provided to these children through other programs, such as foster care or DJJOY community-based initiatives. Although the federal government requires a separate waiver for each of the three distinct disability groups, New York State is administering B2H as a single program. The children may enter the B2H Waiver Program only while in foster care or DJJOY community services supervision, but once in the program they may be eligible for services after discharge from foster care or DJJOY community services supervision until age 21 if the child remains otherwise eligible. Further, by having the same services available in each waiver for the enrolled children, regardless of the qualifying disability, B2H creates new opportunities for serving children with cross-system needs. The roles and responsibilities of both LDSS and OCFS DJJOY staff are identical in most instances referenced throughout this Manual. Therefore, when the acronym LDSS is used in this Manual, it is to be interpreted as including OCFS DJJOY. Exceptions will be noted.

Note: See Appendix B, Terminology Sheet, for a list of terms used in the B2H Waiver Program.

1. Health Care Integration Agencies

To promote efficiency, regional flexibility, and participant choice, OCFS enters into Provider Agreements with Health Care Integration Agencies (HCIAs) across the state. HCIAs are voluntary authorized 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 HCIAs work in conjunction with the Local Departments of Social Services (LDSS) that retain responsibility for making referrals, eligibility determinations, and enrollment decisions.

The HCIAs:

- obtain necessary medical assessments, complete application packets for all identified children for consideration for the most appropriate B2H waiver,
- recruit and work with B2H Waiver Service Providers (WSPs) to offer the full service array to waiver participants,
- propose *Individualized Health Plans (IHPs) (OCFS-8017)* to the LDSS that outline the services needed by the applicant,
- arrange waiver services, and
- assist in B2H Waiver Program oversight.

2. Health Care Integrators

The Health Care Integrators (HCIs), care management staff employed by the HCIAs, have primary responsibility for the child's health care coordination and administration of the *IHP (OCFS-8017)*.

The HCIs:

- provide the service of Health Care Integration, the B2H Waiver service through which the *IHP (OCFS-8017)* is created and managed,
- assess the need for services,
- develop and update the *IHP (OCFS-8017)*,
- link the child and family/caregiver to the identified services,
- consult with the child and caregiver on the appropriate provision of services,

- stabilize the environment for the child and caregiver, and advocate for the child's needs,
- coordinate team meetings,
- coordinate the constellation of services and providers to meet specific needs of each enrolled child, and
- participate in overall quality management of B2H Waiver Program.

3. Waiver Service Providers

WSPs are organizations either under subcontract with HCIAs or are employees of those HCIAs that provide services besides Health Care Integration.

The WSPs:

- attend team meetings to discuss the creation of an *IHP (OCFS-8017)* for each participant,
- provide services as called for in the *IHP (OCFS-8017)* with qualified and trained staff,
- record and report progress on goals and work with the HCI to routinely update the *IHP (OCFS-8017)* to reflect current circumstances, and
- participate in overall quality management for the B2H Waiver Program.

4. Medical Consenters

The B2H Waiver Program is designed to support the enrolled child's freedom to choose service providers. In the case of children in foster care, the ability to give consent to medical care varies with the child's circumstances. Once discharged from foster care, the child or the child's family is authorized to give consent, depending on the child's age. As a result of these variations, the term "medical consenter" has been adopted for the B2H Waiver Program to cover all circumstances in which medical consent is necessary. See Appendix C for a chart that details the individuals who are authorized to give medical consent based on the child's varying circumstances.

The caregiver is the individual who provides for the child's everyday needs, safety, and well-being. For children in foster care who are receiving B2H Waiver services, the foster parent(s) is the primary caregiver. While foster parents are the primary caregiver, they do not provide medical consent. Once the child leaves foster care, the caregiver is the member of the child's household who primarily attends to the needs of the child, such as a birth parent or adoptive parent.

Whenever possible, the child, family, and caregivers participate with the medical consenter in creating the *IHP (OCFS-8017)*. The child, family, and caregivers are encouraged to express their preferences and program goals, to support permanency planning, over the span of the child's enrollment in the B2H Waiver Program. Participation is encouraged in all issues related to the health, welfare and permanency of the child, service selection, and quality of services provided.

5. Participation in Decision Making

There are some instances when a child enrolled in the B2H Waiver or a parent or guardian of such a child is authorized as the medical consenter for the child. In such instances, such a child or the parent/guardian must not only participate in B2H decisions but also must consent to the medical treatment for the child. (See Appendix C for a discussion of the medical consenter and a child's capacity to consent.)

In those instances when the child (or parent/guardian) is not the medical consentor for the child, the following provisions apply. Children who are potentially eligible and children enrolled in the B2H Waiver Program are encouraged to participate in every facet of decision making. The LDSS, HCIA and HCI must create a balance between participation in this decision making with the child's physical, cognitive and developmental abilities. A child receiving B2H services should be able to understand and appreciate the nature and consequences of B2H-related decisions in order to participate in decision-making. An evaluation of the decision-making ability of the child should be made on a case-by-case basis.

The child, his or her parent/guardian, family and caregivers are strongly encouraged to participate with the medical consentor, whenever possible, to express their preferences and program goals over the span of the child's enrollment in the B2H Waiver Program. There may be instances when the participation of these individuals is not possible, such as due to the young age of the child, child protective services issues related to the parent or guardian, or a lack of cooperation by the child's parent/guardian family or the caregiver. The opportunity for participation is encouraged in all B2H issues related to the health and welfare of the child, service selection, and the quality of services provided. However, the final decision-making authority for such B2H issues regarding a child in foster care who is less than 18 years of age and participating in a B2H waiver is maintained by the medical consentor and/or LDSS.

For the B2H Waiver Program, children who are under the age of 18, only the medical consentor is authorized to consent to medical treatment and to sign the *IHP (OCFS-8017)*. A youth receiving B2H services who is 18 years of age or older is authorized to give consent to medical treatment and to sign the *IHP (OCFS-8017)*, regardless of whether the youth remains in foster care or has been discharged from foster care, so long as he or she is able to understand and appreciate the nature and consequences of B2H-related decisions.

B. B2H Waiver Program Enrollment Opportunities

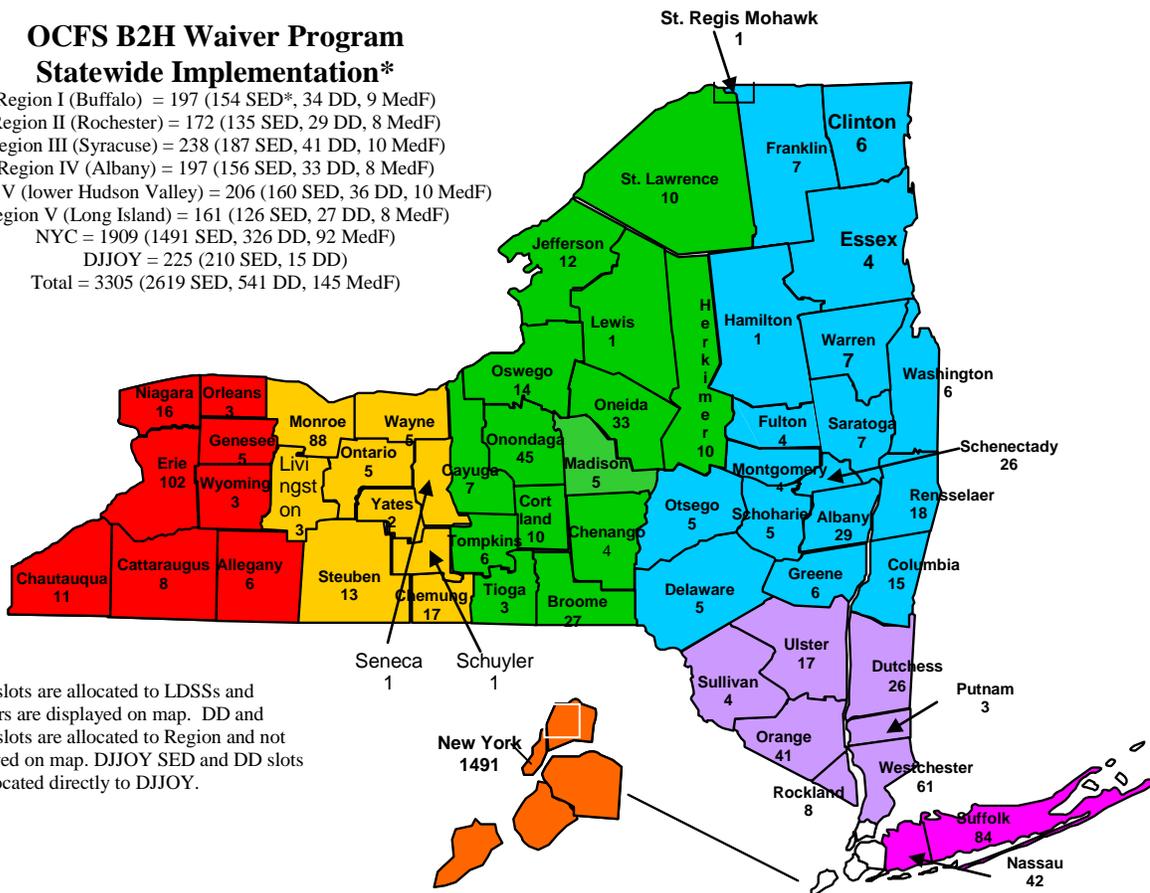
The map on the next page depicts the B2H Waiver Program enrollment opportunities, sometimes referred to as slots. B2H SED slots are allocated directly to each LDSS or OCFS DJJOY. B2H DD and B2H MedF slots are allocated to the OCFS B2H Regions. DJJOY B2H DD waiver slots are allocated directly to DJJOY. DJJOY has not been allocated any B2H MedF slots. OCFS may change the allocation of B2H Waiver enrollment opportunities as necessary. The existing New York State OCFS regions form the basis for the B2H regional-designations. The regional designations are identical, with one exception: OCFS Region V is divided into Lower Hudson Valley and Long Island B2H regions.

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

OCFS B2H Waiver Program Statewide Implementation*

Region I (Buffalo) = 197 (154 SED*, 34 DD, 9 MedF)
 Region II (Rochester) = 172 (135 SED, 29 DD, 8 MedF)
 Region III (Syracuse) = 238 (187 SED, 41 DD, 10 MedF)
 Region IV (Albany) = 197 (156 SED, 33 DD, 8 MedF)
 Region V (Lower Hudson Valley) = 206 (160 SED, 36 DD, 10 MedF)
 Region V (Long Island) = 161 (126 SED, 27 DD, 8 MedF)
 NYC = 1909 (1491 SED, 326 DD, 92 MedF)
 DJJOY = 225 (210 SED, 15 DD)
 Total = 3305 (2619 SED, 541 DD, 145 MedF)



*SED slots are allocated to LDSSs and numbers are displayed on map. DD and MedF slots are allocated to Region and not displayed on map. DJJOY SED and DD slots are allocated directly to DJJOY.

*** Note:** OCFS undertakes a process of review and re-allocation each year. These periodic reviews help to manage enrollments and may result in re-allocation of unused opportunities to the counties/regions with the greatest need.

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

5. OCFS Medicaid Waiver Program SED —Slot Allocation

REGION I - Buffalo	Slot Allocation
Allegany	6
Cattaraugus	8
Chautauqua	11
Erie	102
Genesee	5
Niagara	16
Orleans	3
Wyoming	3
Subtotal	154

REGION II - Rochester	Slot Allocation
Chemung	17
Livingston	3
Monroe	88
Ontario	5
Schuyler	1
Seneca	1
Steuben	13
Wayne	5
Yates	2
Subtotal	135

REGION III - Syracuse	Slot Allocation
Broome	27
Cayuga	7
Chenango	4
Cortland	10
Herkimer	10
Jefferson	12
Lewis	1
Madison	5
Oneida	33
Onondaga	45
Oswego	14
St. Lawrence	10
Tioga	3
Tompkins	6
Subtotal	187

REGION IV - Albany	Slot Allocation
Albany	29
Clinton	6
Columbia	15
Delaware	5
Essex	4
Franklin	7
Fulton	4
Greene	6
Hamilton	1
Montgomery	4
Otsego	5
Rensselaer	18
Saratoga	7
Schenectady	26
Schoharie	5
St. Regis	1
Warren	7
Washington	6
Subtotal	156

REGION V - Lower Hudson Valley	Slot Allocation
Dutchess	26
Orange	41
Putnam	3
Rockland	8
Sullivan	4
Westchester	61
Ulster	17
Subtotal	160

REGION V - Long Island	Slot Allocation
Suffolk	84
Nassau	42
Subtotal	126

Statewide	
DJJOY - Subtotal	210

REGION VI - NYC	
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GRAND TOTAL = 2610

NYC -Subtotal

1491

Chapter 2:

Eligibility, Enrollment, Transitions, Rights and Responsibilities

The Bridges to Health (B2H) Waiver Program is designed to provide community-based health care services and supports to children in foster care and to those who have been discharged from foster care while enrolled in one of the three B2H Waivers. This chapter provides information on eligibility criteria, enrollment and reauthorization procedures, transitions within the program, and rights and responsibilities for enrollees.

A. Eligibility

1. Eligibility Criteria

To be eligible to participate in the B2H Waiver Program, a child must meet *all* of the following criteria:

- be in the custody of a Local Departments of Social Services (LDSS) Commissioner or the custody of the Office of Children and Family Services (OCFS) Commissioner in the Division of Juvenile Justice and Opportunities for Youth (DJJOY),
- be Medicaid eligible,
- have an appropriate and documented qualifying diagnosis of Serious Emotional Disturbance (SED), Developmental Disability (DD), or Medical Fragility (MedF) (see below, Section 3, Qualifying Diagnoses),
- be eligible for admission to a medical institution and assessed to meet the Level of Care criteria for one of the waivers in the B2H Waiver Program:
 - B2H SED Waiver: *The Level of Care For Children with Serious Emotional Disturbances (OCFS-8005A)* is completed and the child has complex health or mental health needs;
 - B2H DD Waiver: The Office for People With Developmental Disabilities (OPWDD) Home and Community Based Services *Level of Care Form (OMRDD 02-02-97)* is used for enrollment. Annual reauthorizations require the *Level of Care ICF/MR-Eligibility Determination Form for Children with Developmental Disabilities (OCFS-8005B)*. There must be a finding of the presence of a life skill deficit related to behavioral needs, healthcare needs, and/or the activities of daily living; or
 - B2H MedF Waiver: The *Level of Care for Children with Medical Fragility Pediatric Patient Review Instrument (OCFS-8005C)* is completed. The child must meet eligibility for nursing home care according to the Pediatric Patient Review Instrument (PPRI) slightly modified for the B2H Waiver Program. The PPRI instrument is used to identify medical events including

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

conditions and treatments, activities of daily living (ADLs), behavioral difficulties, and specialized services that may warrant the need for nursing home care.

The appropriate form must be completed and signed by the authorized entities specified in Chapter 5, Health Care Integration Agencies.

- be willing to enroll in the B2H Waiver Program and live in an environment where caregivers are willing to cooperate and support the child as a B2H waiver participant (residence of 12 beds or less is considered a qualified setting for receiving waiver services),
- be able to benefit from services offered through the B2H Waiver Program,
- be able to be cared for in the community if provided access to B2H Waiver services:
 - **B2H SED:** At enrollment a child must be in foster care and under 19 years of age. If other criteria are met, services may continue until age 21 regardless of foster care status.
 - **B2H DD and MedF:** At enrollment a child must be in foster care or DJJOY community services supervision and under 21 years of age. If other criteria are met, services may continue until age 21 regardless of foster care status,
- have had the Application for Enrollment Packet completed on their behalf, including the *Individualized Health Plan (IHP)(OCFS-8017)*, in cooperation with the Health Care Integrator (HCI) and authorized by the LDSS. The *IHP (OCFS-8017)* describes the B2H services that support the child's health and welfare,
- choose to participate in the B2H Waiver Program rather than reside in a medical institution, which the child/medical consentor acknowledges by signing the *Freedom of Choice Form (OCFS-8003)*, and
- cannot be married.

For waiver reauthorization, children must meet all enrollment criteria except for currently being in foster care and must be under the age of 21. Please see Chapter 2, Section B Enrollment and Reauthorization for more details.

2. Reasons for Denial for Enrollment

The LDSS sends a *Notice of Decision-Denial of Enrollment (OCFS-8010A)* to the child/medical consentor when a child is not eligible to receive B2H Waiver services. The following are potential reasons for ineligibility:

- the child is not Medicaid eligible,
- the child is assessed to be at less than the necessary Level of Care based on the appropriate *Level of Care Form (OCFS-8005A, C or OMRDD 02-02-97)*,
- the child does not have a qualifying diagnosis,

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

- the child is not capable of living in a residence of 12 beds or less (the qualified setting for receiving waiver services) with the assistance of informal supports, foster care services, and/or B2H Waiver services,
- the child resides in an ineligible setting, including any Medicaid funded setting such as an Office of Mental Health (OMH) sponsored Family Based Treatment home, Community Residence or in an OPWDD Family Care home, Community Residence, or Individual Residential Alternative,
- B2H Waiver services are not appropriate for the child,
- the cost of the proposed plan of care is above the level necessary to meet the federally mandated requirement that waiver services must be cost neutral in the aggregate when compared to statewide medical institutional care costs as determined by OCFS,
- the child/medical consentor withdraws the application,
- the child is discharged from foster care prior to enrollment,
- the child turns 19 years old for the B2H SED waiver, or 21 years old for the B2H DD or MedF waivers, prior to being enrolled,
- the child is married, or
- the child resides out of state.

3. Qualifying Diagnoses

B2H SED: Designated Emotional Disturbance Diagnosis is a Diagnostic and Statistical Manual of Mental Disorders (DSM)-IV-TR diagnosis or International Classification of Diseases (ICD)-9-Clinical Modification (CM) equivalent, other than (i) alcohol or drug disorders, (ii) developmental disabilities, (iii) organic brain syndromes, or (iv) social conditions. ICD-9-CM categories and codes that do not have an equivalent in a DSM-IV-TR diagnosis are not included as designated mental illness diagnoses.

B2H DD: A developmental disability is a disability as defined by OPWDD which:

- is attributable to mental retardation, cerebral palsy, epilepsy, neurological impairment, or autism;
- is attributable to any other condition found to be closely related to mental retardation because such condition results in similar impairment of general intellectual functioning or adaptive behavior with mental retardation or requires treatment and services similar to those required for such children;
- is attributable to dyslexia resulting from a disability described above;
- has continued or can be expected to continue indefinitely; and
- constitutes a substantial handicap to such child's ability to function normally in society.

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

B2H MedF: Medical fragility is any physical condition that based on the Pediatric Patient Review Instrument, determines that a child is eligible for a Skilled Nursing Facility.

B. Enrollment and Reauthorization

1. Enrollment Steps

Step 1: LDSS conducts pre-enrollment activities.

The formal referral of children for the B2H Waiver Program must come from the LDSS. Upon determination that a child may be eligible for the B2H Waiver Program, the LDSS:

- confirms that the child's Medicaid eligibility is current or conducts a Medicaid eligibility determination (if needed),
- verifies slot availability/wait list capacity,
- arranges for or provides the child/medical consenter with a list of approved HCIAS serving the OCFS B2H Region, along with their locations and available published, factual information about the HCIAS,
- arranges for or provides assistance in the selection of an HCIA and the selected HCIA's name, address, phone number, and a contact person, and
- refers the child/medical consenter to the selected HCIA to assist the child/medical consenter in the application process via a completed *Referral Form (OCFS-8000)* and provides a copy to the child/medical consenter.

Note: For New York City (NYC) Pre-Referral information see Appendix R: NYC B2H Pre-Referral Process and Request for Services (R4S).

Step 2: LDSS completes Referral Packet to send to HCIA.

The LDSS notifies the HCIA of a referral of a potential applicant by preparing and submitting the B2H Referral Packet to the HCIA.

The Referral Packet must include the following:

- *Referral Form (OCFS-8000)* containing:
 - B2H waiver type,
 - Child's name, DOB, and gender,
 - Child's Medicaid Client Identification Number (CIN),
 - LDSS attestation that the child will benefit from B2H services,
 - LDSS attestation that the child is Medicaid eligible,
 - Assignment of a role to the HCIA in the CONNECTIONS Family Service Stage by the LDSS (for children referred by OCFS Division of Juvenile Justice and Opportunities for Youth refer to the B2H CONNECTIONS/WMS Systems Instructions located at www.ocfs.state.ny.us/main/b2h/), and
 - Name, title, and signature of LDSS staff making the referral.

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

- Diagnosis and supporting documentation that the child has a qualifying diagnosis for one of the three B2H Waivers (B2H SED, B2H DD, or B2H MedF). This documentation must have been signed by a Qualified Health Care Practitioner within the most recent six months. For B2H DD, a current and valid assessment must be completed by a Qualified Health Care Practitioner as determined by OPWDD's eligibility guidelines (see Appendices K-N).
- *Authorization for Release of Information Form (OCFS-8001)*—signed by the child/medical consenter.

Step 3: HCIA reviews Referral Packet.

The HCIA receives the Referral Packet from the LDSS and verifies that the contents are complete. If the contents of the packet are not complete, the HCIA must notify the LDSS. The 60-day time frame within which the HCIA must submit a completed Application for Enrollment Packet to the LDSS does not start until the HCIA receives a complete Referral Packet.

Step 4: HCIA and HCI conduct pre-enrollment activities.

a. Meeting the potential B2H waiver participant: The HCIA conducts an initial interview with each child/medical consenter who is potentially eligible to evaluate eligibility. The HCIA must advise the child/medical consenter of the availability of translation services. The HCIA provides the child and medical consenter with an explanation of the philosophy, goals, rights, and services in the B2H Waiver Program, using available information. By signing the *Understanding the Bridges to Health Medicaid Waiver Program (OCFS-8002)*, the child/medical consenter are confirming an understanding of the enrollment process and the services and supports available through the B2H Waiver Program.

b. Gathering information: The HCIA provides the child/medical consenter with a list of HCIs who are available to assist in developing the Application for Enrollment Packet. The HCIA provides information on available HCIs, such as specific experiences and skills of individual HCIs, knowledge of the community where the child lives, cultural background of the HCIs, and other criteria of relevance to the child/medical consenter. The HCIA gathers information to complete the following forms:

- *Level of Care Form (OCFS-8005A, C or OMRDD 02-02-97; for B2H DD, see below),*
- *Freedom of Choice Form (OCFS-8003),*
- *Health Care Integrator Selection Form (OCFS-8007),*
- *Waiver Participant's Rights Form (OCFS-8008), and*
- *Preliminary IHP (OCFS-8017).*

c. Completing the Level of Care form: To appropriately complete the Level of Care, the HCIA must obtain pertinent information from relevant parties to fully understand the strengths and needs of the child and should include as much information as the HCIA can gather through interviews, records, and other information to develop a plan for services.

Decision point: Once the *Level of Care Form* is completed by the HCIA, the HCIA must notify the LDSS if it believes the child does not meet the criteria for one of the three B2H Waivers. This is done by completing the *Application Form for Enrollment (OCFS-8004)*, including Section 2, and attaching supporting documentation. For children in the B2H DD Waiver, the LDSS informs the child/medical consenter of the OPWDD Developmental Disabilities Service Office (DDSO) decision and the right to appeal. (For more details, see the three-step Level of Care review process in Appendices L and M).

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

Note: For B2H DD in NYC: ACS secures the Level of Care authorization directly from the local DDSO and includes the signed *OMRDD 02-02-97* in the formal Referral Packet. For more information see Appendix S: NYC B2H Initial Level of Care process for the DD Waiver type.

If the HCIA believes the child does meet the criteria, the HCIA prepares the *Level of Care Form* appropriate to the child's disability. See Chapter 5, Health Care Integration Agencies, for detailed information on who can complete and instructions on completing Level of Care evaluations.

d. Completing the Preliminary IHP: The *Preliminary IHP (OCFS-8017)* is completed by the HCI and is the first required *IHP (OCFS-8017)* to be developed for a child whom the HCI is recommending for enrollment. The HCI schedules as many meetings as necessary with the child/medical consentor to complete a *Preliminary IHP (OCFS-8017)*. Development of the *Preliminary IHP (OCFS-8017)* includes obtaining pertinent information from relevant parties to fully understand and document the strengths and needs of the child and should include as much information as the HCI can gather through interviews, records, and other information to develop a plan for services. See Chapter 9, The Individualized Health Plan, for a detailed explanation of completing *IHPs (OCFS-8017)*.

e. Completing the Application for Enrollment Packet

Time frame: The HCI has 25 calendar days from receipt of the Referral Packet from the LDSS to complete this packet for review by the HCIA.

The HCI creates the Application for Enrollment Packet and submits to the LDSS the following completed and signed documents:

- *Application Form for Enrollment (OCFS-8004):* includes the HCIA's recommendation to LDSS on whether the child meets or fails to meet criteria for the B2H Waiver Program and supporting justification,
- *Understanding the Bridges to Health Medicaid Waiver Program (OCFS-8002),*
- *Level of Care Form (OCFS-8005A, C or OMRDD 02-02-97)* with current supporting diagnostic documentation,
- *Freedom of Choice Form (OCFS-8003),*
- *Health Care Integrator Selection Form (OCFS-8007),*
- *Waiver Participant's Rights Form (OCFS-8008),* and
- *Preliminary IHP (OCFS-8017).*

Step 5: HCI sends Application for Enrollment Packet to HCIA.

Time Frame: The HCIA has 10 calendar days to review the application and determine if the request is approved for submission to the LDSS or to return it to the HCI with written feedback on what must be changed to approve the submission. It is expected that corrections required by the HCI are made within 15 calendar days and re-submitted to the HCIA. The HCIA provides the LDSS with the Application for Enrollment Packet for approval within 10 calendar days after receiving the corrections.

The HCIA reviews the Application for Enrollment Packet for completeness and verification that B2H Waiver services are appropriately targeting the child's health and welfare and are cost-effective. This review must be conducted by HCIA staff within the Health Care Administrative Line or the Quality

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

Management Administrative Line as depicted in the chart in Appendix H, HCIA Administrative Separation of Duties.

The HCIA must submit the completed Application for Enrollment Packet to the LDSS for action within 60 days of receipt of a complete Referral Packet from the LDSS.

If the budget in the *Preliminary IHP (OCFS-8017)* is over \$51,600 per year, the HCIA must send a copy of the completed Application for Enrollment Packet to the OCFS Quality Management Specialist (QMS) at the same time the Packet is submitted to the LDSS. The QMS notification is for informational purposes and should not delay the LDSS approval/disapproval process. If a QMS, working with the OCFS Bureau of Waiver Management (BWM), determines that an *IHP (OCFS-8017)* threatens the fiscal neutrality of a B2H Waiver, the QMS must notify the LDSS that changes to the *IHP (OCFS-8017)* will be necessary.

Step 6: LDSS/DJJOY reviews and renders decision on application.

Time Frame: The LDSS reviews the Application for Enrollment Packet and makes an eligibility decision within 30 days of receiving the packet from the HCIA.

The LDSS time-date stamps each document in the Application for Enrollment Packet to determine the initial order of review for completeness of the following:

- *Application Form for Enrollment (OCFS-8004),*
- *Understanding the Bridges to Health Medicaid Waiver Program (OCFS-8002),*
- *Level of Care Form (OCFS-8005A, C or OMRDD 02-02-97),*
- *Freedom of Choice Form (OCFS-8003),*
- *Health Care Integrator Selection Form (OCFS-8007),*
- *Waiver Participant's Rights Form (OCFS-8008),* and
- *Preliminary IHP (OCFS-8017).*

If any of these documents is missing or incomplete, the LDSS must contact the HCIA. The HCIA must respond immediately with the requested information. Once all required information is obtained and the Application for Enrollment Packet is determined complete, it is ready for review for B2H Waiver Program eligibility.

The LDSS reviews the Application for Enrollment Packets for B2H Waiver Program eligibility in the order they are determined complete. For example, if one Application for Enrollment Packet is received first but is not complete, the LDSS is able to begin reviewing the next Application for Enrollment Packet for B2H Waiver Program eligibility as it was determined to be the first complete packet.

At any time that the child is determined ineligible after a referral to an HCIA has been made, the LDSS must un-assign the HCIA's CONNECTIONS role.

During the B2H Waiver Program eligibility determination process, the LDSS:

1. reviews and authorizes the *Level of Care Form*, verifying the qualifications of the signatures on the B2H DD and B2H MedF *Level of Care Form*, and signs the B2H SED *Level of Care Form*.

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

2. reviews the *Preliminary IHP (OCFS-8017)* for appropriateness. If the *Preliminary IHP (OCFS-8017)* is appropriate, the LDSS signs the *Preliminary IHP (OCFS-8017)* indicating approval. If the LDSS disapproves the *IHP (OCFS-8017)*, the HCIA must be provided with the LDSS comments, to permit the HCIA to make the appropriate changes and resubmit the *Preliminary IHP (OCFS-8017)*. The Application for Enrollment Packet cannot be approved unless both the appropriate *Level of Care Form* and *Preliminary IHP (OCFS-8017)* are complete and approved,
3. determines whether the child is eligible for one of the three B2H Waivers,
4. signs and time-date stamps the *Application Form for Enrollment (OCFS-8004)* when the decision is made, to approve the Application for Enrollment Packet and:

For B2H SED: checks slot availability:

- if slot is available, continues to step #5 below;
- if slot is not available, but there is room on the Wait List, places child's name on the LDSS Wait List upon receipt of the Application for Enrollment Packet, using the LDSS decision time-date stamp for list position;
- notifies child/medical consenter via the *Wait List Notification Form (OCFS-8012)*.

For B2H DD and B2H MedF: New York City Administration for Children's Services (ACS) checks slot availability:

- if slot is available, continues to step #5 below;
- if slot is not available, but there is room on the Wait List, places child's name on the ACS Wait List upon receipt of the Application for Enrollment Packet, using the ACS decision time-date stamp for list position;
- notifies child/medical consenter via the *Wait List Notification Form (OCFS-8012)*.

Remaining LDSS (other than ACS) and St. Regis Tribal Nation: contact the appropriate OCFS QMS to determine the following:

- if slot is available, continue to step #5 below;
- if slot is not available but there is room on the Wait List, QMS places child's name on Wait List upon receipt of the Application for Enrollment Packet using the LDSS decision time-date stamp for list position;
- notifies the child/medical consenter using the *Wait List Notification Form (OCFS-8012)*.

OCFS DJJOY checks slot availability for DD children only:

- if slot is available, continues to step #5 below;
- if slot is not available, but there is room on the Wait List, places child's name on the OCFS DJJOY Wait List upon receipt of the Application for Enrollment Packet;
- notifies child/medical consenter via the *Wait List Notification Form (OCFS-8012)*,

5. immediately completes the B2H Authorization via WMS/CONNECTIONS systems entry (for detailed instructions regarding children enrolled in a DJJOY slot see the B2H CONNECTIONS/WMS Systems Instructions located at www.ocfs.state.ny.us/main/b2h/),
6. sends *Notice of Decision-Authorization (OCFS-8009)* to the child/medical consenter with an attached Medicaid Fair Hearing Notice,
7. notifies the HCIA of the decision that the child has been approved for the B2H Waiver Program so that services may begin, and
8. signs the *IHP (OCFS-8017)*, indicating approval and provides a copy to the HCIA for inclusion in the child's B2H case record.

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

For those children determined *ineligible*, the LDSS is responsible for:

- referring an ineligible child to other resources within the community and documenting the referral in the child's case record,
- sending a *Notice of Decision-Denial of Enrollment (OCFS-8010A)* to the child/medical consenter with an attached Medicaid Fair Hearing Notice,
- notifying the HCIA of the decision that the child has been denied for the B2H Waiver Program, and
- signing the *IHP (OCFS-8017)*, indicating denial, and providing a copy to the HCIA for inclusion in the child's B2H case record.

For a full explanation of Notices of Decisions issued by the LDSS, see Chapter 4, LDSS/DJJOY Roles and Responsibilities.

Step 7: HCIA Initiates waiver services and conducts baseline assessments.

After the LDSS has notified the HCIA that a child has been approved for enrollment in a B2H Waiver, services may begin. The HCIA is required to:

- provide the child/medical consenter, and caregiver with contact information for the HCIA, HCI, Waiver Service Provider (WSP) staff, LDSS, OCFS, and Department of Health (DOH) on the *Contact Information List (OCFS-8027)*. When planning times for service provision, it may be helpful to use a weekly schedule, see Appendix D,
- provide a copy of the *Preliminary IHP (OCFS-8017)* to the WSP staff to make them aware that services may begin as stipulated in the *Preliminary IHP (OCFS-8017)*, and
- complete the Child and Adolescent Needs and Strengths B2H (CANS B2H) instrument within 30 days of enrollment.

Step 8: HCI completes the Initial IHP.

a. Arranging a team meeting: Within 30 days of enrollment, the HCI must hold a team meeting to discuss and document any changes that may have occurred since preparation of the *Preliminary IHP (OCFS-8017)* and to complete the *Initial IHP (OCFS-8017)*. The HCI, medical consenter and informed WSP representative(s) must attend this team meeting. In addition, the following parties must be invited to team meetings and are expected to attend: a representative from the LDSS, a representative from the HCIA beyond the HCI, and the case planner. Individuals who may be invited to a team meeting, but whose attendance is not required: the child and anyone the child/medical consenter wishes to have participate. For more detailed information regarding team meeting participation, see Chapter 9 Individualized Health Plans.

b. Completing the Initial IHP and Detailed Service Plans

Time Frame: The *Initial IHP (OCFS-8017)* is submitted to the LDSS for final authorization within 30 days of enrollment.

The *Initial IHP (OCFS-8017)* reflects the changes made to the *Preliminary IHP (OCFS-8017)* as a result of baseline assessments, including the CANS B2H assessment, and preparation of the *Detailed Service Plans (OCFS-8020)*. Regardless of whether there are changes to the *Preliminary IHP (OCFS-8017)*, an

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

Initial IHP (OCFS-8017) must be prepared along with the *Detailed Service Plans (OCFS-8020)*. The HCI may schedule as many meetings as necessary with the child/medical consentor to complete an *Initial IHP (OCFS-8017)*.

Developing the *Initial IHP (OCFS-8017)* and the *Detailed Service Plans (OCFS-8020)* includes obtaining pertinent information from relevant parties to support and document a full understanding of the child's strengths and needs. The *Detailed Service Plans (OCFS-8020)* are used to identify the goals for the child and to document progress towards each goal. The *Initial IHP (OCFS-8017)* should include as much information as the HCIA can provide through interviews, records, and other sources. See Chapter 9, The Individualized Health Plan, for more details on completing IHPs.

c. Quality Review of the IHP: The HCI forwards the *Initial IHP (OCFS-8017)* to the HCI's supervisor and HCIA Quality Management staff.

The HCIA reviews the *Initial IHP (OCFS-8017)* to verify that B2H Waiver services are appropriately addressing the child's health and welfare and are cost-effective. Once the *Initial IHP (OCFS-8017)* has met internal HCIA approval, it is forwarded to the LDSS for review.

Step 9: HCIA notifies OCFS QMS of IHPs exceeding \$51,600 per year.

If the budget in the child's *Initial IHP (OCFS-8017)* is over \$51,600 per year, the HCIA must also send the *Initial IHP (OCFS-8017)* to the OCFS QMS at the same time it is forwarded to the LDSS for action. The services authorized in the *IHP (OCFS-8017)* may begin simultaneously with QMS notification. The QMS may contact the LDSS and/or HCIA for additional information and/or to determine whether the *IHP (OCFS-8017)* under review would cause aggregate waiver costs to exceed fiscal neutrality requirements. In the event the OCFS BWM determines that aggregate costs would exceed fiscal neutrality requirements, the LDSS is notified that changes to the *IHP (OCFS-8017)* are necessary.

Step 10: LDSS approves Initial IHP.

Time Frame: The LDSS reviews the *Initial IHP (OCFS-8017)* and has 30 days from receipt of the *Initial IHP (OCFS-8017)* from the HCIA to notify the HCIA of its decision to approve or deny the *Initial IHP (OCFS-8017)*. The LDSS signs the *IHP (OCFS-8017)*, indicates either approval or denial, and forwards to the HCIA.

2. Reauthorization Process

The HCIA begins the reauthorization process 60 days *prior* to the scheduled annual reauthorization date. The HCIA must submit to the LDSS the necessary documentation to reauthorize a child's participation in the B2H Waiver Program at least 30 days prior to the scheduled annual reauthorization date.

A child's participation in the B2H Waiver Program is authorized by the LDSS on an annual basis. The reauthorization date is either one year from the date of enrollment, one year from the due date established for date coordination with the Family Assessment and Service Plan (FASP), or one year from the most recent reauthorization, unless a change in the child's circumstances, which may necessitate an earlier process. Examples of such a substantive change in the child's circumstances are discharge from foster care or finalization of adoption.

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

All forms must be executed again for each reauthorization period. The HCI completes the Reauthorization Packet with the following information completed and signed:

- *Reauthorization Form (OCFS-8014)*,
- *Level of Care Form (OCFS-8005A, B or C) and current supporting diagnostic documentation**,
- *Freedom of Choice Form (OCFS-8003)*,
- *Waiver Participant's Rights Form (OCFS-8008)*, and
- *Annual Revised IHP (OCFS-8017)*.

***Note:** See Chapter 5 Health Care Integration Agencies for more information on Level of Care at reauthorization.

Review of Reauthorization Packet: The HCI forwards the Reauthorization Packet to the HCI supervisor and HCIA Quality Management staff. The HCI's supervisor and Quality Management staff review the Reauthorization Packet for completeness, which includes verification of supporting diagnostic documentation from a Qualified Health Care Practitioner for Level of Care, and confirms that B2H Waiver services are appropriately supporting the child's health and welfare and are cost-effective as indicated in the *Annual Revised IHP (OCFS-8017)*. The HCIA submits the Reauthorization Packet to the LDSS at least 30 days prior to the reauthorization due date.

Role of OCFS QMS: If the budget in the child's *IHP (OCFS-8017)* is over \$51,600 per year, the HCIA must also send the *IHP (OCFS-8017)* to the OCFS QMS at the same time it is sent to the LDSS for action. The services authorized in the *IHP (OCFS-8017)* may begin simultaneously with QMS notification. The QMS may contact the LDSS and/or HCIA for additional information and/or to determine whether the *IHP (OCFS-8017)* under review would cause aggregate waiver costs to exceed fiscal neutrality requirements. In the event the OCFS BWM determines that aggregate costs would exceed fiscal neutrality requirements, the LDSS is notified that changes to the *IHP (OCFS-8017)* are necessary.

LDSS review and decision: LDSS reviews the Reauthorization Packet and has 30 days to make an eligibility decision. During the review the LDSS does the following:

- communicates with the HCIA regarding missing or incomplete documentation as appropriate,
- reviews the *Annual Revised IHP(OCFS-8017)*,
- determines appropriateness of the newly submitted *Level of Care Form*, and
- signs the *IHP (OCFS-8017)*, indicates approval or denial, and forwards to the HCIA for inclusion in the child's B2H case record.

The LDSS must, at minimum, reauthorize Medicaid annually. DJJOY collaborates with the LDSS to reauthorize Medicaid annually for children in DJJOY B2H slots.

C. Transitions within the Waiver

Children may remain in the B2H Waiver Program as long as they reside in New York State, need B2H Waiver services, and otherwise meet the eligibility criteria. It is important to note that the B2H Waiver

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

slot remains available to and is the responsibility of the LDSS of origin even when the child moves to another county. The changes and transitions that occur for children who are enrolled in the B2H Waiver Program that may require additional steps are: change of HCI; change of HCIA within the same OCFS B2H Region; change of HCIA from one OCFS B2H Region to another due to a placement change or move; or discharge of a child from foster care.

Note: In the event the child who is discharged from foster care moves to a new county, the LDSS of the new county of residence becomes responsible for Medicaid eligibility determination and Medicaid authorization for the child. This rule always applies to children enrolled in a DJJOY B2H waiver slot. Coordination needs to occur between LDSS to avoid gaps in coverage.

The following changes also warrant a review of the *IHP (OCFS-8017)*:

- child is placed with a different caregiver (e.g., another foster family, birth family, adoptive family) or in a different waiver-eligible setting,
- child attends college in New York State, and
- child will be reaching their 21st birthday within 18 months (see Chapters 4 and 5 for information on transition planning).

1. Changing HCIs

The following steps apply:

1. The child/medical consenter contacts the HCI, a representative of the HCIA, or the LDSS case manager to indicate their desire to change HCI, or the HCI/HCIA representative notifies the child/medical consenter that the HCI is changing.
2. The HCIA provides a list of alternative HCIs. The HCIA provides a *Change of Provider Form (OCFS-8006)* to the medical consenter for completion and signature.
3. The new HCI initiates contact with the child/medical consenter.

2. Changing HCIAS within the same OCFS B2H Region

The following steps apply:

1. The child/medical consenter contacts the HCI, a representative of the HCIA, or the LDSS case manager to indicate the desire to change HCIAS.
2. The HCIA or LDSS provides a list of alternative HCIAS serving the region. The HCIA or LDSS provides a *Change of Provider Form (OCFS-8006)* to the child/medical consenter for completion and signature.
3. The current HCIA must have a dialogue with the medical consenter and the receiving HCIA regarding the effective date of transfer.
4. Each HCIA must document the effective date of the transfer in *Progress Notes (OCFS-8019)*.
5. The current HCIA sends the B2H case records to the new HCIA.
6. The current HCIA must notify all current WSPs of the potential changes.
7. The new HCIA must hold a team meeting to determine whether an *IHP (OCFS-8017)* revision is necessary. For further information about team meetings, see Chapter 6: HCI Activities: Leading Team Meetings.

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

8. The existing *IHP (OCFS-8017)* must stand in effect until a *Revised IHP (OCFS-8017)* is authorized by the LDSS.

Note: If the child wishes to continue receiving services from a WSP who is not a part of the new HCIA's network, the new HCIA is obligated to interview the WSP as a possible subcontractor. The HCIA must take the appropriate steps to subcontract with the WSP agency.

HCIA's are responsible for following the schedule of *IHP (OCFS-8017)* submissions and reauthorizations:

- If the change in HCIA is requested at least 60 days prior to the date of reauthorization, the originating HCIA is responsible for submitting the necessary reauthorization documentation to the LDSS.
- If the change in HCIA is requested within 60 days of reauthorization, the receiving HCIA is responsible for submitting the annual reauthorization paperwork to the LDSS.

3. Changing HCIA's between OCFS B2H Regions

The following steps apply:

1. The LDSS shall notify the HCIA of the impending placement change or move as soon as possible.
2. The current HCIA must contact their OCFS QMS, on behalf of the child/medical consentor, to obtain a list of approved HCIA's in the new region. A *Change of Provider Form (OCFS-8006)* should be given to the child/medical consentor for completion and signature.
3. The current HCIA must have a dialogue with the medical consentor and the receiving HCIA regarding the effective date of transfer.
4. Each HCIA must document the effective date of the transfer in *Progress Notes (OCFS-8019)*.
5. The current HCIA transfers the child's B2H case records to the new HCIA.
6. The current HCIA notifies the current WSP's of the effective date of termination of provision of services to this child.
7. After reviewing the current *IHP (OCFS-8017)*, the new HCI must hold a team meeting with the new WSP's and determine whether an *IHP (OCFS-8017)* revision is necessary.
8. The existing *IHP (OCFS-8017)* must stand in effect until a *Revised IHP (OCFS-8017)* is authorized.
9. HCIA's are responsible for following the schedule of *IHP (OCFS-8017)* submissions and reauthorizations. If the notification of the change in HCIA occurs at least 60 days prior to the date of reauthorization, the originating HCIA is responsible for submitting the necessary reauthorization documentation to the LDSS, otherwise the receiving HCIA is responsible for submitting the annual reauthorization paperwork to the LDSS.

4. Discharge of a Child from Foster Care

The following steps apply:

1. The LDSS shall notify the HCIA of the impending discharge as soon as possible.
2. The HCI, in conjunction with the child, medical consentor, and caregiver determines the following:

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

- a. If a change to the *IHP (OCFS-8017)* is warranted. If so, applicable procedures should be followed.
- b. If reauthorization of B2H services prior to the next scheduled date is warranted. If so, applicable procedures should be followed.
- c. If the child is moving to a new region, note the considerations and steps under the previous section, “Changing HCIA’s between OCFS B2H Regions.”
- d. If the child is moving out of state, this results in discontinuance from the B2H Waiver Program. Procedures for discontinuance in Chapter 4 must be followed.

5. Reasons for Discontinuance from B2H Waiver Enrollment

Children in the B2H Waiver Program are issued a *Notice of Decision-Discontinuance from Waiver Program (OCFS-8011A)* at any time after enrollment, including upon a reauthorization determination, for the following reasons:

- the child is no longer Medicaid eligible,
- the child no longer qualifies based on the level-of-care assessment derived from the appropriate *Level of Care Form (OCFS-8005A, B or C)*,
- the child is no longer capable of living in residences of 12 beds or less (the only qualified settings for receiving waiver services) with the assistance of informal supports, foster care services, and/or B2H Waiver services,
- the child cannot participate for more than 30 consecutive days. Examples include: hospitalization, incarceration, detention, and being absent without consent,
- the child moves to a waiver-ineligible setting, including any Medicaid funded setting such as an Office of Mental Health (OMH) sponsored Family Based Treatment home, Community Residence or in an OPWDD Family Care home, Community Residence, or Individual Residential Alternative,
- the B2H Waiver services are no longer appropriate for the child,
- the cost of the proposed plan of care is above the level necessary to meet the federally mandated requirement that waiver service must be cost neutral in the aggregate when compared to statewide institutional care costs, as determined by OCFS,
- the child/medical consentor no longer consents to enrollment in the B2H Waiver Program,
- the child/medical consentor chooses to receive services from another Medicaid waiver,
- the child has turned 21,
- the child moves outside of New York State,
- the child becomes married, or

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

- the child has died.

If any of the above circumstances occur, the HCIA notifies the LDSS by completing the *Loss of Eligibility Recommendation Form (OCFS-8026)*. Upon receipt of the form, the LDSS reviews the child's status and makes a determination whether to issue the *Notice of Decision-Discontinuance from Waiver Program (OCFS- 8011A)*.

If a child whose participation in the B2H Waiver Program is discontinued, and the child is not receiving continuing B2H services pending a Fair Hearing regarding the discontinuance, and the child wishes to re-enroll, the enrollment process must be reinitiated - provided all other eligibility criteria are met.

6. Re-Enrollment Opportunity

Effective January 1, 2011 children who were enrolled in B2H and are subsequently discharged from foster care and discontinued from B2H are eligible to be re-enrolled in the same B2H waiver type (B2H SED, DD or MedF) provided all other B2H eligibility criteria are met. Children are eligible to be re-enrolled in the B2H Waiver Program up to six months from their B2H discontinuance date. Waiver re-enrollment is authorized by the county of initial B2H enrollment and is contingent upon slot availability.

7. Team Meetings and Agency Conferences prior to Medicaid Fair Hearings

When a concern or problem arises that may impact the child's eligibility, the HCI, in collaboration with the LDSS, must address the issue with the child/medical consentor, and caregiver and determine the appropriate course of action. If the child/medical consentor or caregiver still has questions, then a team meeting may be called for further discussion.

If a child receives any *Notice of Decision (Notice of Decision - Authorization (OCFS-8009), Notice of Decision-Denial of Enrollment (OCFS-8010A), Notice of Decision - Denial of Waiver Service(s) (OCFS 8010B), Notice of Decision - Discontinuance from Waiver Program (OCFS-8011A) or Notice of Decision - Discontinuance of Waiver Service(s), Service Provider(s) and/or Reduction of Service(s) (OCFS-8011B)* from the LDSS, a conference to review the LDSS decision may be requested prior to pursuing a formal Medicaid Fair Hearing by the participant, an advocate, the HCI, anyone the child/medical consentor requests, or anyone involved in the development of the application or *IHP(OCFS-8017)*. The conference must be held by the LDSS within 10 days of receipt of the request. This conference is an opportunity for the individual and advocates to review, with a representative from the LDSS, the reasons for the *Notice of Decision* and address the information they feel is not properly represented. Through explanation, discussion, and negotiation, it may be possible to resolve issues without a Medicaid Fair Hearing. The conference does not affect the deadline for requesting a Medicaid Fair Hearing.

Children receiving a *Notice of Decision* for issues related to the B2H Waiver Program are eligible for a Medicaid Fair Hearing. If the child is in receipt of B2H services at the time the *Notice of Decision* is issued, they are eligible to continue receiving B2H services until the hearing decision has been rendered. All *Notice of Decisions* include information about an individual's rights and Medicaid Fair Hearing procedures.

If the LDSS receives notice from the New York State Office of Temporary and Disability Assistance that a Medicaid Fair Hearing request has been received, the LDSS must immediately notify the HCIA, and the

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

HCIA and HCI must continue to serve the child during the appeal process, unless a request has been made not to continue B2H services pending the decision of the Medicaid Fair Hearing.

A child has the right to seek a Medicaid Fair Hearing for many reasons, including issues related to the B2H Waiver Program. Decisions about Medicaid eligibility are addressed through the Fair Hearing process with the LDSS.

The following issues concerning the B2H Waiver Program may be addressed through the Medicaid Fair Hearing process:

- Was the child offered the choice between waiver services and institutional services?
- Were the services of the child's choice denied or discontinued?
- Were the services of a qualified provider of the child's choice that was willing to serve the applicant or participant denied or discontinued?
- Was the decision of denial or discontinuation of waiver enrollment correct?
- Was the decision to deny, reduce, or eliminate individual waiver services correct?

D. Rights and Responsibilities under the B2H Waiver Program

1. Individual Rights and Responsibilities upon Application

Children/medical consenters who wish to apply to the B2H Waiver Program have certain individual rights that are supported by OCFS in the form of notices and procedures. In addition children/medical consenters are responsible for signing the *Waiver Participant's Rights Form (OCFS-8008)*, to confirm that they have been informed of these rights.

Children have the right to:

- be treated as individuals with consideration and respect,
- be informed of their rights prior to receiving any waiver services,
- be offered the assistance of a translator to interpret the information regarding understanding of the B2H waivers, all forms, and services and supports available through the B2H Waiver Program,
- receive services without regard to race, color, creed, gender, national origin, sexual orientation, or disability, and
- have services provided that support their health and welfare.

2. B2H Participant Rights and Responsibilities

In addition to the preceding individual rights and responsibilities upon application, children participating in the B2H Waiver Program and/or the medical consenter have the right to:

- be informed of, and supported in freely exercising their fundamental constitutional and federal and state statutory rights,
- receive training and support in exercising and maintaining decision-making authority,

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

- be informed of and supported in freely exercising their Medicaid due process rights,
- assume reasonable risks and have the opportunity to learn from these experiences,
- be provided with an explanation of all services available in the B2H Waiver Program and other health and community resources that may be of benefit to them,
- request changes to, assist in the development of, and approve, their *Individualized Health Plans (IHPs)* (OCFS-8017),
- 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 B2H Waiver Program,
- work with the Health Care Integrator (HCI) to request changes in services in accordance with their *IHPs* (OCFS-8017),
- be informed of the name and duties of any person providing services under the *IHP* (OCFS-8017),
- have input into when and how waiver services will be provided,
- receive services from approved, qualified individuals and agencies,
- receive contact information for all service providers and their supervisors, the Health Care Integration Agency (HCIA), the New York State Office of Children and Family Services (OCFS) and New York State Department of Health (DOH) from the HCI,
- refuse B2H Waiver Program services after being fully informed of and understanding the consequences of such actions,
- have their privacy respected, including the confidentiality of personal records, and have the right to refuse the release of the information to anyone not authorized to have such records,
- submit grievances/complaints about any violation of rights or any concerns about services provided without jeopardizing participation in the waiver,
- receive support and direction from the HCI in resolving concerns or complaints about services and service providers,
- receive additional support and direction from the LDSS, the OCFS Quality Management Specialist and Bureau of Waiver Management in the event that the HCI is not successful in resolving concerns and complaints about services and service providers,
- have grievance/complaints responded to in a timely fashion and be informed of the resolution,

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

- have service providers protect and promote the child's ability to exercise all rights identified in this Manual and the waiver applications, and
- have all rights and responsibilities outlined in this Manual forwarded to the participant's medical consentor and any other entity authorized to act on the child's behalf.

By participating in the B2H Waiver Program, the child/medical consentor is responsible for:

- working with the HCI to develop/revise service plans for timely submission and/or reauthorization of the *IHP (OCFS-8017)*,
- working with Waiver Service Providers (WSPs) as described in the *IHP (OCFS-8017)*,
- working with the HCI and other WSPs to change or update goals or services, and
- attending appointments as scheduled and providing 24-hour notice if an appointment has to be cancelled.

3. Role of the Caregiver(s)

Active participation of the caregiver(s) is integral to the success of B2H assessment and service delivery. Although caregivers (if other than the medical consentor) do not possess legal authority to consent to B2H services their input and cooperation can help inform the type, amount and effectiveness of the services approved in the *IHP (OCFS-8017)*.

Many variables can influence the level of involvement of a caregiver and it is important to engage them as early in the process as possible. In an effort to assist both LDSS and HCIAS with these efforts, the *Bridges to Health Agreement to Accept Services* form was developed. This form outlines the expectations of a caregiver related to supporting services, team meeting participation and communication with the HCIA. Either the LDSS or the HCIA may choose to present this information to the caregiver and act as the witness for purposes of completing the form. For a copy of this form, see Appendix P.

Chapter 3:

Becoming a Health Care Integration Agency

Health Care Integration Agencies (HCIAs) are not-for-profit voluntary authorized child care agencies across New York State with demonstrated experience in providing operational and administrative functions at such a level as a Medicaid home and community-based waiver would require. The HCIAs, under the guidelines of the Bridges to Health (B2H) Waiver Program, develop and implement an array of supplemental services for a select group of children in foster care and after their discharge from foster care to aid them in living successfully in their communities. As an HCIA, the agency is responsible for serving children in any of the three B2H waivers—B2H for children with Serious Emotional Disturbances (B2H SED), B2H for children with Developmental Disabilities (B2H DD), and B2H for children who are Medically Fragile (B2H MedF).

A. Policy

Any voluntary authorized child care agency that can demonstrate that it meets the established qualifications for becoming an HCIA may enter into a Provider Agreement with the Office of Children and Family Services (OCFS). A voluntary authorized child care agency may apply to become an HCIA in more than one region. OCFS has developed a Request for Applications (RFA) that describes the criteria and necessary documentation for becoming an HCIA. The RFA is available at the OCFS website or upon request.

Applications are accepted anytime after the initial release of the RFA and reviewed on a first-come, first-served basis. OCFS requires, at a minimum, three months to review the documentation and issue a Provider Agreement to the agency for execution. The qualifications for becoming an HCIA are described in detail in the RFA. It is necessary to submit a separate application for each OCFS B2H region in which a potential HCIA wishes to operate.

1. Overview of Health Care Integration Agency Qualifications

The requirements for becoming an HCIA fall into four general categories: (1) Experience, (2) Character and Competence, (3) Administrative and Financial Viability, and (4) Significant Community Standing.

Below is an overview of the requirements.

Experience

- Corporate authority and an operating certificate from OCFS to provide foster care services in settings with 12 beds or less (therapeutic foster boarding home program, foster boarding home program, group home or agency operated boarding home, etc.) and

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

- The HCIA represents that:
 - it is duly authorized under article 31 of the Mental Hygiene Law as a residential treatment facility, community residence or family-based treatment provider and shall maintain that authorization; OR
 - it is duly authorized under article 16 of the Mental Hygiene Law as a clinic or intermediate care facility for the mentally retarded, community residence, family care program, or an individualized residential alternative, and shall maintain that authorization; OR
 - it is duly authorized under article 28 of the Public Health Law as a hospital or clinic and shall maintain that authorization; OR
 - it has a contract with the Department of Health (DOH), or the Office of Mental Health (OMH) or the Office for People With Developmental Disabilities (OPWDD) to provide home and community-based services to children with disabilities.

The HCIA agrees to notify OCFS immediately if there is a change in the status of a license or contract noted above.

Character and Competence

- Demonstrated experience in serving target population.
- An administrative and fiscal infrastructure capable of implementing both Medicaid and B2H Waiver Program requirements.

Administrative and Financial Viability

- Financial resources to provide funding for service delivery until payment is received.
- Corporate authority as an existing, not-for-profit voluntary authorized child care agency as set forth in its Certificate of Incorporation or Certificate of Amendment.
- Board of Directors that has a minimum of three members, and provides a resolution authorizing participation in OCFS' B2H Waiver Program as an HCIA.
- Proven ability to secure services from other specialty service providers.
- Attestation that Medical Assistance and foster care audits are in good standing.

Significant Community Standing

- Letters of support from the majority of Local Departments of Social Services/Administration for

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

Children's Services (ACS), at least 51 percent of districts in the HCIA region. Since New York City (NYC) ACS represents an entire region, a letter of support is necessary only from ACS when an agency is seeking to become an HCIA in the NYC Region.

–The Letter of Support must attest to the HCIA applicant's good standing in the community it currently serves, and the applicant's effective administration of its existing foster care program. There should be no previous compliance issues that have resulted in significant adverse findings, nor should there be any unresolved pending complaints pertaining to the HCIA applicant. Review of the HCIA application is not required.

–Letters of Support must be signed by a Commissioner, Deputy Commissioner or Director of Services in the OCFS B2H region to be served, and indicate unequivocal support of the applicant to administer the B2H Waiver Program, without any implicit or explicit conditions or limitations thereon. Letters of Support conditioned upon or requesting additional information will be deemed insufficient.

- Cultural competency demonstrated through training of staff (may use an attestation of Culturally Competent Services and Assessment as provided to accreditation bodies).
- Satisfactory OCFS on-site reviews of all foster care programs and activities.
- Considered to be in good operating standing with other state agencies.

2. Approval Process

The process for becoming an HCIA is as follows:

- Step 1:** Voluntary authorized child care agency completes and submits the necessary documentation included in the RFA, including B2H Model Subcontracts with potential Waiver Service Provider (WSP) agencies (if applicable).
- Step 2:** OCFS reviews the application, including whether and how the criteria listed in the RFA are met and what organization(s) will provide each of the B2H Waiver services in the OCFS B2H Region.
- Step 3:** OCFS verifies that the application sufficiently describes how all B2H Waiver services are made available.
- Step 4:** OCFS performs a review of the potential HCIA's administrative competency, as specified in the RFA, and the HCIA has no outstanding practice or financial issues that could impede its ability to fulfill its B2H obligations.
- Step 5:** OCFS performs a review of each of the potential WSP subcontracted agencies' administrative competencies listed in the application and confirms that there are no outstanding practice or financial issues that could impede an HCIA's or their potential WSP subcontracted agencies' ability to fulfill its B2H obligations.

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

- Step 6:** OCFS seeks input from OMH, OPWDD, and/or DOH, and OCFS Regional Offices.
- Step 7:** OCFS signs a Provider Agreement with HCIA.
- Step 8:** Upon approval, OCFS forwards Medicaid Provider Enrollment packet to DOH for entry into eMedNY (for HCIA and all WSP subcontracted agencies).
- Step 9:** OCFS notifies LDSS in the OCFS B2H Region of approval of HCIA and posts the information on the OCFS website.
- Step 10:** LDSS may initiate referrals to HCIA.

As all billing and payment for B2H Waiver services is done through eMedNY, all HCIA and WSP agencies must be enrolled as B2H Medicaid Providers. Each potential WSP agency completes the Medicaid Provider Enrollment packet and sends it to the HCIA. The HCIA forwards all pertinent documentation to OCFS Bureau of Waiver Management (BWM); if approved, BWM sends the Provider Enrollment packet to DOH.

The HCIA and WSP agencies are required to maintain their standing as enrolled providers on the DOH eMedNY system. All B2H HCIA and WSP agencies must comply with the disclosure requirements set forth in title 42 Code of Federal Regulations §455.105(a). The HCIA agrees to comply with the rules, regulations, and official directives of the DOH pertaining to Medicaid, including but not limited to Part 504 of 18 NYCRR.

B. Agreements between HCIAS and WSP agencies

The HCIA must subcontract with or provide directly a sufficient number of service providers to make available all B2H Waiver services to every child enrolled in the B2H Waiver Program who has chosen the HCIA. Using the B2H Model Subcontract, any waiver service for which the HCIA is subcontracting at application must be established prior to the submission of a response to the B2H Waiver Program RFA.

The HCIA is responsible for the following:

- recruiting, employing, and contracting with WSP agencies, on an ongoing basis, to provide a sufficient number of waiver services to address the needs of children choosing that HCIA,
- interviewing potential service providers that an enrolled child or caregiver identifies as a possible WSP agency,
- determining if potential service providers are approvable and submitting a recommendation to OCFS to enroll the WSP agency as a B2H provider, in accordance with the procedures set forth in this Manual,

- providing at least two trainings annually to the WSP agencies in the effective and efficient use of B2H Waiver services, policies, and procedures, and
- monitoring the services and quality of care provided by the WSP agencies. The requirements for monitoring the service providers are set forth in Chapter 10, Providing a High Quality Program.

C. Waiver Service Provider Agency Review Process

The following describes the minimum review process that the HCIA shall use when securing services from a potential WSP agency. The forms necessary to complete this process are located in the RFA for Health Care Integration Agencies. For the steps required to become a WSP agency, see Chapter 7, Waiver Service Providers.

- Step 1:** The HCIA evaluates each potential WSP agency that applies to become a B2H WSP agency on their ability to:
- meet the qualifications in Chapter 8 of this Manual for the provision of the specified service(s) for which they have applied,
 - hire and train qualified employees to provide these services, and
 - conduct appropriate background checks on employees as specified in Chapter 11, Participant Safeguards.
- Step 2:** The HCIA interviews agency managers, reviews additional documents as appropriate, and consults with LDSS and OCFS staff on the capacity of each potential WSP agency to provide the applicable B2H services.
- Step 3:** The applicant WSP agency completes and the HCIA reviews an OCFS *Vendor Responsibility Questionnaire Not-For-Profit Business Entity Form (OCFS-7050)* or an *OCFS Vendor Responsibility Questionnaire For-Profit Entity Form (OCFS-7049)* for the services of Adaptive and Assistive Equipment and Accessibility Modifications.
- Step 4:** The HCIA evaluates the character and competence of the potential WSP agency's Board of Directors so as to give a reasonable assurance of the Board's ability to conduct oversight of the affairs of the program. In so doing, the HCIA requires that Directors disclose information for the previous five years about affiliations with New York State agencies, any criminal convictions, and termination of contracts or suspensions from the Medicaid or Medicare programs.
- Step 5:** The HCIA completes the *Vendor Responsibility Determination Checklist (OCFS-7051)* for each WSP agency applicant. All items must be considered, regardless of the transaction amount. OCFS BWM staff is available to assist the HCIA with the review of both the OCFS Fiscal Sanction List and the OCFS Audit and Quality Control list of contracts with poor performance. HCIAS should send an email to OCFS BWM requesting a review of the OCFS Fiscal Sanction List and the OCFS Audit and Quality Control list. In this email, the HCIA must identify the applicant WSP agency's full legal incorporated name and the Federal

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

Employer Identification Number (FEIN). OCFS BWM will respond by email. The HCIA must include OCFS BWM's response in the documents submitted to OCFS as verification that the items above were reviewed.

Note: The notation “unless applying to be a Health Care Integration Agency,” located in the section of the *Vendor Responsibility Determination Checklist* that refers to contracts with Domestic Violence (DV), Adoption or Foster Care providers that have rates regulated by OCFS, also applies to WSP agencies. Therefore, when reviewing a potential WSP agency, the HCIA must complete the section of the Checklist that requires a review of the applicant WSP agency's Internal Revenue Service (IRS) 990 form (or comparable Tax Form) and the section of the Checklist that requires a review of the applicant WSP agency's financial statements for a determination of fiscal responsibility.

The HCIA is not responsible for the section of the Checklist that requires a review of the applicant WSP agency's past performance with OCFS and other State agencies (OCFS BWM will review this section on behalf of the HCIA).

- Step 6:** The HCIA completes the *Vendor Responsibility Profile* for each WSP agency applicant based on all available information.
- Step 7:** Upon completing this review, if all the requirements are satisfied, the HCIA and potential WSP agency sign the B2H Model Subcontract developed by OCFS. The HCIA reviews the *Schedule A- Waiver Service Provider Commitment Form (OCFS-8035)* for each potential waiver service. The HCIA sends all required information and copies to OCFS as a recommendation to accept the request.
- Step 8:** OCFS, upon its review of the *Schedule A - Waiver Service Provider Commitment Form (OCFS-8035)*, decides if additional review is necessary.
- Step 9:** OCFS sends to DOH the eMedNY Provider Enrollment Packets of those organizations that it determines to be qualified to become a B2H HCIA and WSP agency. If OCFS decides not to recommend an agency to DOH, OCFS informs the agency in writing, including a summary of reasons with a copy sent to the recommending HCIA(s).
- Step 10:** The HCIA shall require that WSP agency's employees and employees of the HCIA who engage directly in the care and supervision of children in the B2H waiver submit to an examination of their background to verify that it is appropriate for them to work with children. The HCIA shall determine that all HCIs and WSPs in their employ or under subcontract with a WSP agency possess the requisite capacity, skills, competencies and qualifications to effectively support children enrolled in the B2H Waiver Program. HCIAS shall utilize and maintain the B2H Personnel Checklists along with supporting documentation at the HCIA (see Appendix U). Details on the types of background check required for providers of the different services are described in Chapter 11, Participant Safeguards.

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

The HCIA shall use the following steps when securing services from a potential WSP agency on an on-going basis (outside of the RFA process):

Follow Steps 1-10 as outlined above, forwarding the original documentation and forms, as well as all required copies to the OCFS BWM.

The HCIA shall use the following steps when an existing WSP agency applies to provide additional services:

- Step 1:** The WSP agency completes the *Schedule A - Waiver Service Provider Commitment Form (OCFS-8035)* for each potential waiver service. The HCIA sends the information to the OCFS BWM as a recommendation to accept the request.
- Step 2:** OCFS notifies DOH (eMedNY) of the changes for billing approval. If OCFS decides not to recommend the approved WSP agency to DOH for the service expansion, OCFS will inform the WSP agency in writing, including a summary of reasons with a copy sent to the recommending HCIA(s).

Chapter 4:

LDSS/DJJOY Roles and Responsibilities

A. Background

The New York State Office of Children and Family Services (OCFS) is the state governmental agency charged with oversight of the provision of child welfare services throughout NYS. The 58 Local Departments of Social Services (LDSS) Commissioners, [including the Commissioner of the New York City Administration for Children's Services (ACS)] and the Commissioner of the Saint Regis Mohawk Tribe, directly administer child welfare services. OCFS Division of Juvenile Justice and Opportunities for Youth (DJJOY) provides equivalent types of services in the state's juvenile justice residential and community services programs. All children considered for enrollment in the Bridges to Health (B2H) Waiver Program must be in receipt of foster care services or DJJOY community services supervision and in the custody of a LDSS Commissioner or the Commissioner of OCFS.

Note: For purposes of this Manual, when the acronym LDSS is used, it is to be interpreted as including OCFS DJJOY. Exceptions will be noted.

The B2H Waiver Program permits the LDSS to furnish an array of home and community-based services that assist enrollees, eligible children in foster care, or children discharged from foster care while in the B2H Waiver Program, in living in the community and preventing medical institutionalization, if otherwise eligible. B2H Waiver services are supplementary to services available through other programs and are specifically tailored to address unmet health and other needs related to a child's severe emotional disturbances, developmental disabilities, and/or physical health issues. These services aim to improve the health and welfare of children in foster care in the least restrictive and most integrated setting appropriate to their needs.

Once enrolled in the B2H Waiver Program, services remain available to eligible children until age 21 if otherwise eligible, even as children transition from foster care to a permanent setting through a return home, adoption, another permanent resource, or independence. B2H Waiver enrollment opportunities (sometimes referred to as slots) in the B2H Serious Emotional Disturbance (B2H SED) waiver are allocated directly to each LDSS. B2H Waiver slots for the B2H Developmental Disabilities (B2H DD) and B2H Medically Fragile (B2H MedF) waiver are allocated to the OCFS B2H Regions, with exceptions noted. The B2H Waiver slot remains available to the LDSS or B2H Region of origin. LDSS program activities for enrolled children remain the responsibility of the LDSS of origin when the child moves.

The B2H Waiver Program is designed to respect the preferences and autonomy of the waiver participant and recognize the importance of freedom of choice for children/medical consenters. Services and supports are planned and effectively implemented in accordance with each child's unique needs, expressed preferences, and decisions concerning his/her life in the community, as the child works toward the desired outcomes.

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

LDSS responsibilities for B2H include the following:

- continuing foster care case management,
- establishing a policy for accepting referrals for B2H consideration,
- providing B2H information to enrollees and potential enrollees,
- reviewing all placement facility licenses and certificates,
- referring potentially eligible children to a Health Care Integration Agency (HCIA) and/or other community resources as appropriate,
- making enrollment, authorization, and reauthorization decisions, and appropriate notifications of authorization, denial, and discontinuance,
- authorizing changes or additions to an enrolled child's *Individualized Health Plan (IHP)* (OCFS-8017). Chapter 9: Individualized Health Plan contains further details regarding the HCIA's ability to increase and provide already authorized services up to \$5,000 without obtaining LDSS sign-off, which does not apply to the services of Health Care Integration, Accessibility Modifications or Adaptive/Assistive Equipment,
- managing slot utilization in concert with OCFS,
- assisting in resolving concerns/grievances/complaints as necessary,
- retaining B2H Waiver Program responsibilities for enrolled children, including after discharge from foster care, and
- participating in Medicaid Fair Hearings requested by or on behalf of B2H applicants and enrollees.

B. Specific LDSS Roles and Responsibilities

1. Pre-enrollment Activities

LDSS responsibilities begin with the identification of children who are potentially eligible for B2H Waiver services. This requires the LDSS to review all children referred to it (regardless of source) and to analyze its foster care population for those children diagnosed as Seriously Emotionally Disturbed (SED), Developmentally Disabled (DD), Medically Fragile (MedF), or a combination of these diagnoses. Once identified, the LDSS is responsible for determining if these children likely meet B2H eligibility requirements.

Each LDSS identifies potential enrollees and refers potential enrollees directly to the HCIA selected by the child/medical consentor. In all instances, the unique needs of each candidate must be carefully considered.

Referrals must be for potential qualified children who would benefit from participation in the B2H Waiver Program, which may:

- allow the child to step-down a level of care (e.g., move from a facility to a foster home),
- avert a higher level of placement for the child (e.g., from a foster home to a facility providing foster care),

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

- avert the placement of a child out-of-state, or
- allow the child to move out of foster care sooner.

B2H Waiver Program participation is only available to children who are Medicaid eligible. Although virtually all children in foster care in New York State are categorically eligible for Medicaid, the LDSS must confirm that the child is eligible and that Medicaid is authorized. (See the *OCFS Eligibility Manual for Child Welfare Programs* for instructions on determining Medicaid eligibility located on the OCFS website, www.ocfs.state.ny.us.)

Upon determination that a child may be eligible for the B2H Waiver Program, the LDSS verifies slot availability/wait list capacity and arranges for or provides the child/medical consenter with the following information:

- a list of approved HCIAS serving the OCFS B2H Region, along with their locations and available published, factual information about the HCIAS,
- assistance in the selection of an HCIA, and
- the selected HCIA's name, address, phone number, and a contact person.

Upon completion of the above, the LDSS refers the child/medical consenter to the HCIA for assistance in the waiver application and enrollment process via the *Referral Form (OCFS-8000)*.

The role of the caregiver is essential to the child's life and participation in the B2H Waiver Program. The caregiver's active involvement, cooperation, and support greatly influence the child's ability to benefit from B2H services. Many B2H waiver services are provided in the child's home, while others are provided outside of the caregiver's home and require the caregiver to bring the child to the service location. To engage the caregiver (if other than the medical consenter) in the B2H Waiver Program, the LDSS may choose to present and witness the *Bridges to Health Caregiver Role and Responsibilities* form (See Appendix P). This form outlines the expectations of the caregiver related to supporting services, team meeting participation and communication with the HCIA.

2. LDSS/DJJOY Referral for Waiver Enrollment

LDSS completes and submits a Referral Packet to the HCIA chosen by the child/medical consenter. The packet includes a *Referral Form (OCFS-8000)* that contains pertinent information vital to the HCIA's ability to process the Application for Enrollment Packet. LDSS tracks the date the packet is sent to an HCIA for monitoring purposes. The 60-day time frame within which the HCIA must submit a completed Application for Enrollment Packet to the LDSS does not start until the HCIA receives a complete Referral Packet.

Referral Packet Contents

- Includes the *Referral Form (OCFS-8000)*:
 - Identifies the child's name, date of birth, gender, and Medicaid Client Identification Number (CIN),
 - Identifies the B2H Waiver Type being requested—B2H SED, B2H DD, or B2H MedF,

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

- A statement that LDSS has determined the child would benefit from B2H Waiver services,
 - States that the child is Medicaid eligible, and
 - Confirms LDSS has assigned a role to the HCIA-designated B2H Waiver Program staff in the CONNECTIONS Family Service Stage. If the child does not become enrolled or later leaves the B2H Waiver Program, the LDSS must un-assign the CONNECTIONS role. This does not apply to children referred by DJJOY as they are entered into CONNECTIONS upon enrollment.
- Provides supporting documentation of a qualifying diagnosis. The documentation must be signed by a Qualified Health Care Practitioner within the last six months, with the exception of the B2H DD Waiver. For B2H DD, a current and valid assessment of a qualifying diagnosis is determined by OPWDD's eligibility guidelines (see Appendices K-N). See Chapter 2, Eligibility/Enrollment, Section A 3, Qualifying Diagnoses for further information.
 - Includes the *Authorization for Release of Information (OCFS-8001)*, signed by the child/medical consentor. Sources of information may include hospitals, physicians, doctors, psychiatrists, psychologists, school personnel, child care agencies, and depending on the circumstances, courts and law enforcement.
 - Supplies the name, title, contact information, and signature of LDSS staff making the referral.

3. Waiver Enrollment

HCIA's assist LDSS in developing enrollment applications and obtaining assessments needed for determination of a child's Level of Care. The 60-day time frame within which the HCIA must submit a completed Application for Enrollment Packet to the LDSS does not start until the HCIA receives a complete Referral Packet. The HCIA completes an Application for Enrollment Packet and returns the completed packet to the LDSS within 60 days of the transmittal date indicated on the complete Referral Packet.

Within 30 days of receipt of the Application for Enrollment Packet, LDSS reviews the packet for completeness and renders a decision.

LDSS is required to conduct the following activities:

- Record the time and date of receipt of the Application for Enrollment Packet on the area designated at the bottom of the *Application Form for Enrollment (OCFS-8004)*. The date and time of receipt determines the order in which packets are reviewed for completeness.
- Confirm that all required documents are complete and signed:
 - *Application Form for Enrollment (OCFS-8004)*,
 - *Understanding the Bridges to Health Medicaid Waiver Program (OCFS-8002)*,
 - *Level of Care Form (OCFS-8005 A, C or OMRDD 02-02-97)*,
 - *Freedom of Choice Form (OCFS-8003)*,
 - *Health Care Integrator Selection Form (OCFS-8007)*,

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

- *Waiver Participant's Rights Form (OCFS-8008)*, and
- *Preliminary IHP (OCFS-8017)*.

If any of these documents are missing or incomplete, immediately contact the HCIA. The HCIA must respond with the requested information as soon as possible. Once all required information is obtained and the Application for Enrollment Packet is determined complete, it is ready for review for B2H Waiver Program eligibility.

- Review Application for Enrollment Packets for eligibility in the order they are determined complete. For example, if a packet is received first but is not complete, the LDSS is able to begin reviewing the next packet for B2H Waiver Program eligibility as it was determined to be the first complete packet.
- Once the packet is determined complete, review the *Preliminary IHP (OCFS-8017)*. This includes identifying budgetary trends and making recommendations to OCFS that promote cost effectiveness. For more detail on what is to be included in an *IHP (OCFS-8017)*, see Chapter 9, The Individualized Health Plan.
- Assess Level of Care as follows:

B2H SED Waiver

Review the completed *Level of Care Eligibility Determination Form for Children with Serious Emotional Disturbances (OCFS-8005A)*; current supporting diagnostic documentation and the HCIA's Level of Care recommendation.

SED Level of Care Supporting Diagnostic Documentation: A current and valid assessment completed by a Qualified Health Care Practitioner in the past **six months** that lists the qualifying diagnosis.

In the event the HCIA determines the child does *not* meet the Level of Care criteria, the LDSS should thoroughly review the documentation and recommendation provided by the HCIA. The LDSS should consider a re-referral, if warranted by a review of the Level of Care or by new or emerging documentation or information, or send a *Notice of Decision-Denial of Enrollment (OCFS- 8010A)* to the child/medical consentor.

B2H DD Waiver

Review the completed initial *ICF/MR Level of Care Eligibility Determination Form (OMRDD 02-02-97)*; current supporting diagnostic documentation and the Office for People with Developmental Disabilities (OPWDD) Developmental Disabilities Service Office (DDSO) decision.

DD Level of Care Supporting Diagnostic Documentation: A current and valid assessment completed by a Qualified Health Care Practitioner as determined by OPWDD's eligibility guidelines (see Appendices K-N) that lists the qualifying diagnosis.

In the event the DDSO determines the child does *not* meet the Level of Care criteria, the LDSS should thoroughly review the documentation and decision. The LDSS may communicate with the

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

DDSO, consider a re-referral, if warranted by a review of the Level of Care or by new or emerging documentation or information, or send a *Notice of Decision-Denial of Enrollment (OCFS- 8010A)* to the child/medical consentor.

B2H MedF Waiver

Review the completed *Level of Care for Children with Medical Fragility (MedF) Pediatric Patient Review Instrument (OCFS-8005C)*; current supporting diagnostic documentation and the physician's or registered nurse's recommendation for Level of Care.

MedF Level of Care Supporting Diagnostic Documentation: A current and valid assessment completed by a Qualified Health Care Practitioner in the past **six months** that lists the qualifying diagnosis.

In the event the HCIA determines the child does *not* meet the Level of Care criteria, the LDSS should thoroughly review the documentation and recommendation provided by the HCIA. The LDSS should consider a re-referral, if warranted by a review of the Level of Care or by new or emerging documentation or information, or send a *Notice of Decision-Denial of Enrollment (OCFS- 8010A)* to the child/medical consentor and refer the child to other available resources within the community. DJJOY does not have MedF slots.

The LDSS reviews and verifies the qualifications of the signatures on the MedF and DD Level of Care Forms, and signs the Level of Care form for SED.

The qualifications are as follows:

B2H SED Waiver

First signature: physician (Medical Doctor (MD) or Doctor of Osteopathic Medicine (DO), a licensed registered nurse, a licensed psychologist, a licensed master's social worker (LMSW), a licensed clinical social worker (LCSW), or a nurse practitioner.

Second Signature: Authorized State or LDSS employee who is a physician (MD or DO), a licensed registered nurse, a licensed psychologist, LMSW, LCSW, or a nurse practitioner, or the minimum qualifications of an authorized individual with a Bachelor of Arts degree in a human services field with a minimum of five years experience serving children with SED.

B2H DD Waiver

The *ICF/MR Level of Care Eligibility Determination Form (OMRDD 02-02-97)* must be completed by the HCIA and authorized by the OPWDD DDSO.

The *ICF/MR Level of Care Eligibility Determination Form (OMRDD 02-02-97)* does **not** require a LDSS signature.

B2H Med F Waiver

The *Level of Care for Children with Medical Fragility (MedF) Pediatric Patient Review Instrument (OCFS-8005C)* must be completed by either a physician (MD or DO), or registered nurse.

The *Level of Care for Children with Medical Fragility (MedF) Pediatric Patient Review Instrument (OCFS-8005C)* does **not** require a LDSS signature.

4. Determination of Eligibility and Authorization

The LDSS signs and dates the *Application Form for Enrollment (OCFS-8004)*, records the decision and, depending on the outcome issues a *Notice of Decision-Authorization (OCFS-8009)*, a *Notice of Decision-Denial of Enrollment (OCFS-8010A)*, or a *Wait List Notification Form (OCFS-8012)*, as appropriate. These notices are sent to the child/medical consentor, as well as the HCIA. Enrollment in a specific B2H Waiver Program is on a “first-come, first-served” basis for eligible children. The date and time of the decision as recorded in the LDSS section of the *Application Form for Enrollment (OCFS-8004)* in the B2H Waiver is used to determine order of enrollment.

When the LDSS makes a determination of B2H Waiver eligibility, the LDSS must verify the availability of enrollment opportunities (slot availability) within the LDSS for SED slots and with the OCFS Quality Management Specialist (QMS) for the DD and MedF slots. The exception is in NYC, where NYC ACS manages the wait lists for all three B2H waiver types and DJJOY who manages the wait lists for their SED and DD waiver slots. The enrollment decision is noted on the *Application Form for Enrollment (OCFS-8004)*.

When it is determined the potential waiver participant is eligible for a B2H Waiver and a slot *is* available, the LDSS:

- enters the appropriate waiver type and date of B2H enrollment in to Restriction/Exception subsystem of the Welfare Management System (WMS) and enters the B2H enrollment information in to the B2H Waiver Window in CONNECTIONS and assigns a role to the HCIA designee. Refer to CONNECTIONS/Welfare Management System Instructions on the OCFS website for further information,
- approves the request for B2H Waiver Program Approved and if slot available—completes *Notice of Decision-Authorization (OCFS-8009)*,
- sends a *Notice of Decision-Authorization (OCFS-8009)* with the appropriate B2H Waiver Type box checked with attached Medicaid Fair Hearing Notice to the child/medical consentor and the HCIA,
- signs the *IHP (OCFS-8017)*, indicating approval, and provide a copy to the HCIA for inclusion in the child’s B2H case record, and
- notifies the HCIA of the decision, so that services may begin immediately.

When it is determined the potential waiver participant is eligible for B2H SED Waiver opportunity but *no* slot is available, the LDSS enters the child’s name on the B2H SED Wait List, issues a *Wait List Notification Form (OCFS-8012)* to the child/medical consentor, and sends a copy of the *Wait List Notification Form (OCFS-8012)* to the HCIA. See Section 10, Enrollment Wait Lists.

When it is determined the child is eligible for B2H DD or B2H MedF, the LDSS, with the exception of the NYC ACS, consults with the OCFS QMS regarding slot availability. As NYC ACS maintains its own DD and MedF lists and DJJOY maintains its own DD list, each would determine if a slot is available without consulting QMS. If *no* slot is available, the LDSS issues a *Wait List Notification Form (OCFS-*

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

8012) to the child/medical consenter and the QMS enters the child's name on the appropriate wait list. See Section 10, Enrollment Wait Lists.

For a child determined ineligible for any of the three B2H Waivers, the LDSS must:

- refer the child to other available resources within the community, and
- send a *Notice of Decision-Denial of Enrollment (OCFS-8010A)* to the child/medical consenter and the HCIA with a Medicaid Fair Hearing notice attached.

5. LDSS Notice of Decisions

LDSS sends a *Notice of Decision* directly to the child/medical consenter. LDSS must inform children/medical consenters of the right to a Medicaid Fair Hearing in compliance with 42 CFR § 431.206 Subpart E. This includes the right to a Medicaid Fair Hearing upon receipt of one of the following five forms:

- *Notice of Decision - Authorization (OCFS-8009)*,
- *Notice of Decision - Denial of Enrollment (OCFS-8010A)*,
- *Notice of Decision - Denial of Waiver Service(s) (OCFS-8010B)*,
- *Notice of Decision - Discontinuance from Waiver Program (OCFS-8011A)*, and
- *Notice of Decision - Discontinuance of Waiver Service(s), Service Provider(s) and/or Reduction of Service(s) (OCFS-8011B)*.

When the LDSS is exercising its responsibilities as the medical consenter for a child, the LDSS issues the appropriate *Notice of Decision* with Medicaid Fair Hearing rights to the portion of the LDSS that is exercising its responsibilities as medical consenter for the child.

Concurrent with the eligibility determination, the LDSS completes and mails the corresponding Notice, as appropriate:

Notice of right to a Medicaid Fair Hearing is attached to *all* of the following Notices:

- ***Notice of Decision-Authorization (OCFS-8009)***: When LDSS determines it concurs with the HCIA recommendation(s) for B2H Waiver enrollment, the LDSS approves the *Application Form for Enrollment (OCFS-8004)* and authorizes the child to receive B2H Waiver services. The LDSS must provide the child with a *Notice of Decision – Authorization (OCFS-8009)*. The date and time when the complete Packet was received by the LDSS is recorded at the bottom of the *Application Form for Enrollment (OCFS-8004)* by the LDSS and is used to determine the order of B2H enrollments. Entrance to the waivers is on a first-come, first-served basis.
- ***Notice of Decision - Denial of Enrollment (OCFS-8010A)***: When LDSS makes a determination that the applicant is not eligible for enrollment in the B2H Waiver Program, the LDSS must provide the applicant with a *Notice of Decision - Denial of Enrollment (OCFS-8010A)*, indicating the reason(s) for denial. In addition, LDSS is responsible for referring ineligible individuals to other resources within the community and documenting the referral in the child's case record.

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

- **Notice of Decision - Denial of Waiver Service(s) (OCFS-8010B):** When LDSS makes a determination that the child is being denied a B2H service, the LDSS must provide the child with a *Notice of Decision - Denial of Waiver Service(s) (OCFS-8010B)* indicating the reason(s) for the denial of waiver services.
- **Notice of Decision - Discontinuance from Waiver Program (OCFS-8011A):** In the event the LDSS determines that the child's participation in the B2H Waiver Program is being discontinued, the LDSS then sends a *Notice of Decision - Discontinuance from Waiver Program (OCFS-8011A)*, indicating the reason for discontinuance. In addition, the LDSS is responsible for referring ineligible individuals to other resources within the community, including other Medicaid waiver programs, and documenting the referral in the child's case record.
- **Notice of Decision - Discontinuance of Waiver Service(s), Service Provider(s) and/or Reduction of Service(s) (OCFS-8011B):** In the event the LDSS determines that the child is being discontinued from a service(s), service provider(s) and/or a reduction of service(s), the LDSS sends a *Notice of Decision - Discontinuance of Waiver Service(s), Service Provider(s) and/or Reduction of Service(s) (OCFS-8011B)*, indicating the reason(s) for discontinuance or reduction.

If the LDSS receives notice from the NYS Office of Temporary and Disability Assistance (OTDA) that a Medicaid Fair Hearing request has been received, the LDSS must immediately notify the HCIA. Based on information included in the request B2H Waiver Program, services may need to continue during the appeal process.

The B2H Waiver Program slot may not be taken by another child during the appeal process as it is possible for the appeal to reinstate services for the child.

6. Reauthorization

For annual reauthorizations, the HCIA submits the B2H Waiver Reauthorization Packet to the LDSS 30 days prior to the annual reauthorization date. The LDSS reviews each *IHP (OCFS-8017)*, determines appropriateness of the *IHP (OCFS-8017)* and reviews the list of services with the proposed budget. The LDSS reauthorizes B2H Waiver Program enrollment on an annual basis. The first reauthorization may occur at less than one year from the initial date of enrollment to align the completion due dates of the *Annual Revised IHP (OCFS-8017)* with the Child Welfare Family Assessment and Service Plan (FASP). See Chapter 9, The Individualized Health Plan, for more details.

In subsequent years, the reauthorization due date will be one year from the most recent reauthorization. The HCIA begins the annual reauthorization process 60 days prior to the annual reauthorization date.

Level of Care Reauthorization

B2H SED Waiver

The LDSS reviews the completed *Level of Care Eligibility Determination Form for Children with Serious Emotional Disturbances (OCFS-8005A)*; current supporting diagnostic documentation and the HCIA's Level of Care recommendation.

SED Level of Care Supporting Diagnostic Documentation: A current and valid assessment completed by a Qualified Health Care Practitioner in the past **12 months** that lists the qualifying diagnosis and continued need for the SED Level of Care.

B2H SED Waiver Signatures

First signature: physician (Medical Doctor (MD) or Doctor of Osteopathic Medicine (DO), a licensed registered nurse (RN), a licensed psychologist, a licensed master's social worker (LMSW), a licensed clinical social worker (LCSW), or a nurse practitioner.

Second Signature: Authorized State or LDSS employee who is a physician (MD or DO), a licensed registered nurse (RN), a licensed psychologist, LMSW, LCSW, or a nurse practitioner, or the minimum qualifications of an authorized individual with a Bachelor of Arts degree in a human services field with a minimum of five years experience serving children with SED.

B2H DD Waiver

The completion of the B2H DD Level of Care for reauthorization is different than the B2H DD Waiver initial authorization. For B2H DD Waiver Level of Care reauthorizations, the Level of Care and current supporting diagnostic documentation are verified by the HCIA and LDSS and documented on the *ICF/MR Level of Care Eligibility Determination Form (OCFS-8005B)*.

The *ICF/MR Level of Care Eligibility Determination Form (OCFS-8005B)* must be completed by HCIs. The *OCFS-8005B* does *not* need to be submitted to OPWDD for annual reauthorization, unless the DDSO granted a "provisional eligibility determination" for a child.

DD Level of Care Supporting Diagnostic Documentation: A current and valid assessment completed by a Qualified Health Care Practitioner as determined by OPWDD's eligibility guidelines (see Appendices K-N) that lists the qualifying diagnosis and continued need for the DD Level of Care.

DD Level of Care Signatures

There are two signatures required on the *Level of Care ICF/MR-Eligibility Determination Form for Children with Developmental Disabilities (OCFS-8005B)* form. The first signature is that of a "Review Physician," which is a physician (or physician's assistant or nurse practitioner if so authorized by a physician). OPWDD has issued an optional change in the requirements related to the review and signatures on the ICF/MR Level of Care eligibility determination. A Qualified Mental Retardation Professional (QMRP) who is familiar with the waiver participant's functional level may review and sign the annual *ICF/MR Level of Care Eligibility Determination Form* in place of a physician (or physician's assistant or nurse practitioner if so authorized by a physician) for all individuals enrolled in the B2H DD waiver. See Appendix T for further information regarding QMRP.

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

The HCIA Executive Director or Designee must sign the *Level of Care ICF/MR-Eligibility Determination Form for Children with Developmental Disabilities (OCFS-8005B)* for reauthorization. The HCIA signatory must be employed by the HCIA and at a minimum: have an Associate's degree in a health/human services field or be a RN AND at least one year of experience in working with people with a developmental disability or one year of experience as a service coordinator with any population.

Note: The ICF/MR Level of Care Eligibility Determination Form (OCFS-8005B) does not require a LDSS signature.

B2H MedF Waiver

Review the completed *Level of Care for Children with Medical Fragility (MedF) Pediatric Patient Review Instrument (OCFS-8005C)*; current supporting diagnostic documentation and the physician's or registered nurse's recommendation for Level of Care.

MedF Level of Care Supporting Diagnostic Documentation: A current and valid assessment completed by a Qualified Health Care Practitioner in the past **12 months** that lists the qualifying diagnosis and continued need for the MedF Level of Care.

B2H Med F Waiver

The *Level of Care for Children with Medical Fragility (MedF) Pediatric Patient Review Instrument (OCFS-8005C)* must be completed and signed by either a physician (MD or DO), or registered nurse.

Note: The *Level of Care for Children with Medical Fragility (MedF) Pediatric Patient Review Instrument (OCFS-8005C)* does **not** require a LDSS signature.

Medicaid Reauthorization

The LDSS must, at minimum, reauthorize Medicaid annually. DJJOY collaborates with the LDSS in the county from which the child was placed to reauthorize Medicaid annually for children in DJJOY B2H slots.

7. Ongoing Delivery of Services and Monitoring

IHPs (OCFS-8017) are reviewed by the LDSS to determine that the plans support the health and welfare of the child and are responsive to his/her goals and needs. Changes or additions to the child's *IHP (OCFS-8017)* must be authorized by the LDSS. The LDSS determines the appropriateness of the *IHP (OCFS-8017)* by monitoring the child's progress through the following mechanisms:

- team meetings,
- Annual B2H reauthorization process,
- Service Plan Reviews (review of all child welfare and B2H services), and
- Child and Adolescent Needs and Services (CANS) B2H assessment.

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

The LDSS identifies budgetary trends for all of its B2H Waiver enrollees and makes recommendations to OCFS that promote cost effectiveness. Medicaid claim data should be used to confirm that claims are consistent with services authorized in the *IHP (OCFS-8017)*. The *IHP (OCFS-8017)* should also be used to support the child's foster care permanency goals whenever possible. If possible, the LDSS case manager should coordinate due dates of the *IHP (OCFS-8017)* with the Family Assessment and Service Plan (FASP), which is the case management planning tool required for all children receiving child welfare services through an LDSS. The HCI should be encouraged to participate in the development of the FASP and to provide pertinent information about the child's health and welfare to the LDSS.

The LDSS case manager should participate in the development of the *IHP (OCFS-8017)*, so that there is a complementary relationship and information sharing between the LDSS case manager and the HCI. Prior to submission of any *IHP (OCFS-8017)* to the LDSS, there should be ongoing communication between the HCI and the LDSS regarding the B2H Waiver Services and the contents of the *IHP (OCFS-8017)*. The LDSS must notify OCFS if any HCIA fails to meet and/or potentially violates any of the contractual obligations included in the Provider Agreement or Model Subcontract. Copies of the Provider Agreement and Model Subcontract are available on the OCFS website, www.ocfs.state.ny.us/main/b2h/

Note: effective January 1, 2011, HCIAS may increase and provide already authorized services up to \$5,000 without obtaining LDSS sign-off, which does not apply to the services of Health Care Integration, Accessibility Modifications or Adaptive/Assistive Equipment. The HCI must convene a team meeting and submit a *Revised IHP (OCFS-8017)* to the LDSS. Additionally, increases that cause the *IHP (OCFS-8017)* budget to exceed \$51,600 must be sent to the OCFS QMS at the same time it is sent to the LDSS – see Chapter 2: Eligibility, Enrollment, Transitions, Rights and Responsibilities for more information.

8. Documentation of B2H Services in the Family Assessment and Service Plan (FASP)

While a B2H-enrolled child is in foster care or in receipt of child welfare services after discharge from foster care, he/she has an open Family Services Stage in CONNECTIONS (New York State's Child Welfare Information System). The FASP is the area within CONNECTIONS used to document all services provided on behalf of children in receipt of child welfare services. The foster care case manager of a child enrolled in the B2H Waiver Program records information, or verifies that information has been recorded, regarding B2H Waiver Program services in the child's FASP. The foster care case manager must also record, or verify that information has been recorded, in CONNECTIONS regarding the B2H Waiver Program as specified in Chapter 12, Systems Links.

9. Managing Allocation of Waiver Slots

OCFS monitors enrollments and occupancy in the B2H Waiver Program throughout New York State. For the B2H SED Waiver, once the total authorized enrollment level in any LDSS has been reached, the names of additional qualifying children seeking B2H enrollment must be entered by the individual LDSS on their Enrollment Wait List. New York City ACS is also responsible for its B2H DD and B2H MedF Enrollment Wait Lists, and OCFS DJJOY is responsible for its B2H DD list.

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

OCFS monitors the wait list population and undertakes a process of review and re-allocation each year. OCFS compares the waiver utilization (enrollments and turnover) and the number of children on the wait list against the waiver allocation (total authorized enrollment level). These periodic reviews help to manage enrollments and may result in re-allocation of unused opportunities to the counties/regions with the greatest need.

10. Enrollment Wait Lists

Once the total authorized enrollment level in any LDSS or B2H Region has been reached, the names of additional qualifying children seeking B2H enrollment must be entered on the appropriate B2H Waiver Program Wait List. The LDSS sends a *Wait List Notification Form (OCFS-8012)* to the child/medical consentor that states the waiver has reached its capacity and that the child's name has been placed on the wait list. The Notification form asks the family and referral source to keep the LDSS informed of any changes in the child's circumstances during the waiting period which could affect his/her need for the B2H Waiver Program.

The wait lists are established under each of the three B2H Waiver Program types—SED, DD, and MedF. The wait list must include the child's name, date of birth, Medicaid Client Identification Number (CIN), the date and time recorded in the LDSS section of the *Application Form for Enrollment (OCFS-8004)*, name of medical consentor, foster care/DJJOY status, the responsible LDSS, and selected HCIA.

Applications for the B2H Waiver Program cannot be accepted once the wait list is at capacity, as outlined below for the separate wait lists for each of the three waiver types:

	B2H SED Managed by LDSS/ACS/DJJOY	B2H DD Managed by OCFS QMS/ACS/DJJOY	B2H MedF Managed by OCFS QMS/ACS
Erie, Westchester, Suffolk, Nassau, Monroe, and Onondaga Counties	Not to Exceed 25%	Not to Exceed 25%	Not to Exceed 25%
All other Counties (excluding ACS/NYC)	Not to Exceed 50%	Not to Exceed 25%	Not to Exceed 25%
ACS/NYC	Not to Exceed 10%	Not to Exceed 10%	Not to Exceed 10%
DJJOY	Not to Exceed 10%	Not to Exceed 25%	N/A

B2H SED slots—Wait lists are managed at the LDSS level:

- Erie, Westchester, Suffolk, Nassau, Monroe, and Onondaga counties waiver wait lists may not exceed 25 percent of the districts' allocated B2H SED Waiver slot capacity.

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

- All other upstate districts, wait lists may not exceed 50 percent of the districts' allocated B2H SED Waiver slot capacity.
- The wait list cannot exceed 10 percent of the allocated B2H SED Waiver slot capacity for ACS or DJJOY.

Upstate B2H DD slots—Wait lists are managed at the regional level:

- All upstate districts must confer with the OCFS QMS staff to determine the availability of slots.
- The wait list capacity may not exceed 25 percent of the allocated B2H DD Waiver slot capacity for the region.
- Once the wait list is full, the OCFS QMS contacts the districts in the region to notify them that the wait list is full, and that no referrals can be accepted until further notice.

NYC B2H DD slots—Wait list is managed by ACS:

- ACS maintains its own wait list for B2H DD slots.
- The wait list capacity may not exceed 10 percent of the allocated B2H DD Waiver slot capacity for ACS.

DJJOY B2H DD slots—Wait list is managed by DJJOY:

- DJJOY maintains its own wait list for B2H DD slots.
- The wait list capacity may not exceed 25 percent of the allocated B2H DD Waiver slot capacity for DJJOY.

Upstate B2H MedF slots—Wait lists are managed at the regional level:

- All upstate districts must confer with the OCFS QMS staff to determine the availability of slots.
- The wait list capacity may not exceed 25 percent of the allocated B2H MedF Waiver slot capacity for the region.
- Once the wait list is full, the OCFS QMS contacts the districts in the region to notify them that the wait list is full and that no referrals can be accepted until further notice.

NYC B2H MedF slots—Wait list is managed by NYC:

- NYC maintains its own wait list for B2H MedF slots.
- The wait list capacity may not exceed 10 percent of the allocated B2H MedF Waiver slot capacity for NYC.

11. Managing the Enrollment Wait Lists

Selection of individuals for B2H enrollment is on a first-come, first-served basis for all eligible children. The date-time stamp of approval of eligibility for enrollment in the B2H Waiver Program *Application Form for Enrollment (OCFS-8004)* is used to determine order on the Enrollment Wait List.

LDSS and QMS manage the wait lists using the following guidelines:

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

- The child remains on the wait list and the Application for Enrollment Packet is retained for as long as the child remains eligible for the B2H Waiver Program.
- Update and monitor the wait list for continued eligibility. For example, if a child moves out of foster care or moves out of state, he/she must be removed from the wait list.
- LDSS should refer children on the wait lists for appropriate community services.
- When a LDSS receives notice that a child in its county is eligible for a vacated B2H Waiver slot, the LDSS verifies the child's continued eligibility for B2H Waiver Program services.
- LDSS contacts the child/medical consenter to confirm that the child is still interested in receiving B2H Waiver services. If they are no longer interested, the child's name is removed from the wait list and noted in the record.
- If the child/medical consenter is still interested in receiving B2H Waiver Program services, LDSS sends all information contained in the child's wait list file, including the Referral and the Application for Enrollment Packets to the HCIA for processing.
 - If the child has been on the waitlist for less than six months the Application for Enrollment Packet, and all associated documentation, is sufficient for consideration of enrollment in the B2H Waiver. However, to prevent any lapses in annual Level of Care eligibility from occurring prior to annual reauthorization, initial Level of Care authorization dates should align with initial enrollment dates.
 - If the child has been on the waitlist for six months or longer, the LDSS must re-refer the child to the HCIA. The LDSS completes a new *Referral Form (OCFS-8000)*, checking the Referral Type of "Subsequent Referral." All documents referenced in Chapter 4, LDSS/DJJOY Roles and Responsibilities section 2, LDSS Referral for Waiver Enrollment, are required, along with copies of all documents from the original Referral Packet. The child remains on the Wait List pending the HCIA recommendation and LDSS decision on the subsequent referral. It is recommended that when completing a subsequent referral for any child on a wait list, all annually required forms should be current to align with the anticipated reauthorization dates.

12. LDSS Participation in Team Meetings

The purpose of a team meeting is to allow collaboration and planning among service providers and the child/medical consenter regarding the child's current needs and to support the health, welfare and permanency of the child. Whenever there is a team meeting to discuss the child's IHP (*OCFS-8017*), a representative from the LDSS must be invited and is expected to attend. The LDSS remains responsible for coordinating the B2H Waiver Program with foster care services, and child welfare services in general, and works with the HCI to coordinate the FASP schedule and the *IHP (OCFS-8017)*. For more detailed information regarding team meeting participation, see Chapter 9, Individualized Health Plans.

13. Grievances and Complaints

Children/medical consenters and caregivers may file grievances/complaints at any time regarding the B2H Waiver Program. See Chapter 11: Participant Safeguards, for an explanation of the grievance and complaint process for B2H. The LDSS may be asked to take a role in helping to resolve issues related to the grievances and complaints. LDSS are informed of grievances and complaints by the OCFS QMS, when it has not been possible to resolve the concern informally.

The B2H process for grievance/complaints is not intended to replace the Medicaid Fair Hearing process. If the grievance/complaint is not resolved and a *Notice of Decision* is issued by the LDSS, the child/medical consenter may then request a Medicaid Fair Hearing. An Agency Conference may be called prior to a Fair Hearing, but the Agency Conference does not affect the day requirement for requesting a Medicaid Fair Hearing after a Notice advising the child of his/her right to a Fair Hearing is sent. See Chapter 2: Eligibility, Enrollment, Transitions, Rights and Responsibilities for more information about Agency Conferences and Medicaid Fair Hearing Rights.

14. Transfers within the B2H Waiver Program

When enrolled children move from one county to another within New York State, they remain enrolled. The B2H Waiver slot remains available to and the responsibility of the LDSS of origin, even when the child moves to another county. For all transfers, the county of origin provides a copy of files or arranges for the transfer of the child's files (as appropriate) to the county to which the child moves.

For children enrolled through DJJOY there is an internal transfer process. However, DJJOY staff must contact both the LDSS where the child is moving from and the LDSS the child is moving to, so the LDSS can close and open a Medicaid case for the child to remain eligible for B2H. This process is also described in Appendix I, Transfers within the B2H Waiver Program.

For Children in Foster Care:

1. When a child moves to **a different county in the same OCFS B2H Region and chooses to retain the same HCIA:**
 - The family/caregiver notifies the LDSS of the intent to move and expected time frames.
 - The LDSS of origin (includes DJJOY) contacts the LDSS in the new location four to six weeks prior to the expected move date, if possible, to advise them of the anticipated date of the child's arrival.
 - The LDSS of origin contacts the HCIA to make them aware of the change of address.
 - The HCIA reviews the *IHP (OCFS-8017)* and makes appropriate changes as required.

2. When a child moves to **a different county in the same OCFS B2H Region and selects a different HCIA:**
 - The family/caregiver notifies the LDSS of the intent to move and the expected time frames.

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

- The LDSS of origin (includes DJJOY) contacts the LDSS in the new county four to six weeks prior to the expected move date, if possible, to advise them of the anticipated date of the child's arrival.
- The LDSS of origin contacts the HCIA to advise them of the change of HCIA provider request.
- The LDSS of origin provides information on the other available HCIA's.
- The child/medical consentor completes a *Change of Provider Form (OCFS-8006)*.
- The original HCIA must have a dialogue with the medical consentor and the receiving HCIA regarding the effective date of transfer.
- Each HCIA must document the effective date of the transfer in *Progress Notes (OCFS-8019)*.
- The new HCIA reviews the *IHP (OCFS-8017)* and makes appropriate changes as required.

3. When a child moves to a county in a different OCFS B2H Region:

- The LDSS of origin (includes DJJOY) contacts the new LDSS four to six weeks prior to the expected move date, if possible, to advise them of the anticipated date of the child's arrival.
- The LDSS obtains the list of HCIA's in the new region, and provides the list to the child/medical consentor.
- The LDSS of origin refers the child/medical consentor to the new LDSS. The new LDSS assists the child/medical consentor in the selection of the new HCIA.
- The child/medical consentor completes a *Change of Provider Form (OCFS-8006)*.
- The original HCIA must have a dialogue with the medical consentor and the receiving HCIA regarding the effective date of transfer.
- Each HCIA must document the effective date of the transfer in *Progress Notes (OCFS-8019)*.
- The new HCIA reviews the *IHP (OCFS-8017)* and makes appropriate changes as required.

For all of the scenarios above, LDSS of origin retains responsibility for the Medicaid and B2H Waiver authorizations. DJJOY retains responsibility for B2H Waiver authorizations and collaborates with the LDSS to reauthorize Medicaid annually for children in the DJJOY B2H slots. The B2H Waiver slot remains the responsibility of the LDSS or DJJOY.

Note: *In the event a child is discharged from foster care and moves to another LDSS, the LDSS of the new county of residence becomes responsible for Medicaid eligibility determination and Medicaid authorization for the child. Coordination needs to occur between LDSS to avoid gaps in coverage.*

15. Discharge from Foster Care

Any child discharged from foster care while in the B2H Waiver Program who remains in New York State may continue B2H enrollment, as long as the child retains Medicaid eligibility and remains otherwise eligible. Prior to discharge from foster care, the LDSS must conduct an Medicaid eligibility determination, with the child budgeted as a household of one, disregarding the parent's income and resources, to establish the child's Medicaid status. Children who are returning to a household in receipt of Temporary Assistance should be evaluated to determine coverage that is most beneficial to the child and family.

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

The LDSS of origin continues to be responsible for the B2H Waiver authorization and must continue to approve the *IHP (OCFS-8017)* for the child and for annual reauthorization of the child in the B2H Waiver Program. The B2H Waiver slot remains available to and the responsibility of the LDSS of origin.

Other than determining the child's Medicaid eligibility, the above-referenced transfer procedures, as outlined in Section 14, also apply for a child who is discharged from foster care.

Any child discharged from foster care and moves out of state while in the B2H Waiver Program is no longer eligible for the B2H Waiver Program and must be discontinued from the program. LDSS sends a *Notice of Decision-Discontinuance from Waiver Program (OCFS-8011A)* to the child/medical consentor and the HCIA.

16. Discontinuance of B2H Waiver Enrollment

When the LDSS becomes aware that a child enrolled in the B2H Waiver Program has lost eligibility, or has received a *Loss of Eligibility Recommendation Form (OCFS-8026)* from the HCIA, it must review the child's status and make a determination whether to issue the *Notice of Decision-Discontinuance from Waiver Program (OCFS-8011A)*.

Enrollment discontinuation requires the development of a *Transition Plan (OCFS-8030)* by the HCIA. See Chapters 5 and 6 for more information. LDSS staff are also responsible for un-assigning the HCIA CONNECTIONS role when enrollment is discontinued. The LDSS must terminate the B2H Waiver in the WMS system. If a child whose participation in the B2H Waiver Program is discontinued, and the child wishes to re-enroll, the enrollment process must be reinitiated, as specified in Chapter 2.

17. Re-Enrollment Opportunity

Effective January 1, 2011 children who were enrolled in B2H and are subsequently discharged from foster care and discontinued from B2H are eligible to be re-enrolled in the same B2H waiver type (B2H SED, DD or MedF) provided all other B2H eligibility criteria are met. Children are eligible to be re-enrolled in the B2H Waiver Program up to six months from their B2H discontinuance date. Waiver re-enrollment is authorized by the county of initial B2H enrollment and is contingent upon slot availability.

18. Aging Out of the B2H Waivers

Children in the B2H Waiver Program are no longer eligible upon their 21st birthday. Eighteen months before the enrolled child's 21st birthday, the HCIA must generate and to the extent possible, implement a *Transition Plan (OCFS-8030)* that identifies the action steps required to connect with needed services and the party responsible for completing the action steps. The *Transition Plan (OCFS-8030)* outlines the ongoing Medicaid State Plan services and other services that the child may need to access.

The LDSS needs to evaluate the participant's eligibility for adult services, verifying that all necessary eligibility and/or assessment information is current and accurate to facilitate the child's discharge from the B2H Waiver Program to appropriate adult services, if indicated.

For Children Enrolled in B2H DD Waiver:

Eighteen months prior to the enrolled child's 21st birthday the HCIA must send the following information to the OPWDD DDSO responsible for the county where the child resides:

- *Transition Plan (OCFS-8030)*,
- HCIA contact name and telephone number,
- Updated evaluations and assessments (see Appendix M for further details),
- Most recent *Level of Care ICF/MR-Eligibility Determination Form for Children with Developmental Disabilities (OCFS-8005B)*, and
- Current consent forms and other referral documentation.

After sending this information to the DDSO, the HCI must initiate transition planning discussions with a representative from the appropriate DDSO. DDSO staff is expected to participate in B2H transition planning meetings regarding the child.

19. Managed Care Policy

Managed Care is a term that is used to describe a health insurance plan or health care system that coordinates the provision, quality, and cost of care for its enrolled members. New York Medicaid Managed Care requires most non-elderly Medicaid eligible New Yorkers to choose a Medicaid health plan. Managed Care plans have a network of providers that offer comprehensive set of health care services. The plans focus on preventive health care and provide enrollees with a medical home for themselves and their families.

Children in the care and custody of LDSS and placed with voluntary authorized child care agencies are *excluded* from Managed Care. In other words, they cannot enroll in any health plan but must receive their health care from qualified providers who participate in Medicaid. Children in foster care who are enrolled in the B2H Waiver Program and are not placed with voluntary authorized child care agencies may participate in Medicaid Managed Care if their LDSS Commissioner (or designee) has decided the child should enroll in a health plan.

Under current policy, children enrolled in the B2H Waiver Program who are discharged from foster care are considered *exempt* from mandatory Managed Care enrollment.

When a child is no longer in foster care, LDSS must consider facilitating a Supplemental Security Income (SSI) application and/or SSI-related disability determination. DJJOY CST Case Managers will consider facilitating an SSI application with the LDSS.

20. Recordkeeping and Documentation

Requirements for maintenance of evaluations/re-evaluation records are as follows: Under 42 CFR 441.303(c)(3), the state assures that written and/or electronically retrievable documentation of all evaluations and re-evaluations are maintained. LDSS, HCIA's and WSPs are responsible for the safe retention of B2H records as follows:

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

Record retention requirements:

- Retain all B2H records pursuant to state laws and regulations but, at minimum, for 30 years after the child is discharged from foster care.
- The records are maintained by the LDSS, HCIAs and WSP agencies and are readily retrievable if requested by the Federal Center for Medicare and Medicaid Services (CMS), OCFS, or DOH.
- The complete B2H record must be maintained by LDSS, HCIAs and WSP agencies for 30 years after discharge of a child who has received B2H services from foster care. This requirement pertains to both hardcopy and electronic documents.

Documentation that must be retained includes: copies of all completed forms, including:

- Local claiming forms,
- copies of *Notice of Decisions* issued by LDSS,
- *IHPs (OCFS-8017)*,
- records of eligibility determinations and evaluations,
- medical records regarding the child, and
- correspondence, including emails.

21. Reimbursement for B2H Waiver LDSS Administrative Costs

All costs incurred by an LDSS are reimbursed according to Medicaid rules and are specified in OCFS Administrative Directives and claiming instructions. For information and instructions specific to reimbursement for B2H related costs see Appendix Q: OCFS Transmittal on B2H Claiming Instructions.

Chapter 5:

Health Care Integration Agencies

Health Care Integration Agencies (HCIAs) are voluntary authorized child care agencies across New York State that have met the criteria set by the Office of Children and Family Services (OCFS) and the Department of Health (DOH). HCIAs are eligible for this dual role because of their knowledge of the unique needs of children in foster care, their community standing, administrative viability, and ability to meet specific provider qualifications and comply with Medicaid requirements. An HCIA must maintain its standing as an enrolled Medicaid provider with DOH. HCIAs agree to serve the three Bridges to Health (B2H) Waivers—B2H for children with Serious Emotional Disturbances (B2H SED), B2H for children with Developmental Disabilities (B2H DD) and B2H for children with Medical Fragility (B2H MedF). For information about how to apply to be an HCIA, see Chapter 3, *Becoming a Health Care Integration Agency*.

HCIAs have five functions, as described in this chapter:

- oversight of health care integration services,
- pre-enrollment/enrollment activities,
- ongoing activities,
- service development and network management, and
- quality management.

A. Oversight of Health Care Integration Services

To maintain the high quality of the B2H Waiver Program, an HCIA must recruit, hire, and sustain a qualified workforce of Health Care Integrators (HCIs). For detailed information on the required qualifications and duties of Health Care Integrators, see Chapter 6: *Health Care Integrators*.

B. Pre-Enrollment/Enrollment Activities

1. Pre-enrollment Responsibilities

The HCIA must accept all referrals from Local Department of Social Services (LDSS) or Division of Juvenile Justice and Opportunities for Youth (DJJOY) of children residing in the OCFS B2H Region for evaluation of potential B2H Waiver eligibility and preparation of Application for Enrollment Packets.

Once a child has been referred to an HCIA, an HCIA representative must facilitate a meeting with the child/medical consentor to discuss the B2H Waiver Program, philosophy, and services, and a list of HCIs must be presented to the child/medical consentor so that an HCI may be chosen. Once assigned, the HCI prepares the materials necessary to complete the Application for Enrollment Packet. Within 60 days of receiving a complete referral, the Application Packet must be submitted to the LDSS. HCIAs are

responsible for serving enrolled children and their caregivers who reside in the B2H region in which the HCIA is approved.

2. Application for Enrollment Packet

The following are the components of the Application for Enrollment Packet:

- *Application Form for Enrollment (OCFS-8004)*,
- *Understanding the Bridges to Health Medicaid Waiver Program (OCFS-8002)*, indicating that the child/medical consenter understand the program's enrollment process and philosophy, and the services and supports available through the waiver program,
- *Authorization for Release of Information (OCFS -8001)*, signed by the child/medical consenter. Sources of information may include hospitals, physicians, doctors, psychiatrists, psychologists, school personnel, child care agencies, and depending on the circumstances, courts and law enforcement,

Note: Records obtained pursuant to a valid authorization may be re-released for treatment purposes. Re-disclosure of records containing information pertaining to drug/alcohol treatment or HIV/AIDS information requires a separate specific authorization. To authorize the re-disclosure of drug/alcohol information, please use the TRS-2 form available on the Office of Alcoholism and Substance Abuse Services (OASAS) website: www.oasas.state.ny.us. To authorize the re-disclosure of HIV/AIDS information use form DOH-2557, available on the Department of Health (DOH) website www.health.state.ny.us.

- *Level of Care Form* specific to the disability program for which the child is applying [*Level of Care Form (OCFS-8005A, C or OMRDD 02-02-97)*],
- *Freedom of Choice Form (OCFS-8003)*, indicating the child/medical consenter have been notified that the child may be eligible for B2H services or a medical institution,
- *Health Care Integrator Selection Form (OCFS-8007)*, indicating that the child/medical consenter have selected the HCI,
- *Waiver Participant's Rights Form (OCFS-8008)*, and
- *Preliminary IHP (OCFS-8017)*, the preliminary service plan for the child.

The completed Application for Enrollment Packet must be submitted to LDSS for approval and authorization.

Note: If a child is placed on a B2H waitlist, see Chapter 4, Managing the Enrollment Waitlists.

3. Conducting Level of Care Evaluations

The HCIA is responsible for completing the initial and annual Level of Care evaluations. The exception to this requirement is for B2H DD Waiver: The Office for People With Developmental Disabilities (OPWDD) Developmental Disabilities Service Office (DDSO) authorizes the initial Level of Care. All Level of Care evaluations must be accompanied by current supporting diagnostic documentation from a Qualified Health Care Practitioner.

Level of Care evaluations are conducted in the following manner:

B2H SED Waiver

SED Initial Level of Care Evaluation: The HCIA initiates and completes the *Level of Care Eligibility Determination Form for Children with Serious Emotional Disturbances (OCFS-8005A)*, making a recommendation for the SED Level of Care with supporting diagnostic documentation. The HCIA submits the outcome of their eligibility determination to LDSS, as part of the Application for Enrollment Packet.

SED Initial Level of Care Supporting Diagnostic Documentation: A current and valid assessment completed by a Qualified Health Care Practitioner in the past **six months** that lists the qualifying diagnosis.

SED Annual Reauthorizations of Level of Care: The process for initiating and completing the *Level of Care Eligibility Determination Form for Children with Serious Emotional Disturbances (OCFS-8005A)* remains the same. However, the requirements for supporting diagnostic documentation are different for reauthorization.

SED Level of Care Supporting Diagnostic Documentation at Reauthorization: A current and valid assessment completed by a Qualified Health Care Practitioner in the past **12 months** that lists the qualifying diagnosis and continued need for the SED Level of Care.

B2H DD Waiver

DD Initial Level of Care Evaluation: The HCIA gathers sufficient supporting diagnostic documentation along with a completed *OMRDD Transmittal for Determination of Developmental Disability* form and a completed *Intermediate Care Facility for the Mentally Retarded (ICF/MR) Level of Care Form (OMRDD 02-02-97)* (See Appendices K - N for forms and guidelines) and provides such documentation to the OPWDD DDSO that serves the child's county of fiscal responsibility. The DDSO authorizes the diagnosis and presence of life skill deficits by signing the *OMRDD 02-02-97* and submitting the results of the eligibility determination to the HCIA, who forwards the outcome to LDSS as part of the Application for Enrollment Packet.

Note: For B2H DD in New York City (NYC): Administration for Children's Services (ACS) secures the Level of Care authorization directly from the local DDSO and includes the signed

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

OMRDD 02–02–97 in the formal Referral Packet. For more information see Appendix S: NYC B2H Initial Level of Care process for the DD Waiver type.

DD Initial Level of Care Supporting Diagnostic Documentation: A current and valid assessment completed by a Qualified Health Care Practitioner as specified by OPWDD’s eligibility guidelines (see Appendices K-N) that lists the qualifying diagnosis.

DD Annual Reauthorizations of Level of Care: The *Level of Care ICF/MR-Eligibility Determination Form for Children with Developmental Disabilities (OCFS-8005B)* is completed under the direction of HCIA supervisory staff. Unless otherwise instructed, form *OCFS-8005B* does not require further DDSO involvement. However, in instances of provisional determination for children, the DDSO may request to review the Level of Care determination.

To remain eligible for B2H DD the following must be present on the *Level of Care ICF/MR-Eligibility Determination Form for Children with Developmental Disabilities (OCFS-8005B)*:

- Question #1: documentation of one or more diagnoses; and a “Yes” is checked in either Question #2, #3 or #4.
- Question #2: (check “Yes” if the child’s record indicates that the child exhibits behavior which endangers him/herself or others) OR
- Question #3: (check “Yes” if any of the listed conditions (A, B or C) are evident from the child’s record or from direct observations) OR
- Question #4: (check “Yes” if adaptive behavior deficits are indicated in any of the listed areas).

DD Level of Care Supporting Diagnostic Documentation for Reauthorization: A current and valid assessment completed by a Qualified Health Care Practitioner as specified by OPWDD’s eligibility guidelines (see Appendices K-N) that lists the qualifying diagnosis and continued need for the DD Level of Care.

B2H MedF Waiver

MedF **Initial** Level of Care Evaluation:

The HCIA initiates and a Physician (Medical Doctor (MD) or Doctor of Osteopathic Medicine (DO) or a Registered Nurse (RN) completes the Level of Care evaluation using the *Level of Care Eligibility Determination Form for Children with Medical Fragility Pediatric Patient Review Instruction (OCFS-8005C)*, making a recommendation for the MedF Level of Care with supporting diagnostic documentation. The completed Level of Care, with the results of the eligibility determination, is submitted to the HCIA, who forwards the outcome to the LDSS, as part of the Application for Enrollment Packet.

MedF Initial Level of Care Supporting Diagnostic Documentation: A current and valid assessment completed by a Qualified Health Care Practitioner in the past **six months** that lists the qualifying diagnosis.

MedF Annual Reauthorizations of Level of Care: The process for initiating and completing the *Level of Care Eligibility Determination Form for Children with Medical Fragility Pediatric*

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

Patient Review Instruction (OCFS-8005C), remains the same. However, the requirements for supporting diagnostic documentation are different for reauthorization.

MedF Level of Care Supporting Diagnostic Documentation at Reauthorization: A current and valid assessment completed by a Qualified Health Care Practitioner in the past **12 months** that lists the qualifying diagnosis and continued need for the MedF Level of Care.

The *Level of Care Form* must be signed by individuals with specific qualifications for both initial waiver entry and annual reauthorization. The LDSS verifies the qualifications of the signatures according to the following guidelines:

B2H SED Waiver Initial and Reauthorization Level of Care Signatures:

First signature: physician (Medical Doctor (MD) or Doctor of Osteopathic Medicine (DO), a licensed RN, a licensed psychologist, a licensed master's social worker (LMSW), a licensed clinical social worker (LCSW) or a nurse practitioner.

Second Signature: Authorized State or LDSS employee who is a physician (MD or DO), a licensed RN, a licensed psychologist, a licensed master's social worker (LMSW), a licensed clinical social worker (LCSW), or a nurse practitioner, or the minimum qualifications of an authorized individual with a Bachelor of Arts degree in a human services field with a minimum of five years experience serving children with SED.

B2H DD Waiver Initial Level of Care Signatures: The *OMRDD Transmittal for Determination of Developmental Disability* form and a completed *Intermediate Care Facility for the Mentally Retarded (ICF/MR) Level of Care Form (OMRDD 02-02-97)* must be completed by the HCIA and authorized by the OPWDD DDSO (See Appendices K-N for forms and guidelines).

Note: The *OMRDD Transmittal for Determination of Developmental Disability* form and the *Intermediate Care Facility for the Mentally Retarded (ICF/MR) Level of Care Form (OMRDD 02-02-97)* do **not** require a LDSS signature.

B2H DD Waiver Reauthorization Level of Care Signatures:

There are two signatures required on the *Level of Care ICF/MR-Eligibility Determination Form for Children with Developmental Disabilities (OCFS-8005B)* form. The first signature is that of a "Review Physician," which is a physician (or physician's assistant or nurse practitioner if so authorized by a physician). OPWDD has issued an optional change in the requirements related to the review and signatures on the ICF/MR Level of Care eligibility determination. A Qualified Mental Retardation Professional (QMRP) who is familiar with the waiver participant's functional level may review and sign the annual *ICF/MR Level of Care Eligibility Determination Form* in place of a physician (or physician's assistant or nurse practitioner if so authorized by a physician) for all individuals enrolled in the B2H DD waiver. See Appendix T for further information regarding QMRP.

The HCIA Executive Director or Designee must sign the *Level of Care ICF/MR-Eligibility Determination Form for Children with Developmental Disabilities (OCFS-8005B)* for reauthorization. The HCIA signatory must be employed by the HCIA and at a minimum: have an Associate's degree in a health/human services field or be a RN **AND** at least one year of

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

experience in working with people with a developmental disability or one year of experience as a service coordinator with any population.

Note: The *ICF/MR Level of Care Eligibility Determination Form (OCFS-8005B)* does **not** require a LDSS signature.

B2H MedF Waiver Initial and Reauthorization Level of Care Signatures:

Physician (MD or DO), or RN must complete and sign the *Level of Care Form*.

Note: The *Level of Care for Children with Medical Fragility (MedF) Pediatric Patient Review Instrument (OCFS-8005C)* does **not** require a LDSS signature.

4. The Individualized Health Plan

It is the responsibility of the HCIA to verify that the HCI has completed the *Individualized Health Plan (IHP) (OCFS-8017)* as stipulated in Chapter 9, The Individualized Health Plan. The HCIA must also verify that B2H Waiver services can appropriately support the child's health and welfare.

The HCI must gather necessary data, either from records or interviews, and record information in person-centered language and in a way that gives proper voice to the child's valued outcomes and goals. This includes seeking information and input from the LDSS. The HCI must obtain a complete and accurate picture of the child and/or medical consenters' history, risk factors, needs, strengths and, as appropriate, preferences regarding:

- A. Family/Caregiver,
- B. Foster Care/Permanency Status,
- C. Living Situation,
- D. Physical Health,
- E. Developmental Health,
- F. Mental Health,
- G. Alcohol and Substance Abuse History,
- H. Community Service,
- I. Recreation or Leisure Time,
- J. Spirituality,
- K. Criminal Background,
- L. Education/school,
- M. Vocation or Job (over 14 years of age), and
- N. Budgeting/Money Management (over 14 years of age).

An objective overview of the child's support network must be included in the *IHP (OCFS-8017)*. The *IHP (OCFS-8017)* must reference the individual(s) responsible for assisting the child with daily activities, medication management, and financial transactions.

The HCI must offer the potential waiver participant and medical consenters the opportunity to have family/caregivers, friends, and/or advocates participate in the development of the *IHP (OCFS-8017)*. The request by a capable child/medical consenters that a specific individual not participate in the planning

process is respected unless otherwise required by the court. The *IHP (OCFS-8017)* must identify those services from the full complement of B2H Waiver services that best support the child in the community.

C. Ongoing Activities

1. Changing an HCI, WSP or HCIA

Freedom of Choice is one of the hallmarks of the B2H Waiver Program. As such, the child/medical consenter may choose to change HCIAS, HCIs, and WSPs at any time.

If the child/medical consenter requests a change in HCI, they contact the HCI or HCI supervisor to explain the reason for making the change. If circumstances necessitate a change in HCI, the HCI/HCIA representative must notify the child/medical consenter of this change. The HCI supervisor provides information about other available HCIs and, once an HCI is chosen, assists the child/medical consenter with completing the *Change of Provider Form (OCFS-8006)*.

If the child/medical consenter requests a change of any other Waiver Service Provider (WSP), they contact the HCI or another HCIA representative to explain the reason for making the change. The HCI assists the child/medical consenter in selecting a new WSP and completing a *Change of Provider Form (OCFS-8006)*. The HCI acknowledges receipt of the *Change of Provider Form (OCFS-8006)* by providing a copy to the child/medical consenter, the child's caregiver, and the current and new WSPs.

If the child/medical consenter requests a change in HCIA, they contact the HCI or another HCIA representative to explain the reason for making the change. The HCIA refers the child/medical consenter to the LDSS to select a new HCIA from those available in their B2H Region.

Once the HCIA is chosen, the LDSS representative assists the child/medical consenter in completing the *Change of Provider Form (OCFS-8006)*. The child/medical consenter then works with the new HCIA as specified above to select a new HCI and if appropriate, new WSPs.

2. Reauthorization Activities

The HCIA must begin the reauthorization process 60 days before the annual reauthorization date and submit the reauthorization packet to the LDSS 30 days before the annual reauthorization date. During the completion of the Reauthorization Packet, the LDSS and HCIA should communicate with one another to support a shared understanding of the needs of the child and how the services of the B2H Waiver Program can assist the child in attaining his/her goals.

The first reauthorization may occur in less than one year to allow for aligning the completion due dates of the *IHP (OCFS-8017)* and the Family Assessment Service Plan (FASP) (see Chapter 9, The Individualized Health Plan). The following steps are taken for reauthorization:

1. HCI prepares and updates the Reauthorization Packet (see Chapter 2, Eligibility, Enrollment, Transitions, Rights and Responsibilities and Chapter 5 Health Care Integration Agencies Section B: 3 for further information regarding the contents of the Reauthorization Packet).

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

2. HCI forwards the Reauthorization Packet to the HCI's supervisor and HCIA Quality Management staff.
3. HCI's supervisor and Quality Management staff evaluate the Reauthorization Packet for completeness and verify that B2H Waiver services are cost-effective and are appropriately supporting the child's health and welfare.
4. HCIA submits the Reauthorization Packet to the LDSS 30 days prior to the reauthorization due date.
5. The LDSS reviews the Reauthorization Packet and has 30 days to make a decision to authorize continued participation in the B2H Waiver Program.

3. Circumstances Requiring IHP Revisions

Outside of scheduled updates to the *IHP(OCFS-8017)*, circumstances may arise during scheduled team meetings or during the HCI's monitoring of service provision that require the completion of a *Revised IHP (OCFS-8017)*. A *Revised IHP (OCFS-8017)* is required when it is determined that expected outcomes of the plan are being realized or need to be altered or when the child has experienced significant changes in physical, psychological, cognitive or behavioral status.

There must be a team meeting involving at least the HCI and child/medical consentor where these circumstances are discussed before submitting a *Revised IHP (OCFS-8017)* to the LDSS.

If the *Revised IHP (OCFS-8017)* reduces or discontinues the provision of any B2H waiver service(s), but the child remains enrolled in the B2H Waiver Program, the LDSS, upon approval, issues the appropriate *Notice of Decision* specifying the service(s) that are being reduced or discontinued. See Chapter 4: LDSS/DJJOY Roles and Responsibilities for further information.

4. Circumstances Requiring B2H Waiver Program Discontinuance

The HCIA conducts ongoing monitoring of eligibility for the B2H Waiver Program and in the event that discontinuance is necessary, advises the LDSS of the child's inability to continue to participate. The HCIA must recommend that a child be discontinued from a B2H Waiver for many reasons, including:

- the child is no longer Medicaid eligible,
- the child no longer qualifies based on the level-of-care assessment derived from the appropriate *Level of Care Form (OCFS-8005A, B or C)*,
- the child is no longer capable of living in residences of 12 beds or less (the only qualified settings for receiving waiver services) with the assistance of informal supports, foster care services, and/or B2H Waiver services,
- the child cannot participate in the B2H Waiver program for more than 30 consecutive days. Examples include: hospitalization, incarceration, detention and being absent without consent,

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

- the child moves to a waiver-ineligible setting, including any Medicaid funded setting such as an Office of Mental Health (OMH) sponsored Family Based Treatment home, Community Residence or in an OPWDD Family Care home, Community Residence, or Individual Residential Alternative,
- the B2H Waiver services are no longer appropriate for the child,
- the cost of the proposed plan of care is above the level necessary to meet the federally mandated requirement that waiver service must be cost neutral in the aggregate when compared to statewide institutional care costs, as determined by OCFS,
- the child/medical consentor no longer consents to enrollment in the B2H Waiver Program,
- the child/medical consentor chooses to receive services from another Medicaid waiver,
- the child has turned 21,
- the child moves outside of New York State,
- the child became married, or
- the child has died.

The HCIA must monitor for the aforementioned circumstances and make recommendations to the LDSS to discontinue enrollment of children from B2H Waivers using the *Loss of Eligibility Recommendation Form (OCFS-8026)* as the circumstances warrant. The HCIA must also develop a transition plan for **all** children leaving the B2H Waiver Program using the *Transition Plan (OCFS-8030)*.

5. Transition Planning

Transition planning procedures must be undertaken prior to discontinuance to inform a child/medical consentor of available community services beyond the B2H Waiver Program. During the transition period, the HCI must verify the need and the child's eligibility for ongoing services, as well as ensuring assessments are current and valid. Children may be discontinued from the B2H Waiver Program for many reasons. Eighteen months before reaching his/her 21st birthday; OR a minimum of three (3) months prior to an anticipated discontinuance; OR within 30 days of an unanticipated discontinuance from the B2H Waiver Program, the HCIA generates a *Transition Plan (OCFS-8030)* that identifies the action steps needed to connect the child to needed services and the individuals responsible for conducting the action steps. This *Transition Plan (OCFS-8030)* outlines the ongoing Medicaid State Plan and other services that may need to be accessed. The *Transition Plan (OCFS-8030)* requires evaluation of the child and his/her need for ongoing services, eligibility verification, and up-to-date assessment information.

D. Service Development and Network Management

The HCIA is responsible for making all B2H Waiver services available, either through its own staff or through subcontract with WSP agency(ies). In addition to providing Health Care Integration, HCIAS may also provide any of the other B2H Waiver services for which they have the required expertise. In this capacity, they may offer services both to children they serve as an HCIA and to the children whose care is managed by another HCIA. In no case may staff providing one of the other B2H Waiver services be an HCI.

1. Administrative Policies and Procedures

The HCIA is required to have policies and procedures that support separation of service provision from the development of the *IHP (OCFS-8017)*. The necessary procedures and policies include:

- HCIs and HCI supervisors must report to a cabinet or executive level manager who does not have responsibility for other B2H Waiver Programs and services.
- Health Care Integration cannot be provided by staff that deliver or manage other B2H Waiver services.
- For an HCI who also has non-B2H responsibilities, the HCIA is responsible for maintaining sufficient records to properly allocate costs between the HCI's B2H and non-B2H activities.
- HCIA quality management functions are discharged by staff that do not have a role in B2H service delivery or the development of B2H Waiver enrollment packages. Further, HCIA quality management staff must report to a senior manager who has no service delivery responsibility and who does not report to an executive who oversees service delivery.
- The HCI is responsible for providing unbiased and comprehensive information to the child/medical consenter about available B2H Waiver services and WSPs. Children/medical consenters must be informed that, if enrollment is approved, there are multiple opportunities to select providers and the HCIA and HCI will provide support in the selection process. HCIs must inform applicants of all HCIAS that are authorized in their communities and that they are under no obligation to remain with the HCIA that helped develop the B2H Waiver Enrollment Packet.
- The HCIA agrees to establish any other safeguards necessary to structurally separate its service delivery responsibilities from its administrative responsibilities as directed by OCFS.

2. Qualified Providers

The HCIA is responsible for recruiting, employing, and contracting with WSP agencies, on an ongoing basis, to provide a sufficient number of WSPs to address the needs of children choosing that HCIA. The HCIA must use the B2H Model Subcontract developed by OCFS to subcontract with any qualified WSP

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

agency. See section C, Waiver Service Provider Review Process in Chapter 3, Becoming a Health Care Integration Agency.

The HCIA must interview potential WSP agencies that a child/medical consentor identifies as a possible WSP. If the WSP agency identified by the child/medical consentor is determined qualified to provide B2H Waiver services, the HCIA must determine if they are approvable and submit to OCFS a recommendation for the WSP agency's enrollment in the B2H Waiver Program. The HCIA is responsible for training the WSP on B2H Waiver Program policies and procedures and for monitoring the services and quality of care provided by the WSPs.

The HCIA shall determine that all HCIs and WSPs in their employ or under subcontract with a WSP agency possess the requisite capacity, skills, competencies and qualifications to effectively support children enrolled in the B2H Waiver Program. HCIAS shall utilize and maintain the B2H Personnel Checklists along with supporting documentation at the HCIA (see Appendix U). The HCIA shall require that appropriate employees self-disclose any criminal record that they may have, that their backgrounds have been checked against the New York State Sex Offender Registry and that it is appropriate that they are engaged directly in the care and supervision of children. See Chapter 11: Participant Safeguards for further information.

3. Training

The HCIA must verify credentials, document that staff are trained in all required areas, and promote professional development. HCIAS are expected to provide training to HCIs and all staff providing B2H Waiver Program Services. See Chapter 14: Training Requirements for further information.

4. Safety Planning

B2H Waiver Program staff safety is paramount to the appropriate operation and execution of services provided to children and their caregivers. The HCIA must design and implement safety programs that promote safety for all staff working in the B2H Waiver Program. Each agency must implement procedures that outline how staff safety is provided for in the child's home and in other environments where staff are engaged with children. The risk potential of both the child and the community must be assessed on a regular basis. In addition, staff must be given the option of requesting that they be accompanied on the visit by designated, trained personnel for safety purposes.

It is recommended that all B2H Waiver Program staff be trained in personal safety techniques and de-escalation techniques should they encounter hostile individuals in the workplace or community. If the HCIA does not already have a protocol in place, it should develop a mechanism for tracking the location and movements of their staff in the community during and after business hours. All B2H staff must have the appropriate means and proper instructions to summon assistance. The use of restraints or restrictive interventions is not permitted in the B2H Waiver Program.

5. Interpretation and Translation Services

HCIAS are required to make arrangements to provide interpretation or translation services for potential and active children/medical consentors who need these services. Potential or active children/medical consentors with Limited English Proficiency must be advised that services are available. Potential or

active children/medical consenters who are of Limited English Proficiency may bring a translator of their choice with them to meetings with WSPs and/or the HCI. However, a potential or active waiver children/medical consenter who is of Limited English Proficiency, cannot be required to provide their own translator, and no potential or active waiver participant who is of Limited English Proficiency can be denied access to services or enrollment in the waiver on the basis of a HCIA's temporary inability to provide adequate interpretation or translation services at no cost to the potential or active waiver participant/medical consenter.

E. Quality Management

Quality management activities are conducted on a continuous basis to determine whether HCIAs are operating in accordance with B2H Waiver Program requirements, statutes and regulations, and to achieve desired outcomes for children. The HCIA is required to use staff and lines of supervision that are separate from service delivery functions to fulfill this important aspect of the B2H Waiver Program. See Appendix H, HCIA Administrative Separation of Duties Chart, for more information.

The following are the key quality management strategies that center on the needs and goals of children:

1. Completing Regular Reviews of Documentation

The HCIA is required to review all supporting documentation for appropriate and efficient use of services. In this review, it needs to be determined that:

- selected services in the *IHP (OCFS-8017)* are appropriate for the child and family/caregiver,
- service delivery and/or availability coincide with the start date specified on the *IHP (OCFS-8017)*,
- required signatures are provided in the *IHP (OCFS-8017)*,
- *Detailed Service Plans (OCFS-8020)* describe the goals and intervention strategies for each authorized service, as well as the child's achievement of goals at six-month intervals,
- *Service Summary Forms (OCFS-8018)* are maintained in the child's case record to support service delivery and progress toward goals,
- *Progress Notes (OCFS-8019)* are completed and submitted on a monthly basis to capture contacts on behalf of or with the child, and
- outcomes are being adequately measured and documented through use of the Child and Adolescent Needs and Strengths (CANS) B2H instrument.

2. Reviewing Incidents and Complaints

The HCIA must establish a Serious Reportable Incident Review Committee to review all Serious Reportable Incidents to determine if incidents are handled properly and to the satisfaction of the child/medical consenter. Each HCIA must also develop or use a system for receiving and handling B2H-related grievances/complaints. See Chapter 11, Participant Safeguards, for more information.

3. Caregiver Satisfaction Survey

As part of the B2H Waiver Program quality framework, assessment of caregiver satisfaction is monitored. The B2H Caregiver Satisfaction Survey is administered for each child in the B2H Waiver Program when the child has completed 6 or more months of B2H enrollment.

The B2H Caregiver Satisfaction Survey meets several goals:

- obtain caregivers' perceptions of the B2H Waiver Program and waiver services,
- assess interim child outcomes from the caregiver's perspective,
- provide HCIA and WSP agencies with information they can use for quality assurance purposes, and
- provide OCFS with information to compare results across regions, HCIA and WSP agencies, B2H waiver types, services, and other analyses.

The B2H Caregiver Satisfaction Survey is administered in the following order of preference:

- online survey,
- phone interview by non-B2H staff entered into the online survey, or
- in cases where online or telephone interview are not available, a paper version completed by the caregiver, and entered into the online survey by non-B2H staff.

A caregiver's refusal or failure to complete the Caregiver Satisfaction Survey has no effect upon a participant's eligibility for B2H services. The survey may be completed by birth parents, foster parents, group home staff, and/or adoptive parents. The survey is accessed on-line at www.ocfs.state.ny.us/main/b2h/survey .

4. Maintaining Proper Documentation

The complete B2H record, including records referring to eligibility determinations, *IHPs (OCFS-8017)* , and service provision must be retained for a minimum of thirty (30) years after the child is discharged from foster care. The records are maintained by the HCIA and need to be readily retrievable if requested by the Centers for Medicare and Medicaid Services (CMS), OCFS, DOH, or other authorized entity.

For children enrolled in the B2H Waiver Program and living in a Group Home or Agency Operated Boarding home, an individual Medication Administration Record (MAR) must be maintained in the child's foster care medical record (the file containing all available information and documents related to the child's health, including assessments and maintained by qualified health staff and organized in such a way that the information is easily accessible and useable), and be accessible to staff who administer medication to that child. The MAR must include the date and time that each dose is administered and the initials of the individual who administered, helped, or supervised the self-administration of the medication. The MAR must also include documentation of medication errors, actions taken, and the effects of the errors.

5. Reporting to OCFS

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

As the primary oversight agency for the B2H Waiver Program, OCFS plays a major role in quality management. For OCFS to perform this function, HCIAs must report to the OCFS Bureau of Waiver Management (BWM), Quality Management Specialist (QMS), and the appropriate LDSS using the *Health Care Integration Agency Quarterly/Annual Report (OCFS-8015A)* and the *Serious Incident Review Committee Quarterly Report (OCFS- 8015B)*.

The *Health Care Integration Agency Quarterly/Annual Report (OCFS-8015A)*, provides information about: referrals, sufficiency of providers, waiver budgets, compliance with submission of *IHPs (OCFS-8017)*, and trends or best practices.

The HCIA must also submit the *Serious Incident Review Committee Quarterly Report (OCFS- 8015B)* to OCFS. This includes the number of incidents and the waiver providers' responses to closed serious reportable incidents from the Serious Reportable Incident Committee.

Any reporting of medication errors must be made on the *Medication Error Report (OCFS-8036)*. Providers are required to record the following errors: waiver participant in receipt of prescribed medication, dosage, routing, and dosage timing and frequency. The *Medication Error Report* must be made available, if requested, to OCFS, DOH or CMS.

6. Intake Deferral

When OCFS becomes aware of or is notified of (an) issue(s) regarding quality of service provision by a HCIA, or at the request of the HCIA, OCFS and the HCIA may decide to temporarily defer new referrals to that HCIA via the Intake Deferral Process. Where appropriate, OCFS notifies the HCIA in writing that the HCIA is placed on Intake Deferral, including the duration of and specified reason(s) for the deferral, and request a written Correction Plan from the HCIA. OCFS also notifies the referring LDSS of the HCIA's Intake Deferral status.

The Intake Deferral Process notification serves as the written notice that the HCIA and OCFS agree that the HCIA is ineligible to receive new referrals of the B2H Waiver Program participants. Reasons for Intake Deferral may include, but are not limited to, the following items as described and/or defined in this Manual:

- Untimely and/or inadequate documentation, including but not limited to: *Individualized Health Plans (OCFS-8017)*, *Detailed Service Plans (OCFS-8020)*, and/or *Service Summary Forms (OCFS-8018)*;
- Unacceptable provider practices;
- Unacceptable service provision;
- Provider's failure to deliver specific services; and/or
- Provider's failure to follow B2H waiver policies and procedures.

Within ten (10) business days of notification of Intake Deferral, the HCIA must submit a written Correction Plan describing its actions to address and remediate identified deficiencies, in addition to strategies to prevent future occurrence of the specific issue(s). When the Correction Plan is deemed acceptable by OCFS, the HCIA receives notice from OCFS that the Intake Deferral ceases as of a specific date. OCFS also notifies the LDSS that the HCIA submitted an acceptable Correction Plan and the specified end date of the HCIA's Intake Deferral.

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

This Intake Deferral Process does not affect B2H participants currently being served by the HCIA.

Nothing entitles an HCIA to the Intake Deferral Process or affects the ability of OCFS to pursue the termination of the Provider Agreement pursuant to the terms of the Provider Agreement and/or this Manual.

7. Site Visits by Governmental Agencies

HCIAAs are required to fully cooperate with OCFS and other governmental entities during site visits and audits, and submit corrective action plans within prescribed time frames.

8. HCI Billing Policies

For information on HCI Billing Policies, see Chapter 13, Billing.

Chapter 6:

Health Care Integrators

Health Care Integrators (HCIs) are employed by Health Care Integration Agencies (HCIAs). HCIs are responsible for Health Care Integration, the B2H Waiver service through which the *Individualized Health Plan (IHP) (OCFS-8017)* is created and managed. Their role is to assess the need for services, develop and update the *IHP (OCFS-8017)*, link the child and family/caregiver to the identified services, consult with the child and caregiver on the appropriate provision of services, stabilize the environment for the child and caregiver, and advocate for the child's needs. See Chapter 2, Eligibility/Enrollment, for information on the HCI's responsibilities related to authorization and enrollment activities.

From information supplied by the Local Department of Social Services (LDSS) and obtained from the child/medical consentor, and caregiver, the HCI identifies the health care service needs of the child and develops the *IHP (OCFS-8017)*. The HCI communicates with the child's caregiver/family to construct the plan and arranges for the necessary medical, social, rehabilitative, vocational, and educational services. The HCI must link with the caregivers and professionals associated with the child throughout the child's enrollment with the HCIA.

The HCI is responsible for monitoring all Waiver Service Providers' (WSPs) work in relation to the requirements of the stated goals in the *IHP (OCFS-8017)*. The HCI is expected to intercede on behalf of the child or caregiver to gain access to and/or facilitate needed services and supports. The HCI provides the link between the child and the WSPs. The HCI must also monitor and observe the child, family/caregiver and WSPs to confirm that needed health care services and supports are delivered.

Interaction between the HCI and the Caregiver

For the purposes of the B2H Waiver Program, the caregiver is the individual who provides for the child's everyday needs, safety, and well-being. For children in foster family boarding homes who are receiving B2H Waiver services, the foster parent(s) are the primary caregivers. For the children in foster care congregate facilities of 12 beds or less who are receiving B2H Waiver services, the staff of the facility are the caregivers. Once the child leaves foster care, the caregiver is the member of the child's household who primarily attends to the needs of the child, such as the birth parent or adoptive parent.

The role of the caregiver is essential to the child's life and participation in the B2H Waiver Program. The caregiver's active involvement, cooperation, and support will greatly influence the child's ability to benefit from B2H Waiver services. Many of the waiver services are provided in the caregiver's home, while others are provided outside of the caregiver's home and may require the caregiver to bring the child to the service location. In an effort to engage the caregiver (when other than the medical consentor) in the B2H Waiver Program, the HCI may choose to present and witness the *Bridges to Health Caregiver Role and Responsibilities* form, see Appendix P. This form outlines the expectations of the caregiver related to supporting services, team meeting participation and communication with the HCIA.

The HCI introduces all WSPs to the child and caregiver and works to establish good rapport. The HCI assists with scheduling the delivery of services in and out of the home, as needed. The HCI must also

inform the caregiver of his/her ability to file a grievance or complaint regarding services provided through the B2H Waiver Program.

A. Qualifications and Training Requirements

HCIAAs hire B2H staff that possess or exceed the minimum skills and training required to provide an assigned B2H service and to meet the primary objective of protecting and promoting the health, safety and well-being of children receiving B2H services. When assigning HCI staff, the HCIA will match the skills of a B2H employee with the most recent assessment of the particular child who is receiving B2H services.

1. Qualifications

The preferred qualifications for an HCI are:

- a master's degree in social work, psychology, or other related field, or to be licensed as a Qualified Health Care Practitioner, a Registered Nurse (RN), or a Special Education teacher, *and*
- a minimum of one year of experience providing service coordination and information, linkages, and referrals for community-based services to children with special needs, individuals with disabilities, or seniors.

The minimum qualifications for an HCI are:

- a bachelor's degree in social work, psychology, or other related field *and*
- four years of experience providing service coordination.

An HCI working with children enrolled in the B2H Waiver Program for the Medically Fragile population must be a RN. There are two options available to HCIAAs to meet this requirement:

Option 1: The HCI is an RN.

Option 2: The HCI is a non-RN with the support of a RN for medical oversight as more fully described below. The training requirements of the RN include attendance of OCFS sponsored Training for Health Care Integrators.

Referral and Application for Enrollment

- Upon receipt of a MedF Referral Packet, the HCIA assigns an HCI and refers the case to the HCIA Medical Director to assign the case to the HCIA's RN's caseload for medical oversight.
- The assigned RN reviews child's medical record and meets with the HCI to review information contained in the Referral Packet.
- The HCI and RN schedule a joint initial home visit upon receipt of the referral, preferably within two weeks.
- The RN conducts an assessment and completes and submits the *Level of Care (LOC) Pediatric Patient Review Instrument (OCFS-8005C)* to the HCI.

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

- The RN recommends appropriate service delivery goals for WSPs to the HCI.

Once a child is enrolled in B2H MedF, it is estimated that the RN will average 6 hours per month per child to:

- conduct one face-to-face visit every two months (preferably with the HCI),
- document all home/community visits with the child on *Progress Notes (OCFS-8019)*,
- attend the initial team meeting (within 30 days of enrollment),
- attend one additional team meeting annually,
- confer with the HCI on a regular basis and document the same in a *Progress Notes (OCFS-8019)*,
- at Annual Reauthorization, the RN will complete a *Level of Care (LOC) Pediatric Patient Review Instrument (OCFS-8005C)* for the *Annual Revised IHP (OCFS-8017)*. The HCI is responsible for all other documentation related to the annual reauthorization,
- in the event the RN becomes aware of any Serious Reportable Incident (SRI), the RN is responsible for recording and reporting the incident to the HCI. The HCI will share all SRIs with the assigned RN and confer with the RN regarding any follow-up and steps to be taken, and
- be consulted and provide input whenever a *Transition Plan (OCFS-8030)* or Discharge Plan is being formulated for a child. The HCI remains responsible for the transition and discharge plans.

2. Training Requirements

Mandatory Training

All HCIs and HCI supervisors are required to have appropriate training, see Chapter 14, Training Requirements for all B2H training requirements.

B. HCI Activities

1. Pre-Enrollment responsibilities

Once a child has been referred to an HCIA by the LDSS for assessment and completion of an Application for Enrollment Packet, the HCI directs the preparation of the packet. This process must begin by meeting with the child/medical consentor, and other caregivers to discuss the B2H Waiver Program, philosophy, and services available. Information gathering is both a formal and informal process, and should be done with the goal of obtaining the fullest and clearest picture of the child and the child's life. LDSS should be included in information gathering.

Within 60 days of receiving referrals from the LDSS, the HCIs are responsible for the accurate and appropriate completion of Application for Enrollment Packets. Completed packets must be submitted to the HCIA supervisor and Quality Management staff for review and submittal to the LDSS for approval. The Application for Enrollment Packet includes:

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

- *Application Form for Enrollment (OCFS-8004),*
- *Understanding the Bridges to Health Medicaid Waiver Program Form (OCFS-8002)*
- *Level of Care (OCFS-8005 A, C or OMRDD 02-02-97) Form* specific to the B2H Waiver diagnosis of the child,
- *Freedom of Choice Form (OCFS-8003),*
- *Health Care Integrator Selection Form (OCFS-8007),*
- *Waiver Participant's Rights Form (OCFS-8008),* and
- *Preliminary IHP (OCFS-8017).*

The LDSS then has 30 days to make a decision regarding authorization of the service plan and waiver enrollment and notify the HCIA of the enrollment decisions.

For a complete discussion of the Enrollment Process refer to Chapter 2, Eligibility/Enrollment.

2. Preparing Individualized Health Plans (IHPs)

The HCI is the primary architect of the *IHP (OCFS-8017)* and the plan represents the blueprint for delivery of B2H community-based services and supports. The HCI is responsible for the completion of the *IHP (OCFS-8017)* and monitoring that the child is receiving the specified services.

The *IHP (OCFS-8017)* is a multi-page document that contains assessment information, child and family needs and preferences, and outlines the constellation of B2H Waiver services needed to support the child in their home and community. The *IHP (OCFS-8017)* identifies the WSP responsible for each B2H Waiver service the child needs and must also reflect Medicaid State Plan services.

During the development of the *IHP (OCFS-8017)*, the HCI must offer the child/medical consentor the opportunity to have family/caregiver, friends, and/or advocates participate. The request by a child/medical consentor that a specific individual not participate in the planning process must be respected unless otherwise required by the court.

The HCI must gather necessary data, either from records or interviews, and record that information in person-centered language and in a way that gives proper voice to the valued outcomes and goals of the identified child. The HCI must seek information and input from the child's case planner and case manager. The HCI must obtain a complete and accurate picture of the child and/or medical consentor's history, risk factors, needs, strengths and, as appropriate, preferences concerning the following topics:

- A. Family/Caregiver,
- B. Foster Care/Permanency Status,
- C. Living Situation,
- D. Physical Health,
- E. Developmental Health,
- F. Mental Health,
- G. Alcohol and Substance Abuse History,
- H. Community Service,
- I. Recreation or Leisure Time,
- J. Spirituality,

- K. Criminal Background,
- L. Education/School,
- M. Vocation or Job (over 14 years of age), and
- N. Budgeting/Money Management (over 14 years of age).

An objective overview of the child's support network must also be obtained and included in the plan documents. The plan must also reference individuals responsible for helping the child with daily activities, medication management, and financial transactions.

3. IHP Revisions/Annual Reauthorizations

Outside of scheduled updates to the *IHP (OCFS-8017)*, circumstances may arise during team meetings or during the HCI's monitoring of service provision that require the completion of a *Revised IHP (OCFS-8017)*. A *Revised IHP (OCFS-8017)* is required when it is determined that expected outcomes of the plan are being realized or need to be altered or when the child has experienced significant changes in physical, psychological, cognitive, or behavioral status that require a change in service provision. A *Revised IHP (OCFS-8017)* must be submitted to the LDSS when a waiver service is increased*, decreased, added, or discontinued. There must be a team meeting involving at least the HCI and child/medical consentor where these circumstances are discussed before submitting a *Revised IHP (OCFS-8017)* to the LDSS. For details on reauthorization activities see Chapter 5, Health Care Integration Agencies

If a *Revised IHP (OCFS-8017)* ends the provision of an individual B2H Waiver service(s), but the child remains enrolled in the B2H Waiver Program, the LDSS, upon approval, issues the appropriate *Notice of Decision* specifying the service(s) that are being reduced or denied. The child/medical consentor may pursue a Medicaid Fair Hearing for any *Notice of Decision* received. See Chapter 4: LDSS/DJJOY Roles and Responsibilities.

Regardless of whether there have been revised *IHPs (OCFS-8017)* completed for a child, an *Annual Revised IHP (OCFS-8017)*, and all other contents of the Reauthorization Packet, must be submitted to the LDSS at least 30 days prior to the annual reauthorization. The first reauthorization may occur at less than one year from the date of enrollment to align the completion due dates of the *IHP (OCFS-8017)* with the Family Assessment and Service Plan (FASP). Until the LDSS has formally approved the *Annual Revised IHP (OCFS-8017)*, the existing *IHP (OCFS-8017)* must stand in effect. See Chapter 9, The Individualized Health Plan, for more details.

***Note:** effective January 1, 2011, HCIA's may increase and provide already authorized services up to \$5,000 without obtaining LDSS sign-off, which does not apply to the services of Health Care Integration, Accessibility Modifications or Adaptive/Assistive Equipment. The HCI must convene a team meeting and submit a Revised IHP (OCFS-8017) to the LDSS. Additionally, increases that cause the IHP (OCFS-8017) budget to exceed \$51,600 must be sent to the OCFS QMS at the same time it is sent to the LDSS – see Chapter 2: Eligibility, Enrollment, Transitions, Rights and Responsibilities for more information.

4. Post-Enrollment Responsibilities

Upon receiving confirmation of enrollment from the LDSS, the HCI's next steps in the process of linking children to services are as follows:

1. Notify the child/medical consentor and caregiver that services will begin.
2. Notify the WSPs to initiate B2H services.
3. Complete the Child and Adolescent Needs and Strengths (CANS) B2H baseline assessment within the first 30 days of enrollment. The CANS B2H assessments for all enrolled children must be administered every six months, at program discontinuance, and more frequently if the child has experienced significant changes in physical, psychological, cognitive, or behavioral status.
4. Oversee completion of the *Detailed Service Plans (OCFS-8020)*, which identify goals, intervention strategies, and time frames, and status of progress towards goals. The HCI is responsible for completing the *Detailed Service Plans (OCFS-8020)* for the following B2H services: Health Care Integration, Skill Building, Family/Caregiver Supports and Services, Planned Respite, Adaptive/Assistive Equipment, and Accessibility Modifications. For accessibility modifications and/or adaptive/assistive equipment, the *Detailed Service Plan (OCFS-8020)* is captured in the *Accessibility Modifications and/or Adaptive and Assistive Equipment Description, Cost Projection and Final Cost Form (OCFS-8028)*. The HCI is responsible for monitoring the completion of *Detailed Service Plans (OCFS-8020)* completed by WSPs for all other B2H services. The HCI, or WSP supervisor, completes the *Detailed Services Plans (OCFS-8020)* when WSP staff is not identified.
5. Confirm and compile information for preparing the *Initial IHP (OCFS-8017)*. This document differs in its depth and detail from the *Preliminary IHP (OCFS-8017)*, but not necessarily in direction or choice of services. The HCI must incorporate pertinent information from relevant parties to gain a full understanding and document the strengths and needs of the child.

5. Facilitating a Change in HCIA, HCI or WSP

The child/medical consentor may choose to change HCIA, HCI, and WSPs at any time. The HCI is responsible for assisting the child/medical consentor with the process that accompanies a request to change any B2H WSPs as outlined below.

The child/medical consentor may request a change in HCIA or WSPs, at any time by informing the HCI or another HCIA representative and explaining the reason for the change. The HCI assists the child/medical consentor in completing a *Change of Provider Form (OCFS-8006)*. The HCI sends the completed *Change of Provider Form (OCFS-8006)* to the child/medical consentor, the caregiver, the current and new WSP, the LDSS and case planning agency if applicable.

If the child/medical consentor wishes to change HCIs, the child/medical consentor contacts the HCI or HCI supervisor or if circumstances necessitate a change in HCI, the HCI/HCIA representative must notify the child/medical consentor of this change. The HCI supervisor or other HCIA representative provides

information to the child and medical consentor about available HCIs and assists the medical consentor with completing the *Change of Provider Form (OCFS-8006)*.

6. Caseload Responsibilities, Management, and Required Service Contacts

The HCI must make a minimum of two face-to-face contacts with the child per month. The face-to-face contacts must total 90 minutes in duration. The HCI should anticipate that each contact take place for 45 minutes in duration. These contacts determine whether the services are meeting the child's needs and whether the child/medical consentor are satisfied with service provision. At least one of these meetings must be in the family caregiver setting. It is suggested that the child's caregiver be present at these meetings. These meetings may occur more frequently, if needed, throughout the child's enrollment in the B2H Waiver Program.

The HCI must also make at least two documented contacts with informed WSPs from the *IHP (OCFS-8017)* each month. These interchanges may be made in person, by phone, or electronically, but must show evidence of communication between the HCI and WSP. In addition, while the child is in foster care, the HCI must have at least two contacts per month with the child's case planner/case manager to determine if there have been any changes in the child's life that would require revisions to the *IHP (OCFS-8017)* and/or the FASP.

Six enrollees is the maximum caseload for each HCI. When the HCI has less than a full caseload of six enrollees, the HCIA may allow the HCI to perform other non-B2H duties for the HCIA. The HCI cannot provide other B2H Waiver services beyond Health Care Integration. For an HCI who functions in another non-B2H capacity, the HCIA may only use employees who meet HCI qualifications and must maintain documentation that costs are properly allocated between the B2H and non-B2H functions of the HCI. The HCIA must not permit any other duties to interfere with HCI responsibilities. A foster care case planner, also employed as a HCI, cannot serve both roles for the same child.

Note: One HCI supervisor may supervise no more than five HCIs.

7. Documentation Reviews: Detailed Service Plans, Service Summary Forms, & Progress Notes

The HCI is required to review the following documentation:

- *Detailed Service Plan (OCFS-8020)*,
- *Service Summary Form (OCFS-8018)*, and
- CONNECTIONS *Progress Notes* and *Progress Notes (OCFS-8019)*.

A *Detailed Service Plan (OCFS-8020)* is developed for each authorized service in the B2H child's *IHP (OCFS-8017)*. These plans identify goals, intervention strategies, and time frames, and status of progress towards goals. The *Detailed Service Plan (OCFS-8020)* 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. The HCI is responsible for completing certain *Detailed Service Plans (OCFS-8020)* and verifies the completion of *Detailed Service Plans (OCFS-8020)* by other

WSPs, which are maintained in the B2H case record. See Chapter 9, Individualized Health Plan, for more details.

The *Service Summary Form (OCFS-8018)* documents and tracks service provision, verifies billing, and communicates the child's progress, including any concerns and necessary remediation. The *Service Summary Form (OCFS-8018)* is completed after each service contact as defined in Chapter 8: Services. The HCI must complete the *Service Summary Form (OCFS-8018)* after each service contact and submit for review within five business days. WSP must complete *Service Summary Forms (OCFS-8018)* within five business days of the contact. WSPs must sign, date, verify services against the *IHP (OCFS-8017)*, and submit to the HCIA. The HCI reviews the *Service Summary Form(s) (OCFS-8018)*, submits them to the HCI supervisor, and includes them in the child's B2H case record.

The HCI, as having an assigned role in CONNECTIONS, uses CONNECTIONS *Progress Notes* to document significant information relevant to the case planner/case manager. CONNECTIONS *Progress Notes* should be printed and kept in the B2H case record. In circumstances where the CONNECTIONS case is closed, OCFS *Progress Notes (OCFS-8019)* should be used. *Progress Notes* are the documentation that captures all contacts, including team meetings, beyond the Service Summary that the HCIs or WSPs have on behalf of or with the child, and/or family/caregiver. *Progress Notes* concisely summarize all relevant information about the case, updating any interactions with the child and family/caregiver, and are completed whether or not the information is needed to support billing; *Progress Notes* are submitted every month, or more frequently as needed, to the HCI for review. Copies of *Progress Notes* are maintained in the B2H case record.

8. Leading Team Meetings

The HCI is responsible for arranging and facilitating team meetings, and creating an agenda for each meeting that can include issues raised by other involved parties. Team meetings are necessary to gain input for service planning and development of all the *IHPs (OCFS-8017)*. These meetings are opportunities for collaboration among the WSPs, the child/medical consentor, and caregivers regarding the child's current needs and may involve case planners and case managers, as appropriate. Team meetings must support the health, welfare and permanency of the child, and honor the child's choices. It is not necessary for the child to be present at team meetings when the child is not the medical consentor, but it is preferable when possible. A team meeting does not qualify as a required HCI face-to-face contact and therefore cannot be used as a substitution for this requirement. Team meetings are also addressed in Chapter 9, The Individualized Health Plan.

The caregiver must be invited and is expected to attend all of the child's team meetings to develop an understanding of the *IHP (OCFS-8017)* and to report on any changes in the child's life that may affect the provision of services.

Team meetings are an opportunity to review the adequacy of the *IHP (OCFS-8017)* as well as B2H and Medicaid eligibility. Some of the issues that could be discussed include, but are not limited to:

- continued B2H eligibility,
- the child's Medicaid "thru date" and actions to maintain Medicaid coverage,
- progress towards goals,

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

- need for changes in services,
- barriers to providing the indicated services, and
- potential for a transition to another home and community-based services waiver program, such as those offered by the New York State Office of Mental Health and Office for People With Developmental Disabilities (OPWDD).

Informed WSP representatives must attend the first team meeting (held within 30 days of enrollment) and at least one team meeting every 6 months thereafter. Team meetings may be held at the Service Plan Reviews.

Team meetings must occur:

- within 30 days of enrollment, and at least every 90 days thereafter throughout the child's first year in the B2H Waiver Program,
- at least two months prior to the due date of the *Annual Revised IHP (OCFS-8017)*,
- after the first year of enrollment in the B2H Waiver, at least every six months,
- prior to submission of a *Revised IHP (OCFS-8017)*,
- at any time determined by the HCI,
- at the request of the child/medical consentor, and
- at the request of the responsible LDSS.

There must be a sign-in sheet and minutes kept for each team meeting. Minutes from these team meetings are documented in *Progress Notes (OCFS-8019)* and must include the list of attendees, the date and time of the meeting, the reason the meeting was called, a summary of the topics discussed, conclusions reached, and any changes decided upon. The HCI is responsible for sharing and reviewing this information at each team meeting, and for making it available to those who cannot attend the meeting. The minutes and sign-in sheet must be kept in the child's B2H case record.

9. Circumstances Requiring B2H Waiver Program Discontinuance

The HCI monitors ongoing eligibility for the B2H Waiver Program and in the event that a discontinuance of enrollment is necessary, makes the necessary recommendation to the LDSS of the child's inability to continue to participate using the *Loss of Eligibility Recommendation Form (OCFS-8026)*. The HCI must recommend that a child discontinue enrollment in the B2H Waiver for many reasons, including:

- the child is no longer Medicaid eligible,
- the child no longer qualifies based on the level-of-care assessment derived from the appropriate *Level of Care Form (OCFS-8005A, B or C)*,
- the child is no longer capable of living in residences of 12 beds or less (the only qualified settings for receiving waiver services) with the support of informal supports, foster care services, and/or B2H Waiver services,
- the child moves to a waiver-ineligible setting for more than 30 consecutive days. Reasons may include, among others: hospitalization, incarceration, detention, and absence without consent

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

- the B2H Waiver services are no longer appropriate for the child,
- the cost of the proposed plan of care is above the level necessary to meet the federally mandated requirement that waiver service must be cost neutral in the aggregate when compared to statewide institutional care costs, as determined by OCFS,
- the child/medical consentor no longer consents to enrollment in the B2H Waiver Program,
- the child/medical consentor chooses to receive services from another (non-B2H) Medicaid waiver,
- the child has turned 21,
- the child moves outside of New York State,
- the child became married, or
- the child had died.

The HCI must also develop a transition plan for all children leaving the B2H Waiver Program at least three months prior to an anticipated discontinuance or within 30 days of an unanticipated discontinuance using the *Transition Plan (OCFS-8030)*.

Aging Out of the B2H Waivers

As stated above, children enrolled in the B2H Waiver are no longer eligible to remain in the program once they have turned 21 years of age. To maintain continuity of services for a child aging out, the HCI completes a *Transition Plan (OCFS-8030)* 18 months before the enrolled child's 21st birthday, identifying the action steps required to connect with needed services and the party responsible for completing the action steps. The *Transition Plan (OCFS-8030)* outlines the ongoing Medicaid State Plan services and other services, including other Medicaid waiver services that the child may need to access.

The LDSS needs to evaluate the participant's eligibility for adult services, verifying that all necessary eligibility and/or assessment information is current and accurate to facilitate the child's discharge from the B2H Waiver Program to appropriate adult services, if indicated.

For children enrolled in B2H DD Waiver:

Eighteen months before the enrolled child's 21st birthday the HCIA must send the following information to the OPWDD Developmental Disabilities Services Office (DDSO):

- *Transition Plan (OCFS-8030)*,
- HCIA contact name and telephone number,
- updated evaluations and assessments,

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

- most recent *Level of Care ICF/MR-Eligibility Determination Form for Children with Developmental Disabilities (OCFS-8005B)*, and
- current consent forms and other referral documentation.

After sending this information to the DDSO, the HCI must initiate transition planning discussions with a representative from the appropriate DDSO. DDSO staff is expected to participate in B2H transition planning regarding the child.

11. Quality Management

The HCI, in concert with supervisors and HCIA quality management staff, plays a critical role in the delivery of the B2H Waiver Program by ensuring compliance with state and federal mandates as well as effective service delivery.

The HCI's role in this process is as follows:

- develop and implement an *IHP (OCFS-8017)* that assists the child in meeting his/her goals and supports the child's health and welfare,
- monitor service delivery as specified in the *IHP (OCFS-8017)*,
- inform the child/medical consenter of the HCIA's grievance and complaint procedures, and assist in resolving complaints whenever possible,
- work with the child/medical consenter to find mutually agreeable solutions when problems arise. If an agreeable solution cannot be found, then a team meeting and/or an Agency Conference may be called to discuss the issue further. The LDSS and OCFS QMS may be included as necessary. If the issue is not resolved, a Medicaid Fair Hearing may be requested, as appropriate,
- report to the LDSS when there is concern that the B2H Waiver Program cannot support the child's health and welfare. This concern should be clearly discussed with the child/medical consenter. The HCIA should consider this information and assess whether to submit a *Loss of Eligibility Recommendation Form (OCFS-8026)* to the LDSS. This information assists the LDSS in deciding whether to issue a *Notice of Decision-Discontinuance from Waiver Program (OCFS-8011A)*,
- provide the child/medical consenter with information to identify actions described as abuse, neglect and exploitation,
- provide the child/medical consenter with the *Waiver Participant's Rights Form (OCFS-8008)*,
- provide the *Contact Information List (OCFS-8027)* for the HCIA, the OCFS BWM toll-free B2H consultation number, WSPs, LDSS, the Statewide Central Register of Child Abuse and Maltreatment, and the Department of Health,

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

- promptly report any potential Medicaid fraud which would include any instances of erroneous or fraudulent billing to the attention of the OCFS QMS, and
- properly record, report, and follow up on all Serious Reportable Incidents. See Chapter 11, Participant Safeguards for a more detailed discussion.

See Chapter 10: Providing a High Quality Program, for a detailed review of quality oversight responsibilities.

Chapter 7: Waiver Service Providers

Waiver Service Providers (WSPs) are an essential component of the Bridges to Health (B2H) Waiver Program. WSPs provide B2H Waiver services in the child's home, while others are provided at community-based sites. As such, WSPs must be knowledgeable about the child's and caregivers' circumstances to provide effective service provision and communicate regularly with the Health Care Integrator (HCI).

The B2H Waiver Program is designed to support the enrolled child's freedom to choose service providers. WSP staff must be capable of providing services and making service decisions that take into account the needs and preferences of the child/medical consentor and caregiver while in these settings, as Freedom of Choice is paramount in B2H.

A. Becoming a Waiver Service Provider agency

A community-based organization is permitted to provide any B2H service for which it is qualified by subcontracting an HCIA as a WSP agency as described in Chapter 8: Services. A community-based organization may subcontract with as many HCIA's as they are capable of serving. OCFS maintains a list of HCIA's and WSP agencies on the OCFS B2H website, www.ocfs.state.ny.us/main/b2h/.

A community-based organization who would like to become a WSP agency must work with the HCIA and submit the following documentation:

- *OCFS Vendor Responsibility Questionnaire Not-For-Profit Business Entity Form (OCFS-7050)* or an *OCFS Vendor Responsibility Questionnaire For-Profit Entity Form (OCFS-7049)* as well as any supporting documentation required by an affirmative response,
- An audit report OR most recent Internal Revenue Service 990 (for not-for-profit) if audit report is not applicable,
- Interim financial statements for the previous six months,
- Annual report OR audited annual financial report,
- Application for Enrollment in the New York State Medicaid Program,
- *Qualification Form (OCFS-8034)*,
- *Schedule A-Waiver Service Provider Commitment Form (OCFS-8035)*, and
- a completed, signed and notarized B2H Model Subcontract.

If approvable, the HCIA must sign the B2H Model Subcontract developed by OCFS, and the HCIA submits the above documentation to OCFS.

By signing the B2H Model Subcontract with an HCIA, a WSP agency is agreeing to all the conditions of the Model Subcontract to serve children and their families in their home and community, and hire qualified individuals to provide these services. In the event the child/medical consentor requests to work with a community-based provider not under subcontract with the HCIA, the HCIA is required to

interview the potential WSP agency. If that provider is interested in becoming a WSP agency, the HCIA must determine if the potential WSP agency may be approved.

B. Waiver Service Provider Staff Qualifications

To maintain B2H Waiver Program quality, HCIAS and WSP agencies must recruit, hire, and maintain a competent workforce with diverse ethnic and cultural backgrounds on an ongoing basis. HCIAS and WSP agencies must verify credentials, train staff, and promote professional development. WSP agencies and staff are required to support quality management activities by using the B2H Personnel Checklist to verify staff's education and experience, criminal history and background checks as well as training. HCIAS shall utilize and maintain the B2H Personnel Checklists along with supporting documentation at the HCIA (see Appendix U).

HCIA and WSP agencies hire B2H staff that possess or exceed the minimum skills and training required to provide an assigned B2H service and to meet the primary objective of protecting and promoting the health, safety and well-being of children receiving B2H services.

The components that constitute B2H qualified providers include: education and experience, background checks, and training. WSP staff must comply with the following requirements:

- education and experience requirements as specified in Chapter 8: Services,
- criminal history background checks and the Statewide Central Register of Child Abuse and Maltreatment (SCR) screening process requirements as specified in Chapter 11: Participant Safeguards, and
- training requirements as specified in Chapter 14: Training Requirements.

Supervisors are expected to judge the skill and competence of staff, and to assess the need for additional training and support. Supervisors must assess staff competence through oversight of service provision, the outcomes of customer satisfaction surveys, and review of the grievance/complaint file. Through ongoing and direct supervision, HCIA and WSP agencies must verify that staff is able to assist the child/medical consentor in making key decisions about the goals of each waiver service and to provide the service.

C. Ongoing Responsibilities of Waiver Service Providers

1. Individualized Health Plans and Detailed Service Plans

The *Individualized Health Plan (IHP) (OCFS-8017)* guides the WSP in service delivery. The *IHP (OCFS-8017)* specifies the child's goals, the services necessary to maintain the child in his/her home community, and the quantity and frequency of those services. WSP agencies are required to monitor service provision for compliance with the *Individualized Health Plan (IHP) (OCFS-8017)*.

WSP staff is required to offer comments for all *IHPs (OCFS-8017)*, to assist in tracking the extent to which children have met goals established in prior *IHPs (OCFS-8017)* and to assess whether the goals have been met within established time frames. *Detailed Service Plans (OCFS-8020)* document how each waiver service is contributing to the child's progress, justify the continuation of services and represent the

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

provider's request for continued approval to provide waiver services. WSP staff is required to complete *Detailed Service Plans (OCFS-8020)* as applicable, based on the chart below:

Providers responsible for completing the Detailed Service Plan	For the following B2H service(s):
Health Care Integrator (HCI)	Health Care Integration Skill Building Family/Caregiver Supports and Services Planned Respite Adaptive/Assistive Equipment* Accessibility Modifications*
Crisis Avoidance, Management and Training Specialist	Crisis Avoidance, Management and Training Immediate Crisis Response Services Intensive In-home Supports and Services Crisis Respite
Day Habilitation Specialist	Day Habilitation
Prevocational Service Specialist	Prevocational Services
Supported Employment Specialist	Supported Employment
Specialist Special Needs Community Advocacy and Support	Special Needs Community Advocacy and Support

***Note:** For accessibility modifications and/or adaptive/assistive equipment, the *Detailed Service Plan (OCFS-8020)* is captured in the *Accessibility Modifications and/or Adaptive and Assistive Equipment Description, Cost Projection and Final Cost Form (OCFS-8028)*.

The HCI, or WSP supervisor, completes the *Detailed Services Plan(s) (OCFS-8020)* when WSP staff is not identified. WSP staff is required to provide documentation of progress toward goal attainment from one *IHP (OCFS-8017)* period to the next.

2. Coordination with the HCI

There are multiple B2H forms to facilitate information sharing amongst providers. However, HCIs and WSP staff must communicate on a regular basis to promote stability and continuity with the child/medical consentor's experience within the B2H Waiver Program.

3. Team Meetings

To facilitate service provision, informed WSP representatives must attend team meetings for each child being served as follows: the first team meeting (held within 30 days of enrollment) and at least one team meeting every 6 months thereafter. WSPs must participate in the appropriate sharing of information related to delivery of B2H Waiver services with the HCIAAs, the WSP agencies and LDSS.

4. Service Provision and Documentation Review

Each HCIA and WSP agency, when assigning B2H staff, will match the skills of a B2H employee with the most recent assessment of the particular child who is receiving B2H services. The HCIA and WSP agencies must consider the types of services that will meet the needs of the child/medical consentor, with

particular attention as to how to use B2H services and WSP staff to promote stability and continuity in the child's case. WSP agencies may consider clustering services and service providers to maximize the number of WSP staff able to provide more than one B2H service to a child/medical consentor. Efforts to minimize the number of individuals in a household should be considered.

WSPs are required to implement a self-monitoring process to verify the accuracy of service delivery and completeness of all *Service Summary Forms (OCFS-8018)*. A *Service Summary Form (OCFS-8018)* provides a description of the service provided and the child's response to the service, and includes progress towards identified goals or intervention strategies. WSP staff must maintain documentation in the child's B2H case record that indicates progress, as well as any significant changes in needs. WSP staff is responsible for reporting cognitive, psychological, physical, and/or behavioral changes during service provision to the HCI that may require intervention. Signature by the WSP indicates verification and attestation that all records are true and correct.

5. Billing and Documentation

WSPs are required to complete a *Service Summary Form (OCFS-8018)* as documentation for billing. *Service Summary Forms (OCFS-8018)* provide an opportunity for objective observations during home visits, telephone contacts and during other service provision occasions. *Service Summary Forms (OCFS-8018)* present a picture of the child and family as well as the HCIA's implementation of the B2H Waiver Program. Copies of these documents must be provided to the child's HCIA (with whom the WSP agency has a subcontract), within five business days of the contact. The WSP agencies must bill eMedNY directly for services provided to the enrolled child. See Chapter 8, Services, for more information.

6. Incident Reporting and Grievances

All B2H Waiver service providers are required to record, conduct an inquiry and/or share the information received with appropriate parties and are subject to reviews when there is a Serious Reportable Incident. See Chapter 11, Participant Safeguards, for more details on the requirements for incident reporting, as well as the grievance and complaint process.

7. Quality Management

WSP agencies and staff are required to support quality management activities by using the B2H Personnel Checklist to verify staff's education and experience, criminal history and background checks as well as training. HCIAS shall utilize and maintain the B2H Personnel Checklists along with supporting documentation at the HCIA (see Appendix U). In addition, WSP agencies must respond appropriately to Serious Reportable Incidents (SRIs) and Recordable Incidents include events, concerns, grievances and complaints that do not meet the level of severity of SRIs but that impact the child's life in the community. See Chapter 11, Participant Safeguards. In addition, WSP agencies and staff provide oversight and review of service delivery.

Providers must maintain quality management data for review by OCFS, New York State Department of Health, or Federal Centers for Medicare and Medicaid Services (CMS). For more information on quality management, see Chapter 10, Providing a High Quality Program.

8. Interpretation and Translation Services

WSP agencies are required to make arrangements to provide interpretation or translation services for potential and active waiver participants/medical consenters who need these services. Potential or active children/medical consenters with Limited English Proficiency must be advised that services are available. Potential or active children/medical consenters who are of Limited English Proficiency may bring a translator of their choice with them to meetings with WSPs and/or the HCI. However, a potential or active waiver children/medical consenter who is of Limited English Proficiency cannot be required to provide their own translator, and no potential or active waiver participant who is of Limited English Proficiency can be denied access to services or enrollment in the waiver on the basis of a WSP agency's temporary inability to provide adequate interpretation or translation services at no cost to the potential or active waiver participant/medical consenter.

Chapter 8: Services

Bridges to Health (B2H) Waiver services are tailored to meet the child's specific, presenting health care needs, and are not available through other programs these children attend. The 14 services in the B2H Waiver Program are as follows:

1. Health Care Integration
2. Family/Caregiver Supports and Services
3. Skill Building
4. Day Habilitation
5. Special Needs Community Advocacy and Support
6. Prevocational Services
7. Supported Employment
8. Planned Respite
9. Crisis Avoidance, Management and Training
10. Immediate Crisis Response Services
11. Intensive In-home Supports and Services
12. Crisis Respite
13. Adaptive and Assistive Equipment
14. Accessibility Modifications.

A. General Requirements

With the exception of the service of Health Care Integration, B2H services can be provided in the community or in any waiver-eligible setting (a residence of 12 beds or less) to the child and other individuals involved with the child including the family/caregiver. The following general requirements apply to all providers of B2H Waiver services, excluding providers of adaptive/assistive equipment and accessibility modifications, unless specified otherwise under the *Individualized Health Plan (IHP)* (OCFS-8017).

1. Training Requirements

Mandatory Training

All Health Care Integrators (HCIs), HCI supervisors and Waiver Service Providers (WSPs), including staff hired by the Health Care Integration Agency (HCIA) to provide B2H Waiver services, are required to have appropriate training. See Chapter 14, Training Requirements, for more information on training requirements.

2. Documentation Requirements

For further details on the following forms, see Chapter 9, Individualized Health Plan.

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

Detailed Service Plan (OCFS-8020)

The *Detailed Service Plan (OCFS-8020)* 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 LDSS to approve/continue a service, the *Detailed Service Plan (OCFS-8020)* must clearly describe how the continuation of this service can help maintain the child in the community.

The *Detailed Service Plan (OCFS-8020)* must be completed within 30 days of enrollment into the B2H Waiver Program and every six months thereafter, or revised more frequently for the duration of the program. *Detailed Service Plans (OCFS-8020)* beyond the initial plan must be submitted to the HCI 30 days before the due date. The HCI, or WSP supervisor, completes the *Detailed Services Plans (OCFS-8020)* when WSP staff is not identified.

Service Summary Form (OCFS-8018)

For **every** B2H Waiver service delivered to an enrolled child or family member, the worker must complete a *Service Summary Form (OCFS-8018)*. Medicaid requires that service documentation be contemporaneous with service provision. The *Service Summary Forms (OCFS-8018)* must be complete and timely and must accurately relate to and identify the child's service plan goals and objectives. *Service Summary Forms (OCFS-8018)* for **all** B2H Waiver services must be submitted to the HCIA within five business days of the service contact.

The following information must be documented in each *Service Summary Form (OCFS-8018)*:

- child's name & Medicaid Client Identification Number (CIN),
- type of service provided,
- date of service and service location,
- start and stop times,
- description of service provided,
 - When training is part of the service, include specifics of the training material with course outline and expected actions and outcomes.
- participant's response to service, including progress towards any identified goals or intervention strategies,
 - When participant training is part of the service, include evaluations and participant commentary.
- attestation by documenter of service provision, and
- date of service documentation.

CONNECTIONS Progress Notes and Progress Notes (OCFS-8019)

Progress Notes provide the documentation that captures all contacts, beyond those detailed in the Service Summary, that the HCIs or WSPs have on behalf of or with the child and/or family/caregiver, including Team Meetings. *Progress Notes* summarize all relevant information about the case that cannot be billed. These are submitted within a month of the contact or sooner if requested by the HCI.

The WSP must retain all documentation specified above for a period of at least 30 years from the date the child has been discharged from foster care.

3. Verification of Credentials

The HCIA, or OCFS when the HCIA is the agency providing the service, is responsible for verifying provider qualifications. The provider is responsible for verifying that individual employee(s) and contractors maintain necessary licensure and/or certification. Verification of providers must be conducted before signing the Model Subcontract.

After initial verification, the HCIA, or OCFS when the HCIA is the agency providing the service, must annually verify that licenses, certificates, and/or contracts are in good standing. The HCIA must verify that licensure and/or certification of employee(s) and contractors upon hire and annually thereafter. The HCIA shall determine that all HCIs and Waiver Service Providers (WSPs) in their employ or under subcontract with a WSP agency possess the requisite capacity, skills, competencies and qualifications to effectively support children enrolled in the B2H Waiver Program. HCIAS shall utilize and maintain the B2H Personnel Checklists along with supporting documentation at the HCIA (see Appendix U).

B. Health Care Integration

The service of Health Care Integration is described in Chapter 6: Health Care Integrators. The overall general requirements of training for all other services are listed below, as well as specifics related to the remaining 13 services beyond Health Care Integration.

C. Family/Caregiver Supports and Services

Family/caregiver supports and services enhance the child's ability to function as part of a family/caregiver unit and enhance the family/caregiver's ability to care for the enrolled child in the home and/or community. Families/caregivers may include foster families, pre-adoptive/adoptive families and birth families.

1. Services

This service may be provided to individual children and their family/caregivers in small groups of a maximum of two B2H children and their support networks, where the child and/or family/caregivers participate with others who are in similar situations.

Based upon the family/caregiver supports and services plan (the *Detailed Service Plan OCFS-8020*) developed by the HCI, this service provides opportunities to:

- interact and engage with family/caregivers and children to offer educational, advocacy, and support resources to develop family/caregivers ability to independently access community services and activities,

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

- maintain and encourage the families/caregivers' self-sufficiency in caring for the child in the home and community,
- address needs and issues of relevance to the family/caregiver unit as the child is supported in the home and community, and
- educate and train the family/caregiver unit on resource availability so that they might better support and advocate for the needs of the child and appropriately access needed services.

2. Provider Qualifications

Agency Requirements: Not-for-profit family/caregiver supports and services agencies.

Individual Requirements: A paraprofessional employed by the agency with a high school diploma or equivalent and appropriate skills and training.

HCIAAs are responsible for verifying staff and/or subcontractor qualifications and approving training materials.

3. Training Requirements

OCFS-sponsored Training: Within six months of starting to provide B2H Waiver services, Family/Caregiver Support providers are expected to attend OCFS-sponsored training designed specifically to address issues pertinent to their areas of assignment.

Family/caregiver supports and service providers are required to attend the following service-specific trainings:

- Module #1: Bridges to Health Waiver Service Provider Training: Documentation
- Module #2: Bridges to Health Waiver Service Provider Training: Building Resilience
- Module #3: Bridges to Health Waiver Service Provider Training: Safety in the Community
- Module #4: Bridges to Health Waiver Service Provider Training: Essential Elements for Service Provision
- Family Caregiver Supports/Services—four hours.

4. Documentation Requirements

Detailed Service Plan (OCFS-8020)

The HCI completes the *Detailed Service Plan (OCFS-8020)*.

5. Billing Policies

- Family/Caregiver Supports and Services are billed in 15-minute increments.
- With appropriate documentation, the provider may bill for up to one hour (four 15-minute units) of services planning (e.g., to attend team meetings and other service development preparation activities) every six months and in six month intervals thereafter.

- Family support services can be offered to up to two children in the B2H Waiver Program and their families at one time. A bill may be generated for one unit of family support for each child/family.
- This service cannot be delivered nor billed while an enrolled child is in an in-eligible setting, including hospitalization.
- When submitting a bill for direct services provided or services planning, the WSP should use the date of service as the billing date.

D. Skill Building

Skill building services support, guide, mentor, coach and/or train the child and/or family/caregiver in successful functioning in the home and community within the special context of the child's disability, involvement in the foster care system, and post-discharge circumstances.

1. Services

This service may be delivered one-on-one or in small groups, but no more than two enrolled children and their support networks may be served at the same time. Skill building activities may take place at any time of the day, so long as they do not supplant a child's expected educational activities or program. Based on a skill building plan (the *Detailed Service Plan OCFS-8020*) developed by the Health Care Integrator (HCI), the WSP provides support, guidance, mentoring, coaching, and/or training.

These services assist the child and family/caregiver in acquiring, developing, and using functional skills and/or techniques that enable the child to function successfully in the home and community environments. Services/skills include task completion; communication; socialization; interpersonal behavior; sensory/motor development; participating in community activities; conducting activities of daily living; problem-solving; managing money; and eliminating maladaptive behaviors.

2. Provider Qualifications

Agency Requirements: Not-for-profit skill building agencies.

Individual Requirements: A paraprofessional employed by the agency with a high school diploma or equivalent and appropriate skills and training.

HCIAs are responsible for verifying staff and/or subcontractor qualifications and approving training materials.

3. Training Requirements

OCFS-sponsored Training: Within six months of starting to provide B2H Waiver services, Skill Builders are expected to attend OCFS-sponsored training designed specifically to address issues pertinent to their areas of assignment. Skill builders are required to attend the following service-specific trainings:

- Module #1: Bridges to Health Waiver Service Provider Training: Documentation

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

- Module #2: Bridges to Health Waiver Service Provider Training: Building Resilience
- Module #3: Bridges to Health Waiver Service Provider Training: Safety in the Community
- Module #4: Bridges to Health Waiver Service Provider Training: Essential Elements for Service Provision
- Skill Building—four hours.

4. Documentation Requirements

Detailed Service Plan (OCFS-8020)

The HCI completes the *Detailed Service Plan (OCFS-8020)*.

5. Billing Policies

- Skill Building is billed in 15-minute increments.
- With appropriate documentation, the WSP may bill for up to one hour (four 15-minute units) of services planning (e.g., to attend team meetings and other service development preparation activities) every six months and in six month intervals thereafter.
- This service may be delivered one-on-one or in small groups of not more than two enrolled children and their support networks.
- This service cannot be delivered nor billed while an enrolled child is in an in-eligible setting, including hospitalization.
- When submitting a bill for direct services provided or services planning, the WSP should use the date of service as the billing date.

E. Day Habilitation

Day habilitation services, in an established program model, assist individuals with developmental disabilities with the self-help, socialization, and adaptive skills necessary for successful functioning in the home and community when other types of skill-building services are not appropriate.

1. Services

This service may be delivered in a one-to-one session or in a group setting. The service includes assistance with acquiring, retaining, or improving skills related to: personal grooming and cleanliness; bed making and household chores; eating and/or preparing food; social and adaptive skills; transportation; communication skills; and participating in community activities, safety skills, managing money, and making informed choices.

2. Provider Qualifications

Agency Requirements: New York State Office for People With Developmental Disabilities (OPWDD)-certified, not-for-profit day habilitation provider agencies.

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

Individual Requirements: An individual employed by the agency approved to provide this service.

HCIAs are responsible for verifying staff and/or subcontractor qualifications and approving training materials.

3. Training Requirements

OCFS-sponsored Training: Within six months of starting to provide B2H Waiver services, Day Habilitation providers are expected to attend OCFS-sponsored training designed specifically to address issues pertinent to their areas of assignment. Providers are required to attend the following service-specific trainings:

- Module #1: Bridges to Health Waiver Service Provider Training: Documentation
- Module #2: Bridges to Health Waiver Service Provider Training: Building Resilience
- Module #3: Bridges to Health Waiver Service Provider Training: Safety in the Community
- Module #4: Bridges to Health Waiver Service Provider Training: Essential Elements for Service Provision.

4. Documentation Requirements

Detailed Service Plan (OCFS-8020)

The Day Habilitation Specialist completes the *Detailed Service Plan (OCFS-8020)*.

5. Billing Policies

- Day Habilitation is billed in one-hour increments.
- With appropriate documentation, the provider may bill for up to two hours (two 1-hour units) of services planning (e.g., to attend team meetings and other service development preparation activities) every six months and in six month intervals thereafter.
- This service cannot be delivered nor billed while an enrolled child is in an in-eligible setting, including hospitalization.
- When submitting a bill for direct services provided or services planning, the WSP should use the date of service as the billing date.

F. Special Needs Community Advocacy and Support

Participating in community activities and attending school are important activities for all youth, including children with disabilities. Success in these activities and school is dependent not only on the youth but on the people who interact with and support the youth in these endeavors. Special needs community advocacy and support improves the child's ability to gain from the educational experience and enables the child's school to respond appropriately to the child's disability and/or health care issues.

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

Special needs community advocacy and support is intended to assist the child, family/caregiver, and community/school staff in understanding and addressing the waiver participant's needs related to their disability(ies) in order to minimize interruption in a child's education.

Special needs community advocacy and support provides family, caregivers, and community/school personnel with techniques and information not generally available in schools so that they can better respond to the needs of the B2H Waiver Program participant. The use of this service may appropriately be provided to prevent problems in community/school settings as well as when the child is experiencing difficulty. *Individualized Health Plan (OCFS-8017)* objectives must clearly state how the service can prevent as well as ameliorate existing problems and to what degree. This service cannot be used to develop an Individualized Education Program (IEP), the plan for students with disabilities who meet the federal and state requirements for special education, or to provide special education services to the child.

1. Services

This service may be provided in an individual session or in a group setting. The service includes:

- Training (one-on-one or group) for the child and/or the family/caregiver regarding methods and behaviors to enable success in the community and school. Each group must not exceed 12 participants (enrollees and collaterals).
- Direct advocacy in the community and with the educational system or others regarding the child's disability(ies) and needs related to his or her health care issues.
- Advocacy training for the child and/or family/caregiver, including during community and school transitions.

2. Provider Qualifications

Agency Requirements: A not-for-profit corporation whose corporate purposes include the provision of special needs community advocacy and support services.

Individual Requirements: Preferred Qualifications: An individual employed by the agency with a master's degree in education, or a master's degree in a human services field plus one year of applicable experience. Minimum Qualifications: An individual employed by the agency with a bachelor's degree plus two years of related experience.

HCIA's are responsible for verifying staff and/or subcontractor qualifications and approving training materials.

3. Training Requirements

OCFS-sponsored Training: Within six months of starting to provide B2H Waiver services, Special Needs Community Advocacy and Support specialists are expected to attend OCFS-sponsored training designed specifically to address issues pertinent to their areas of assignment. Providers are required to attend the following service-specific trainings:

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

- Module #1: Bridges to Health Waiver Service Provider Training: Documentation
- Module #2: Bridges to Health Waiver Service Provider Training: Building Resilience
- Module #3: Bridges to Health Waiver Service Provider Training: Safety in the Community
- Module #4: Bridges to Health Waiver Service Provider Training: Essential Elements for Service Provision
- Special Needs Community Advocacy and Support—four hours.

4. Documentation Requirements

Detailed Service Plan (OCFS-8020)

The Special Needs Community Advocacy and Support Specialist completes the *Detailed Service Plan (OCFS-8020)*.

5. Billing Policies

- Special Needs Community Advocacy and Support is billed in 15-minute increments.
- Telephone contacts for Special Needs Community Advocacy and Support are allowable, but must be limited. Telephone contact should be no more than four 15-units of service per day, with a limit of 48 units of service by phone per year. Any telephone contact must include discussion of the child/medical consenter's needs, strengths, and progress towards goals.
- With appropriate documentation, the provider may bill for up to two hours (eight 15-minute units) of services planning (e.g., to attend team meetings and other service development preparation activities) every six months and in six month intervals thereafter.
- This service may be provided in group settings but to no more than 12 participants. No more than three children enrolled in the B2H Waiver Program may attend a group activity at the same time.
- This service cannot be delivered nor billed while an enrolled child is in an in-eligible setting, including hospitalization.
- When submitting a bill for direct services provided or services planning, the WSP should use the date of service as the billing date.

G. Prevocational Services

Prevocational services are individually designed to prepare a youth age 14 or older with severe disabilities to engage in paid work. 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.

1. Services

This service may be delivered in a one-to-one session or in a group setting. Prevocational services are structured around teaching concepts such as compliance, attendance, task completion, problem solving, and safety based on a specific curriculum related to youth with disabilities. In addition, prevocational services assist with facilitating appropriate work habits, acceptable job behaviors, and learning job

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

production requirements. 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.

2. Provider Qualifications

Agency Requirements: Not-for-profit vocational service providers.

Individual Requirements: Preferred qualifications: an individual employed by the agency with a bachelor's degree plus two years experience. Minimum Qualifications: an individual employed by the agency with an associate's degree plus two years of related experience.

HCIAAs are responsible for verifying staff and/or subcontractor qualifications and approving training materials.

3. Training Requirements

OCFS-sponsored Training: Within six months of starting to provide B2H Waiver services, Prevocational Service providers are expected to attend OCFS-sponsored training designed specifically to address issues pertinent to their areas of assignment. Providers are required to attend the following service-specific trainings:

- Module #1: Bridges to Health Waiver Service Provider Training: Documentation
- Module #2: Bridges to Health Waiver Service Provider Training: Building Resilience
- Module #3: Bridges to Health Waiver Service Provider Training: Safety in the Community
- Module #4: Bridges to Health Waiver Service Provider Training: Essential Elements for Service Provision
- Prevocational and Supported Employment Services —four hours.

4. Documentation Requirements

Detailed Service Plan (OCFS-8020)

The Prevocational Specialist completes the *Detailed Service Plan (OCFS-8020)*.

5. Billing Policies

- Prevocational Services are billed in one-hour units/increments.
- These services may be delivered in a one-to-one session or in a group setting.
- With appropriate documentation, the provider may bill for up to two hours (two 1-hour units) of services planning (e.g., to attend team meetings and other service development preparation activities) every six months and in six month intervals thereafter.
- This service cannot be delivered nor billed while an enrolled child is in an in-eligible setting, including hospitalization.

- When submitting a bill for direct services provided or services planning, the WSP should use the date of service as the billing date.

H. Supported Employment

Supported employment services are individually designed to prepare children with severe disabilities age 14 or older to engage in paid work. Supported employment services provide assistance to waiver participants with severe disabilities as they perform in a work setting.

1. Services

This service may only be provided in an individual, one-to-one session. Supported employment services may be provided in a variety of settings, particularly work sites.

Supported employment services include the following:

- supervision and training
- intensive ongoing support
- transportation to and from the job site
- interface with employers regarding the child's disability(ies) and needs related to his or her health care issue(s)
- other activities needed to sustain paid work (e.g., employment assessment, job placement, adaptive/assistive equipment necessary for employment)
- job finding and development
- training in work behaviors
- assessing the interest and fit of a child for particular job opportunities
- staff work with employers and job sites preparing them to be able to make necessary and reasonable accommodations; on-site support for the child as they learn specific job tasks
- monitoring through on-site observation through communication with job supervisors and employers.

2. Provider Qualifications

Agency Requirements: Not-for-profit vocational service providers.

Individual Requirements: Preferred Qualifications: an individual employed by the agency with a bachelor's degree plus two years experience. Minimum Qualifications: an individual employed by the agency with an associate's degree plus two years of related experience.

HCIA's are responsible for verifying staff and/or subcontractor qualifications and approving training materials.

3. Training Requirements

OCFS-sponsored Training: Within six months of starting to provide B2H Waiver services, Supported Employment providers are expected to attend OCFS-sponsored training designed specifically to address issues pertinent to their areas of assignment. Providers are required to attend the following service-specific trainings:

- Module #1: Bridges to Health Waiver Service Provider Training: Documentation
- Module #2: Bridges to Health Waiver Service Provider Training: Building Resilience
- Module #3: Bridges to Health Waiver Service Provider Training: Safety in the Community
- Module #4: Bridges to Health Waiver Service Provider Training: Essential Elements for Service Provision
- Prevocational and Supported Employment Services —four hours.

4. Documentation Requirements

Detailed Service Plan (OCFS-8020)

The Supported Employment Specialist completes the *Detailed Service Plan (OCFS-8020)*.

5. Billing Policies

- Supported Employment is billed in one-hour increments.
- These services may only be provided in one-to one, individual sessions.
- With appropriate documentation, the provider may bill for up to two hours (two 1-hour units) of services planning (e.g., to attend team meetings and other service development preparation activities) every six months and in six month intervals thereafter.
- This service cannot be delivered nor billed while an enrolled child is in an in-eligible setting, including hospitalization.
- When submitting a bill for direct services provided or services planning, the WSP should use the date of service as the billing date.

I. Planned Respite

Planned respite services provide planned short-term relief for family/caregivers (non-shift staff) that are needed to enhance the family/caregiver's ability to support the child's disability and/or health care issues.

1. Services

This service may only be provided in a one-to-one, individual session. The service is direct care for the child by staff trained to support the child's disability-related needs while providing relief from caregiver activities for the family/caregiver. This may occur on an hourly basis (in-home or out-of-home by an approved respite care and services provider under Part 435 of Book 18 of New York State Codes, Rules

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

and Regulations (18 NYCRR) or on a daily/overnight basis (in-home or out-of-home by an approved respite care and services provider under Part 435 of 18 NYCRR).

2. Provider Qualifications

Agency Requirements: Out-of-home, non-medical respite agencies must be approved respite care and services providers under Part 435 of 18 NYCRR.

Individual Requirements:

- Provision of service in child's residence:
 - Planned respite providers are paraprofessionals with a high school diploma or equivalent with appropriate skills and training.
 - For children in B2H MedF, the HCIA will define and arrange for specific training of respite workers based upon the child's needs. This information is documented on the child's *IHP (OCFS-8017)*.
- Provision of service outside child's residence in a foster boarding home:
 - Planned respite providers are Licensed Foster Parents pursuant to Part 435 of 18 NYCRR.
 - For children in B2H MedF, the HCIA will define and arrange for specific training of respite workers based upon the child's needs. This information is documented on the child's *IHP (OCFS-8017)*.
- Provision of service outside child's residence in a licensed group home setting:
 - Planned respite providers are paraprofessionals with a high school diploma or equivalent and with appropriate skills and training.
 - For children in B2H MedF, the HCIA will define and arrange for specific training of respite workers based upon the child's needs. This information is documented on the child's *IHP (OCFS-8017)*.

HCIA's are responsible for verifying staff and/or subcontractor qualifications and approving training materials.

Note: If a foster home is only providing B2H respite and not accepting children for purposes of foster care, CONNECTIONS Vacancy Control can be used to identify the home as a B2H only provider. To accomplish this, the primary FAD worker must mark the beds within the home as occupied and enter the word "B2H" under the "Child Info." column. This will eliminate the B2H provider from appearing on any Vacancy Control search.

3. Training Requirements

OCFS-sponsored Training: Within six months of starting to provide B2H Waiver services, Respite providers are expected to attend OCFS-sponsored training designed specifically to address issues pertinent to their areas of assignment. Respite providers are required to attend the following service-specific trainings:

- Module #1: Bridges to Health Waiver Service Provider Training: Documentation
- Module #2: Bridges to Health Waiver Service Provider Training: Building Resilience
- Module #3: Bridges to Health Waiver Service Provider Training: Safety in the Community

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

- Module #4: Bridges to Health Waiver Service Provider Training: Essential Elements for Service Provision
- Planned and Crisis Respite—eight hours.

4. Documentation Requirements

Detailed Service Plan (OCFS-8020)

The HCI completes the *Detailed Service Plan (OCFS-8020)*.

5. Billing Policies

- Planned Respite is billed in 15-minute increments up to four hours (less than full day). For four or more hours per day, the daily rate applies. There is a separate rate for children in the B2H MedF Waiver Program.
- These services may only be provided in one-to-one, individual sessions.
- With appropriate documentation, the provider may bill for up to one hour (four 15-minute units) of services planning (e.g., to attend team meetings and other service development preparation activities) every six months and in six month intervals thereafter.
- This service cannot be delivered nor billed while an enrolled child is in an in-eligible setting, including hospitalization.
- When submitting a bill for direct services provided or services planning, the WSP should use the date of service as the billing date.

J. Crisis Avoidance, Management and Training

This service includes psycho-education and training to address specific issues that disrupt or jeopardize the child's successful functioning in the community. Special emphasis must be given to "anticipatory guidance," the capacity to proactively identify and plan for those significant or sentinel events in the child's life that may trigger anxiety, frustration and crisis with the potential for leading to deterioration in the child's condition and/or the need for institutional care.

1. Services

This service may be provided in individual sessions or group settings but to no more than 12 participants. No more than three children enrolled in the B2H Waiver Program may attend a group activity at the same time. This service includes:

- Developing and updating the *Detailed Service Plan OCFS-8020* that identifies "sentinel events" and creates strategies or interventions to avoid predictable crises and use in the event of an impending crisis.
- Developing the *Detailed Service Plans (OCFS-8020)* for the services of **Immediate Crisis Response, Intensive In-home Supports and Services** and **Crisis Respite** when such services have been identified as appropriate strategies or interventions.

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

- Coaching and/or mentoring to support child and/or family/caregiver efforts to avoid and/or manage crises.
- Training on appropriate actions that may prevent or minimize crises.
- Psycho-education (one-on-one or group) involving the child and/or the family/caregiver.
- Conducting scheduled and unscheduled visits to the family/caregiver environment to monitor crisis management and/or behavior management activities.

2. Provider Qualifications

Agency Requirements: Not-for-profit crisis management provider agencies.

Individual Requirements: Preferred Qualifications: an individual employed by the agency with a master's degree in social work, psychology or a master's in a related human services field plus one year of applicable experience. Minimum Qualifications: an individual employed by the agency with a bachelor's degree plus two years of related experience.

HCIA's are responsible for verifying staff and/or subcontractor qualifications and approving training materials.

3. Training Requirements

OCFS-sponsored Training: Within six months of starting to provide B2H Waiver services, Crisis Avoidance staff are expected to OCFS-sponsored training designed specifically to address issues pertinent to their areas of assignment. Crisis Avoidance staff are required to attend the following service-specific trainings:

- Module #1: Bridges to Health Waiver Service Provider Training: Documentation
- Module #2: Bridges to Health Waiver Service Provider Training: Building Resilience
- Module #3: Bridges to Health Waiver Service Provider Training: Safety in the Community
- Module #4: Bridges to Health Waiver Service Provider Training: Essential Elements for Service Provision
- Crisis Services —eight hours.

4. Documentation Requirements

Detailed Service Plan (OCFS-8020)

The Crisis Avoidance, Management and Training Specialist completes the *Detailed Service Plan (OCFS-8020)*.

5. Billing Policies

- Crisis Avoidance, Management and Training is billed in 15-minute increments.
- With appropriate documentation, the provider may bill for up to two hours (eight 15-minute units) of services planning (e.g., to attend team meetings and other service development preparation activities) every six months and in six month intervals thereafter.

- This service may be provided in individual sessions or in group settings but to no more than 12 participants. No more than three children enrolled in the B2H Waiver Program may attend a group activity at the same time.
- This service cannot be delivered nor billed while an enrolled child is in an in-eligible setting, including hospitalization.
- When submitting a bill for direct services provided or services planning, the WSP should use the date of service as the billing date.

K. Immediate Crisis Response Services

Immediate crisis response services are 24-hour services designed to respond immediately to crises that threaten the stability of the child's placement and the child's ability to function in the community. This service is intended to be of very short duration and primarily to engage/link to other services and resources, e.g., intensive in-home supports and services.

1. Services

This service may only be delivered in an individual, one-to-one session. The service includes: crisis de-escalation, crisis resolution support, and the development of a crisis stabilization plan (the *Detailed Service Plan OCFS- 8020*), in coordination with the HCI, for any additional crisis response services that are needed to resolve the immediate crisis. This service also consists of the Immediate Crisis Response Specialist making recommendations for revisions to the *Detailed Service Plan (OCFS-8020)* that is developed by the Crisis Avoidance, Management and Training Specialist.

2. Provider Qualifications

Agency Requirements: Not-for-profit crisis management provider agencies.

Individual Requirements: Preferred Qualifications: an individual employed by the agency with a master's degree in social work, psychology, or a master's in a related human services field plus one year of applicable experience. Minimum Qualifications: an individual employed by the agency with a bachelor's degree plus two years of related experience.

HCIA's are responsible for verifying staff and/or subcontractor qualifications and approving training materials.

3. Training Requirements

OCFS-sponsored Training: Within six months of starting to provide B2H Waiver services, Immediate Crisis Response Specialists are expected to attend OCFS-sponsored training designed specifically to address issues pertinent to their areas of assignment. Providers are required to attend the following service-specific trainings:

- Module #1: Bridges to Health Waiver Service Provider Training: Documentation

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

- Module #2: Bridges to Health Waiver Service Provider Training: Building Resilience
- Module #3: Bridges to Health Waiver Service Provider Training: Safety in the Community
- Module #4: Bridges to Health Waiver Service Provider Training: Essential Elements for Service Provision
- Crisis Services —eight hours.

4. Documentation Requirements

Detailed Service Plan (OCFS-8020)

The Crisis Avoidance, Management and Training Specialist completes the *Detailed Service Plan (OCFS-8020)*.

5. Billing Policies

- Immediate Crisis Response Services are billed in 15-minute increments.
- These services may only be delivered in an individual, one-to-one session. However, telephone phone calls for Immediate Crisis Response are allowable but must be limited. Telephone contact for Immediate Crisis Response should be no more than four 15-minute units of service per day, with a limit of 48 units of service by phone per year. Any telephone contact must be followed up by a face-to-face contact with the Immediate Crisis Response Specialist or the Crisis Avoidance, Management and Training Specialist **within 24 hours** of the telephone contact.
- With appropriate documentation, the provider may bill for up to two hours (eight 15-minute units) of services planning (e.g., to attend team meetings and other service development preparation activities) every six months and in six month intervals thereafter.
- This service cannot be delivered nor billed while an enrolled child is in an in-eligible setting, including hospitalization.
- When submitting a bill for direct services provided or services planning, the WSP should use the date of service as the billing date.

L. Intensive In-home Supports and Services

Intensive in-home supports and services are delivered as specified in the crisis stabilization plan (the *Detailed Service Plan OCFS-8020*) called for in “Immediate Crisis Response Services.” These services are designed to provide interventions to secure the health and safety of the child and family/caregiver following a crisis.

1. Services

These services may only be delivered in an individual, one-to-one session. They include psycho-education, crisis stabilization, and crisis resolution support.

2. Provider Qualifications

Agency Requirements: Not-for-profit in home support provider agencies.

Individual Requirements: Preferred Qualifications: an individual employed by the agency with a master's degree in social work, psychology, or a master's in a related human services field plus one year of applicable experience. Minimum Qualifications: an individual employed by the agency with a bachelor's degree plus two years of related experience.

HCIA's are responsible for verifying staff and/or subcontractor qualifications and approving training materials.

3. Training Requirements

OCFS-sponsored Training: Within six months of starting to provide B2H Waiver services, intensive in-home supports and service providers are expected to attend OCFS-sponsored training designed specifically to address issues pertinent to their areas of assignment. Intensive in-home supports and service providers are required to attend the following service-specific trainings:

- Module #1: Bridges to Health Waiver Service Provider Training: Documentation
- Module #2: Bridges to Health Waiver Service Provider Training: Building Resilience
- Module #3: Bridges to Health Waiver Service Provider Training: Safety in the Community
- Module #4: Bridges to Health Waiver Service Provider Training: Essential Elements for Service Provision
- Crisis Services —eight hours.

4. Documentation Requirements

Detailed Service Plan (OCFS-8020)

The Crisis Avoidance, Management and Training Specialist completes the *Detailed Service Plan (OCFS-8020)*.

5. Billing Policies

- Intensive In-home Supports and Services is billed in 15-minute increments.
- These services may only be delivered in an individual, one-to-one session.
- With appropriate documentation, the provider may bill for up to two hours (eight 15-minute units) of services planning (e.g., to attend team meetings and other service development preparation activities) every six months and in six month intervals thereafter.
- This service cannot be delivered nor billed while an enrolled child is in an in-eligible setting, including hospitalization.

- When submitting a bill for direct services provided or services planning, the WSP should use the date of service as the billing date.

M. Crisis Respite

Crisis respite provides emergency short-term relief for family/caregivers (non-shift staff) needed to resolve a crisis and segue back to the child's successful functioning and engagement in *Individualized Health Plan (OCFS-8017)* activities. Crisis respite assists the family/caregivers in supporting the child's disability and/or health care issues.

1. Services

This service may only be delivered in an individual, one-to-one session. The service provides direct care for a child while providing relief from caregiver activities for the family/caregiver during a crisis. Crisis respite may be provided on an hourly basis (in-home or out-of-home by an authorized foster care provider) or daily/overnight basis (in-home or out-of-home by an authorized foster care provider).

2. Provider Qualifications

Agency Requirements: Out-of-home, non-medical respite agencies must be approved respite care and services providers under Part 435 of 18 NYCRR.

Individual Requirements:

- Provision of service in child's residence:
 - Crisis respite providers are paraprofessionals with a high school diploma or equivalent and with appropriate skills and training.
 - For children in B2H MedF, the HCIA will define and arrange for specific training of respite workers based upon the child's needs. This information is documented on the child's *IHP (OCFS-8017)*.
- Provision of service outside child's residence in a foster boarding home:
 - Crisis respite providers must be a Licensed Foster Parent pursuant to Part 435 of 18 NYCRR.
 - For children in B2H MedF, the HCIA will define and arrange for specific training of respite workers based upon the child's needs. This information is documented on the child's *IHP (OCFS-8017)*.
- Provision of service outside child's residence in a group home setting:
 - Crisis respite providers are paraprofessionals with a high school diploma or equivalent and with appropriate skills and training.
 - For children in B2H MedF, the HCIA will define and arrange for specific training of respite workers based upon the child's needs. This information is documented on the child's *IHP (OCFS-8017)*.

HCIA's are responsible for verifying staff and/or subcontractor qualifications and approving training materials.

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

Note: If a foster home is only providing B2H respite and not accepting children for purposes of foster care, CONNECTIONS Vacancy Control can be used to identify the home as a B2H only provider. To accomplish this, the primary FAD worker must mark the beds within the home as occupied and enter the word “B2H” under the “Child Info.” column. This will eliminate the B2H provider from appearing on any Vacancy Control search.

3. Training Requirements

OCFS-sponsored Training: Within six months of starting to provide B2H Waiver services, crisis respite providers are expected to attend OCFS-sponsored training designed specifically to address issues pertinent to their areas of assignment. Respite providers are required to attend the following service-specific trainings:

- Module #1: Bridges to Health Waiver Service Provider Training: Documentation
- Module #2: Bridges to Health Waiver Service Provider Training: Building Resilience
- Module #3: Bridges to Health Waiver Service Provider Training: Safety in the Community
- Module #4: Bridges to Health Waiver Service Provider Training: Essential Elements for Service Provision
- Planned and Crisis Respite—eight hours.

4. Documentation Requirements

Detailed Service Plan (OCFS-8020)

The Crisis Avoidance, Management and Training Specialist completes the *Detailed Service Plan (OCFS-8020)*.

5. Billing Policies

- Crisis Respite is billed in 15-minute increments up to four hours (less than full day). For four or more hours per day, the daily rate applies. There is a separate rate for children in the B2H MedF Waiver Program.
- With appropriate documentation, the provider may bill for up to one hour (four 15-minute units) of services planning (e.g., to attend team meetings and other service development preparation activities) every six months and in six month intervals thereafter.
- This service cannot be delivered nor billed while an enrolled child is in an in-eligible setting, including hospitalization.
- When submitting a bill for direct services provided or services planning, the WSP should use the date of service as the billing date.

N. Adaptive and Assistive Equipment

This service provides technological aids and devices that can be added to the home, vehicle, or other waiver-eligible residence of the enrolled child to enable him/her to accomplish daily living tasks that are

necessary to support the health, welfare, and safety of the child. The adaptive and assistive equipment available through the B2H Waiver Program cannot duplicate equipment otherwise available through the Medicaid State Plan or Title IV-E funding. The equipment enables the child to increase, maintain and/or improve his or her ability to function in the home and community based setting with independence and safety.

Section N-1:

Adaptive and Assistive Equipment

Adaptive/assistive equipment may be obtained at the time the child becomes enrolled in B2H, at any time the child is enrolled or up to 30 days prior to a planned discontinuance. This equipment may be provided where the child currently lives or is expected to live within a reasonable period of time. If the child is in foster care, the provision of this equipment must be consistent with the child's permanency goals. All modifications must be approved by the LDSS, and included and authorized in the IHP.

1. Equipment

The following is a detailed list of the adaptive/assistive equipment that can be provided under the three B2H waivers:

- Communication aids and devices:
 - Personal emergency response systems (PERS): an electronic device that enables certain high-risk patients to secure help in the event of an emergency. The recipient may also wear a portable "help" button to allow for mobility. The system is connected to a patient's phone and programmed to signal a response center once a "help" button is activated.
 - Direct selection communicators
 - Alphanumeric communicators
 - Scanning communicators
 - Encoding communicators
 - Speech amplifiers
 - Electronic speech aids/devices
 - Voice-activated, light-activated, motion-activated and electronic devices.
- Adaptive/assistive aids and devices:
 - Standing boards/frames
 - Adaptive switches/devices
 - Meal preparation aids/devices/appliances
 - Specially adapted locks
 - Motorized wheelchairs
 - Electronic/hydraulic and manual lifts and ramps and ancillary equipment or modifications necessary to guarantee full access to and safety in a motor vehicle: e.g., wheelchair and individual restraint systems, electrical safety interlock devices for lifts (e.g., transmission, ignition) stretcher stations (e.g., restraints, tie-downs), structural vehicle modifications (e.g., door height and width, interior headroom, roof height), interior grab bars, skid resistant floor

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

coverings, exterior and interior lighting, and flip seating for ambulatory passengers who may be accompanying the person.

- Other such adaptive/assistive aids and devices as are required by the *IHP (OCFS-8017)* that would not otherwise be covered by the State Medicaid Plan, and whose purchase and price is approved by the HCI prior to purchase.

Repairs to such adaptive/assistive devices must be cost-effective and approved by the HCI.

Adaptive/assistive aids and devices are expected to be a one-time only purchase. Replacements, repairs, upgrades or enhancements made to existing equipment will be paid if documented as a necessity and with appropriate approvals.

2. Funding Limits

Adaptive and assistive equipment planned for purchase and installation is subject to the overall funding limit for accessibility modifications and adaptive/assistive equipment. The requests for purchase are forwarded to the LDSS, assuming the HCI has determined that the planned expenditures do not result in more than a \$15,000 maximum per child, per five-year period, for any combination of accessibility modifications and adaptive/assistive equipment.

Additional guidelines are as follows:

- All changes must be prior-approved by the LDSS through a revision to the *IHP (OCFS-8017)*.
- There is also a \$5,000 maximum expenditure per address for associated permanent home modifications for rented homes over the five-year period.
- For planned expenditures that do not exceed the five-year, combined \$15,000 limit, and do not exceed \$5,000 for the modification, the LDSS has approval authority.
- LDSS has approval authority for planned modifications that do not exceed \$5,000 for the combined five-year period.
- OCFS Quality Management Specialist (QMS) must also approve expenditures that exceed a total of \$5,000 in a combined five-year period.
- OCFS Bureau of Waiver Management (BWM) must also approve planned expenditures that exceed the five-year, combined \$15,000 limit.

3. Provider Qualifications

Agency Requirements: Approved Medicaid providers. Agencies approved to provide this service by the New York State Department of Health, Office for People With Developmental Disabilities, or Office of Mental Health may be approved by OCFS to provide this service under the B2H Waiver Program. The adaptive/assistive equipment provider must ascertain that individuals working on the adaptive/assistive

equipment are appropriately qualified and/or licensed to comply with state and local rules. All materials and products used must meet state and local construction requirements. Safety issues addressed in Article 18 of the New York State Uniform Fire Prevention and Building Code Act, as well as all local building codes, must be strictly adhered to.

HCIA's are responsible for verifying staff and/or subcontractor qualifications and approving training materials.

4. Approval Process for Adaptive and Assistive Equipment for a Home

- Step 1:** During the development of any *IHP (OCFS-8017)*, the child, HCIA representative (who has knowledge of construction and/or finance), the HCI, medical consentor, caregiver and anyone selected by the child determine if adaptive/assistive equipment is required.
- Step 2:** The HCIA representative must complete a comprehensive assessment to determine the specifications of the adaptive/assistive equipment.
- Step 3:** The child, the HCIA representative, medical consentor, and caregiver must explore all other available resources to pay for adaptive/assistive equipment (i.e., informal supports, community resources, and state/federal agencies).
- Step 4:** When all other resources have been exhausted, the HCIA representative begins the bid procurement and selection process to obtain the equipment.
- Step 5:** The adaptive/assistive equipment provider obtains the needed bids for the related modifications and selects one provider based on cost, comparability of services, and professional skills. For adaptive/assistive equipment costing less than \$1,000, only one bid is required. For adaptive/assistive equipment costing \$1,000 or more, three bids are necessary.
- Step 6:** Bids are submitted to the HCIA representative for selection.
- Step 7:** The HCIA representative submits the adaptive/assistive equipment proposal using the *Accessibility Modifications and/or Adaptive and Assistive Equipment Description, Cost Projection and Final Cost Form (OCFS-8028)* to the LDSS for review and approval along with the *IHP (OCFS-8017)*. Information that must be submitted includes, but is not limited to:
- justification for the adaptive/assistive equipment;
 - all comprehensive assessments completed to determine the specifications of the adaptive/assistive equipment;
 - information about the residence where the adaptive/assistive equipment is proposed, including the name of the homeowner or landlord (the owner's approval for the renovations, including any lease or rental contract, must be included); and
 - if the child or caregiver is having other renovations or repairs done to the house along with the installation of adaptive/assistive equipment, the scope of work clearly

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

distinguishing the B2H Waiver-covered modifications related to the adaptive/assistive equipment from those supported by other funding sources.

- Step 8:** The LDSS reviews the adaptive/assistive equipment proposal and requests additional information, if necessary. Approval is contingent on the costs meeting overall funding limits, as detailed below. The LDSS notifies the HCIA representative of the decision.
- Step 9:** The HCIA representative notifies the adaptive/assistive equipment provider of the approval and obtains a signed contract from the provider. The adaptive/assistive-equipment provider is responsible for coordinating the installation of the adaptive/assistive equipment, including obtaining necessary permits, supervising the construction, setting beginning and end dates, and successfully completing the project.
- Step 10:** The HCIA representative forwards the signed contracts to the LDSS, assuming the HCI has determined that the planned expenditures do not result in more than a \$15,000 maximum per child, per five-year period, for any combination of accessibility modifications and adaptive/assistive equipment.
- Step 11:** Upon completion of the adaptive/assistive equipment installation, the HCIA representative submits a summary of the work, with actual costs, to the LDSS on the *Accessibility Modifications and/or Adaptive and Assistive Equipment Description, Cost Projection and Final Cost Form (OCFS-8028)*.
- Step 12:** The LDSS reviews the *Accessibility Modifications and/or Adaptive and Assistive Equipment Description, Cost Projection and Final Cost Form (OCFS-8028)*, approves the final cost of the adaptive/assistive equipment, and notifies the HCIA representative.
- Step 13:** The HCIA representative notifies the adaptive/assistive equipment provider that the expenditure has been approved and authorized for payment.

5. Repairs

Repairs for adaptive/assistive equipment that are cost effective may be allowed. Equipment that has worn out through normal use may be replaced using the above adaptive/assistive-equipment approval process. Repair and/or replacement may be contingent on developing and implementing a plan to minimize repeated damage.

6. Reimbursement

Adaptive/assistive equipment must be provided by an LDSS-approved provider and included in the *IHP (OCFS-8017)* to be reimbursed. Adaptive/assistive equipment purchases initiated prior to the approval of the *IHP (OCFS-8017)* are not reimbursable.

These services are reimbursed according to the final cost of the project approved by the LDSS, and planned expenditures must be less than the \$15,000 limit per child, per five-year period, for any combination of accessibility modifications and adaptive/assistive equipment.

Section N-2:**Adaptive and Assistive Equipment and Modifications for Vehicles**

Adaptive/assistive equipment for vehicles provides the child with the means to access services and supports in the community, increase independence, and promote productivity. Adaptive/assistive equipment that is available from the dealer by factory installation as a standard or optional feature is *not* covered under the B2H Waiver Program. These items, as well as ongoing maintenance and repair of the vehicle, are the responsibility of the child's caregiver or an individual who provides primary long-term support to the child. Adaptive/assistive equipment modifications must be made only to a vehicle if it is the primary source of transportation for the child and it is available to the child without restrictions. All vehicles that are modified under the B2H Waiver Program must be insured and meet New York State inspection standards before and after the modifications are completed.

1. Equipment and Modifications for Vehicles

Adaptive/assistive equipment allowable through the B2H Waiver Program is designed to enable a child to be transported, or obtain a driver's license to transport him or herself, and is not otherwise available through the vehicle's manufacturer. Adaptive/assistive equipment includes:

- hand controls
- deep dish steering wheels
- spinner knobs
- wheelchair lock downs
- parking brake extensions
- foot controls
- wheelchair lifts, including maintenance contracts
- left foot gas pedals

Vehicle modifications include adaptations and/or changes to the structure and internal design of existing vehicle equipment. Vehicle modifications include:

- replacement of a roof with a fiberglass top
- floor cut-outs
- extension of steering column
- raised door
- repositioning of seats
- wheelchair floor
- dashboard adaptations

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

Adaptive/assistive equipment and vehicle modifications may only be provided if the following conditions are met:

- The child is not eligible for these services through any other resource [e.g., Vocational and Educational Services for Individuals with Disabilities (VESID), Veterans Administration or Workers Compensation Insurance].
- The child/medical consentor, caregiver, and the owner of the vehicle must sign a statement indicating that the vehicle is available to the child without restrictions.

Limitations on adaptive/assistive equipment and modifications for vehicles are as follows:

- The HCIA representative must recommend the most cost-effective and least complicated adaptive equipment that meets the child's functional capabilities and safety needs, while also meeting appropriate requirements/standards.
- A van can only be considered for modification if a car cannot be modified to meet the child's needs.
- Modifications to a vehicle that the child is not driving are limited to modifications that are essential to safe transportation and access in and out of the vehicle.
- Modifications may not exceed the current market value of the vehicle.

2. Funding Limits

Vehicle equipment planned for purchase and installation is subject to the overall funding limit for accessibility modifications and adaptive/assistive equipment. The requests for purchase are forwarded to the LDSS, assuming the HCI has determined that the planned expenditures do not result in more than a \$15,000 maximum per child, per five-year period, for any combination of accessibility modifications and adaptive/assistive equipment.

Additional guidelines are as follows:

- All changes must be prior-approved by the LDSS through a revision to the *IHP (OCFS-8017)*.
- For planned expenditures that do not exceed the five-year, combined \$15,000 limit, and do not exceed \$5,000 for the modification, the LDSS has approval authority.
- LDSS has approval authority for planned modifications that do not exceed \$5,000 for the combined five-year period.
- OCFS Quality Management Specialist (QMS) must also approve expenditures that exceed a total of \$5,000 in a combined five-year period.
- OCFS Bureau of Waiver Management (BWM) must also approve planned expenditures that exceed the five-year, combined \$15,000 limit.

3. Used Vehicles

The B2H Waiver Program may cover the modification of used vehicles or the cost of modifications to a used vehicle only if the vehicle meets the following additional criteria:

- The vehicle must pass New York State inspection, be registered and insured.
- The vehicle must be structurally sound and not in need of mechanical repairs.
- The vehicle must not have any rust or deficiencies in the areas to be modified or in the areas already modified.
- The vehicle must be less than five years old or register fewer than 50,000 miles.

4. Used Adaptive and Assistive Equipment for Vehicles

Used adaptive/assistive equipment is sometimes available for purchase. For safety and proper performance, OCFS approves only used equipment purchased from businesses dealing in the sale of vehicles or adaptive/assistive equipment. The equipment must be able to safely meet the child's needs, and be in good working condition as determined by the vehicle modifier.

Assessing the Value of Used Adaptive and Assistive Equipment

To assess the equipment's value, determine the value of the used vehicle as though no modifications had been made. Subtract this figure from the asking price of the previously modified vehicle. The difference is the asking price of the adaptive/assistive equipment.

To determine the Medicaid reimbursement potentially available for the used adaptive/assistive equipment, first ascertain the original cost of the modification from the dealer. Since adaptive/assistive equipment depreciates 10 percent each year, the current value may be determined by reducing the original cost by the 10-percent per-year depreciation. This figure is the current value of the adaptive/assistive equipment. This is the amount that Medicaid may cover provided it does not exceed the overall spending limits specified in this Manual.

5. Approval Process for Adaptive and Assistive Equipment for a Vehicle

- Step 1:** During the development of an *IHP (OCFS-8017)*, the child/medical consenter, HCIA representative, and anyone selected by the child determine if adaptive/assistive equipment is required.
- Step 2:** The child/medical consenter, HCIA representative, and child's caregiver must explore all other resources to pay for the purchase.
- Step 3:** When all other resources have been exhausted, the HCIA representative and child/medical consenter select an adaptive/assistive vehicle-equipment provider.
- Step 4:** The adaptive/assistive equipment provider obtains the needed bids for the related modifications and selects one provider based on cost, comparability of services, and

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

professional skills. For adaptive/assistive equipment costing less than \$1,000, only one bid is required. For adaptive/assistive equipment costing \$1,000 or more, three bids are necessary.

Step 5: Bids are submitted to the HCIA representative for selection.

Step 6: The HCIA representative submits the request for the adaptive/assistive equipment, the *Accessibility Modifications and/or Adaptive and Assistive Equipment Description, Cost Projection and Final Cost Form (OCFS-8028)*, which includes vehicle identification requirements, to the LDSS along with the *IHP (OCFS-8017)* for review and approval. Information that must be submitted includes but is not limited to:

- justification for the vehicle adaptive/assistive equipment;
- all comprehensive assessments
- and a copy of the selected bid and the projected costs.

Step 7: The LDSS or QMS reviews the proposal and may request more information. Approval is contingent on the funding limits detailed above.

Step 8: The LDSS or QMS reviews the proposed adaptive/assistive equipment for the vehicle and notifies the HCIA representative of the decision. The HCIA representative notifies the adaptive/assistive equipment provider of the approval and obtains a signed contract from the provider.

Step 9: Documentation must be included verifying that the vehicle is insured and inspected by New York State following the modifications.

Step 10: The HCIA representative submits to the LDSS: (a) the *Accessibility Modifications and/or Adaptive and Assistive Equipment Description, Cost Projection and Final Cost Form (OCFS-8028)* and (b) statement indicating that the completed adaptive/assistive equipment complies with the original recommendations.

Step 11: The LDSS reviews the *Accessibility Modifications and/or Adaptive and Assistive Equipment Description, Cost Projection and Final Cost Form (OCFS-8028)* and approves the final cost of the vehicle adaptive/assistive equipment and notifies the HCIA representative.

Step 12: The HCIA representative notifies the adaptive/assistive equipment provider that the expenditure has been approved and authorized for payment.

6. Repairs

Reimbursement for B2H Waiver Program services does not cover general vehicle repairs or maintenance. All warranties and guarantees must be fully utilized. Requests for repairs to adaptive/assistive equipment for vehicles must follow the same procedures as required for initial purchases.

7. Reimbursement

Vehicle modifications must be provided by an approved Medicaid provider or agencies approved by DOH, Office of Mental Health (OMH) and/or OPWDD, or may also be approved by OCFS. These services must be included in the *IHP (OCFS-8017)* to be reimbursed. The purchase of adaptive/assistive equipment for vehicles initiated prior to the approval of the *IHP (OCFS-8017)* is not reimbursable. Vehicle modifications are reimbursed at cost if the procedures described in this section have been followed and upon approval by the LDSS.

O. Accessibility Modifications

This service provides internal and external physical adaptations to the home or other waiver-eligible residences of the enrolled child that are necessary to support the health, welfare, and safety of the child. These modifications are additive to services available through Medicaid State Plan or Title IV-E funds, and enable the child to function with greater independence related to the child's disability and/or health care issues and prevent medical institutionalization.

1. Modifications

Accessibility Modifications may be obtained at the time the child becomes enrolled in the B2H Waiver Program, at any time the child is enrolled, or up to 30 days prior to a planned B2H waiver discontinuance. These modifications may be provided where the child resides or is expected to reside within a reasonable period of time. They have to be consistent with the child's permanency goals and approved by the LDSS. All modifications must be included and authorized in the *IHP (OCFS-8017)*.

Allowable improvements and modifications necessary to support the child's health and welfare may include, but are not limited to, the following:

- ramps
- widening of doorways and hallways
- allergen controls
- lifts: hydraulic, manual or electric, for porch, bathroom or stairs. Lifts may also be rented if it is determined that this is more cost-effective
- hand rails and grab bars
- automatic or manual door openers and doorbells
- bathroom and kitchen modifications, additions, or adjustments to allow accessibility or improved functioning include:
 - roll-in showers
 - sinks and tubs
 - water faucet controls
 - plumbing adaptations to allow for cutouts, toilet/sink adaptations
 - turnaround space changes/adaptations
 - worktable/work surface adaptations
 - cabinet and shelving adaptations

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

- Medically necessary heating/cooling adaptations required as part of a medical treatment plan. Any such adaptations used solely to improve a child's living environment are not reimbursable under the B2H Waiver Program.
- Electrical wiring to accommodate other adaptations or equipment installation.
- Specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that have been determined medically necessary.
- Other appropriate modifications, adaptations, or repairs necessary to make the living arrangements accessible or to accommodate for the child's independence and daily functioning and to provide for emergency fire evacuation.

Allowable improvements do not include improvements to the home (such as carpeting, roof repair, central air conditioning), that are not medically necessary nor promote the child's independence and well-being in the home or community.

2. Funding Limits

Accessibility Modifications planned for purchase and installation are subject to the overall funding limit for accessibility modifications and adaptive/assistive equipment. The requests for purchase are forwarded to the LDSS, assuming the HCI has determined that the planned expenditures do not result in more than a \$15,000 maximum per child, per five-year period, for any combination of accessibility modifications and adaptive/assistive equipment.

Additional guidelines are as follows:

- All changes must be prior-approved by the LDSS through a revision to the *IHP (OCFS-8017)*.
- There is also a \$5,000 maximum expenditure per address for associated permanent home modifications for rented homes over the five-year period.
- For planned expenditures that do not exceed the five-year, combined \$15,000 limit, and do not exceed \$5,000 for the modification, the LDSS has approval authority.
- LDSS has approval authority for planned modifications that do not exceed \$5,000 for the combined five-year period.
- OCFS QMS must also approve expenditures that exceed a total of \$5,000 in a combined five-year period.
- OCFS BWM must also approve planned expenditures that exceed the five-year, combined \$15,000 limit.

3. Provider Qualifications

Agency Requirements: A corporation whose corporate purposes include the provision of accessibility modifications as defined under the three B2H Waivers. Agencies approved to provide this service by the New York State Department of Health, Office of Mental Health, or Office for People With Developmental Disabilities may be approved by OCFS to provide this waiver service.

The providers may be HCIAs and/or qualified entities under subcontract with HCIAs. An approved provider must demonstrate that subcontracted individuals or entities are appropriately qualified and/or licensed to comply with any state and local rules. All materials and products used must also meet any state or local construction requirements. Providers must adhere to safety issues addressed in Article 18 of the New York State Uniform Fire Prevention and Building Code Act, and must meet all state and local building codes.

HCIAs are responsible for verifying staff and/or subcontractor qualifications and approving training materials.

4. Approval Process for Accessibility Modifications for a Home

- Step 1:** During the development of any *IHP (OCFS-8017)*, the child, the HCIA representative (who has knowledge of construction and or finance), the HCI, medical consentor, caregiver and anyone selected by the child determine if any accessibility modifications are required.
- Step 2:** The HCIA representative must complete a comprehensive assessment to determine the specifications of the accessibility modifications.
- Step 3:** The child, the HCIA representative, medical consentor, and caregiver must explore all other available resources to pay for accessibility modifications (i.e., informal supports, community resources and state/federal agencies).
- Step 4:** When all other resources have been exhausted, the HCIA representative begins the bid procurement and selection process. There are three options for paying for the accessibility modifications. (See section 7, below, Paying for Accessibility Modifications for a Home.)
- Step 5:** The HCIA representative submits the accessibility modifications' proposal using the *Accessibility Modifications and/or Adaptive and Assistive Equipment Description, Cost Projection and Final Cost Form (OCFS-8028)* to the LDSS for review and approval along with the *IHP (OCFS-8017)*. Information that must be submitted includes, but is not limited to:
- justification for the accessibility modifications;
 - all comprehensive assessments completed to determine the specifications of the accessibility modification;
 - information about the residence where the accessibility modifications are proposed, including the name of the homeowner or landlord (the owner's approval for the renovations, including any lease or rental contract, must be included); and

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

- if the child or caregiver is having other renovations or repairs done to the house along with the accessibility modifications, the scope of work should clearly distinguish the B2H Waiver-covered accessibility modifications from those supported by other funding sources.

- Step 6:** The LDSS reviews the accessibility-modification proposal and requests additional information, if necessary. Approval is contingent on the costs meeting overall funding limits, as detailed below. The LDSS notifies the HCIA representative of the decision.
- Step 7:** The HCIA representative notifies the accessibility-modifications provider of the approval and obtains a signed contract from the provider. The accessibility modifications provider is responsible for coordinating the accessibility modifications, including obtaining necessary permits, supervising the construction, setting beginning and end dates, and successfully completing the project.
- Step 8:** The HCIA representative forwards the signed contracts to the LDSS, assuming the HCI has determined that the planned expenditures do not result in more than a \$15,000 maximum per child, per five-year period, for any combination of accessibility modifications and adaptive/assistive equipment.
- Step 9:** Upon completion of the accessibility modifications, the HCIA representative submits a summary of the work, with actual costs, to the LDSS on the *Accessibility Modifications and/or Adaptive and Assistive Equipment Description, Cost Projection and Final Cost Form (OCFS-8028)*
- Step 10:** LDSS reviews the *Accessibility Modifications and/or Adaptive and Assistive Equipment Description, Cost Projection and Final Cost Form (OCFS-8028)*, approves the final cost, and notifies the HCIA representative.
- Step 11:** The HCIA representative notifies the accessibility-modifications provider that the expenditure has been approved and authorized for payment.

5. Repairs

Repairs for home modifications that are cost effective may be allowed. Modifications that have worn out through normal use (such as faucet controls, ramps, handrails, etc.) may be replaced using the above accessibility modifications approval process for new accessibility modifications. Repair and/or replacement may be contingent on developing and implementing a plan to minimize repeated damage.

6. Reimbursement

Accessibility modifications must be provided by an LDSS-approved provider and included in the *IHP (OCFS-8017)* to be reimbursed. Accessibility modifications initiated prior to the approval of the *IHP (OCFS-8017)* are not reimbursable.

These services are reimbursed according to the final cost of the project approved by the LDSS, and planned expenditures must be less than the \$15,000 limit per child, per five-year period, for any combination of accessibility modifications and adaptive/assistive equipment.

7. Paying for Accessibility Modifications for a Home

Option 1

The HCIA can use the services of an employee to perform the construction (i.e., a carpenter on the HCIA staff). This is considered to be an “in-house” service and there is no additional administrative management fee paid to the HCIA for the services of the employee. The HCIA is expected to complete the construction, monitor its completion, and verify compliance with state and local building codes.

The HCIA submits bills for reimbursement to eMedNY for the costs of construction.

Option 2

HCIA's are responsible for hiring subcontractors and then overseeing and monitoring the construction process needed to complete the modifications. Billing is not allowed until the construction is complete. The HCIA submits bills to eMedNY and is reimbursed for the costs of construction and is responsible for paying the subcontractors. In addition, for projects that exceed \$1,000, OCFS requires three bids to be obtained and the most reasonable bid be accepted (not necessarily the lowest bid). If a job exceeds the amount of the accepted bid by no more than 10 percent, the costs are automatically allowed. However, if a job costs 10 percent or more above the amount of the accepted bid, further justification and approval are necessary.

The HCIA may receive, through eMedNY, 10 percent of the amount of the accepted bid, which includes any allowed cost increases above of the cost of the accessibility modification for their work. When the final cost of the accessibility modifications has been determined, the HCIA adds 10 percent of that cost to the total. The 10 percent administrative rate is intended to cover the costs of obtaining the bids, monitoring and supervising the construction, verifying the compliance with existing standards, billing, and paying the vendor. In addition, if costs exceed the amount of the accepted bid, the HCIA is required to obtain approval.

Option 3

Construction, monitoring, and supervising may be entirely contracted to outside parties by the HCIA. The HCIA bills and is reimbursed through eMedNY for the costs of the construction and is responsible for paying the subcontractors. For projects that exceed \$1,000, OCFS requires three bids to be obtained and the most reasonable bid accepted (not necessarily the lowest bid).

The subcontractor is responsible for completion and must verify project compliance with state and local building codes.

BRIDGES TO HEALTH (B2H)

**NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES
HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM**

Under this option, the addition of an administrative rate to the cost of the accessibility modifications is not permitted since there is no HCIA oversight. The cost of securing the three bids is assumed in the HCI monthly rate.

Chapter 9: The Individualized Health Plan

The *Individualized Health Plan (IHP) (OCFS-8017)* is the 12-month plan of services in the Bridges to Health (B2H) Waiver Program. The *IHP (OCFS-8017)* specifies the child's goals and the services necessary to maintain the child in his/her home community. The Health Care Integration Agencies (HCIAs) are responsible for the development and review of every *IHP (OCFS-8017)* to monitor that the *IHPs (OCFS-8017)* support the child's goals, meet the child's needs and are cost-effective.

The HCIA must provide detailed written information to the child/medical consentor on the purpose and design of available B2H Waiver services and the *IHP (OCFS-8017)* development process. The Health Care Integrator (HCI) is responsible for providing unbiased and comprehensive information to the child/medical consentor about available B2H Waiver services and Waiver Service Providers (WSPs). The HCI is also responsible for monitoring the implementation of the *IHP (OCFS-8017)*, making sure that the activities outlined in the *IHP (OCFS-8017)* are carried out and that they are sufficient to support the child's health and welfare.

The *IHP (OCFS-8017)* is supported by the *Detailed Service Plan (OCFS-8020)*, the *Service Summary Form (OCFS-8018)*, and *Progress Notes (OCFS-8019)*.

A. Role of the LDSS/DJJOY

The role of the Local Department of Social Services (LDSS) or OCFS Division of Juvenile Justice and Opportunities for Youth (DJJOY) in the *IHP (OCFS-8017)* includes:

- approving the *IHP (OCFS-8017)*,
- coordinating with HCI, and
- coordinating the Family Assessment and Service Plan (FASP) or DJJOY Treatment Team Plan Notes (TTPN) and the *IHP (OCFS-8017)*.

1. Approving the IHP

The *IHP (OCFS-8017)* must be approved and signed by the LDSS on an annual basis, at minimum, or more frequently as indicated by a change in the child's needs. When a B2H Waiver service is increased*, decreased, added or discontinued, changes to the *IHP (OCFS-8017)* must be authorized by the LDSS. Only services authorized in the *IHP (OCFS-8017)* can be provided and billed.

The LDSS reviews *all IHPs (OCFS-8017)* to determine if:

- the *IHP (OCFS-8017)* 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 *IHP (OCFS-8017)* support the child's health and welfare,
- informal and non-waiver services are used whenever appropriate, and

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

- discontinuance is appropriate.

Until the LDSS has formally approved any *Revised IHP (OCFS-8017)*, the existing *IHP (OCFS-8017)* must stand in effect.

Note: effective January 1, 2011, HCIA's may increase and provide already authorized services up to \$5,000 without obtaining LDSS sign-off, which does not apply to the services of Health Care Integration, Accessibility Modifications or Adaptive/Assistive Equipment. The HCI must convene a team meeting and submit a *Revised IHP (OCFS-8017)* to the LDSS. Additionally, increases that cause the *IHP (OCFS-8017)* budget to exceed \$51,600 must be sent to the OCFS QMS at the same time it is sent to the LDSS – see Chapter 2: Eligibility, Enrollment, Transitions, Rights and Responsibilities for more information.

2. Coordination Responsibilities

For a child in foster care, an *IHP (OCFS-8017)* should be considered a component of the service plan or FASP whenever possible. For children enrolled in a DJJOY B2H Waiver slot, the DJJOY Community Services Team (CST) case manager coordinates the child's transition plan in the TTPN. The HCI should be encouraged to participate in the development of the FASP/TTPN and to provide pertinent information about the child's health and welfare to the LDSS or DJJOY. The LDSS/DJJOY case manager should participate in the development of the *IHP (OCFS-8017)* whenever possible. It is important for the HCI and case manager to form a complementary relationship and share information in support of the child's permanency, health and well-being.

When a child enrolled in the B2H Waiver Program is no longer in foster care, the LDSS/DJJOY case manager continues to maintain overall responsibility for the child's plan and approving the *IHP (OCFS-8017)*. It is important for the LDSS to continue the relationship with the HCI after the child is discharged from foster care to facilitate the appropriate LDSS oversight of the child's B2H case.

Before submitting any *IHP (OCFS-8017)* to the LDSS, it is strongly recommended that there be ongoing communication with the HCI and the LDSS regarding the B2H Waiver services and the contents of the *IHP (OCFS-8017)*.

3. FASP–IHP Due Date Coordination

The FASP is the case management planning tool required for all children receiving child welfare services through an LDSS. After the initial FASP is completed, a Service Plan Review (SPR) meeting takes place and an updated reassessment FASP is due every six months. Since all of the children at B2H enrollment and some during their enrollment remain in foster care, many of the individuals in the *IHP (OCFS-8017)* process would be involved in FASP formation and maintenance. It is a goal of the B2H Waiver Program to coordinate the due dates of the FASP and the *IHP (OCFS-8017)*.

Under the guidelines of B2H, an *Annual Revised IHP (OCFS-8017)* is required every 12 months. However, to align the FASP and *IHP (OCFS-8017)* cycles, HCIA's are allowed to adjust the date of the first *Annual Revised IHP (OCFS-8017)*. The first *Annual Revised IHP (OCFS-8017)* must still be

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

completed within 12 months of the date of enrollment, but it can be completed as early as six months and one day after enrollment to align with a FASP due date.

B. Team meetings

The purpose of a team meeting is to allow for collaboration among the HCI, WSPs, the medical consentor, the child, the caregiver, the LDSS and anyone else the child/medical consentor wishes to have participate in this meeting. The HCI must organize team meetings to review the child’s current needs, plan for services and develop *IHPs* (OCFS-8017). A team meeting does not qualify as a required HCI face-to-face contact and therefore cannot be used as a substitution for this requirement. Additional information on the role of the HCI and team meetings is provided in Chapter 6, Health Care Integrators.

Team meetings are permitted but not required for the *Preliminary IHP* (OCFS-8017). All subsequent *IHPs* (OCFS-8017), (Initial, Revised, and Annual Revised), require team meetings.

The following chart details the participants for team meetings and attendance requirements:

Must attend	Must be invited and expected to attend	May be invited and may attend
<ul style="list-style-type: none"> ○ Health Care Integrator ○ Medical Consentor ○ Informed Waiver Service Provider (WSP) <p>representative(s) for each service the child receives – must attend the first meeting (within 30 days of enrollment) and at least every 6 months thereafter.</p>	<ul style="list-style-type: none"> ○ a representative from the LDSS or DJJOY ○ a representative from the HCIA beyond the HCI ○ a representative from the voluntary case planning agency if the child is in foster care ○ family members and caregivers ○ a representative from the Office for People With Developmental Disabilities (OPWDD) Developmental Disabilities Service Office (DDSO) (on a case specific basis) ○ the OCFS QMS (on a case specific basis) 	<ul style="list-style-type: none"> ○ the child ○ anyone the child or medical consentor wishes to have participate

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

The frequency with which team meetings must occur is:

- for the first year of enrollment:
 - 1st required team meeting** within 30 days of enrollment,
 - 2nd required team meeting** to be held 90 days from the 30 day team meeting (approximately 120 days from enrollment),
 - 3rd required team meeting** to be held 90 days from the 2nd team meeting (approximately 210 days from enrollment),
 - 4th required team meeting** to be held 90 days from the 3rd team meeting (approximately 300 days from enrollment). This is also the planning meeting for the annual re-authorization which must occur 60 days prior to the annual reauthorization date and submitted to the LDSS 30 days prior to the annual reauthorization date,
- at least two months prior to the due date of the *Annual Revised IHP (OCFS-8017)*,
- after the first year of enrollment in the B2H Waiver, at least every six months,
- prior to submission of a Revised IHP (*OCFS-8017*), at the request of the HCI and/or the child/medical consentor, and
- at the request of the LDSS.

As previously discussed in Chapter 6, Health Care Integrators, agendas for the meetings may include issues raised by any involved party and are an opportunity to review the adequacy of the *IHP (OCFS-8017)*. Some of the issues that could be discussed include, but are not limited to:

- continued B2H eligibility,
- the child's Medicaid "thru date" and actions to maintain Medicaid coverage,
- progress towards goals,
- barriers to providing the indicated services,
- need for changes in services, and
- potential for a transition to another home and community-based services waiver program, such as those offered by the OPWDD.

A sign-in sheet and minutes for each team meeting must be retained in the child's case record. This information must be shared and reviewed at each team meeting, and made available to those who cannot attend the meeting. Minutes from team meetings are documented in *Progress Notes* and must include the list of attendees, the date and time of the meeting, the reason the meeting was called, summary of the discussion, and the decisions reached.

C. Contents of the IHP

The child's strengths, abilities and preferences are the starting point for developing the *IHP (OCFS-8017)*. The HCI conducts an assessment using a multifaceted approach which may include self-assessment and discussion with birth, adoptive or foster parents, family members, school personnel, case managers, case planners, other professionals and service providers involved with the child.

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

The following domains are included in every *IHP (OCFS-8017)*:

- Dates of team meetings to develop the *IHP (OCFS-8017)* and individuals who assisted in the development of the *IHP (OCFS-8017)*, including their relationship to the child.
- Summary of the child's assessment based upon interviews and documentation acquired, including the Child and Adolescent Needs and Strengths (CANS) B2H assessment. The HCI must obtain a complete and accurate picture of the child and/or medical consentor's history and risk factors, needs, strengths and as appropriate, preferences concerning the following topics:
 - A. Family/Caregiver,
 - B. Permanency Goal,
 - C. Living Situation,
 - D. Physical Health,
 - E. Developmental Health,
 - F. Mental Health,
 - G. Alcohol and Substance Abuse,
 - H. Community Service,
 - I. Recreation or Leisure Time,
 - J. Spirituality,
 - K. Criminal History,
 - L. Education/School,
 - M. Vocation or Job (for over 14 years of age), and
 - N. Budgeting/Money Management (for over 14 years of age).
- For each B2H Waiver service that is selected, the goal is attached to the service and/or the reason for receiving the service. This information guides the WSPs involved in the child's *IHP (OCFS-8017)* regarding the goals or reason(s) the child needs a service.
- List of Medicaid State Plan Services that the child is currently receiving, which informs the HCI of the services that exist to support this child's welfare.
- List of Non-Medicaid State Plan Services that the child is currently receiving, which also informs the HCI of the services that exist to support this child's welfare.
- Individuals who are responsible for assisting the child with daily activities, medication management and financial transactions. Emergency contact for fire, safety issues, and backup plans are included.
- An itemized list of the B2H Waiver service types to be provided (column A), by which provider (columns B and C); the rate type (column D), the start/end dates (column E-F), the billable units of service (column G), the units per month (column H), the rate per unit (column I), the projected cost (column J), number of months of service (column K) that calculates the Projected cost of service for the upcoming 12 months (column L), which determines the **Total Projected Costs of All Services Over the upcoming 12 months**. The LDSS authorizes the B2H waiver service types (column A on the budget) to be provided.

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

Note: the LDSS authorizes the B2H Waiver Services Type (Column A on the Projected Budget). If the WSP provides a different Rate Type (column D on the Projected Budget), the explanation must be documented. For example, group Skill Building is approved in the *IHP (OCFS-8017)*. The WSP arrives to provide the group Skill Building service and one of the two group participants is absent. The WSP may deliver Skill Building on an individual basis instead. The WSP must document service provision to the individual child and indicate why the group did not occur on the *Service Summary Form (OCFS-8018)*. The HCI must monitor its effect on the *IHP (OCFS-8017)* and act accordingly.

- The HCIs calculate a budget for each *IHP (OCFS-8017)* using the published rates for B2H Waiver services available on the OCFS B2H website: www.ocfs.state.ny.us/main/b2h/ . The projected budget for any *IHP (OCFS-8017)* is authorized for a period of 12 months from the enrollment date and once every 12 months thereafter. The total projected budget cannot exceed \$51,600 per each 12 month period from the enrollment date regardless of any budget modifications within that 12 month period.
- A target B2H Waiver transition date and the reason(s) for the target date. The HCI must monitor goal achievement in the context of the anticipated transition date via documenting the CANS B2H scores during the period the *IHP (OCFS-8017)* covers.
- By signing the *IHP (OCFS-8017)*, the participants acknowledge that they have added their input to the *IHP (OCFS-8017)*. The *IHP (OCFS-8017)* must be signed by the following:
 - Child (as appropriate)
 - Medical consentor,
 - Health Care Integrator,
 - Health Care Integration Agency Representative,
 - Case planner (if applicable) for the child in foster care and
 - LDSS case manager.

Any disagreement about any aspect of an *IHP (OCFS-8017)* should be discussed during the team meeting and, if still unresolved, referred to LDSS for a decision. If necessary, the child/medical consentor can request a Medicaid Fair Hearing when a B2H service has been denied or discontinued.

D. Four Types of IHPs

1. Preliminary IHP

The *Preliminary IHP (OCFS-8017)* is the first *IHP (OCFS-8017)* that must be developed for the child and submitted to the LDSS for review *before* enrollment.

a. Initial Interview: After the child is referred to an HCIA by the LDSS using the *Referral Form (OCFS-8000)*, the HCIA conducts an initial interview with the child/medical consentor to evaluate eligibility. The HCIA provides the child with an explanation of the philosophy, goals and services available through the B2H Waiver Program.

b. Completing the Preliminary IHP: After the initial interview is complete, the HCIA may schedule as many meetings as necessary with the child/medical consentor to complete the *Preliminary IHP (OCFS-8017)*. The *Preliminary IHP (OCFS-8017)* is included in the package of information that is transmitted to the LDSS to review and make enrollment decisions. The process of developing the *Preliminary IHP (OCFS-8017)* includes obtaining pertinent information from relevant parties through interviews, records and other sources to fully understand and document the strengths and needs of the child.

2. Initial IHP

The *Initial IHP (OCFS-8017)* is completed after the child is initially enrolled into a B2H Waiver and submitted to the LDSS for review within 30 days after enrollment.

Within 30 days of authorization for the B2H Waiver Program, the HCI must hold a team meeting. The purpose of this team meeting is to complete and submit the *Initial IHP (OCFS-8017)*. The HCI may schedule as many meetings as necessary with the child/medical consentor to complete an *Initial IHP (OCFS-8017)*. The process of developing the *Initial IHP (OCFS-8017)* includes obtaining pertinent information from relevant parties to fully understand and document the strengths and needs of the child. At the time of the meeting to prepare the *Initial IHP (OCFS-8017)*, the HCI must provide the child/medical consentor with a *Contact Information List (OCFS-8027)* listing the names and phone numbers of waiver provider staff, their supervisors, contact information for the HCIA, the LDSS, OCFS Quality Management Specialist (QMS), Bureau of Waiver Management (BWM), the NYS Statewide Central Register of Child Abuse and Maltreatment and the Department of Health (DOH) in case any concerns arise. When planning times for service provision it may be helpful to complete a weekly schedule, see Appendix D.

Baseline Assessments: Before initiating the *Initial IHP (OCFS-8017)*, the HCI must complete baseline assessments within 30 days of enrollment for children in the B2H Waiver Program to maintain documentation of waiver participant progress and outcomes. The HCI must use the CANS B2H instrument during this initial period with the child to obtain a baseline assessment. Once the initial baseline of the CANS B2H is administered, it must be re-administered every six months, at transition and as otherwise needed. For children no longer in foster care, the CANS B2H must be administered on the same schedule.

3. Revised IHP

A *Revised IHP (OCFS-8017)* is completed whenever there is a need for a significant change in the level or amount of services that a child receives. These changes occur:

- when the expected outcomes of the *IHP (OCFS-8017)* are either realized or need to be altered; or
- when the child has experienced significant changes in physical, cognitive, psychological, or behavioral status that require alteration (increase*, decrease, add, or discontinue) of services provided.

The *Revised IHP (OCFS-8017)* must be submitted to the LDSS for review and approval. A team meeting must occur prior to the submission of a *Revised IHP (OCFS-8017)*.

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

*Note: effective January 1, 2011, HCIAAs may increase and provide already authorized services up to \$5,000 without obtaining LDSS sign-off, which does not apply to the services of Health Care Integration, Accessibility Modifications or Adaptive/Assistive Equipment. The HCI must convene a team meeting and submit a *Revised IHP (OCFS-8017)* to the LDSS. Additionally, increases that cause the *IHP (OCFS-8017)* budget to exceed \$51,600 must be sent to the OCFS QMS at the same time it is sent to the LDSS – see Chapter 2: Eligibility, Enrollment, Transitions, Rights and Responsibilities for more information.

4. Annual Revised IHP

The *Annual Revised IHP (OCFS-8017)* is required for annual reauthorization of B2H Waiver services and is submitted to the LDSS for review. The HCIA begins the reauthorization process 60 days *before* annual reauthorization, so that the *Annual Revised IHP (OCFS-8017)* can be submitted 30 days before the annual reauthorization date. The B2H Waiver is re-authorized by the LDSS on an annual basis, one year from the date of Authorization. For children enrolled in an OCFS DJJOY B2H Waiver slot, upon approval of the *IHP (OCFS-8017)*, DJJOY also collaborates with the appropriate LDSS to reauthorize Medicaid annually for children in the B2H slots.

The HCI may schedule as many meetings as necessary with the child/medical consentor to complete an *Annual Revised IHP (OCFS-8017)*. The process of developing the *Annual Revised IHP (OCFS-8017)* includes obtaining pertinent information from relevant parties to fully understand changes and document the strengths and needs of the child. The *Annual Revised IHP (OCFS-8017)* must include as much information as the HCI can gather through interviews, records and other information to develop a plan for services.

This is an opportunity to consider whether the child would be better served by another Medicaid waiver program administered by OPWDD, OMH, or DOH.

E. Scheduling Services in the IHP

The services in the *IHP (OCFS-8017)* must be scheduled in a manner that is reasonable and feasible for a child to attend services within the constraints of the child's life, taking into account the school day, community activities and any other regular appointments or commitments. See Appendix D, Weekly Schedule of B2H Waiver Services, for a form that may be used to assist the HCI in scheduling B2H Waiver services.

A WSP must notify the HCI when a child/medical consentor refuses a service. The HCI should review the *IHP (OCFS-8017)* with the child/medical consentor to determine if it needs to be revised to more accurately reflect the goals and abilities of the participant. If a child refuses *all* waiver services, it is necessary to discontinue the child's enrollment in the B2H Waiver Program. See Chapter 2, Eligibility, Enrollment for more details.

F. Changing Waiver Service Providers

The child/medical consentor has the right to change WSPs at any time. With the assistance of the HCI or the HCI supervisor, the child/medical consentor completes a *Change of Provider Form (OCFS-8006)*, which is sent to the HCIA. The HCIA sends an acknowledgment of receipt of the Change of Provider Request to the child/medical consentor, the HCI, the current and new WSPs, the LDSS and the case planning agency if applicable.

If the child/medical consentor wishes to change HCIs, the medical consentor may contact the HCI or another HCIA representative or if circumstances necessitate a change in HCI, the HCI/HCIA representative must notify the child/medical consentor of this change. The HCIA provides information to the child and medical consentor about HCIs and assists the medical consentor in completing the *Change of Provider Form (OCFS-8006)*. For more information on changing WSPs, including HCIs and HCIAS, see Chapter 2, Eligibility/Enrollment.

G. Recordkeeping and Documentation

Accurate recordkeeping is essential to monitor the health and well-being of the children in the B2H Waiver Program and to document the expenditures of Medicaid funds. Documentation assists the child/medical consentor and the WSP in defining goals and outcomes. With the process of setting goals, developing and applying an intervention strategy and reviewing the effectiveness of the intervention strategy, the child/medical consentor can better understand whether the goals can be realized and what interventions and/or goals need to be revised.

Recordkeeping for Medicaid billing is a requirement for all Medicaid providers. Providers are responsible for having clear and accurate documentation to support all Medicaid claims. The *Detailed Service Plan (OCFS-8020)*, *Service Summary Form (OCFS-8018)* and *CONNECTIONS Progress Notes and Progress Notes (OCFS-8019)* must be forwarded to the HCI for inclusion in the child's case record. All records must be maintained for at least 30 years after the child has been discharged from foster care.

1. The Detailed Service Plan

The *Detailed Service Plan (OCFS-8020)* needs to be developed for each service in the *IHP (OCFS-8017)*. The *Detailed Service Plan (OCFS-8020)* identifies goals, intervention strategies, time frames and progress towards goals. *Detailed Service Plans (OCFS-8020)* document how each waiver service is contributing to the child's progress, justify the continuation of services and represent the provider's request for continued approval to provide waiver services. For the LDSS to re-approve/continue a service, the *Detailed Service Plans (OCFS-8020)* must clearly describe how the continuation of this service helps to maintain the child in the community.

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

Providers responsible for completing the Detailed Service Plan	For the following B2H service(s):
Health Care Integrator	Health Care Integration Skill Building Family/Caregiver Supports and Services Planned Respite Adaptive/Assistive Equipment* Accessibility Modifications*
Crisis Avoidance, Management and Training Specialist	Crisis Avoidance, Management and Training Immediate Crisis Response Services Intensive In-home Supports and Services Crisis Respite
Day Habilitation Specialist	Day Habilitation
Prevocational Service Specialist	Prevocational Services
Supported Employment Specialist	Supported Employment
Special Needs Community Advocacy and Support Specialist	Special Needs Community Advocacy and Support

***Note:** For accessibility modifications and/or adaptive/assistive equipment, the *Detailed Service Plan (OCFS-8020)* is captured in the *Accessibility Modifications and/or Adaptive and Assistive Equipment Description, Cost Projection and Final Cost Form (OCFS-8028)*.

The *Detailed Service Plan (OCFS-8020)* must be completed within 30 days of enrollment into the B2H Waiver Program and every six months thereafter, or more frequently, if necessary. *Detailed Service Plans (OCFS-8020)*, beyond the initial *Detailed Service Plans (OCFS-8020)*, must be submitted to the HCI 30 days before the due date. The HCI, or WSP supervisor, completes the *Detailed Services Plans (OCFS-8020)* when WSP staff is not identified.

Content of the Detailed Service Plan

The *Detailed Service Plan (OCFS-8020)* outlines the following components:

- Goals: that can be defined and attained.
- Intervention strategy: what interventions are needed to achieve goals.
- Time frames: to describe the frequency and time needed to reach the goal.
- Answers the following questions:
 - What goals have been worked on?
 - What did staff do to assist the participant to accomplish his/her goals?
 - The reason(s) a goal was established, attained, continued, remain the same, be revised, or discontinued.

2. Service Summary Forms

Service Summary Forms (OCFS-8018) are completed when any service is provided in any of the three B2H Waivers and are the supporting documentation for a billable contact. *Service Summary Forms (OCFS-8018)* provide an opportunity for objective observations during home visits, telephone contacts

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

and during other service provision occasions. *Service Summary Forms (OCFS-8018)* present a picture of the child and family as well as the HCIA's implementation of the B2H Waiver Program.

Service Summary Forms (OCFS-8018) are reviewed in audits for comparison against Medicaid billing claims and in relationship to goals and objectives. All *Service Summary Forms (OCFS-8018)* must indicate both whether the contact was with the child or collateral and whether it was face-to-face or by telephone. In addition, *Service Summary Forms (OCFS-8018)* must specify which of the B2H Waiver services is being provided. Each *Service Summary Form (OCFS-8018)* must be complete, timely and must accurately relate to and identify the child's *IHP (OCFS-8017)* goals and objectives. Each HCIA must develop and implement the quality assurance standards detailed in Chapter 5, Health Care Integration Agencies, such that all individual workers' notes, as well as other documentation, are reviewed periodically by a supervisor. Supervisors must document corrective actions needed, how each is to be accomplished and a time frame for completion.

For **every** B2H Waiver service delivered, the worker must complete a *Service Summary Form (OCFS-8018)* that complies with all of the above criteria. The HCI must complete the *Service Summary Form (OCFS-8018)* after each service contact and submit for review within five business days. The WSP must submit *Service Summary Forms (OCFS-8018)* to the HCIA within five business days of the contact. The HCI monitors service delivery and coordinates any needed services that arise from other worker contact with the child and family.

Content of the Service Summary Forms

Since Medicaid requires that service documentation be contemporaneous with service provision, the following information must be documented on each *Service Summary Form (OCFS-8018)*:

- child's name & Medicaid Client Identification Number (CIN),
- type of service provided,
- date of service and service location,
- start and stop times,
- description of face-to-face service,
- child's response to service, including progress towards any identified goals or intervention strategies,
- attestation by documenter of service provision, and
- date of service documentation.

3. Progress Notes

The HCI, as having an assigned role in CONNECTIONS, uses CONNECTIONS *Progress Notes* to document significant information relevant to the case planner/ case manager. CONNECTIONS *Progress Notes* should be printed and kept in the B2H case record. In circumstances where the CONNECTIONS case is closed, OCFS *Progress Notes (OCFS-8019)* should be used. *Progress Notes (OCFS-8019)* are the documentation that captures all contacts beyond the Service Summary that the HCIs or WSPs have on behalf of or with the child/medical consentor and/or family/caregiver, including team meetings. The *Progress Notes* summarize all relevant information about the case that is outside of billing information.

Chapter 10:

Providing a High Quality Program

A. Overview

The Bridges to Health (B2H) Quality Management program is used to continually determine whether the B2H 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 Health Care Integration Agency (HCIA) 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 HCIA staff that has key roles and responsibilities in managing program quality.

Quality management strategies must be able to demonstrate whether the children in the B2H Waiver Program have been able to achieve the outcomes outlined in the *Individualized Health Plans (IHPs) (OCFS-8017)* and have been successful in avoiding placement in a medical institution. 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 Children and Family Services Bureau of Waiver Management (OCFS BWM) is responsible for the design, development, implementation, and oversight of the B2H Waiver Program. BWM coordinates the activities of the Quality Management Specialists (QMS), located in OCFS Regional Offices. QMS are the key resource for providing the Local Departments of Social Services (LDSS), HCIA's and Waiver Service Provider (WSP) agencies ongoing program and technical support for the successful implementation and operation of the B2H Waiver Program. When the acronym LDSS is used in this Manual, it is to be interpreted as including OCFS Division of Juvenile Justice and Opportunities for Youth (DJJOY). Exceptions will be noted.

As outlined in previous chapters, LDSS, HCIA's and WSP agencies all play critical roles in the implementation of the B2H Waiver Program. This chapter aggregates all B2H Waiver Program standards in one place.

The LDSS is responsible for making enrollment decisions in all cases and must review and approve the *IHPs (OCFS-8017)* submitted by the HCIA's. As outlined in Chapter 4, LDSS Roles and Responsibilities, the LDSS also perform a number of administrative tasks that include providing information to enrollees and potential enrollees, participating in the management of enrollment opportunities and assisting in resolving concerns, grievances and complaints. As outlined in Chapter 5, Health Care Integration Agencies, the HCIA's responsibilities include *IHP (OCFS-8017)* development, WSP network development and quality management activities. OCFS assists in promoting the quality of the B2H Waiver Program. A list of activities undertaken by OCFS is included at the end of this chapter.

B. Quality Management Program Components

The quality framework for B2H is built around assessments of seven areas of program focus:

1. Waiver Participant Access
2. Waiver Participant-Centered Service Planning
3. Provider Capacity and Capabilities
4. Waiver Participant Safeguards
5. Waiver Participant Rights and Responsibilities
6. Waiver Participant Outcomes and Satisfaction
7. System Performance

Through ongoing program review and data analysis, OCFS makes adjustments and changes to the B2H 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 B2H Performance Measures are the standards that OCFS will use to evaluate how well the B2H Waiver Program is meeting each of the six CMS assurances.

The six CMS assurances are as follows:

1. Level of Care.
2. Service Plan.
3. Provider Qualifications.
4. Health and Welfare.
5. Financial Accountability.
6. Administrative Authority.

See Appendix V: Bridges to Health (B2H) Performance Measures to meet Centers for Medicare and Medicaid Services' (CMS) Six Assurances for further information.

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

The following standards highlight the methodologies that allow for discovery, remediation and improvement of the B2H Waiver Program.

1: Individuals have ready access to home and community-based services and supports in their communities.		
Agency	Action	Frequency
LDSS promotes access to the B2H Waiver Program.	Provide information about B2H philosophy, eligibility and services to potential enrollees.	Ongoing
LDSS makes B2H Waiver services accessible to children in foster care.	Maintain list of qualified HCIA's. Assist potential enrollees in selecting HCIA's and refer potential enrollees to HCIA's to assist in B2H application process.	Ongoing Enrollment
LDSS determines B2H eligibility and refers ineligible individuals to available resources within the community.	Authorize Medicaid eligibility on Welfare Management System (WMS). Review Application for Enrollment Packet and Reauthorization Packet; issue appropriate <i>Notice of Decision(s)</i> .	Enrollment and annual reauthorization Initial enrollment and annual reauthorization
LDSS verifies appropriate <i>Level of Care Form (OCFS- 8005 A, B, or C)</i> determination.	Track and review Level of Care. For B2H SED, LDSS signs Level of Care. For B2H DD, use the DDSO for the initial Level of Care. For B2H MedF, LDSS confirms signatures and signs Level of Care.	Enrollment and annual reauthorization Ongoing
LDSS and OCFS QMS monitor enrollment capacity.	LDSS and QMS develop wait lists. LDSS issues <i>Wait List Notification Form (OCFS-8012)</i> .	Ongoing
HCIA tracks information about referrals made to it.	Complete report of number of referrals received, eligible vs. ineligible referrals, reasons for referral being ineligible, time required to meet potential waiver participants, sufficiency of providers, waiver budgets, identification of trends or best practices that can assist the HCIA with implementing training and other activities via the <i>Health Care Integration Agency Quarterly/Annual Report (OCFS-8015A)</i> .	Quarterly/Annually

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

HCIA assists the potential participant and/or medical consentor in understanding the enrollment process, the B2H philosophy and available services.	<p>Review the Waiver process with participant/medical consentor.</p> <p>Offer and make available the assistance of a translator to interpret the <i>Understanding the Bridges to Health Medicaid Waiver Program (OCFS-8002)</i>.</p>	<p>Each initial interview</p> <p>Enrollment and as needed</p>
HCIA assists the applicant in the selection of an HCI.	Provide a list of available HCIs to applicant. Child/medical consentor selects an HCI and signs the <i>Health Care Integrator Selection Form (OCFS-8007)</i> .	Enrollment
HCIA reviews the Referral Packet, including: <i>the Referral Form (OCFS-8000)</i> , supporting documentation of qualifying diagnosis and <i>Authorization for Release of Information Form (OCFS-8001)</i> to assess potential eligibility status of child.	Monitor that the Application for Enrollment Packet is completed and submitted to LDSS within 60 days of receipt of a completed packet, including: <i>Application Form for Enrollment (OCFS-8004)</i> ; <i>Understanding the Bridges to Health Medicaid Waiver Program (OCFS-8002)</i> ; <i>Level of Care (OCFS-8005 A, C or OMRDD HCBS Level of Care Form- OMRDD 02-02-97)</i> ; <i>Freedom of Choice Form (OCFS-8003)</i> ; <i>Health Care Integrator Selection Form (OCFS-8007)</i> ; <i>Waiver Participant's Rights Form (OCFS-8008)</i> and <i>Individualized Health Plan (Preliminary IHP) (OCFS-8017)</i> .	Within 60 days of receipt of referral
HCIA is responsible for prompt delivery of services as specified in the <i>IHP (OCFS-8017)</i> .	<p>Monitor commencement of services against <i>Service Summary Forms (OCFS-8018)</i> and Medicaid claims, that each waiver service begins on date specified in the <i>IHP (OCFS-8017)</i>.</p> <p>Track <i>Notice of Decision - Authorization (OCFS-8009)</i> dates, start dates of services and <i>Service Summary Forms (OCFS-8018)</i>.</p>	<p>Monthly</p> <p>Ongoing</p>
HCIA is responsible for access to all B2H Waiver services in their B2H Region.	<p>Develop services within the HCIA or through subcontracts.</p> <p>Conduct outreach and publicity program to advertise B2H.</p>	<p>Prior to start-up and ongoing.</p> <p>On-going</p>
HCIA identifies the action steps to obtain ongoing supports and services when a child is no longer eligible for the B2H Waiver Program, including attaining adulthood.	Develop a <i>Transition Plan (OCFS-8030)</i>	Eighteen (18) months prior to 21st birthday OR a minimum of three (3) months prior to an anticipated discontinuance; OR within 30 days of an unanticipated discontinuance

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

HCIA continually assesses the eligibility status of child.	Monitor that the Reauthorization Packet is completed and submitted to LDSS 30 days prior to annual reauthorization date, including: <i>Re-authorization Form (OCFS-8014)</i> ; <i>Level of Care (OCFS- 8005 A, B, or C)</i> ; <i>Freedom of Choice Form (OCFS-8003)</i> ; <i>Waiver Participant's Rights Form (OCFS-8008)</i> and <i>Individualized Health Plan (Annual Revised IHP) (OCFS-8017)</i> .	Annually OR As required by significant changes in the child's status
HCI provides for freedom of choice for potential B2H enrollees.	Inform applicant of right to choose between receiving services in a medical institution or B2H Waiver services. Applicant signs the <i>Freedom of Choice Form (OCFS-8003)</i> .	Enrollment and annual reauthorization.

2: Services and supports are implemented in accordance with each waiver participant's unique needs and expressed preferences.

Agency	Action	Frequency
LDSS supports a comprehensive <i>IHP (OCFS-8017)</i> that addresses a child's need for services in accordance with their preferences and goals.	Review each <i>IHP (OCFS-8017)</i> for appropriateness and authorize via signature of LDSS.	Ongoing
HCIA reviews all <i>IHPs (OCFS-8017)</i> for adequacy and appropriateness.	Each <i>IHP (OCFS-8017)</i> is signed by the child/medical consenter and participants in its development, indicating approval of the contents.	Prior to each <i>IHP's (OCFS-8017)</i> submission to LDSS
HCIA facilitates team meetings and reviews all <i>IHPs (OCFS-8017)</i> before submission.	Team meetings must occur with any <i>Revised IHP (OCFS-8017)</i> . The HCI and the medical consenter must attend team meetings. Informed WSP representative(s) must attend the first team meeting and at least every 6 months thereafter. A representative from the LDSS, the HCIA beyond the HCI, and the voluntary case planning agency (if the child is in foster care), family/caregivers; a representative from the DDSO (case by case basis) and the QMS (case by case basis) must be invited and are expected to attend. The child and anyone the child or medical consenter wishes to have participate may	Prior to the submission of an <i>IHP (OCFS-8017)</i> , at any time at the request of the HCI, the child and/or medical consenter, LDSS.

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

	attend. Team Meetings are documented on <i>Progress Notes (OCFS-8019)</i> .	
HCIA provides continuous access to and assistance in coordination of services. HCIA promptly address issues.	Provide child/medical consentor with <i>Contact Information List (OCFS-8027)</i> .	Ongoing
HCIA continually monitors the child's B2H eligibility and supports a comprehensive <i>IHP (OCFS-8017)</i> that addresses the child's need for services in accordance with their preferences and goals.	Re-evaluate Level of Care, review and revise <i>IHP (OCFS-8017)</i> for type and amount of services received and confirm that the child's needs are being met.	Ongoing and at annual reauthorization
HCIA monitors services provision as stated in <i>IHP (OCFS-8017)</i> .	Monitor WSP staff for timeliness, proper documentation of interaction and staff supervision.	Ongoing
HCIA and HCI support the child/medical consentor's right to choose and change among qualified and enrolled B2H providers as requested.	The child/medical consentor sign the <i>Health Care Integrator Selection Form (OCFS-8007)</i> to select the HCI and use the <i>IHP (OCFS-8017)</i> to select the WSPs. To change HCIA/HCI/WSPs, use the <i>Change of Provider Form (OCFS-8006)</i> .	Enrollment Ongoing
HCIA and WSP maintain documentation of the child's progress and outcomes and offer comments. An 80% achievement rate for each of these measures is considered acceptable performance: percentage of goals met/percentage of time frames met.	Complete the <i>Detailed Service Plans (OCFS-8020)</i> for every service specified in the <i>IHP (OCFS-8017)</i> .	30 days after enrollment, every six months, and more frequently as needed
HCIA and WSP support the child's rights.	Explain waiver rights and responsibilities and provide the <i>Waiver Participant's Rights Form (OCFS-8008)</i> to the child/medical consentor for signature.	Enrollment and annual reauthorization
HCI gathers comprehensive information, assessments regarding child's and/or medical consentor's goals, needs, preferences, strengths, history and risk factors used to develop the <i>IHP (OCFS-8017)</i> .	Develop the <i>IHP (OCFS-8017)</i> that includes information and assessments regarding child's and/or medical consentor's goals, needs, preferences, strengths, history and risk factors. HCI meets with the child, medical consentor, caregiver and network to gather input and discuss relevant plan elements. Each WSP provides input, based on assessments and information related to health and welfare	At the development of the <i>Preliminary IHP (OCFS-8017)</i> , and any <i>Revised IHPs (OCFS-8017)</i> , <i>Annual Revised IHPs (OCFS-8017)</i> 2 face to face contacts per month (1 in the family caregiver setting)

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

	issues, to the <i>IHP</i> (OCFS-8017).	
HCI and WSP responds to significant changes in child's needs or circumstances, including an assessment of each child to determine the services needed to successfully handle sentinel events.	Document significant needs and circumstance changes in the child's record and indicate how these changes have been addressed. Complete the <i>Detailed Service Plan</i> (OCFS-8020) and the <i>Revised IHP</i> (OCFS-8017).	30 days after enrollment, every six months, and as needed
HCI reports to LDSS/DJJOY when there is concern that B2H cannot support the child's health and welfare or the child has otherwise lost B2H eligibility.	Complete the <i>Loss of Eligibility Recommendation Form</i> (OCFS- 8026).	Ongoing
WSPs provide services in compliance with specifications of the <i>IHP</i> (OCFS-8017). Report any changes in the child's cognitive, physical, psychological and/or behavioral health to the HCI.	Complete and submit <i>Service Summary Form</i> (OCFS-8018) to the HCIA Complete and submit <i>Progress Notes</i> (OCFS-8019) to the HCIA.	Ongoing and submitted within five business days of every billable service Ongoing and submitted monthly or as requested
3: There are sufficient WSPs who possess and demonstrate the capability to effectively serve B2H Waiver Program participants.		
Agency	Action	Frequency
HCIA supports OCFS' efforts to develop policies and procedures that affect quality service delivery.	Gather data on numbers of WSPs and their capacity and availability to meet the needs of children in their communities using <i>Health Care Integration Agency Quarterly/Annual Report</i> (OCFS-8015A). Follow up on all inquiries from qualified WSPs.	Quarterly/Annually
HCIA and WSP develop and use culturally competent, qualified staff for service delivery.	Record qualifications and training receipt of HCIs/WSPs in personnel files. Comply with Background Checks as specified in Chapter 11.	Ongoing/Annually
HCIA and WSP encourage staff development to improve service delivery.	Document all training attendance and provide <i>Certificates of Attendance</i> (OCFS-8025), if appropriate. HCIA verify completion of CANS B2H training.	Ongoing Ongoing
HCI and WSP demonstrate ability to provide services in an effective and efficient manner.	HCIA reviews submitted: <i>Detailed Service Plan</i> (OCFS-8020);	Within 30 days of enrollment and every six months thereafter

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

	<p><i>Service Summary Form (OCFS-8018);</i></p> <p><i>Progress Notes (OCFS-8019)</i></p>	<p>Within five business days of every billable service</p> <p>Monthly or as requested</p>
WSP demonstrates competence in service delivery.	Document qualifications and licensure of WSP using the <i>Qualification Form (OCFS-8034)</i> and <i>Schedule A – Waiver Service Provider Commitment Form (OCFS-8035)</i> .	Ongoing

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

Agency	Action	Frequency
LDSS and HCIA assess living arrangements to promote independence and safety.	Review the currency of all licenses and certificates related to housing and program sites for all services provided, as appropriate.	Ongoing
HCIA identifies trends in critical incidents and participates in policy development to alleviate safety concerns.	Convene Serious Reportable Incident Committee and report to OCFS using <i>Serious Incident Review Committee Quarterly Report (OCFS-8015B)</i> .	Quarterly
HCIA and WSP consider and plan for reducing child risk and increasing safety.	Document all considerations, including potential interventions with the informed involvement of the child and/or medical consentor. Adhere to Serious Reportable and Recordable Incident policies and procedures using the <i>Serious Reportable Incident Form (OCFS-8021)</i> and the <i>Serious Reportable Incident Status/Progress Report (OCFS-8022)</i> . See Chapter 11 for more details.	Ongoing
HCIA and WSP support effective and appropriate management of medications; including the child's ability to self-administer medication.	<p>Review Individual Medication Plan (IMP) and Medication Administration Record (MAR). If medication errors occur, use the <i>Medication Error Report (OCFS-8036)</i>.</p> <p>Review and validate by signature on the <i>IHP (OCFS-8017)</i> and subsequent <i>IHPs (OCFS-8017)</i> that staff are familiar with the medication plan as outlined in the <i>IHP (OCFS-8017)</i>.</p>	Ongoing

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

HCIA and WSP protect and support participants in the event of natural disaster or public emergency.	Create, maintain, and share disaster and emergency plans with child, medical consentor, and caregivers.	Ongoing
HCI identifies risk factors and offers modifications to promote independence and safety.	Meet with the child in their home to document any safety concerns and necessary action steps.	Quarterly OR or more frequently as needed
HCIA and WSP may not use restrictive interventions.	Document any use of restrictive interventions, including all de-escalation and preventive measures used. Determine if it is a Serious Reportable or Recordable Incident; document appropriately.	Ongoing

5: Waiver participants receive support to exercise their rights and in accepting personal responsibility.

Agency	Action	Frequency
LDSS supports due process.	Issue <i>Notice of Decisions</i> with Medicaid Fair Hearing information and documentation, attached to every <i>Notice of Decision-Authorization (OCFS- 8009)</i> , <i>Denial of Enrollment (8010A)</i> , <i>Denial of Waiver Service(s) (8010B)</i> , <i>Discontinuance from Waiver Program (8011A)</i> or <i>Discontinuance of Waiver Service(s) Service Provider(s) and/or Reduction of Service(s) (8011B)</i> . Attend Agency Conferences, as necessary.	Enrollment and ongoing Ongoing
HCIA supports the child/medical consentor's decision-making authority.	Services and supports must be planned and effectively implemented in accordance with each child's unique needs, expressed preferences and decisions concerning his/her life in the community, which is evidenced by signatures on the <i>Health Care Integrator Selection Form (OCFS-8007)</i> ; <i>Freedom of Choice Form (OCFS-8003)</i> and the <i>IHP (OCFS-8017)</i> .	Enrollment Enrollment, annual reauthorization and ongoing
HCIA, WSP, and LDSS support seeking resolution of grievances/complaints.	Inform child and medical consentor of agency grievance/complaint policies and procedures and adhere to such policies. Use the <i>Grievance/Complaint Packet (OCFS-8024)</i> for grievances/complaints not resolved at the agency level. In addition, HCIs will provide the child/medical consentor access to assistance to coordinate services and promptly address issues via the <i>Contact</i>	Ongoing

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

	<i>Information List (OCFS-8027).</i>	
HCIA and WSP support civil and human rights.	Document child's right to freely exercise his/her rights by reviewing and signing the <i>Waiver Participant's Rights Form (OCFS-8008)</i> .	Enrollment and annual reauthorization

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

Agency	Action	Frequency
HCIA and WSP solicit child and medical consenters' satisfaction information.	Solicit feedback using standardized satisfaction survey tools, review results and incorporate appropriate recommendations.	Annually
HCIA supports positive outcomes for each child.	Administer standardized outcome measure via the CANS B2H and/or document goal attainment.	CANS B2H administered within 30 days of enrollment, re-administered every six months, at transition and as otherwise needed

7: The system supports Waiver Program participants efficiently and effectively and constantly strives to improve quality.

Agency	Action	Frequency
LDSS tracks utilization and B2H Waiver Program growth.	Review Medicaid claims to verify appropriate numbers of participants, and slots. Monitor Wait Lists.	Monthly Ongoing
HCIA engages in data collection and analysis to assess program performance and impact.	Provide BWM, through e-mails and telephone calls, information about any barriers that may prevent the B2H Waiver Program from reaching its stated goals. Submit required reports as specified in Chapter 5. Support OCFS audit policies and practices.	Ongoing
HCIA supports child and stakeholder involvement in B2H.	Solicit feedback from WSP, children/medical consenters, caregivers and inform BWM about concerns.	Ongoing
HCIA maintains necessary separation of HCI functions,	Develop strict guidelines and appropriate safeguards.	Ongoing

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

other B2H services and Quality Management responsibilities.		
HCIA and WSP work to continuously improve provision of B2H services.	HCIA and WSP implement self-monitoring process. Meet with WSPs to clarify B2H policies and provide necessary training in effective use of services.	2-4 times a year
HCIA and WSP support children and caregivers of diverse cultural and ethnic backgrounds.	Recruit WSPs with diverse cultural and ethnic backgrounds.	Ongoing
HCIA and WSP support timely processing of billing and payment.	Submit bills and make payments promptly in accordance with eMedNY claims processing.	Monthly
HCIA and WSP support the financial integrity of B2H.	Review eMedNY claims against <i>Service Summary Forms (OCFS-8018)</i> and <i>IHPs (OCFS-8017)</i> to verify appropriate and accurate use of services.	Monthly
	HCIA notifies OCFS QMS of any <i>IHP (OCFS-8017)</i> over \$51,600 per year.	Ongoing

C. OCFS Activities

In addition to these specific responsibilities, OCFS undertakes a series of activities to support the overall goal of quality management for the B2H Waiver Program. These include, but are not limited to:

- OCFS issues policy directives, interpretations and technical assistance when necessary to implement the intent of the B2H Waivers.
- OCFS publishes this Manual and such forms and instructions as are necessary to implement the Waivers. OCFS oversees the performance of LDSS participating in the B2H Waiver Program and all participating HCIA's. In so doing, OCFS gathers, evaluates and monitors program and fiscal data and other reports submitted by the HCIA and LDSS to determine the effectiveness of the B2H Waiver Program and areas that may need change or improvement. The HCIA cooperates with OCFS, LDSS and federal monitoring activities. OCFS develops and monitors the processes necessary to oversee the proper fiscal performance of the B2H Waivers in accordance with the applications filed with the CMS and New York State requirements.
- OCFS, upon its review of the supporting HCIA recommendation of acceptance of a WSP agency, decides if additional review is warranted. OCFS then forwards Medicaid Provider enrollment documentation for those WSP agencies that it determines to be qualified to DOH for enrollment in eMedNY as a B2H provider of selected B2H Waiver services. WSP agencies in compliance with DOH enrollment requirements are enrolled by DOH in eMedNY. If OCFS determines that an HCIA's recommendation should not be advanced to DOH, it informs the provider agency in writing, including a summary of reasons and sends a copy to the HCIA.
- OCFS sponsors training to prepare HCIs and their supervisors for the work of health plan development and integration. OCFS also sponsors training to address issues pertinent to WSPs.
- OCFS formed a Quality Advisory Board and facilitate and/or direct regular meetings. This Board acts as an Implementation and Quality Advisory Board to provide OCFS with adequate advice to successfully administer the B2H Waivers.
- OCFS may facilitate any unresolved disputes presented by the children/medical consenters with the HCIA.
- OCFS assesses the satisfaction of the delivered services to children/medical consenters, using a Caregiver Satisfaction Survey on an annual basis and addresses trends that may require modifications of particular policies and procedures.
- OCFS conducts annual Regional Forums of children/medical consenters, families, advocates and providers to gather information on how the B2H Waiver is functioning in each region.
- OCFS conducts Administrative Reviews at the HCIA's and documents findings and corrective actions, as set forth in the Waiver Applications to CMS to verify the aforementioned assurances of: Service Plans, Health and Welfare, and Qualified Providers.

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

- OCFS provides a toll-free telephone consultation line for use by children/medical consenters and others to obtain general information and documents the results via the *Bridges to Health Consultation Line Form (OCFS-8013)*.
- OCFS reviews *IHPs (OCFS-8017)* that are in excess of \$51,600 per year for the purpose of evaluating the appropriateness and reasonableness of the cost of the B2H Waiver services.
- OCFS monitors the HCIA's review of *Serious Reportable Incident Reporting Forms* as required in Chapter 11: Participant Safeguards and the B2H applications. This review by OCFS shall include a sample of the incident reports that have been closed by the HCIA to verify that these closures were appropriate.
- OCFS serves as a resource to the HCIA during the incident investigation stage of a Serious Reportable Incident.
- OCFS conducts retrospective reviews of the records of the HCIA and other documentation to determine if service providers and HCIA subcontractors meet qualifications and are in compliance with program requirements. Such reviews include an examination of the activities of the HCIA to determine whether HCIA oversight of its subcontractors is being conducted as determined herein.
- OCFS reviews a representative sample of case records as set forth in the Waiver Applications to CMS to verify the aforementioned assurances of: Level of Care, Service Plans, and Health and Welfare. OCFS engages in remediation and improvement strategies to assess that the HCIAS and WSPs correct instances of non-compliance, so that OCFS can implement systems improvements that will increase compliance of providers and improve the lives of children and families.

Chapter 11: Participant Safeguards

The Bridges to Health (B2H) Waiver Program provides services for vulnerable children. It is imperative that adequate safeguards are in place to protect their rights, health and safety throughout their enrollment in waiver services.

This chapter describes the policies and procedures required to make certain that children/medical consenters, caregivers and interested parties are given sufficient opportunity to voice concerns about the quality and operation of the B2H Waiver Program and to be informed of how those concerns must be addressed and monitored. This chapter also includes the requirements for background checks of Health Care Integration Agency (HCIA) employees and Waiver Service Provider (WSP) agency employees, the policy for the use of restraints and restrictive interventions and the policy for administration of medication.

A. Critical Event or Incident Reporting

Incidents, complaints, concerns and grievances that impact a child's ability to remain in the B2H Waiver Program can be communicated by phone, in person or in writing to any member of the B2H Waiver Program community: HCIA, Health Care Integrator (HCI), Waiver Service Provider (WSP) agency, WSP staff, Local Department of Social Services (LDSS), Office of Children and Family Services (OCFS) Quality Management Specialist (QMS), OCFS Bureau of Waiver Management (BWM) and Department of Health (DOH). The toll-free OCFS B2H Consultation Line, 1-888-250-1832, can also be used for this purpose. All providers of B2H Waiver services are required to record, conduct an inquiry and/or share the information received with appropriate parties and are subject to reviews for compliance, program requirements and processes. Reports fall into two categories: "Serious Reportable Incidents" and "Recordable Incidents."

The HCI must provide the child/medical conserter with the following:

- information to identify actions that may constitute abuse, neglect and/or maltreatment,
- a copy of the *Waiver Participant's Rights Form (OCFS-8008)*,
- information on how to contact the HCIA, OCFS QMS and OCFS BWM, the Statewide Central Register (SCR) of Child Abuse and Maltreatment, DOH and the OCFS toll-free B2H Waiver Consultation Line, listed on the *Contact Information List (OCFS-8027)*, and
- explanation that the name and identifying information concerning the source of a report is confidential and a report may be made anonymously.

The HCI provides the above-noted information to the child/medical conserter at the time of the development of the *Individualized Health Plan (IHP) (OCFS-8017)* and annually thereafter.

If an employee of an HCIA or WSP agency suspects abuse or maltreatment, the employee must immediately report the incident to the SCR at 1-800-342-3720. **HCIA's and WSP agencies must**

cooperate in, and not interfere with, all Child Protective Services (CPS) and law enforcement investigations.

1. Serious Reportable Incidents

A Serious Reportable Incident (SRI) is any situation in which an enrolled child experiences a perceived or actual threat to his/her health and welfare. SRIs fall into three general categories:

- allegations of physical, sexual and psychological abuse or maltreatment, including all such allegation types contained in the child abuse or maltreatment reporting protocols,
- serious injury and/or accident that threatens the child's ability to maintain waiver services. This category also includes the child's death, hospitalization and designation as a missing person, as well as instances of serious bodily injury occurring during the provision of B2H services, and
- an incident that causes a significant disruption of the caregivers' capacity to care for the child.

Who Must Report a Serious Reportable Incident

Any employee of an HCIA or WSP agency who becomes aware of an event or witnesses an action or lack of attention that constitutes a SRI is required to notify the child's assigned HCIA within one business day. It is best practice that the HCIA establish a protocol and/or contact person for SRI.

If the incident constitutes an emergency, employees must initiate their agencies' emergency procedures.

If the reporting employee is concerned that notifying the HCIA directly may create a conflict of interest, the employee may also contact the LDSS or OCFS QMS or use the B2H Consultation Line number to notify OCFS BWM. The reporting employee's name and/or identifying information must be considered confidential and shared only with persons conducting the inquiry who have a legitimate need. While an employee may report the information anonymously to the HCIA, doing so does not fulfill their reporting responsibility.

Time Frames and Documentation for a Serious Reportable Incident:

1. The HCIA is responsible for documenting and reporting on all SRIs reported to them. If there is a conflict of interest, OCFS BWM determines the lead agency.
2. Within one business day of learning of the death of a child participating in the B2H Waiver, any employee of an HCIA or WSP agency must call the B2H Consultation Line, 1-888-250-1832, to report the death. Staff from HCIAS and WSP agencies must also follow their employer's policies and procedures in the event of a death.
3. Within one business day of becoming aware of a SRI:
 - a. The HCIA must fax a completed copy of the *Serious Reportable Incident Form (OCFS-8021)* to the OCFS QMS and the appropriate LDSS **AND**

–if the SRI **does not involve a report to the SCR**, the HCIA must inform the child/medical consentor, family/caregiver and all waiver service provider staff at the

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

HCIA or the WSP agency of the SRI and the potential impact on B2H service provision; **OR**

–if the Serious Reportable incident **involves a report to the SCR and impacts B2H service delivery, the HCIA informs the child/medical consenter, family/caregiver and all other WSP staff at the HCIA or WSP agency about the impact on B2H services, not the circumstances of the incident. The concern is that notification may jeopardize the CPS investigation.**

4. The existing laws, regulations and protocols regarding reports to the SCR as described during Mandated Reporter training apply, including but not limited to mandated reporter expectations, training for staff, time frames for the CPS investigation, cooperation with the CPS investigation, notifications of reports, determinations of reports and corrective action plans.
5. The involved waiver provider must immediately comply with any requests for supplemental information from the HCIA, the appropriate LDSS, the OCFS QMS and/or the OCFS BWM, as well as cooperate with all on-site inquiries and elements of any authorized CPS or criminal investigation.
6. When OCFS QMS receives a *Serious Reportable Incident Form (OCFS-8021)*, the form is logged into a database of incidents and assigned a report number. This number must be included in all subsequent reports and correspondence relating to the incident.
7. Within one week of the submission, OCFS QMS evaluates the *Serious Reportable Incident Form (OCFS-8021)*, determines if further follow-up is necessary and returns a *Serious Reportable Incident Response Form (OCFS-8023)*, containing the report number, with the status and comments to the HCIA and the appropriate LDSS.
8. If it is determined that additional follow-up is necessary, the HCIA must submit the *Serious Reportable Incident Status/Progress Report (OCFS-8022)* to the appropriate LDSS and OCFS QMS within 30 days of the initial report.
9. If the inquiry must remain open at the time of the status report, the HCIA shall submit a *Serious Reportable Incident Status/Progress Report (OCFS-8022)* on a monthly basis to the appropriate LDSS and OCFS QMS until a determination is made by the OCFS that the inquiry is closed.
10. If at any time the HCIA becomes aware of significant information that impacts the inquiry or status of the child, the HCIA must complete the *Serious Reportable Incident Status/Progress Report (OCFS-8022)*, checking the “Additional Information” box and fax the report to the appropriate LDSS and OCFS QMS.
11. OCFS QMS responds to the HCIA and the appropriate LDSS, within one week of receiving the ongoing status reports with comments and/or a decision regarding the inquiry status.
12. Once the inquiry is determined to be closed by the OCFS QMS, the HCIA must inform the child/medical consenter and family/caregivers of the decision to close the inquiry.

13. If it is determined that there is conflict of interest necessitating a change in the lead agency conducting the inquiry, OCFS can alter the above process, as appropriate.

14. If a SRI involves a report to the SCR, then all SCR-related investigation and reporting requirements and time frames apply.

2. Serious Reportable Incident Follow-up

HCIA Responsibilities

The HCIA must designate at least one individual to be responsible for conducting a thorough and objective inquiry. This individual is required to have appropriate experience and/or training in conducting inquiries. The results of the inquiry are presented to the HCIA Serious Incident Review committee as described later in this chapter.

HCIA staff conducting the inquiry must *not* include:

- individuals directly involved in the incident,
- individuals interviewed during the inquiry, and
- individuals who are the supervisor, supervisee, spouse, significant other, or immediate family member of anyone involved in the incident.

The lead agency must include the following information on the *Serious Reportable Incident Form (OCFS-8021)*:

- a clear and objective description of the event under inquiry. This must include a description of the people involved in the alleged incident, the names of all witnesses and the time and place the incident occurred,
- identification of whether this was a unique occurrence or if this is believed to be related to previously reported or unreported incidents,
- conclusions derived from the inquiry and the reasoning behind the conclusion, and
- recommendations for action. The action(s) may be directed towards individual employees or the child, or may address larger program concerns such as training, supervision or agency policy.

Oversight by OCFS for Serious Reportable Incidents

OCFS tracks and monitors all aspects of SRIs and uses the data collected and included in reports to determine if there are systemic issues involved that need to be addressed and plan a strategy for preventing Serious Reportable Incidents from occurring or recurring.

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

In the event that any B2H service provider is found to be non-compliant with these policies and procedures, the state takes appropriate action. This may include terminating the B2H Provider Agreement.

OCFS works cooperatively with other state agencies that provide services to individuals with disabilities, informing them when shared providers experience significant or numerous SRIs.

3. Recordable Incidents

Recordable Incidents include events, concerns, grievances and complaints that do not meet the level of severity of SRIs but that impact the child's life in the community. Examples of these incidents are an accidental injury that affects waiver service provision or a complaint about the punctuality of a staff person providing services. Recordable Incidents do not need to be reported to OCFS unless they rise to the level of a SRI, or if the concern cannot be resolved to the child/medical consentor's or caregiver's satisfaction through the WSP agency and HCIA.

Throughout the Recordable Incident process, the complainants must be made aware of their ability to contact other members of the B2H service provision community. OCFS reserves the right to review Recordable Incidents at any time.

HCIA and WSP agency policies and procedures regarding Recordable Incidents must include an explanation or identification of the following:

1. process for reporting and resolving Recordable Incidents within the agency,
2. process for identifying patterns of incidents that involve a specific participant or employee, or patterns within the agency that threaten the health and welfare of participants in general,
3. system for tracking the reporting and outcome of all Recordable Incidents, and
4. process for reviewing these incidents and verifying that they are not actually a SRI that needs to be reported to OCFS.

B. Formal Grievance Procedures

As stated in the *Waiver Participant's Rights Form (OCFS-8008)*, a child/medical consentor or caregiver may initiate a verbal or written grievance at any time through their HCI, HCIA, WSP agency or WSP staff, OCFS QMSs, or OCFS BWM. All parts of any grievance and complaint, regardless of the filing method, must be documented from intake through resolution.

OCFS requires that each HCIA and WSP agency develop and implement a policy for responding to grievances and complaints raised by the child/medical consentor, or caregiver. Each policy must not run counter to the laws and regulations of oversight agencies as appropriate including OCFS, Office of Mental Health (OMH), Office for People With Developmental Disabilities (OPWDD), and DOH and those of any other oversight agency that might impact a specific HCIA or WSP agency. The grievance process is limited to those areas that are external to, but not in lieu of, the existing right to request access to the Medicaid Fair Hearing system. The OCFS QMS reviews the internal policies and procedures of each HCIA and WSP agency to aid in monitoring the grievance and complaint process.

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

A child/medical consentor or caregiver may file a grievance or complaint through various mechanisms. These include providing a written or verbal complaint to any staff person associated with the B2H Waiver Program. Grievances or complaints can be filed regarding the type, delivery and frequency of services; problematic issues; and general concerns about the waiver program.

OCFS also offers a toll-free B2H Consultation Line, 1-888-250-1832, which allows children/medical consentors and caregivers an alternative means of communicating grievances/complaints. OCFS contacts the appropriate HCIA and the HCIA or the B2H WSP agency conducts the inquiry, as appropriate. If the HCIA is cited in the complaint, OCFS determines if there is a conflict of interest and who should conduct the inquiry. If the OCFS staff and/or the HCIA deem the complaint to be at a significant level of concern, it may be turned into a SRI. The OCFS informs the LDSS of complaints and grievances.

In addition, at service initiation, to affirm that the child/medical consentor and caregiver have proper access to the grievance/complaint process, the HCI provides them with a list of telephone numbers of their WSP staff from the HCIA and/or the WSP agencies, and supervisors, as well as the telephone numbers of the OCFS QMS. Children/medical consentors and caregivers are informed by the individual conducting the inquiry that filing a grievance or making a complaint is not a prerequisite or substitute for a Medicaid Fair Hearing.

The HCIA is responsible for developing a process and informing the child/medical consentor and caregiver of the process for addressing written and verbal complaints. This process must include contacting and updating the child/medical consentor and caregiver within 72 hours of receiving the complaint. When a complaint cannot be resolved by the HCIA, the formal grievance process begins and the LDSS and OCFS QMS are notified.

The B2H process for inquiry and completion of all steps in the Grievance Process cannot exceed 45 days from the receipt of the complaint. Therefore, the HCIA's and WSP agency's initial response to the complaint must not take more than seven calendar days from the date the complaint was filed.

OCFS has created a *Grievance/Complaint Packet (OCFS-8024)* to be used when a complaint cannot be resolved to the satisfaction of the grievant via the HCIA or the WSP agency internal process. The procedure for the use of this form is as follows:

1. On or before the seventh calendar day from receipt of the initial complaint, the HCIA and/or WSP agency and the grievant must determine if a grievance has not been addressed to the grievant's satisfaction. If it has not, a representative from the HCIA must provide the grievant with an *OCFS Grievance/Complaint Packet (OCFS-8024)*.
2. The *OCFS Grievance/Complaint Packet (OCFS-8024)* can be completed by the grievant or, if the grievant prefers, the HCIA representative may summarize the concerns. The grievant approves the summary by signing it under Step 1, Section A, of the packet.
3. The HCIA representative records the response under Step 1, Section B, approves it with a signature and returns the document to the grievant. Step 1, Sections A and B, must be completed within five calendar days of the grievant having received the packet.

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

4. Within five calendar days of receiving the packet with Step 1 completed, the grievant may appeal the HCIA response by completing Step 2, Section A and mailing the original document to their OCFS QMS. If the grievant fails to send an appeal, it is assumed that the Step 1 decision has been accepted.
5. Within seven calendar days of receipt of the *Grievance/Complaint Packet (OCFS-8024)*, the OCFS QMS must contact the appropriate parties, gather information and provide their decision under Step 2, Section B and return the original packet to the grievant with copies sent as appropriate to the child/medical consentor, the caregiver, the HCIA and the LDSS.
6. If the grievant is not satisfied with the QMS decision, the grievant has five calendar days to complete Step 3 of the *Grievance/Complaint Packet (OCFS-8024)* and send the original packet to OCFS BWM for a final decision. If the grievant fails to send an appeal, it is assumed that the Step 2 decision has been accepted.
7. If the Step 2 decision is appealed, the OCFS BWM has seven calendar days from the date of receipt to contact the appropriate parties, gather information and render the final decision under Step 3, Section B of the *Grievance/Complaint Packet (OCFS-8024)*. BWM then mails the original packet to the grievant with copies sent as appropriate to the child/medical consentor, the caregiver, the HCIA and the LDSS.
8. The OCFS BWM decision is final.

C. HCIA Serious Incident Review Committee

1. Organization and Membership of the Serious Incident Review Committee

- The committee may be organized on an agency-wide, multi-program or program-specific basis. Agencies may use a current incident review committee if one has been established.
- It is recommended that the committee contain at least five individuals drawn from a cross-section of staff, including professional, direct care, quality management and administrative.
- The committee must meet at least quarterly and within 30 days of an SRI report of a B2H Waiver participant.

2. Responsibilities of the Serious Incident Review Committee

This committee is responsible for reviewing the inquiry of every SRI. It is also recommended that the committee review Recordable Incidents. The committee evaluates the response of the agency and any involved provider for thoroughness. The committee determines whether the final recommendations and actions taken are sufficient, in line with the best clinical practice and in compliance with the B2H Waiver applications and guidelines.

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

In addition, the committee:

- makes certain that the agency's Incident Reporting Policies and Procedures comply with the OCFS B2H Incident Reporting Policy,
- determines if its response and that of any involved provider have been thorough and complete,
- ascertains that necessary and appropriate corrective, preventive and/or disciplinary action has been taken in accordance with the committee's recommendations and the B2H guidelines. If different or additional actions are taken, the committee must document the original recommendations and explain why the recommendations were revised,
- develops recommendations for changes in provider policies and procedures to prevent or minimize the occurrence of similar situations. These recommendations must be presented to the appropriate staff,
- identifies trends in SRIs (by type, child, site, employee, involvement, time, date, circumstance, etc.) and recommends appropriate corrective and preventive policies and procedures, and
- submits a *Serious Incident Review Committee Quarterly Report (OCF-8015B)* to OCFS; OCFS reviews the committee's quarterly reports on identified preventive and disciplinary actions.

3. Documentation of Serious Incident Review Committee Activity

- The committee must take minutes for all meetings and keep them in one location. These minutes must be retained thirty (30) years after the last discharge of a named child in foster care.
- Minutes addressing the review of SRIs must state the identification number of the incident, the child's name and CIN number, a brief summary of the situation that caused the report to be generated (including date and type of incident), committee findings and recommendations and actions taken on the part of the agency/program as a result of such recommendations.
- Minutes are to be maintained in a confidential manner.
- OCFS may request to review minutes at any time.

All information related to SRI reports including, but not limited to, that collected to complete the inquiry, the report resulting from the inquiry, and minutes of the standing Serious Incident Review Committee must be maintained separately from the child's B2H Waiver Program case records.

D. Restraints and Restrictive Interventions

Staff from HCIA and WSP agencies is not authorized to use restraints or restrictive interventions during the provision of B2H Waiver services. Restraints are defined in Title 18 of the New York State Codes, Rules and Regulations, as the containment of acute physical behavior by physical, mechanical or pharmacological intervention or room isolation.

Although OCFS has policies that allow the use of restraints and restrictive interventions by foster care or other licensed providers under certain limited situations, these policies do not apply to B2H HCIA and WSP agencies.

Any use of restraints or restrictive interventions by staff from an HCIA or WSP agency is considered a Recordable Incident and follows the processes described in this chapter unless the incident falls into one of the three categories outlined above in the definition of a Serious Reportable Incident.

E. Background Checks

All members of the B2H Waiver Program community engaged directly in the care and supervision of children in the waiver must submit to an examination of their backgrounds to verify that it is appropriate for them to work with children. Agencies conduct this examination based upon the statutes and regulations of their governing agency, as well as those prescribed as appropriate by NYS OCFS. All completed background check information should be maintained in the prospective employee's personal history file.

The tools used to conduct background checks under NYS OCFS statute and regulation include:

- Criminal History Records Checks against the NYS Division of Criminal Justice Services (DCJS) database,
- checks against the NYS DCJS Sex Offender Registry (Level 1, 2, and 3 Offenders*),
- attestations by individuals to their complete Criminal History, and
- database checks against the Statewide Central Register of Child Abuse and Maltreatment (SCR).

***Note:** The entire DCJS Sex Offender Registry (SOR) (Levels 1-3) must be screened. Information about Sex Offenders of **all risk levels**, including those whose risk levels are pending, is available by calling DCJS at (518) 457-5837 or 1-800-262-3257. The DCJS Sex Offender Website <http://www.criminaljustice.state.ny.us/nsor/index.htm> provides further details regarding methods of conducting SOR checks as well as documentation requirements.

NYS OCFS requires that the following background checks be conducted on the different members of the B2H Waiver provider community as follows:

- HCIA employees providing direct services to children in the B2H Waiver Program must provide an attestation of their criminal history to the HCIA and must be checked by their agency against the NYS Sex Offender Registry. Pursuant to NYS Social Services Law Section 424-a(1) (b),

those employees must also provide information to their agency for a database check against the SCR.

- Employees of WSP agencies providing direct services to children in the B2H Waiver Program must provide an attestation of their criminal history to their employer and must be checked by their agency against the Sex Offender Registry. Pursuant to NYS Social Services Law Section 424-a(1) (b), those employees must also provide information to their agency for a database check against the SCR.
- Planned and Crisis Respite providers who accept children in the B2H Waiver Program into their foster home are required by NYS Social Services Law Section 378-a, to provide fingerprints to be sent by their agency to the OCFS Criminal Record History Unit for criminal history record checks. Also per NYS Regulation (18 NYCRR 435.2.b), the individual must provide information to their employer to be sent to the SCR for a database check.
- Planned and Crisis Respite providers who provide care in a foster home of a child in the B2H Waiver Program must provide an attestation to their criminal history to their employing agency and must be checked by their agency against the Sex Offender Registry. Pursuant to NYS Social Services Law Section 424-a(1) (b), those employees must also provide information to their agency for a database check against the SCR.

F. Administering Medication

The management of medication for a child enrolled in the B2H Waiver Program must be described in the *IHP (OCFS-8017)* and carefully monitored by the assigned HCI. The HCI must review medication management at least every six months and is responsible for making sure that involved staff and caregivers are kept informed. All B2H staff is responsible for reporting cognitive, physical, psychological and/or behavioral changes that may require intervention to the HCI.

Children in the B2H Waiver Program living in homes (foster homes, kinship homes, or their birth family's homes) must be monitored for their ability to self-administer medications. No child in the B2H Waiver Program may self-administer medication unless it is authorized in writing by the child's health care provider. Agreement with this authorization is confirmed in writing by the medical consentor.

Upon admission into the waiver, every six months and as necessary, the HCI gathers information regarding the child's ability to self-administer medications. If problems are identified, the child/medical consentor and family/caregiver are referred to an appropriate service provider for an assessment and/or training and assistance to support safe management of the child's medication.

While a child in the B2H Waiver Program is in foster care, the HCI reviews medication administration practice in the child's residence—Foster Boarding Home, Agency Operated Boarding Home (AOBH) or Group Home—to verify compliance with OCFS policies regarding who is authorized to conduct medication administration activities and how medication administration errors are reported. When a child in the B2H Waiver Program is placed in an AOBH or Group Home, the HCI must also review the child's Individual Medication Plan and Medication Administration Record.

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

Any reporting of medication errors must be made on the *Medication Error Report (OCFS-8036)*. Providers are required to record the following errors: waiver participant in receipt of prescribed medication, dosage, routing, and dosage timing and frequency. The *Medication Error Report* must be made available, if requested to OCFS, the Department of Health (DOH) or the Federal Centers for Medicare and Medicaid Services (CMS).

Chapter 12: System Links

Members of the Bridges to Health (B2H) Waiver Program provider community use three computer applications to record information concerning a child's participation in the B2H Waiver Program.

- Waiver Service Provider (WSP) agencies and Health Care Integration Agencies (HCIA) submit bills for B2H Waiver Program services they provide using eMedNY, the New York State Medicaid tracking and billing system.
- The Welfare Management System (WMS) is used by Local Departments of Social Services (LDSS) to record Medicaid and B2H eligibility.
- The Health Care Integrator (HCI) and/or LDSS staff record B2H Waiver Program specific information in CONNECTIONS.

There are “B2H CONNECTIONS and Welfare Management System (WMS) Systems Instructions” regarding CONNECTIONS and WMS entries located on the B2H website www.ocfs.state.ny.us/main/b2h/.

A. Welfare Management System

To be eligible to receive B2H Waiver Program services, a child must first be Medicaid-eligible. Virtually all children in foster care are considered categorically eligible for Medicaid. This eligibility must be determined and recorded in WMS by LDSS staff using normal standards and procedures before other information about the B2H Waiver Program can be entered. See the “MEDICAID ELIGIBILITY FACT SHEET” on the B2H website for information.

When it is determined that a child is authorized to receive B2H Waiver services, LDSS staff enter an exception code in the Restrictions and Exceptions portion of WMS to indicate in which of the three waivers—Seriously Emotionally Disturbed (SED), Developmentally Disabled (DD), or Medically Fragile (MedF)—the child is enrolled. For all districts other than ACS, the Exception Code is entered directly into WMS. For ACS, the selection of the B2H waiver type in CONNECTIONS will feed entry of the Exception Code into WMS. The following exception codes are used to indicate which waiver the child has been determined to be eligible for:

- Exception Code “72” indicates a child is eligible for and enrolled in the B2H SED waiver,
- Exception Code “73” indicates a child is eligible for and enrolled in the B2H DD waiver, or
- Exception Code “74” indicates a child is eligible for and enrolled in the B2HMedF waiver.

By entering the appropriate code in WMS, eMedNY recognizes the child as being eligible to receive B2H Waiver services under the chosen waiver, and allows payments to be made.

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

LDSS staff is required to re-determine the child's Medicaid eligibility and reauthorize it in WMS at least every 12 months for payments to be made for B2H Waiver services provided. DJJOY staff must collaborate with the appropriate LDSS to verify Medicaid eligibility.

B. eMedNY

All HCIA and WSP agencies bill eMedNY directly for services rendered on behalf of children in the B2H Waiver Program. HCIA and WSP agencies are enrolled as Medicaid providers through the Request For Applications process established by the Office of Children and Family Services (OCFS). HCIA and WSP agencies will only be paid for the provision of services for which they have been approved. eMedNY provides billing instructions to be followed for submitting claims for payment. The rate codes for the different B2H Waiver Program service types can be found on the eMedNY website, <http://www.emedny.org/>

C. CONNECTIONS

CONNECTIONS is New York State's Statewide Automated Child Welfare Information System that is used to record and track information on all services provided to and on the behalf of children receiving child welfare services. As all children initially enrolled through an LDSS in the B2H Waiver Program must be placed in foster care, the information regarding any services they receive through the B2H Waiver Program **must** be captured in the Family Assessment and Service Plan (FASP) within CONNECTIONS.

Children placed through DJJOY will be entered into the B2H CONNECTIONS screens once enrolled. For detailed instructions refer to the B2H CONNECTIONS/WMS Systems Instructions located at www.ocfs.state.ny.us/main/b2h/.

Information about a child enrolled in the B2H Waiver Program can be recorded in CONNECTIONS by any worker with a system-assigned role in the child's CONNECTIONS stage/case. Members of the B2H Waiver Program services community who may have a role in the stage/case would include the LDSS case manager, the case planner, and the Health Care Integrator (HCI).

For the LDSS to assign an HCI a role in a CONNECTIONS stage, the HCI must be set up in a CONNECTIONS Unit along with their supervisor and any other HCIs within the HCIA. The HCIA's CONNECTIONS Security Coordinator can assist with this task.

Once established in CONNECTIONS, HCIA staff initially receive a role in the referred child's CONNECTIONS case to access information that will assist in the assessment of eligibility for B2H Waiver services. If a child is approved and enrolled in B2H Waiver services, the child's assigned HCI should then receive that role. The CONNECTIONS Job Aid on the OCFS website describes its functionality in for recording the enrollment and the provision of services, as well as the Child and Adolescent Needs and Strengths (CANS) B2H assessment scores for children who qualify for the B2H Waiver Program.

BRIDGES TO HEALTH (B2H)

**NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES
HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM**

The HCIA and all workers assigned a role in the stage have the ability to record *Progress Notes* in CONNECTIONS and must document all information to communicate with the case planner/ case manager using CONNECTIONS *Progress Notes*.

Chapter 13:

Billing

Bridges to Health (B2H) Waiver Program services are reimbursed through Medicaid, and payments for service provision are processed through the eMedNY system. The published rates for B2H Waiver services are available on the OCFS website at www.ocfs.state.ny.us/main/b2h/. To be reimbursed, Health Care Integration Agencies (HCIAs) and Waiver Service Provider (WSP) agencies must first be enrolled in the Medicaid program as a B2H service provider. Once enrolled as a B2H service provider, eMedNY forwards confirmation of a B2H provider number to be used on all billing documentation. Detailed instructions for preparing and submitting bills are available on the New York State Department of Health (DOH) eMedNY website: www.emedny.org.

A. General Rules for Billing

1. Date of Service

The B2H Waiver Program services have rate codes for monthly, daily, hourly, and 15 minute units of service. The rules for the date of service to be used are as follows:

- Services provided on a monthly basis are submitted using a date of service of the first day of the month following the service provision. For example, Health Care Integration services provided during January are billed using February 1. For months where there is a transfer from one Health Care Integration Agency to another, see Section 4 of this chapter “Transfers between HCIAs.”
- Services provided on a daily, hourly or 15-minute basis are submitted using the actual date the service was provided. For example, if Skill Building is provided on January 14, that day is used as the date of service.

2. Delivery of Services

There can be no double billing—no individual worker may deliver more than one B2H Waiver service at a time. However, billing is allowed for work performed during distinct time periods as follows:

- More than one B2H Waiver service may be delivered on the same day.
- A child and family may receive more than one session of the same service on the same day if indicated in the *Individualized Health Plan (IHP) (OCFS-8017)*.
- B2H Waiver services may not be delivered or billed for the **same** individual/group at the same time. If workers delivering different services find themselves at the same site at the same time to serve the same individual/group, they both cannot bill for the time they are there together but rather divide their time appropriately. For example, if a Skill Builder’s two hour session is

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

interrupted by an Immediate Crisis Response worker at the second hour of the service delivery, the Skill Builder may only bill for the first hour.

- There may be instances where more than one B2H service can be provided at the same time, as specified in the *IHP (OCFS-8017)*. For example, a Family/Caregiver Supports and Services worker may meet with the family to enhance the family's ability to care for the child while a Special Needs Community Advocacy and Support worker works directly with the educational system regarding the child's disability(ies), and a Skill Builder works with the child on interpersonal behaviors.

3. Proper Documentation

To bill for services, HCIAs and WSPs must be able to:

- document they have met minimum service standards required for billing and
- identify the "rate code" that corresponds to the service and waiver type – B2H Seriously Emotionally Disturbed (SED), B2H Developmentally Disabled (DD), or B2H Medically Fragile (MedF).

If an agency provides more than one type of service for a particular child in a month, separate bills must be submitted for each service type.

All documentation that supports the delivery of B2H Waiver services must be safeguarded and retained for a period of thirty (30) years from the date the child was discharged from foster care, even for individuals an agency no longer serves and for services an agency no longer provides.

Documentation that must be retained includes bills and related documentation. This includes, but is not limited to:

- *Individualized Health Plan (OCFS-8017)*,
- *Service Summary Forms (OCFS-8018)*, which include:
 - Participant name & Medicaid Client Identification (CIN) number,
 - Type of service provided,
 - Date of service and service location,
 - Start and stop times,
 - Description of service provided,
 - Participant's response to service, including progress towards any identified goals or intervention strategies,
 - Attestation by documenter of service provision and date of service documentation,
- *Progress Notes (OCFS-8019)*, and
- *Detailed Service Plans (OCFS-8020)*.

Billing must always be based on actual program attendance and a determination that service has been delivered in accordance with billing standards. The staff that provide the service must sign this documentation and date it contemporaneous with service delivery. The documentation should clearly

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

indicate face-to-face service to the person served, where required. During a later review or audit, failure to produce required documentation evidencing the delivery of services may result in serious financial and legal repercussions for an agency.

Note: B2H rates have been developed with the expectation that, in addition to providing direct services, B2H service providers need to travel, document B2H Waiver service provision, and consult with supervisors. These related activities are accommodated in the billing rate. For this reason, separate billing is not allowed for these activities.

4. Billing at the Correct Payment Level

B2H service providers must make sure that the level at which they bill matches the duration of the service provided. The B2H Waiver Program does not allow rounding up of service time; for example, if a WSP provides services for 25 minutes, they may bill for only 15 minutes.

5. Timely Submission of Bills

Claims must be submitted within 90 days of the date of service unless the delay is due to circumstances beyond the control of the provider. Such acceptable reasons include: litigation involving payment of the claim; Medicare and third party processing delays or delay in updating client eligibility for Medicaid including fair hearing, administrative delay in the application approval process, or rejection of an original claim due to a reason unrelated to the 90-day regulation. For all but the last of these reasons, claims should be submitted within 30 days of the time that submission comes within the control of the provider. If the delay is due to rejection of an original claim, the claim should be resubmitted within 60 days of the date of notification.

6. Ensuring Accuracy in Billing

OCFS conducts periodic reviews and audits of B2H Waiver Medicaid billing records. As such, B2H service providers must implement practices to adequately document billing for B2H Waiver services.

7. Correcting Billing Mistakes

If B2H service providers notice errors in prior billings, they can request an adjustment or void of those billings. Adjustments are submitted to *change* one or more pieces of information on a previously paid claim, and voids are submitted to *negate* a previously paid claim. The time limit for requesting adjustments or voids is six years from the date of service. Adjustments or voids can only be made to previously paid claims. Denied claims cannot be adjusted or voided.

B. Billing Policies for Health Care Integration Services

B2H services cannot be provided until a LDSS enrolls a child in the Welfare Management System. Once enrolled in B2H, a Health Care Integrator (HCI) manages a child's B2H services on a monthly basis until the child is discharged from the B2H Waiver Program. For the purpose of this section, when "month" or

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

“monthly” is referenced it denotes a calendar month. There are four distinct billing categories for the service of Health Care Integration, each with varying requirements. Each of these categories and the corresponding requirements are outlined within this section.

1. Enrollment Month Billing

To account for the work performed by the HCI during the child’s enrollment process, the **Enrollment Month** rate code may be submitted in addition to the **Regular Full Month** rate code. The **Enrollment Month** rate code may be billed only one time per enrollment.

2. Regular Full Month Billing

Regular Full Month is the rate code that denotes the monthly service of Health Care Integration. However, if a child is hospitalized or transferred – refer to the latter sections of this chapter for further explanations for billing during these occurrences.

The child must be enrolled in B2H, and so documented, for at least one day during the month to bill the **Regular Full Month** rate. The following constitute the **Minimum Mandatory** contacts required to bill for the **Regular Full Month** rate:

- The HCI must make a minimum of two face-to-face contacts with the child per month. The face-to-face contacts must total 90 minutes in duration. The HCI should anticipate that each contact take place for 45 minutes in duration. These contacts determine whether the services are meeting the child’s needs and whether the child/medical consenter is satisfied with service provision. **Note:** At least one of these face-to-face contacts must be in the family caregiver setting.
- The HCI must also make at least **two** documented contacts with informed WSPs from the *IHP (OCFS-8017)* each month. These interchanges may be made in person, by phone, or electronically, but must show evidence of communication between the HCI and WSP.
- While the child is in foster care, the HCI must make at least **two** contacts per month with the child’s case planner/case manager. These interchanges may be made in person, by phone, or electronically, but must show evidence of communication between the HCI and case planner/case manager.

3. Hospitalization Occurrence Billing

When a child enrolled in B2H is hospitalized, only the service is Health Care Integration may be delivered and billed concurrently with the hospitalization. Billing for the service of Health Care Integration is allowed during the month of a hospitalization in the following manner:

- If a child is hospitalized for 1-10 days during a calendar month and the HCI has made the **Minimum Mandatory** contacts as stipulated in the **Regular Full Month** billing, the HCI may submit a bill for Health Care Integration services using the rate code of **Hospitalization Occurrence from 1 - 10 days**. The minimum face to face contacts may occur in the hospital

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

setting. For example, if a child were hospitalized 3 days in the beginning of the month and hospitalized again for four additional days in the same month, the HCIA would bill using the rate of **Hospitalization Occurrence from 1 - 10 days**.

- If a child hospitalized in a calendar month for 11-30 days and the HCI has made the **Minimum Mandatory** contacts as stipulated in the **Regular Full Month** billing, the HCIA may bill using the rate of **Hospitalization Occurrence from 11 - 30 days**. The minimum face to face contacts may occur in the hospital setting. For example, if a child were hospitalized for 10 days in the beginning of the month and hospitalized again for two additional days within the same month, the HCIA would bill using the rate of **Hospitalization Occurrence from 11 – 30 days**.

4. Transfers between HCIAAs

When a child transfers from one HCIA to a different HCIA, special challenges for the billing process arise and the rules for billing during a Transfer Month supersede all other billing rules.

For billing purposes:

- If the child is enrolled with either the original or new HCIA for less than 11 days during a Transfer Month, the HCIA who serves the child for less than 11 days may **not** bill for that month.
- If the child is enrolled with the original HCIA for at least 11 days but less than 21 days during the Transfer Month, the original HCIA may bill using the **HCIA Transfer from Original HCIA** rate code, as well as make the following **Transfer Month Minimum Required Contacts**:
 - The HCI must make a minimum of one face-to-face contact with the child per month. The HCI should anticipate that the contact take place for 45 minutes in duration. Additional contacts during the Transfer Month can and should take place and may be of shorter duration.
 - The HCI must also conduct at least one documented contact with an informed WSP from the *IHP (OCFS-8017)*. These interchanges may be made in person, by phone or electronically, but must show evidence of communication between the HCI and WSP.
 - In addition, while the child is in foster care, the HCI must have at least one contact with the child's case planner/case manager. These interchanges may be made in person, by phone, or electronically, but must show evidence of communication between the HCI and case planner/ case manager.
- Services provided for the first half-monthly basis during a Transfer Month are submitted using a date of service of the first day of the month following the service. For example, Health Care Integration services provided during the first half of January during a Transfer Month are billed using a date of February 1st.
- If the child is enrolled with the new HCIA for at least 11 days but less than 21 days during the Transfer Month and the **Transfer Month Minimum Required Contacts** are made, and the

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

original HCIA cannot bill for the full month, the new HCIA may bill using the HCIA Transfer to a New HCIA rate code.

- Services provided for the second half-monthly basis during a Transfer Month are submitted using a date of service of the second day of the month following the service. For example, Health Care Integration services provided during the second half of January during a Transfer Month are billed using a date of February 2nd.
- If the child is enrolled with the original HCIA for at least 21 days during the Transfer Month and the **Minimum Mandatory** contacts are made for **Regular Full Month** billing, the original HCIA may bill using the **Regular Full Month** rate code.*
- If the child is enrolled with the new HCIA for at least 21 days during the Transfer Month, and the **Minimum Mandatory** contacts are made for **Regular Full Month** billing, the new HCIA may bill using the **Regular Full Month** rate code.*

***Note:** only one HCIA may bill for any Full Month rate code for the same child.

5. Billing at Discontinuance

To account for the additional work performed by an HCI during the month the child's enrollment ends, the HCI may submit a bill at the **Regular Full Month** rate code as long as the **Minimum Mandatory** contacts have occurred and no other bills for Health Care Integration services have been submitted for the month. The child must be enrolled at least one day during the month to bill for a child who is being discontinued from B2H. When the child's enrollment in B2H is discontinued, the last day of eligibility is the date of service. For example, if a child's enrollment in B2H is discontinued on January 26, that day is used as the date of service.

Chapter 14: Training Requirements

The effectiveness of the B2H Waiver Program relies on the quality of interaction and engagement between B2H Waiver services staff and enrolled children. Improving outcomes for children requires competent staff who can engage meaningfully and effectively with the people involved in the lives of children in the B2H Waiver Program. Training is one way to improve the skills, knowledge, and attitudes of employees to support the successful conduct of the B2H Waiver Program. Effective training reduces risk to employees and children as it improves employee morale, motivation, efficiency, and innovation.

In circumstances where the Health Care Integration Agency (HCIA) or the Waiver Service Provider (WSP) agency is providing training, pre-and post-testing must be used to determine whether staff have acquired the information presented. Each HCIA and WSP is required to track and document the completion of all required training for each B2H Waiver Program in the employee's personnel file.

A. Mandatory Training

All HCIs, HCI supervisors and WSPs, including staff hired by the HCIA to provide B2H Waiver services, are required to have appropriate training in the following areas **prior** to providing B2H services:

- First Aid,
- Cardiopulmonary Resuscitation (CPR),
- Mandated Reporting on Suspected Child Abuse and Neglect, and
- Overview of B2H Waiver Program Documentation Requirements, which is available on the OCFS website and on DVD.

All HCIs, HCI supervisors and WSPs, including staff hired by the HCIA to provide B2H services, are required to have appropriate training in the following areas within **three months** of starting to provide B2H Waiver services:

- Recognizing and Understanding Cultural Differences and Diversity and
- Child and Adolescent Development.

B. HCIA Sponsored Mandatory Training

HCIA's are required to provide training to their HCIs, HCI supervisor and WSPs, including staff hired by the HCIA to provide B2H services, in the following areas within **three months** of starting to provide B2H Waiver services:

- Communication Skills and Behavioral Support and
- Interaction of the B2H Waiver Program and Child Welfare (see Appendix O for outline).

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

HCIA sponsored trainings are anticipated to take 8 hours of a B2H employee's time. Attendance at additional trainings designed to enhance a worker's knowledge of and skills in current issues in child welfare, advocacy, integration services, and cultural competence should be encouraged. While voluntary, these continuing educational opportunities allow appropriate professional development for the HCIs and WSPs to support better service delivery for the child.

C. OCFS Sponsored Training for Waiver Service Providers and WSP Supervisors

All WSPs are required to attend the following trainings within the first six months of starting to provide B2H Waiver services. WSP supervisors must attend and complete the following trainings within three months of providing supervision to other WSP staff.

The following denotes the contents of the WSP training :

Part A – “Online Modules”:

- Module #1: Bridges to Health Waiver Service Provider Training: Documentation
- Module #2: Bridges to Health Waiver Service Provider Training: Building Resilience
- Module #3: Bridges to Health Waiver Service Provider Training: Safety in the Community
- Module #4: Bridges to Health Waiver Service Provider Training: Essential Elements for Service Provision.

Part - B “B2H Service Specific Modules”:

In addition, the following service-specific training is required, as applicable:

<u>B2H Service</u>	<u>Corresponding Required Training Module</u>
Family Caregiver Supports and Services	Family Caregiver Supports and Services*
Skill Building	Skill Building*
Special Needs Community Advocacy and Support	Special Needs Community Advocacy and Support*
Prevocational Services	Prevocational and Supported Employment Services*
Supported Employment	Prevocational and Supported Employment Services*
Planned Respite	Planned and Crisis Respite**
Crisis Respite	Planned and Crisis Respite**
Crisis Avoidance, Management and Training	Crisis Services**
Immediate Crisis Response	Crisis Services**
Intensive In-home Supports and Services	Crisis Services**

* denotes four hours of training; ** denotes eight hours of training.

D. OCFS Sponsored Training for Health Care Integrators and HCI Supervisors

All HCIs and HCI supervisors are required to be trained in and receive certification in CANS B2H **prior** to providing B2H Waiver services and must update the certification annually. Initial and annual certification can be completed on line using the CANS B2H website www.communimetrics.com/NewYorkCW/Default.aspx

The Office of Children and Family Services (OCFS) sponsors a three-day training session to prepare Health Care Integrators (HCIs) and HCI supervisors for health plan development and service integration. All HCI supervisors must attend and satisfactorily complete this training *before* providing supervision to HCI staff. All Health Care Integrators must attend and satisfactorily complete the three-day training within their first six months of starting to provide Health Care Integration services. *No one* should be performing HCI duties if this training has not been satisfactorily completed within the first six months of starting to provide B2H Waiver services, unless exempted from this requirement in writing by the OCFS Bureau of Waiver Management (BWM).

The training program is designed specifically for the Health Care Integrator. Pre- and post-testing is employed to test worker knowledge and knowledge retention. Successful training outcomes include but are not limited to:

- knowledge of roles and responsibilities of the HCI,
- knowledge of the B2H Waivers and ability to disseminate information to the child/medical consentor and caregiver,
- the ability to advise and guide children in selection of WSPs and disseminate information about the HCI's role in developing the child's *Individualized Health Plan (IHP) (OCFS-8017)*,
- knowledge of all forms and releases associated with the B2H Waivers,
- ability to appropriately engage B2H children and their family networks,
- knowledge of the B2H Waiver Program enrollment process and ability to execute the enrollment process,
- knowledge of the B2H quality management strategies that includes customer satisfaction, and the grievances and complaint process, and
- ability to develop and implement *IHPs (OCFS-8017)* and monitor B2H Waiver services.

E. Informational Training and Technical Assistance

OCFS has designed and sponsors informational training, technical assistance specific to the B2H Waiver Program for staff at Local Departments of Social Services, Voluntary Agencies, and B2H service providers. Arrangements for these trainings can be made through BWM.

BRIDGES TO HEALTH (B2H)

**NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES
HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM**

F. Service Providers Training Requirements Chart

Training Requirements for Bridges to Health Medicaid Waiver Program

Time Frame	Health Care Integrators and Health Care Integrator Supervisors	Waiver Service Providers*
Prior to providing B2H Waiver Services	Mandatory Training: First Aid CPR Mandated Reporting Overview of B2H Documentation Requirements	Mandatory Training: First Aid CPR Mandated Reporting Overview of B2H Documentation Requirements
	OCFS Sponsored: Complete and maintain CANS B2H Certification	
Within 3 Months of starting to provide B2H Waiver Services	Mandatory Training: Recognizing and Understanding Cultural Differences and Diversity Child and Adolescent Development	Mandatory Training: Recognizing and Understanding Cultural Differences and Diversity Child and Adolescent Development
Within 3 Months of starting to provide B2H Waiver Services	HCIA Sponsored Mandatory Training: Communication Skills and Behavioral Support Interaction of the B2H Waiver Program and Child Welfare	HCIA Sponsored Mandatory Training: Communication Skills and Behavioral Support Interaction of the B2H Waiver Program and Child Welfare
Within 6 Months starting to provide B2H Waiver Services	OCFS Sponsored: Complete HCI training Note: HCI Supervisors MUST complete HCI Training prior to providing supervision for B2H Waiver Services	OCFS Sponsored: Complete WSP training Includes the following: Module #1: Bridges to Health Waiver Service Provider Training: Documentation Module #2: Bridges to Health Waiver Service Provider Training: Building Resilience Module #3: Bridges to Health Waiver Service Provider Training: Safety in the Community Module #4: Bridges to Health Waiver Service

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

		<p>Provider Training: Essential Elements for Service Provision</p> <p>Service Specific Training is also required for certain B2H Waiver Service Providers based upon the service provided. (See following chart for specific training requirements.)</p> <p>Note: Waiver Service Provider (WSP) Supervisors must complete WSP training within 3 months of providing supervision to other WSPs.</p>
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***Note:** The general and specific training requirements apply to all WSPs, **excluding** providers of adaptive/assistive equipment and accessibility modifications, unless specified otherwise under the *Individualized Health Plan (OCFS-8017)*.

B2H Service Specific WSP Training Requirements	
Service Type	Corresponding Required Training Module
Family Caregiver Supports and Services	Family Caregiver Supports and Services
Skill Building	Skill Building
Special Needs Community Advocacy and Support	Special Needs Community Advocacy and Support
Prevocational Services	Prevocational and Supported Employment Services
Supported Employment	Prevocational and Supported Employment Services
Planned Respite	Planned and Crisis Respite
Crisis Avoidance, Management and Training	Crisis Services
Immediate Crisis Response	Crisis Services
Intensive In-home Supports and Services	Crisis Services
Crisis Respite	Planned and Crisis Respite

BRIDGES TO HEALTH (B2H)

NEW YORK STATE OFFICE OF CHILDREN & FAMILY SERVICES HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

Appendices

- Appendix A: B2H Acronyms
- Appendix B: Terminology Sheet
- Appendix B-1: B2H Case Record
- Appendix C: Consent for Routine Medical Services for Children in Foster Care Chart
- Appendix D: Weekly Schedule of B2H Services
- Appendix E: Forms—Alphabetical List
- Appendix F: Forms—Numerical List (8000–8036)
- Appendix G: Weblinks
- Appendix H: HCIA Administrative Separation of Duties Chart
- Appendix I: Transfers within the B2H Waiver Program
- Appendix J: B2H Waiver Program Referral and Enrollment Process
- Appendix K: Advisory Guideline-Determining Eligibility for Services: Substantial Handicap and Developmental Disability dated 8/10/01 and OMRDD Form OMRDD 02–02–97 (ICF/MR Level of Care Eligibility Determination)
- Appendix L: Clarification of Provisions of the August 2001 Eligibility Advisory dated 12/13/02
- Appendix M: Eligibility for OMRDD Services-Important Facts dated June 2006
- Appendix N: OMRDD Transmittal for Determination of Developmental Disability
- Appendix O: Interaction of the B2H Waiver Program and Child Welfare Outline
- Appendix P: Bridges to Health Agreement to Accept Services Form
- Appendix Q: OCFS transmittal for Bridge to Health Claiming Instructions
- Appendix R: NYC B2H Pre-Referral Process and Request for Services (R4S)
- Appendix S: NYC B2H Initial Level of Care (LOC) process for the DD Waiver type
- Appendix T: OMRDD Administrative Memorandum #2009-05 ICF/MR Level of Care Eligibility Form (LCED) Qualified Mental Retardation Professional (QMRP) authorized to sign annual LCED forms and OMRDD Memorandum dated March 2, 2010 Clarifying Information Administrative Memorandum #2009-05
- Appendix U: B2H Personnel Record Checklists for Health Care Integrators and Waiver Service Providers
- Appendix V: Bridges to Health (B2H) Performance Measures to meet Centers for Medicare and Medicaid Services' (CMS) Six Assurances

Appendix A: B2H Acronyms

ADM	Administrative Directive
B2H	Bridges to Health
BWM	Bureau of Waiver Management
CANS	Child and Adolescent Needs and Strengths
CIN	Client Identification Number
CONX	CONNECTIONS
CMSO	Community Multiservice Office
CST	Community Service Team
DD	Developmental Disability
DDSO	NYS OMRDD Developmental Disabilities Services Office
DHHS	U.S. Department of Health and Human Services
DOH	NYS Department of Health
DJJOY	OCFS Division Juvenile Justice and Opportunities for Youth
FASP	Family Assessment and Service Plan
HCBS	Home and Community-Based Services Waiver
HCI	Health Care Integrator
HCIA	Health Care Integration Agency
ICF/MR	Intermediate Care Facility for the Mentally Retarded
IHP	Individualized Health Plan
IMP	Individual Medication Plan
LDSS	Local Department of Social Service
LGU	Local Government Unit for Mental Health Services
LOC	Level of Care
MA	Medical Assistance (Medicaid)
MAR	Medication Administration Record
MedF	Medically Fragile
MOU	Memorandum of Understanding
OCFS	NYS Office of Children and Family Services
OMH	NYS Office of Mental Health
OPWDD	NYS Office for People With Developmental Disabilities
OTDA	NYS Office of Temporary and Disability Assistance
PPRI	Pediatric Patient Review Instrument
QMS	Regional Quality Management Specialist
RFA	Request for Applications
SCR	Statewide Central Register for Child Abuse and Maltreatment
SED	Serious Emotional Disturbance
SNF	Skilled Nursing Facility
WMS	Welfare Management System
WSP	Waiver Service Provider

Appendix B: Terminology Sheet

1. **Administrative Directive (ADM):** Policy guidance issued by NYS Office of Children and Family Services (OCFS), the NYS Office of Temporary and Disability Assistance (OTDA) or the NYS Department of Health to Local Departments of Social Services (LDSS)/Division of Juvenile Justice and Opportunities for Youth (DJJOY).
2. **Agency Conferences:** May be conducted by the LDSS/DJJOY to review decisions prior to pursuing a Medicaid Fair Hearing. Such a review by the LDSS may be requested by the child/medical consentor, an advocate, the HCI, or anyone involved in the development of the application for enrollment or service plan. This review is an opportunity for the individual and advocates to review, with a representative from the LDSS, the reasons for the Notice of Decision and to address the information they feel is not properly represented.
3. **Authorized Child Care Agency:** See not-for-profit voluntary authorized agency.
4. **Bridges to Health (B2H):** The name of the initiative/program that includes three Home and Community-Based Services waivers for children with Seriously Emotionally Disturbance (SED), Developmental Disabilities (DD), or Medical Fragility (MedF)—administered by OCFS. Each waiver has 14 services developed for children in foster care with disabilities and their caretakers.
5. **Bureau of Waiver Management (BWM):** The unit within the OCFS Division of Development and Prevention Services responsible for the implementation and monitoring of B2H.
6. **Caregiver:** Any individual, such as a parent, foster parent, adoptive parent, head of a household or family member who attends to the needs of the child.
7. **Case Manager:** The LDSS staff person responsible for authorizing the provision of services, approving client eligibility determinations and approving, by signature or electronic equivalent, the family assessments and service plans for children in foster care.
8. **Case Planner:** The caseworker on staff of an authorized child care agency or LDSS with the primary responsibility for providing or coordinating and evaluating the provision of child welfare services to the family. Case planning includes referring the child and his or her family to providers of services, as needed, and delineating the roles of the various service providers. The case planner must collaborate with all caseworkers assigned to the case so that a single family assessment and service plan is developed for a child.
9. **Child and Adolescent Needs and Strengths (CANS):** An evidence-based instrument used to monitor and provide documentation of waiver participant progress and outcomes.
10. **Community Multi-Service Office (CMSO):** DJJOY office located in each of the OCFS Regions statewide. Incorporates the functions of the Community Service Team (CST) intake and post-residential supervision in the community, as well as other available community providers who may be co-located in the office: Multi-Systemic Therapy (MST), Functional Family Therapy (FFT), Mental Health Services (MH), etc.
11. **Community Service Team (CST):** Composed of the original DJJOY Bureaus of Intake Services, Family Advocacy, and After Care Services, plus Voluntary Agency Support Services, Release Planning Coordinators, DJJOY Foster Care and the Intensive Aftercare Program Services as part of the DJJOY Regional Redesign. The CSTs come under the oversight of the DJJOY Associate Commissioner for Community Partnerships.
12. **CONNECTIONS (CONX):** The electronic child welfare system of record that is used to track B2H referrals and enrollments.
13. **Consenter:** See Medical Consenter.
14. **Department of Health (DOH):** The single state agency for Medicaid. DOH sets Medicaid policy and is responsible to CMS for oversight of all waivers.

Appendix B: Terminology Sheet

15. **Department of Health and Human Services (DHHS):** The Federal government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves.
16. **Developmental Disabilities Services Offices (DDSOs):** The OMRDD regional entities responsible for the organization and certification of regional voluntary providers. The DDSOs evaluate the Level of Care assessment for a potential developmentally disabled enrollee's initial entry into the B2H DD waiver.
17. **Developmental Disability (DD):** A clinical diagnosis necessary for B2H DD eligibility.
18. **Division of Juvenile Justice and Opportunities for Youth (DJJOY):** As part of OCFS, this division is responsible for the generation of NYS juvenile justice initiatives and oversight of the juvenile justice system.
19. **EMedNY:** The Medicaid billing and payment system for all B2H services.
20. **Fair Hearing:** See Medicaid Fair Hearing.
21. **Family:** Individuals and members of households involved with the waiver enrollee's life. The term may include the foster family, birth family, and/or adoptive family.
22. **Family Assessment and Service Plan (FASP):** the case management planning tool required for all children receiving child welfare services through an LDSS.
23. **Health Care Integrators (HCIs):** Individuals employed by Health Care Integration Agencies (HCIAs) responsible for the development, implementation, and ongoing monitoring of Individualized Health Plans.
24. **Health Care Integration Agency (HCIA):** Voluntary not-for-profit child care agencies under contract with OCFS for 1) employing HCIs; 2) WSP network development-management; 3) enrollment activities; and 4) program-quality management.
25. **Home:** A dwelling place together with the family or social unit that occupies it.
26. **Home and Community-Based Services Waiver (HCBS):** Authorized under the federal Social Security Act, waivers are Medicaid funded services intended to allow enrollees to live in the most integrated, least restrictive setting at home or in the community.
27. **Individual Medication Plan (IMP):** A medication administration plan developed for children in foster care. The IMP is developed at the initial comprehensive health assessment by a licensed medical practitioner and is reviewed and updated annually and whenever there is a change in medication. It includes the condition or diagnosis for which a prescribed or over-the-counter medication is to be used, medication name, dosage and route of administration, frequency of administration, monitoring standards for each medication, the child's capability to self-administer medication, and specific instructions related to the medication. It is maintained in the child's medical record and accessible to staff who administer medication to that child.
28. **Individualized Health Plan (IHP):** The document that describes B2H enrollees' needs and strengths, and the authorized B2H Waiver service's frequency, unit, duration, and provider.
29. **Intermediate Care Facility for the Mentally Retarded (ICF/MR):** A medical institution for individuals with developmental disabilities and/or mental retardation.
30. **Level of Care (LOC):** A federally-required eligibility determination that indicates that a Waiver applicant's disabilities would require placement in a medical institution, were it not for the provision of home and community-based services. Each of the three B2H Waivers uses its own LOC assessment instrument.
31. **Local Department of Social Service (LDSS):** The local governmental unit responsible for children in foster care and for determining Medicaid eligibility, determining B2H eligibility, and authorizing B2H enrollment. In New York City, the LDSS is the Administration for Children's Services (ACS).

Appendix B: Terminology Sheet

32. **Local Government Unit (LGU):** The local governmental unit for mental health services; counties and New York City.
33. **Medicaid (MA):** A program for those who cannot pay for medical care.
34. **Medicaid Fair Hearing:** A state hearing held at the request of B2H applicants and enrollees after LDSS/DJJOY issue a Notice of Decision. The request for a fair hearing is made to the Office of Temporary and Disability Assistance, which conducts and manages the Fair Hearing process.
35. **Medical Record:** The term used for the file containing all available information and documents related to the child's health, including assessments. For each child in foster care, the authorized agency caring for the child must maintain a continuous individual medical record. If the authorized agency is the LDSS/DJJOY (i.e., the child is in direct foster care), then the LDSS/DJJOY maintains the medical record. If the child is in the care of a voluntary agency, that agency maintains the record. The medical record should be maintained by qualified health staff and organized in such a way that the information is easily accessible and useable.
36. **Medical Consenter:** The person or entity legally authorized to give consent for a child's medical care.
37. **Medically Fragile (MedF):** A clinical diagnosis necessary for B2H MedF eligibility.
38. **Medication Administration Record (MAR):** A record maintained in the child's medical record and made accessible to staff who administer medication to that child. The MAR must include the date and time that each medication dose is administered, and the initials of the individual who administered, or assisted or supervised the self-administration of the medication. The MAR also documents medication errors, actions taken, and effects of the errors.
39. **Memorandum of Understanding (MOU):** An agreement between state agencies. For B2H, there are two MOUs—one between OCFS and DOH and the other between OCFS and OMRDD to define roles and responsibilities.
40. **Not-for-profit Voluntary Authorized Agency:** An agency defined in social service law section 371(10) (a). "Authorized agency" means any agency, association, corporation, institution, society or other organization which is incorporated or organized under the laws of this state with corporate power or empowered by law to care for, to place out or to board out children, which actually has its place of business or plant in this state and which is approved, visited, inspected and supervised by the department (now OCFS) or which shall submit and consent to the approval, visitation, inspection and supervision of the department as to any and all acts in relation to the welfare of children performed or to be performed under this title. The use of the term voluntary eliminates a social services district.
41. **Notice of Decision (NOD):** Official notice to an individual of approval, denial, reduction or discontinuance of B2H enrollment or services issued by an LDSS/DJJOY.
42. **Office of Children and Family Services (OCFS):** The NYS agency responsible for promoting the well-being and safety of children and families, including oversight and implementation of the B2H Waiver Program.
43. **Office of Mental Health (OMH):** The NYS agency that operates psychiatric centers across the State, and also regulates, certifies, and oversees more than 2,500 programs operated by local governments and nonprofit agencies.
44. **Office for People With Developmental Disabilities (OPWDD):** The NYS agency that has the responsibility for the prevention and early detection of mental retardation and developmental disabilities and for the comprehensively planned provision of services including care, treatment, habilitation, and rehabilitation of citizens with mental retardation and developmental disabilities. Formerly the New York State Office of Mental Retardation and Developmental Disabilities.

Appendix B: Terminology Sheet

45. **Office of Temporary and Disability Assistance (OTDA):** The NYS agency that provides economic assistance and supportive services to needy adults and families. OTDA conducts and manages the Fair Hearing process for the B2H Waiver Program.
46. **Pediatric Patient Review Instrument (PPRI):** The assessment tool used to determine the level of care required by medically fragile children including care offered through the B2H Med F waiver.
47. **Qualified Health Care Practitioner (QHCP):** A person with a professional license whose authorization to practice and use of a professional title is administered by the New York State Education Department Office of the Professions.
48. **Quality Management Specialist (QMS):** The OCFS regional office staff responsible for technical assistance, monitoring and oversight of HCIA's and LDSS. QMS report to BWM.
49. **Request for Applications (RFA):** The document that describes the criteria for becoming an HCIA and is issued by OCFS to solicit applications.
50. **Serious Emotional Disturbances (SED):** A clinical mental health diagnosis necessary for B2H SED eligibility.
51. **Skilled Nursing Facility (SNF):** A medical institution for individuals with physical impairments.
52. **Statewide Central Register for Child Abuse and Maltreatment (SCR):** NYS provides a toll-free number to report child abuse and neglect to the Register.
53. **Team Meeting:** An opportunity for collaboration among service providers, the waiver participant, and/or medical consentor regarding the waiver participant's needs, to support the health and welfare of the waiver participant.
54. **Waiver Participant:** An individual participating in one of the B2H waivers. This includes children enrolled in B2H who are currently in foster care or who have been discharged from foster care but continue to be enrolled in the B2H waiver. Because waiver participants can range from infants to 20-year-old youths, the B2H Waiver Program assumes that the sharing of information and involvement in meetings must be appropriate to the child's age and capacity. The B2H Waiver Program requires the child's involvement wherever possible and appropriate.
55. **Waiver Service Provider (WSP):** The phrase WSP is used to describe the following:
 1. Agencies and staff under subcontract with the HCIA to provide B2H Waiver Services, other than Health Care Integration.
 2. Staff employed by the HCIA who provide B2H Waiver Services other than Health Care Integration.
 3. Staff employed by the HCIA to provide Health Care Integration.
56. **Welfare Management System (WMS):** The system of record for Medicaid and B2H Waiver authorizations.

Appendix B-1: B2H Case Record

The B2H case record is a compilation of multiple documents and forms related to the child's application, authorization and participation in the B2H Waiver Services Program. This information includes the required service documentation for Medicaid billing, the Individual Service Plan (IHP), Detailed Service Plan, and Service Summary.

The information contained in the B2H case record also includes documentation that supports the child's progress in achieving goals. This includes the Progress Notes and CANS B2H Instrument.

Who maintains the B2H case record?

B2H case records are to be maintained by the Health Care Integration Agencies (HCIAs) and are to be readily retrievable upon the request of LDSS, OCFS, DOH, or U.S. Department of Health and Human Services Centers for Medicaid & Medicare Systems (CMS).

What documents should the B2H case record contain?

Every document with the child's name must be maintained as part of the B2H case record. The LDSS, as the referring and authorizing entity, and the HCIAs and Waiver Service Providers (WSPs) as provider agencies, are responsible for generating documentation that must be maintained in the B2H case record.

It is expected that some documents with shared information will be maintained in both the LDSS and HCIA records. The B2H case record must include the following:

- Individualized Health Plans (IHP)
- Detailed Service Plans
- Service Summaries
- Progress Notes
- Notes/minutes from all Team Meetings
- Notice of Decisions (NODs) issued by the LDSS
- Notes/minutes from Serious Reportable Incident Committee Meetings
- Notes/minutes from Service Plan Review Meetings
- Other related B2H documentation

The attached OCFS Form Chart details each B2H Waiver form, the entity responsible for generating the document, and location where the document of record is to be maintained. It is suggested that the document originator keep a copy of every document it generates as part of the B2H case record.

How is the B2H case record different from the medical record maintained by the foster care agency?

For each child in foster care, the authorized agency caring for the child must maintain a continuous individual medical record. The medical record is the file containing all available information and documents related to the child's health, including assessments. If the authorized agency is the LDSS (i.e., the child is in direct foster care), then the LDSS maintains the medical record. If the child is in the care of a voluntary authorized child care agency, that agency maintains the record. The medical record should be maintained by qualified health staff and organized in such a way that the information is easily accessible and useable.

Appendix B-1: B2H Case Record

The medical record maintained by the foster care agency is the record of routine and specialized health care needs and services, including emergency care. This includes medical, dental, mental health, developmental, substance abuse, dental evaluations and treatment regimes. The health record includes consent to release past health records, the child's health records and history and a file for current and future health activities for the child.

The B2H case record contains documentation supporting the diagnosis for the B2H Waiver Program. Participation in a waiver program is intended to support the child's health and well-being through the provision of the 14 different B2H Waiver services. It is vital that the Health Care Integrators and foster care entities/case planning agencies coordinate the exchange of information regarding a child's disability and provision of services. This coordination will lead to better outcomes for children.

How long must B2H case records be kept?

All B2H case record documentation must be kept and made available for 30 years after the child has been discharged from foster care.

Who has access to the case record?

The child/medical consentor, LDSS, HCIA, HCI, OCFS, DOH and CMS.

Appendix C: Consent for Routine Medical Services for Children in Foster Care Chart

Consent for Routine Medical Services for Children in Foster Care

Placement Authority	Citation	District/Agency Actions	Parental Consent Unavailable
FCA Article 10 (Child Protective)	18 NYCRR 441.22(d) SSL 383-b	Request authorization in writing from the child's parent/guardian within 10 days of entry into foster care.	If child has been removed or court-ordered into LDSS custody pursuant to Article 10, Commissioner or designee may provide consent.
FCA Article 7 (Persons In Need of Supervision)	18 NYCRR 441.22(d)	Request authorization in writing from the child's parent/guardian within 10 days of entry into foster care.	Seek a court order.
FCA Article 3 (Juvenile Delinquents)	18 NYCRR 441.22(d) FCA 355.4	Request authorization in writing from the child's parent/guardian within 10 days of entry into foster care.	If the youth is in the custody of the OCFS Commissioner, for DJJOY, the court order constitutes consent unless there is an order to the contrary. If parental consent cannot be obtained, seek a court order. Obtain from LDSS if placement is Article 10.
Juvenile Offenders (OCFS facility)	NY Penal Law 70.20 (4)(b) & (c)	Court asks whether parent/guardian consents for OCFS to provide routine care.	If no consent has been obtained, the commitment order shall be deemed to grant consent.
Voluntary Placement	SSL 384-a	Include consent to medical services in the placement agreement signed by the parent/guardian and LDSS.	The authorized agency has no authority to consent to medical services. Seek a court order or initiate Article 10 action.
Surrender (both parents)	SSL 383-c SSL 384	LDSS Commissioner or authorized agency to whom the child was surrendered provides written authorization for medical services.	Consents signed by the parent/guardian are no longer valid.
Termination of Parental Rights (both parents)	SSL 384-b	LDSS Commissioner provides written authorization for medical services.	Consents signed by the parent/guardian are no longer valid.

Appendix C: Consent for Routine Medical Services for Children in Foster Care Chart

Consent for Person Who is 18 Years of Age or Older

Section 2504 of the Public Health Law (PHL) sets forth the general rule that a person who is 18 years of age or older may give consent for medical, dental, health and hospital services for himself or herself. A minor under the age of 18 years thus generally is incapable of giving effective legal consent for medical care.

Section 2504 of the PHL contains some additions that could permit a minor under age 18 to consent to medical care.

- Any person who is the parent of a child or has married, may give effective consent for medical, dental, health and hospital services for himself or herself, and the consent of no other person shall be necessary.
- Any person who has been married or who has borne a child may give effective consent for medical, dental, health and hospital services for his or her child.
- Any person who is pregnant may give effective consent for medical, dental, health and hospital services relating to prenatal care.
- Medical, dental, health and hospital services may be rendered to persons of any age without the consent of a parent or legal guardian when, in the physician's judgment an emergency exists and the person is in immediate need of medical attention and an attempt to secure consent would result in delay of treatment which would increase the risk to the person's life or health.
- There are other specific instances when either the consent to medical treatment may be provided by a person under age 18 or medical treatment may be provided without parental consent. These instances include HIV-testing, outpatient mental health services, psychotropic medication administered in a psychiatric hospital or unit, alcohol and substance abuse services, and reproductive health and abortion services.

Consent for Juvenile Delinquent or Person in Need of Supervision Under Age 18

When a child is placed in foster care through Articles 3 (Juvenile Delinquent) or 7 (Person in Need of Supervision) of the Family Court Act, a social services district is not authorized to consent to medical, dental, health and hospital services for the child unless written authorization from the child's parent or guardian or a court order is obtained. Without such a written authorization or court order, the parent/guardian or child must be the medical consentor for B2H medical, dental, health or hospital services unless there has been a completed termination of parental rights proceeding or surrender. For a youth placed as a Juvenile Delinquent in the custody of OCFS, the Family Court Act authorizes the Commissioner of OCFS to consent to medical, dental and mental health services and treatment for the youth.

Appendix D: Weekly Schedule of B2H Services

BRIDGES TO HEALTH (B2H) MEDICAID WAIVER PROGRAM

**Projected weekly schedule of all services
(Include informal supports, waiver and non-waiver services).**

Child's Name:

Time	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
7:00 AM							
8:00							
9:00							
10:00							
11:00							
NOON							
1:00 PM							
2:00							
3:00							
4:00							
5:00							
6:00							
7:00							
8:00							
9:00							
10:00							
11:00							
12:00 AM							
12:00 AM - 7:00 AM							

Appendix E: Forms—Alphabetical List

Form Name	Form #
Accessibility Modifications and/or Adaptive and Assistive Equipment Description, Cost Projection and Final Cost	8028
Application Form for Enrollment	8004
Authorization for Release of Information	8001
Bridges to Health Consultation Line Form	8013
Certificate of Attendance	8025
Change of Provider Form	8006
Contact Information List	8027
Detailed Service Plan	8020
Transition Plan	8030
Freedom of Choice Form	8003
Grievance/Complaint Packet	8024
HCIA Waiver Qualification Form for Service Providers	8034
Health Care Integration Agency Quarterly/Annual Report (Form A) and Serious Incident Review Committee Quarterly Report (Form B)	8015 A and B
Health Care Integrator Selection Form	8007
Individualized Health Plan (IHP): Preliminary, Initial, Revised, and Annual Revised	8017
Level of Care (LOC) Forms – Level of Care for Children with Serious Emotional Disturbances (SED) (Form A), ICF/MR Level of Care Eligibility Form for Children with Developmental Disabilities (DD) (Form B) and Level of Care for Children with Medical Fragility (MedF) Pediatric Patient Review Instrument (Form C)	8005 A, B, and C
Loss of Eligibility Recommendation Form	8026
Medication Error Report	8036
Notice of Decision -- Authorization	8009
Notice of Decision – Denial of Enrollment	8010 A
Notice of Decision – Denial of Waiver Service(s)	8010 B
Notice of Decision -- Discontinuance from Waiver Program	8011 A
Notice of Decision -- Discontinuance of Waiver Service(s), Service Provider(s) and/or Reduction of Service(s)	8011 B
Progress Notes	8019
Reauthorization Form	8014

Appendix E: Forms—Alphabetical List

Referral Form	8000
Schedule A - Waiver Service Provider Commitment Form	8035
Serious Reportable Incident Form	8021
Serious Reportable Incident Response Form	8023
Serious Reportable Incident Status/Progress Report	8022
Service Summary Form	8018
Understanding the Bridges to Health Medicaid Waiver Program	8002
Wait List Notification Form	8012
Waiver Participant's Rights Form	8008

Appendix F: Forms—Numerical List (8000–8036)

B2H Waiver Program Forms and Reports			
OCFS Form #	Name of Form	Originating Entity	Original and copies
8000	Referral Form	LDSS/DJJOY	original -- HCIA copy of 8000 and all related documents: LDSS or DJJOY copy of 8000 form only -- child/medical consentor, caregiver, case planning agency, QMS
8001	Authorization for Release of Information	LDSS/DJJOY	original -- HCIA copy -- child/medical consentor, LDSS or DJJOY, all parties listed on Release of Information
8002	Understanding the Bridges to Health Medicaid Waiver Program	HCIA	original -- HCIA copy -- child/medical consentor, caregiver
8003	Freedom of Choice Form	HCIA	original -- HCIA copy -- child/medical consentor, LDSS or DJJOY
8004	Application Form for Enrollment	HCIA	original -- HCIA copy of completed 8004 form only to -- child/medical consentor, case planning agency, caregiver, QMS copy of 8004 form and supporting documentation: LDSS or DJJOY
8005 A, B, and C	Level of Care (LOC) Forms – Level of Care for Children with Serious Emotional Disturbances (SED) (Form A), Level of Care ICF/MR Eligibility Form for Children with Developmental Disabilities (DD) (Form B) and Level of Care for Children with Medical Fragility (MedF) Pediatric Patient Review Instrument (Form C)	HCIA	original -- HCIA copy – LDSS or DJJOY, case planning agency

Appendix F: Forms—Numerical List (8000–8036)

B2H Waiver Program Forms and Reports			
OCFS Form #	Name of Form	Originating Entity	Original and copies
8006	Change of Provider Form	HCIA	original -- HCIA copy -- child/medical consentor, LDSS or DJJOY, case planning agency, caregiver
8007	Health Care Integrator Selection Form	HCIA	original -- HCIA copy -- child/medical consentor, LDSS or DJJOY, case planning agency, caregiver
8008	Waiver Participant's Rights Form	HCIA	original -- HCIA copy -- child/medical consentor, LDSS or DJJOY, caregiver
8009	Notice of Decision -- Authorization	LDSS or DJJOY	original -- child/medical consentor copy -- LDSS or DJJOY, HCIA, case planning agency, caregiver
8010 A	Notice of Decision – Denial of Enrollment	LDSS or DJJOY	original -- child/medical consentor copy – LDSS or DJJOY, HCIA, case planning agency, caregiver, QMS and BWM (for B2H DD Waiver only)
8010 B	Notice of Decision – Denial of Waiver Service(s)	LDSS or DJJOY	original -- child/medical consentor copy – LDSS or DJJOY, HCIA, case planning agency, caregiver
8011 A	Notice of Decision -- Discontinuance from Waiver Program	LDSS or DJJOY	original -- child/medical consentor copy – LDSS or DJJOY, QMS, HCIA, case planning agency, caregiver
8011 B	Notice of Decision -- Discontinuance of Waiver Service(s), Service Provider(s) and/or Reduction of Service(s)	LDSS or DJJOY	original -- child/medical consentor copy – LDSS or DJJOY, OCFS BWM, HCIA, case planning agency, caregiver
8012	Wait List Notification Form	LDSS or DJJOY	original -- child/medical consentor copy – LDSS or DJJOY, QMS, HCIA, case planning agency, caregiver
8013	Bridges to Health Consultation Line Form *not web posted	OCFS	original -- BWM
8014	Reauthorization Form	HCIA	original -- HCIA copy of completed 8014 Form only to -- child/medical consentor, case planning agency, caregiver copy of 8014 form and supporting documentation to: LDSS or DJJOY

Appendix F: Forms—Numerical List (8000–8036)

B2H Waiver Program Forms and Reports			
OCFS Form #	Name of Form	Originating Entity	Original and copies
8015 A and B	Health Care Integration Agency Quarterly/Annual Report (Form A) and Serious Incident Review Committee Quarterly Report (Form B)	HCIA	8015 A original -- BWM copy --HCIA, DJJOY, all Regional LDSS and QMS; 8015 B original -- BWM copy --HCIA, LDSS, DRS and QMS
8017	Individualized Health Plan (IHP): Preliminary, Initial, Revised, and Annual Revised	HCIA	original -- HCIA copy – LDSS or DJJOY, child/medical consentor, case planning agency
8018	Service Summary Form	HCIA/WSP	original --Originating entity copy --HCIA
8019	Progress Notes	HCIA and WSP(s)	original -- Originating entity copy -- HCIA
8020	Detailed Service Plan	HCIA and WSP(s)	original -- HCIA copy -- WSP
8021	Serious Reportable Incident Form	HCIA/OCFS	original -- BWM copy --HCIA, QMS, LDSS or DJJOY
8022	Serious Reportable Incident Status/Progress Report	HCIA/OCFS	original -- BWM copy --HCIA, QMS, LDSS or DJJOY
8023	Serious Reportable Incident Response Form	OCFS	original -- HCIA copy --BWM, QMS, LDSS or DJJOY
8024	Grievance/Complaint Packet	HCIA	original -- grievant copy -- HCIA, BWM, QMS, LDSS or DJJOY
8025	Certificate of Attendance	OCFS	original -- individual who participated in training copy -- HCIA or WSP
8026	Loss of Eligibility Recommendation Form	HCIA	original -- HCIA copy -- LDSS, DJJOY, case planning agency, QMS

Appendix F: Forms—Numerical List (8000–8036)

B2H Waiver Program Forms and Reports			
OCFS Form #	Name of Form	Originating Entity	Original and copies
8027	Contact Information List	HCIA	original -- child/medical consentor copy -- HCIA, caregiver, case planning agency
8028	Accessibility Modifications and/or Adaptive and Assistive Equipment Description, Cost Projection and Final Cost	HCIA	original -- HCIA copy – LDSS or DJJOY, child/medical consentor, BWM, QMS
8030	Transition Plan	HCIA	original -- HCIA copy -- child/medical consentor, LDSS, DJJOY, case planning agency, caregiver, OMRDD's DDSO (for B2H DD Waiver Type)
8034	HCIA Waiver Qualification Form for Service Providers *for RFA purposes only	HCIA/WSPs	original -- OCFS BWM
8035	Schedule A - Waiver Service Provider Commitment Form *for RFA purposes only	HCIA/WSPs	original -- OCFS BWM
8036	Medication Error Report	HCIA and WSP(s)	original -- HCIA copy -- WSP, (Made available if requested by OCFS)

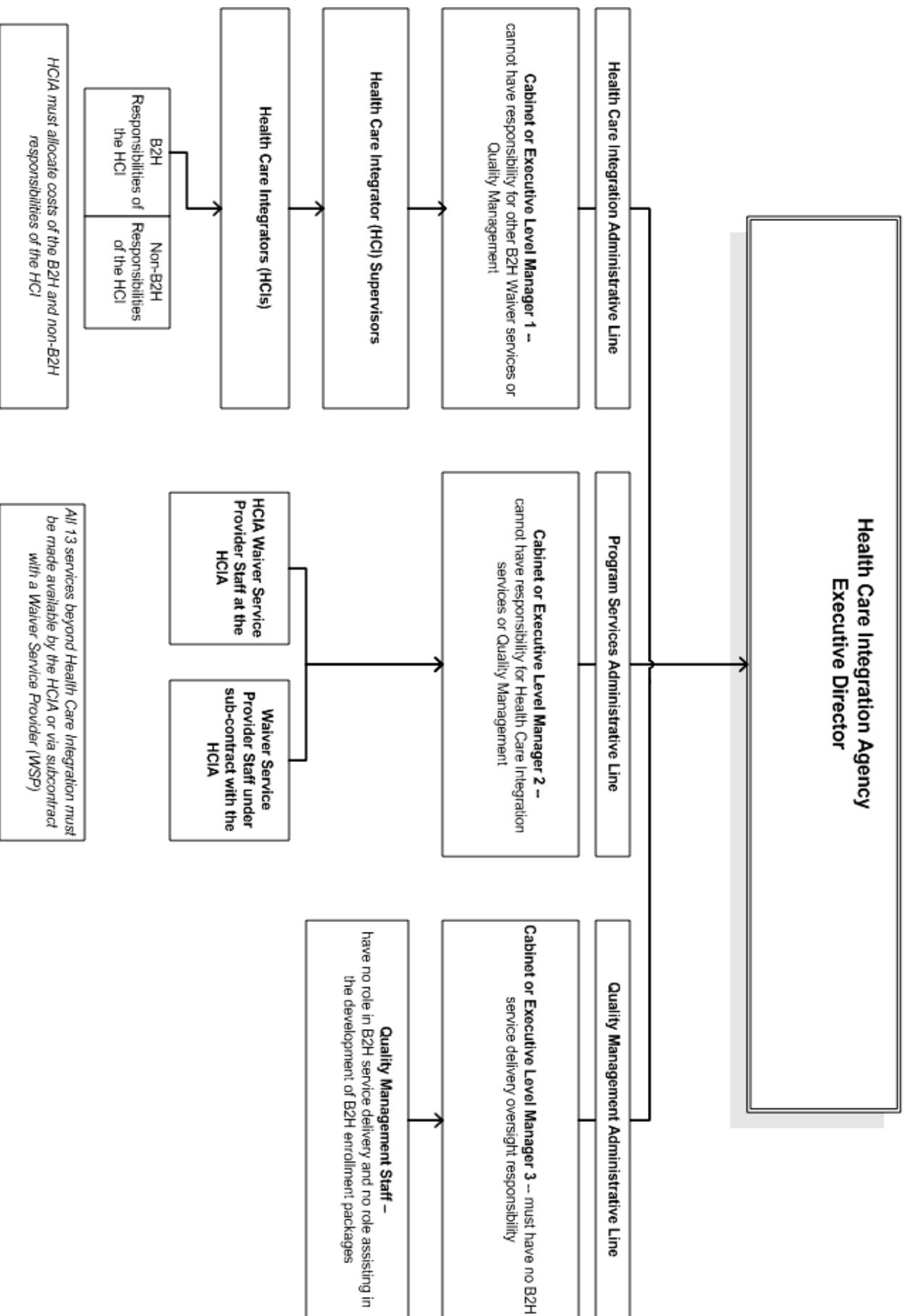
Appendix G: Weblinks

The documents referenced in this Program Manual are available on the OCFS website at <http://www.ocfs.state.ny.us/main/b2h/> and include the following:

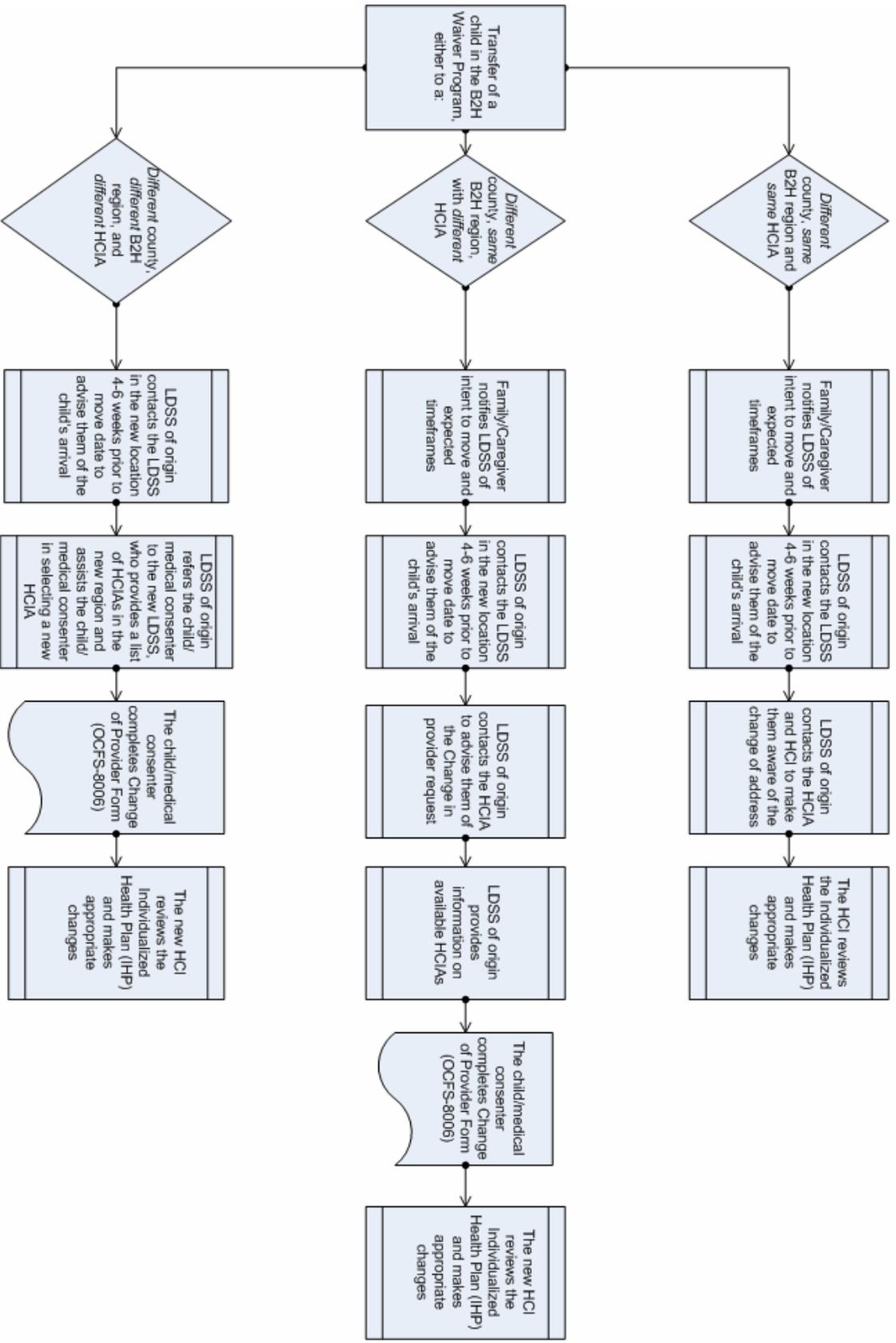
- Federally Approved Waiver Applications:
 - B2H for children with Serious Emotional Disturbances (SED)
 - B2H for children with Developmental Disabilities (DD)
 - B2H for children with Medical Fragility (Med F)
- Provider Agreement
- Model Subcontract
- Request for Applications for Health Care Integration Agencies
- Approved Rates for Rates for B2H Waiver Program effective January 1, 2008

Health Care Integration Agency (HCIA)

Administrative Separation of Duties



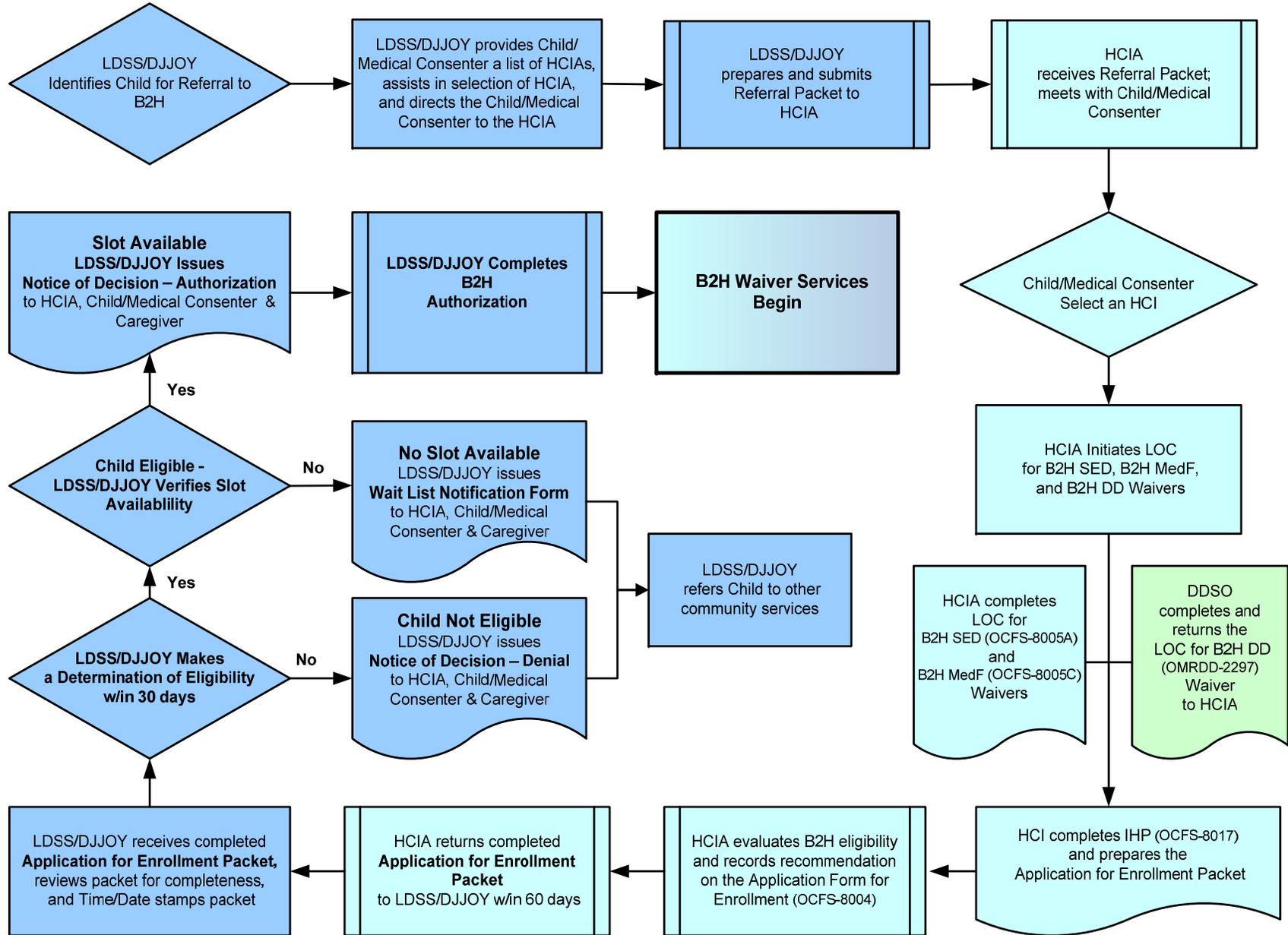
Transfers within the B2H Waiver Program



LDSS of origin retains responsibility for the Medicaid and B2H Waiver authorizations; the B2H Waiver slot remains the responsibility of the LDSS or OCFS OMS regional staff. **Note:** In the event a child is discharged from foster care and moves to another LDSS, the new LDSS of residence becomes responsible for Medicaid eligibility determination and Medicaid authorization for the child.

Appendix J: B2H Waiver Program Referral and Enrollment Process

B2H Waiver Program Referral and Enrollment Process January 1, 2008



Office of Children and Family Services - Appendix K 11/11
Modified from NYS Office for People With Developmental Disabilities'
LCED Form 02.02.97 (5/2010, 4/2011)

**Instructions for the Completion of the ICF/MR Level of Care Eligibility
Determination (LCED) Form for Bridges to Health Waiver Participants
B2H**

Purpose:

The following information is intended to provide guidance on the completion of the ICF/MR Level of Care Eligibility Determination (LCED) and LCED form for children served by the Bridges to Health (B2H) Waiver. The LCED form is used for the initial determination and annual redetermination (i.e., reevaluation) of an individual's eligibility to receive B2H Waiver services. This information includes the criteria for determining eligibility as well as the step-by-step instructions for completing the LCED form. The criteria used are the same for the initial and annual redetermination reviews for HCBS enrolled individuals.

This guidance replaces the Instructions for "Completion of the ICF/MR Level of Care Eligibility Form" information contained in The Key to Individualized Services, The Home and Community Based Services Waiver (OMRDD 1997) and Appendix K of the B2H Program Manual, 1/11.

Background:

Pursuant to federal regulations, B2H waiver services can only be provided to recipients who would otherwise require services consistent with the level of care provided in a Medicaid certified hospital, nursing facility or ICF/MR (42 CFR Section 441.301(b)(1)(iii)(c)).

Once an individual is admitted to a waiver program, states must certify through an **annual** level of care redetermination (i.e., re-evaluation) process that he or she continues to present needs consistent with the level of care provided within those settings noted above (42 CFR Section 441.302(c)(2)).

Federal regulation 42 CFR Section 441.302 requires that a B2H waiver recipient's level of care be determined no less frequently than annually.

Qualifications of Persons Performing LCED Initial Determinations and Redeterminations; Required Signatures; and LCED Timeframes:

Initial (i.e. first) LCED:

The initial LCED is signed by OPWDD's DDSO. Redeterminations are the responsibility of the HCIA who is serving the individual in the B2H waiver.

The initial LCED is completed by a professional with a minimum of one year's experience in the performance of assessments and the development of plans of care for individuals with developmental disabilities. This professional may be the designated Qualified Mental Retardation Professional (QMRP) (see 42 CFR Section 483.430 or ADM #2009-05 "ICF/MR Level of Care Eligibility Determination Form (LCED) Qualified Mental Retardation Professional (QMRP) authorized to sign annual LCED forms"), a person assigned by the DDSO, or a qualified person at the voluntary agency who is familiar with the needs of the individual applying for HCBS waiver services (for example, the individual's HCI or HCIA representative).

The initial LCED must be reviewed, signed, and dated by a physician. The initial LCED information that is reviewed by the physician must include the relevant pre-admission evaluations: physical (medical), social, and psychological. The psychological evaluations must be conducted by qualified practitioners who may administer and interpret standardized measures of intelligence and adaptive behavior. A qualified practitioner is a person with a directly relevant master's degree or doctoral degree in psychology, who has training and supervised experience in the use and interpretation of such measures consistent with the recommendations contained in the respective test manuals and with the requirements of American Psychological Association (APA)/ American Educational Research Association (AERA)/ National Council on Measurement in Education (NCME) (1999) standards for test administration and use and interpretation of individual test results. A copy of the pre-enrollment evaluations must be sent to the DDSO along with the initial LCED form so they can be retained in the B2H Enrollment permanent record. The MSC vendor should also retain these documents in the individual's service coordination record.

The DDSO Director or DDSO Director's designee must also review, sign, and date the initial LCED and write in the effective date of the Eligibility Determination. Before signing, the DDSO Director or designee must review the LCED's supporting documentation and must assure that a DDSO Developmental Disability eligibility determination has been completed in accordance with the OPWDD eligibility guidelines, and that the findings substantiate DD eligibility. The effective date of the LCED can precede the signature date of the DDSO Director or DDSO Director's designee but it can be no earlier than the date the physician reviewed/signed the LCED Form.

B2H waiver enrollment and billing for B2H waiver services cannot precede the effective date of the LCED determination as indicated in the field "ICF/MR Level of Care Approved Effective (mm/dd/yy)" which is completed by the DDSO Director or designee. The HCI enters the B2H enrollment date, once known.

Annual LCED Redeterminations:

The purpose of the annual redetermination is to ascertain if the individual continues to meet ICF/MR level of care eligibility criteria. As it is unlikely that there will be significant changes to an individual's disability and level of functioning over a year's time, the person completing the annual LCED redetermination should be able to assess the development status of the individual based on the following: direct knowledge of the individual based on observations and discussions with them; a review of the most recent psychological evaluation, social history, physical/medical history, and other applicable information; and/or a review of the criteria outlined in the initial LCED Form (i.e., diagnosis, disability manifested before the age of 22; behavioral problems; health care needs; adaptive behavior deficits). If additional information is needed to make a determination, updates to the physical/medical examination, social evaluation, and/or psychological evaluation should be requested and reviewed. Updates may consist of notations and signatures on evaluations verifying that the current status of the individual remains unchanged or may include newly completed evaluations.

The LCED Form must be reviewed and approved (and signed and dated) by a QMRP (as defined in federal regulation 42 CFR 483.430(a)) who is familiar with the participant's functional level, a physician or a physician's assistant or nurse practitioner (if so authorized by a physician). See Appendix T of the B2H Program Manual for more information.

The LCED Redetermination must be completed and signed annually, not to exceed one year (i.e., 365 days) from the effective date of the initial Eligibility Determination or from the signature date of the previous year's redetermination review date.

In paper format, the LCED Form includes a section for Annual Level of Care Eligibility Redetermination, in which the qualified person (e.g., QMRP) completes the review as outlined in these instructions, and if there are no changes that impact ICF/MR level of care, signs and dates the redetermination section of the form. This date becomes the effective date of the redetermination. As long as there are no changes that impact the individual's eligibility for ICF/MR level of care, the same form can be used to certify the yearly LCED until the qualified reviewer chooses to complete a new form for the Redetermination. If a new form is completed for Redetermination, the reviewer is required to complete numbers 1-5 (Eligibility Determination Criteria) on the first page, fill out the identifying information on the second page, and sign and date on the first line under Annual Level of Care Eligibility Redeterminations on the second page. This date would be the effective date of the LCED Redetermination.

If the annual LCED redetermination indicates that the individual may no longer meet the ICF/MR level of care criteria, the reviewer must refer the individual to the DDSO for further review and action which may include a Second Step Review or a Notice of Determination (NOD) notifying the individual that he/she is no longer eligible for B2H Waiver services because he/she no longer meets the ICF/MR level of care eligibility criteria required for continued participation in the B2H waiver.

Determination of Eligibility:

An individual is determined eligible for ICF/MR Level of Care for B2H waiver services if:

There is documentation of one or more of the diagnoses listed under Question 1 (i.e., mental retardation, epilepsy, autism, neurological impairment, cerebral palsy, familial dysautonomia, or other)

AND

Question 2 (i.e., the disability manifested prior to age 22) is selected "Yes"

AND

A "Yes" is selected in either:

Question 3 (select "Yes" if the individual's record indicates that he/she exhibits severe behavior problems which endanger himself/herself or others)

OR

Question 4 (select "Yes" if any of the listed conditions are evident from the individual's record or from observations of the individual, specifically: A. medical condition which requires daily individualized attention from health care staff; B. Self-injurious behavior which necessitates monitoring and treatment; C. deficits in self-care skills are evident from review of the individual's record or from observations of the individual)

OR

Question 5 ("Yes" is selected to indicate adaptive behavior deficits in any of the listed areas).

COMPLETING THE FORM FOR ICF/MR LEVEL OF CARE ELIGIBILITY DETERMINATION

Form Fields	Instructions
Name of Individual	Insert individual's first and last name and middle initial.
Address	Insert the address where the individual will be residing while receiving B2H Waiver services.
D.O.B. (Date of Birth)	Insert the individual's date of birth. Include the month, day, and year.
Status (620 or 621)	N/A for B2H.
Responsible Medicaid District	Insert the name of the LDSS in which the individual's Medicaid case is currently active.
Medicaid No	Insert the individual's Medicaid Identification Number (i.e., CIN).
TABS ID	Insert the individual's TABS ID (i.e. OPWDD Tracking and Billing System Identification number)- completed by OPWDD DDSO.

Medical, psychological and social evaluations are necessary for determining an individual's eligibility. However, the reviewer should also examine other portions of the record containing information which would assist him/her in determining an individual's eligibility as well as information that would allow him/her to gain a composite picture of the individual.

Dates of Pre-enrollment (i.e., pre-admission) evaluations	
Note: The dates for preadmission evaluations need only be included on the form for the initial LCED determination . However, all assessments should be reviewed prior to the annual redetermination.	
Physical	Insert the date of the current (completed within the last year) physical exam completed by a physician, registered physician's assistant, or nurse practitioner.
Social	Insert the date of the current evaluation (i.e., assessment) or update completed by the service coordinator or social worker. Ensure the social evaluation is a reflection of the individual's current social functioning.
Psychological	Insert the date of the current psychological evaluation. An annually updated evaluation is not needed if there is sufficient information in the individual's record to complete the diagnosis and adaptive behavior deficit/learning portions of the LCED form. A current evaluation (full

assessment or update) must be carried out by a qualified practitioner if the person completing and/or approving the LCED form finds that there is not sufficient psychological information to complete the form.

Eligibility Information	
1. Diagnosis	<p>Select all that apply. There must be documentation that a physician has made or approved each diagnosis. In the case of an individual who also has a mental health/psychiatric diagnosis, the individual's <u>primary</u> diagnosis (that which is dominant in terms of affecting their level of functioning) <u>must</u> include one or more of those diagnoses listed under A-E at the time of the LCED determination.</p> <p><i>According to NYS Mental Hygiene Law section 1.03 (22), a "developmental disability" means a disability of a person which: (a)(1) is attributable to mental retardation, cerebral palsy, epilepsy, neurological impairment, familial dysautonomia, or autism; (2) is attributable to any other condition of a person found to be closely related to mental retardation because such condition results in similar impairment of general intellectual functioning or adaptive behavior to that of persons with mental retardation or requires treatment and services similar to those required for such person; OR (3) is attributable to dyslexia resulting from a disability described in 1 or 2 above; (b) originates before such person attains age 22; (c) has continued or can be expected to continue indefinitely; AND (d) constitutes a substantial handicap to such person's ability to function normally in society.</i></p>
2. Disability manifested prior to age 22	<p>Select "Yes" or "No" in accordance with the following</p> <p>Select "YES" if the individual's impairment has been documented as having occurred prior to age 22 (e.g., through medical records showing a diagnosis of DD, within a school record, within the social history indicating significant delays in achieving developmental milestones, or through records documenting admission prior to age 22 to any program certified or operated by OPWDD).</p> <p>Select "NO" if there is no documentation indicating that the impairment originated prior to the individual reaching age 22.</p> <p style="text-align: center;">OR</p> <p>There is documentation that the impairment originated <i>after</i> the individual reached age 22.</p>
3. Severe Behavior Problem	<p>Select "Yes" or "No" in accordance with the following</p> <p>Select "YES" if the individual's record indicates that he/she exhibits severe behavior problems which make the individual a danger to himself/herself or others. If "YES" is indicated, complete the frequency</p>

	<p>indicator.</p> <p>Examples include but are not limited to:</p> <p style="padding-left: 40px;">A. Self-destructive behavior (e.g. attempted suicide) or other behaviors which actively threaten the life or safety of the individual.</p> <p style="padding-left: 40px;">B. Aggressive or assaultive behaviors that threaten the safety of other individuals and which could potentially result in criminal prosecution.</p> <p style="padding-left: 40px;">C. Severe property damage which could potentially result in criminal prosecution.</p> <p>NOTE: Before selecting "yes", incidents which occurred more than one year ago should be evaluated in terms of severity, likelihood of reoccurrence and from the perspective of the individual's overall functioning level.</p> <p>Select "NO" if the above does not apply.</p>
<p>4. Health Care Need</p>	<p>Select "YES" if any of the conditions listed below (A, B, or C) are evident from the individual's record or from observation of the individual.</p> <p style="padding-left: 40px;">A. Medical Condition: The individual requires daily individualized care by health care staff (staff trained in observing and monitoring health care needs) to address a medical condition.</p> <p style="padding-left: 40px;">B. Self-Injurious Behavior: The individual demonstrates self-injurious behavior(s) which results in or could result in a condition that requires attention by health care staff.</p> <p style="padding-left: 40px;">C. Health Related Skill Deficit The individual demonstrates a deficit in health care skills which are identified in a clinical evaluation. The results of the evaluation should indicate that the individual has deficits as described below:</p> <p style="padding-left: 80px;">1. The individual has no self-care skills (staff must provide total care in performing self-care tasks).</p> <p style="text-align: center;">OR</p> <p style="padding-left: 80px;">2. The individual has some self-care skills but needs assistance and/or training in carrying out self-care skills.</p> <p>Select "NO": if there is no evidence of a health care need.</p>

<p>5. Adaptive Behavior Deficit</p>	<p>Select "Yes" if any adaptive behavior deficits are indicated in areas A-E below. If A-E are all selected "No", select "No" for this question.</p> <p>A. <u>Communication</u></p> <p>Select "YES" if (1) or (2) is "YES."</p> <ol style="list-style-type: none"> 1. Select "YES" if the individual has extremely limited, or no, expressive or receptive communication skills. 2. Select "YES" if the individual has some expressive or receptive communication skills, but requires assistance and/or training to communicate self-care needs. <p>B. <u>Learning</u></p> <p>Select "YES" for this deficit area if (1), (2), (3), (4) or (5) is checked "YES".</p> <ol style="list-style-type: none"> 1. Select "YES" if I.Q. cannot be determined and there is a statement certifying that the individual is untestable from a qualified psychologist. <p style="text-align: center;">OR</p> <ol style="list-style-type: none"> 2. Select "YES" if the individual evidences an I.Q. of less than 50 on an individually administered standardized instrument assessing cognitive functioning which has been administered by a qualified practitioner and demonstrates no pre-academic skills, or if there is a statement certifying that the individual is untestable from a qualified psychologist. <p style="text-align: center;">OR</p> <ol style="list-style-type: none"> 3. Select "YES" if, for individuals over 21 years of age, their reading and computational skills are at the first grade level or below as documented by a standardized instrument. <p style="text-align: center;">OR</p> <ol style="list-style-type: none"> 4. Select "YES" if the individual evidences an I.Q. of 50-69 on an individually administered standardized test of intellectual functioning which has been administered by a qualified practitioner. <p style="text-align: center;">OR</p> <ol style="list-style-type: none"> 5. Select "YES" if, for individuals over 21 years of age, their reading and computational skills are at the third grade level or below as documented by a standardized instrument.
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C. Mobility

This refers to basic ambulation, with or without adaptive equipment.

Select "YES" for this deficit area if (1) or (2) is "YES."

D. Capacity for Independent Living

Select "YES" for this deficit area if (1) or (2) is "YES"

1. Select "YES" if the individual is completely dependent on others for all household activities.

2. Select "YES" if the individual needs assistance and/or training to perform tasks that would enable him or her to be a participating member of a household (e.g. using the telephone, using cooking appliances and utensils, using laundry equipment).

E. Self Direction

Select "YES" for this deficit area if (1), (2), (3) or (4) is "YES."

1. Select "YES" if the individual demonstrates a lack of internal control and direction in his or her interpersonal or individual behavior as evidenced by weekly or more frequent exhibition of the following inappropriate or challenging behaviors requiring individualized programming:

- a) Actively resists supervision
- b) Temper tantrums
- c) Verbally abusive to others
- d) Wandering, roaming or running away
- e) Inappropriately handles/plays with bodily wastes
- f) Eats non-food substances
- g) Ritualistic or perseverative behaviors which interfere with social relationships
- h) Other behavior inappropriate to social situations

2. Select "YES" if the individual is completely dependent on others for management of his or her personal affairs within the general community.

3. Select "YES" if the individual demonstrates a lack of internal control and direction in his or her interpersonal or individual behavior as evidenced by monthly or more frequent exhibition of any of the inappropriate or challenging behaviors requiring individualized programming (see a-h listed in question (1) of this section).

	4. Select "YES" if the individual needs assistance or training for management of his or her personal affairs within the general community.
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Authorizations and Signatures for Initial ICF/MR Level of Care (page 2 of LCED form)

<u>Form Fields</u>	<u>Instructions</u>
Signature of the Qualified Person Completing the Form And Review Date	<p>The HCI , QMRP, or other authorized person who completes the initial ICF/MR Level of Care Eligibility Determination Form signs. The review date is the date of the reviewer’s signature.</p> <p>If the form is being completed for redetermination purposes, the qualified person must be the QMRP, Physician, <u>or</u> a physician’s assistant or nurse practitioner (if so authorized by a physician).</p>
This section to be completed by the DDSO for initial LCED determinations only	
Signature of Review Physician And Review Date	<p>Review by a physician is required for initial eligibility determination. The physician who reviews selects whether the criteria for ICF/MR level of care has been met, signs the form, and inserts the date of the review (i.e. signature date).</p> <p>The initial LCED information that is reviewed by the physician must include the relevant pre-admission evaluations: physical (medical), social, and psychological.</p>
Has the OPWDD process for DD Eligibility been completed by the DDSO?	<p>This line is used for the initial LCED determination only.</p> <p>Select “YES” if there is evidence that the DDSO has determined DD eligibility in accordance with the OPWDD eligibility guidelines, and that the findings substantiate DD eligibility.</p> <p>If “NO” is selected, the LCED cannot be approved and waiver eligibility must be declined until appropriate documentation is available.</p>
ICF/MR Level of Care Approved Effective (mm/dd/yy): _____	<p>For initial determinations, the DDSO Director (or designee) should write the date of approval for ICF/MR Level of Care on this line. This form is effective for one year from the date on this line; redeterminations must be completed within 365 days from the approved effective date. Only the DDSO Director (or designee) should fill in this line. The effective date of the LCED can be as early as the same day the physician signs the form, however,</p>

	<p>the effective date cannot precede the review date by the physician.</p> <p>If the initial level of care indicates that the individual may not meet the ICF/MR level of care, the reviewer must refer the individual to the DDSO for further review and action. This action may include a Second Step Review or a Notice of Determination (NOD) notifying the individual that he or she is not eligible for B2H Waiver services because he or she does not meet the ICF/MR level of care eligibility criteria required for participation in the B2H waiver.</p> <p>For redetermination purposes, if a new form is completed, the QMRP or other qualified reviewer completes numbers 1-5 on the first page (Eligibility Determination Criteria), completes identifying information on the top of the second page, and signs and dates on the first line under "Annual Level of Care Redetermination" on the second page. This date is the effective date of the LCED.</p>
ICF/MR Level of Care not recommended	Select if the individual does not meet the criteria for ICF/MR Level of Care.
Date of Waiver Enrollment (mm/dd/yy)	The HCIA inserts the enrollment date once the Notice of Decision is received from the LDSS.
Signature of DDSO Director (or Designee) and Date:	<p>For the initial determination, the DDSO Director or his/her designee must indicate whether the level of care is approved or not approved and must sign and date the form (include month, day, and year). If the initial determination is approved, the effective date is written in the "ICF/MR Level of Care Approved Effective" box above the signature box. It is acceptable for the effective date of the LCED to precede the date of the DDSO Director/designee's signature, but not the date of the physician's signature.</p> <p>Note that the initial LCED is only valid for 365 days from the effective date (in the field "ICF/MR Level of Care Approved Effective (mm/dd/yy): _____").</p>

Annual Level of Care Eligibility Redetermination (i.e., Reevaluation) for B2H Waiver Enrolled Individuals

The "Annual Level of Care Eligibility Redetermination" section of the form can be used instead of completing an entirely new "ICF/MR Level of Care Eligibility Determination

Form” for individuals who have not experienced any changes to their abilities which would result in a change in the required level of care for their continued participation in the B2H waiver. *This section of the form replaces the OCFS 8005B.*

After reviewing the information on the first page of the ICF/MR Level of Care Eligibility Determination Form, the “Annual Level of Care Eligibility Redetermination” section on page two of the form should be signed and dated by a qualified person (i.e. the QMRP who is familiar with the person, a physician, or a physician’s assistant or nurse practitioner (if so authorized by a physician), within 365 days of the previous LCED effective date (generally, that is the previous signature date). The person signing the form should also include his or her title. See Appendix T of the B2H Program Manual for further information on the QMRP.

As long as there are no changes that impact the individual’s eligibility for ICF/MR level of care, the same LCED Form can be used every 365 days to complete the annual LCED redetermination until the qualified reviewer chooses to complete a new LCED Form for the Redetermination. The reviewer can also attach additional pages to the LCED when signature lines run out as long as the certification language is present.

If a new form is completed for Redetermination the reviewer is required to complete numbers 1-5 (Eligibility Determination Criteria) on the first page, fill out the identifying information on the second page, and sign and date on the first line under Annual Level of Care Eligibility Redeterminations on the second page. This date would be the effective date of the LCED Redetermination.

Additional signature lines are available if a provider prefers to have optional review by another person, such as a supervisor, advocate, or a physician.

There should be no break in the history of the documentation of Level of Care Eligibility; the redetermination should be completed within 365 days from the previous determination as triggered by the date of signature of the qualified person completing/signing the LCED redetermination.

Document Retention:

The initial LCED and a copy of the pre-enrollment evaluations must be permanently retained by the DDSO where they can be retrieved in the event of an audit.

The annual LCED form must be retained in the individual’s Case Record for a period of six years from the date the case coordination service was delivered, or when the service was billed, whichever is later (i.e., there will generally be at least the six most recent LCED forms in a person’s record).

Appendix L: Clarification of Provisions of the August 2001 Eligibility Advisory dated 12/13/02

George E. Pataki
Governor



Thomas A. Maul
Commissioner

STATE OF NEW YORK
OFFICE OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES

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MEMORANDUM

TO: DDSO Directors
Central Office Leadership Team

FROM: Helene DeSanto

RE: Clarification of Provisions of the August 2001 Eligibility Advisory

DATE: December 13, 2002

OMRDD has received a number of requests from consumers, advocates, and providers to provide clarification regarding the Eligibility Guidelines that were distributed in August 2001. This memo provides clarification of operational aspects of the Guidelines.

Thank you in advance for your attention to this and the ongoing work of you and your staff related to eligibility determination.

This memo discusses concerns with respect to:

- Consistency in DDSO Implementation
- Central Office Role
- Notifications in the Course of Determinations
- Required and Discretionary Documentation
- Assuring Timely Determinations
- Further Clarification of Related Conditions

Consistency in DDSO Implementation of Eligibility Reviews

- DDSO directors remain responsible for the final determination of general eligibility.
- The three-step process has been restructured. In Step One an intake worker and intake coordinator; and if further review is needed, a licensed psychologist, and other staff are involved; in Step Two the DDSO director and a second licensed psychologist are involved, at a minimum. A third step will now be provided by NYCRO and the Upstate Regional Office. Step Two reviews will be completed by the DDSO for all negative determinations at Step One.

Appendix L: Clarification of Provisions of the August 2001 Eligibility Advisory dated 12/13/02

- Consumers and their advocates must be afforded the opportunity to request a third level review of a negative determination outcome at the second level.

Regional and Central Office Role in Eligibility Determination

- NYCRO and URO eligibility determination committees will be established. These committees will provide an additional level of review, following determination of ineligibility at the second step of the DDSO process. Referrals for review by these committees may be requested by a consumer, advocate, or referring voluntary agency and must be forwarded by the DDSO.

Notifications in the Course of Eligibility Determinations

- When a referral is made and documentation is incomplete, the DDSO is responsible for informing the referring party of any additional information that is required with respect to types of assessments or specialty assessments needed and why they are needed.
- When a negative determination is made, the DDSO is responsible for informing the referring party of the three-step process, and availability of the third level review following completion of the local process. When a negative determination is made the DDSO is responsible for providing the referring party with a list of the materials or reports that were reviewed in order to make the determination, and the reasons for denial based on criteria in MHL(1.03)(22).
- If application is made for a Medicaid service, as one aspect of a general application for eligibility determination, then a Notice of Decision must be issued, and processes available to applicants will include all aspects of the Medicaid fair hearing and due process.

Required Documentation and Discretionary Documentation

- The eligibility advisory lists adaptive behavior measures that are acceptable based upon their properties. This memo removes the AAMR Adaptive Behavior Scales - Residential and Community 2, adult scales from this list. People already determined to be eligible, using this scale, should not be redetermined.
- Each manual for each adaptive behavior scale contains required criteria for personnel who may complete the scale, conduct interviews to collect the necessary information, and score the scale. DDSOs should accept adaptive behavior scales administered only in the manner, and only by qualified interviewers or raters, required by the criteria stated for those scales in the respective manual. A DDSO psychologist should be involved in review of this information at the second step review to confirm that these criteria have been met and measures have been completed properly.
- Some DDSOs have advised consumers that use of one or another specific adaptive behavior scale is required to document substantial handicap. The intent of the eligibility advisory is to permit use of any of the listed adaptive behavior scales for determination purposes. Adaptive behavior scales should be completed in a manner that accurately reflects typical behavior, as specified in the respective manuals, rather than optimal skills under optimal circumstances.
- Some DDSOs have been very comprehensive in their requirements for referral materials. It is reasonable to request a social history or documentation of onset, an intellectual and adaptive behavior assessment, and available medical reports for review at the first step. DDSO staff should request other materials from the referring party only if more information is required.
- A notification summary is attached, titled "Important Facts: Eligibility for OMRDD Services." When consumers or advocates request a determination, a copy of this summary should be provided to them, together with any additional information the DDSO wishes to provide.

Appendix L: Clarification of Provisions of the August 2001 Eligibility Advisory dated 12/13/02

Assuring that Determinations are Made in a Timely Manner

The following operational guidelines should be followed by DDSOs:

- **Step One Determination:** Once a complete referral documentation packet is received, the DDSO should make a decision within 30 days. If found eligible, the DDSO should notify the referring party. If not found eligible at Step One, a referral must be made to Step Two.
- **Step Two Determination:** If needed, those involved in the Step Two review can ask for additional documentation. Once a complete referral packet (including any newly requested information) is received, the DDSO should make a decision within 14 days. If found eligible, the DDSO should notify the referring party. If found ineligible, the DDSO must provide the referring party with a list of materials or reports that were reviewed and the reasons for denial. In addition, if found ineligible, the availability of a third step review must be made known to referring party.
- **Step Three Determination:** Upon the receipt of complete referral documentation from the DDSO, the NYCRO or URO review committee will have 30 days to determine eligibility and notify the DDSO of its finding. The DDSO will then have 10 days to notify the referring party.

Further Clarification of Related or Similar Conditions

- Related conditions include presence of neurological impairment or degeneration as a result of a disease or disorder, such as muscular dystrophy (MD), which has pathologic vectors affecting the integrity of both musculature and the central nervous system, should be included as an eligible type of condition, even though MD may be manifested primarily in the form of impaired motor function.
- OMRDD has examined the relationship between this definition of "similar conditions" and the consequences of central nervous system disorders with respect to effects upon individual intellectual or adaptive functioning and resulting service needs, and has concluded that the present requirement of central nervous system disorder is an appropriate and reasonable approach for defining similar conditions.

Appendix M: Eligibility for OMRDD Services—Important Facts dated June 2006

Page 1 of 2

ELIGIBILITY FOR OMRDD SERVICES

Important Facts

June 2006

OMRDD, through its local Developmental Disabilities Services Offices (DDSO), determines whether a person has a developmental disability and is eligible for OMRDD funded services. This fact sheet describes the Three-Step process and the type of information OMRDD needs to make an eligibility determination of developmental disability.

NOTE: A determination of developmental disability does not mean the person is eligible for all OMRDD funded services. Some OMRDD funded services have additional eligibility criteria. For example, ICFs and HCBS waiver programs include an additional level of care determination, and individuals are eligible for HCBS services only when they reside in appropriate living arrangements. These and other additional criteria for eligibility of specific OMRDD services are not reviewed through this process.

ELIGIBILITY DETERMINATION PROCESS

Eligibility Request

An OMRDD Transmittal Form must accompany all requests submitted to the DDSO for eligibility determinations. The Transmittal Form includes the name of the person, the name of the person's representative, and relevant contact information. Documentation of the person's developmental disability, as described on page 2 of this fact sheet, must also be included as part of the eligibility request.

1st Step Review

DDSO staff review the eligibility request for completeness and share the information with other staff designated by the Director, as necessary. After this review, the DDSO notifies the person in writing that:

- (a) Eligibility or provisional eligibility has been determined; or
- (b) The request is incomplete and requires additional documentation; or
- (c) The request has been forwarded for a 2nd Step Review.

2nd Step Review

DDSO clinicians designated by the DDSO Director conduct a 2nd Step Review of the eligibility request forwarded by the 1st Step Review, along with any additional documentation provided by the person. If these clinicians require additional medical information, psychological test results, or historical documentation, the person is notified in writing of the type of information needed and the date by which it must be submitted to the DDSO.

Following the 2nd Step Review, the DDSO provides the person with written notification of its determination. If the person is found ineligible for OMRDD services because he or she does not have a developmental disability, the letter shall offer the person and his or her representative the opportunity to:

- (a) Meet with DDSO staff to discuss the determination and documentation reviewed; and
- (b) Request a 3rd Step Review; and
- (c) Request a Medicaid Fair Hearing in cases where Medicaid funded services are sought.

Note that a Notice of Decision informing the person of his or her right to request a Medicaid fair hearing is sent only when the Transmittal Form indicates that the person is interested in receiving Medicaid funded OMRDD services if determined eligible. If the person has not indicated Medicaid funded services, no fair hearing is offered and the decision of the DDSO is final.

The person may choose one, two or all three of the above options. If a fair hearing is requested, a 3rd Step Review will automatically be conducted.

3rd Step Review

Eligibility Determination Committees located in the New York City Regional Office (for New York City residents) or at the Upstate Regional Office in Albany (for all other New York residents) conduct the 3rd Step Reviews. Committee members include licensed practitioners who are not directly involved in the determinations made at the 1st and 2nd Step Reviews. The Committees review the submitted eligibility request and any additional documentation provided by or on behalf of the person. The Committee forwards its recommendations to the DDSO 2nd Step Review coordinator. The DDSO Director or designated staff person considers the 3rd Step recommendations and informs the person of any change in the DDSO's determination. 3rd Step reviews will be made prior to any fair hearing date.

Appendix M: Eligibility for OMRDD Services—Important Facts dated June 2006

Page 2 of 2

REQUIRED AND ADDITIONAL DOCUMENTS NEEDED

The DDSO will need the following information, in most cases, to determine whether someone is eligible for OMRDD services. Clarification to the current fact sheet (dated 9/02) is made in **bold**.

A **medical** or specialty report (for example, a neurological report) **health status and diagnostic findings to support a qualifying diagnosis other than mental retardation; For persons qualifying with mental retardation only, a recent general medical report, if available**

A psychological report which includes assessment of intellectual functioning with reporting of intelligence scores (**including subscale, part, and full scale scores**), and, for people with IQs above 60, **standardized** assessment of adaptive behavior with reporting of scale and summary scores (**for people with IQ's below 60, assessment may be based on qualitative review via interview with care-providers, review of records, and direct observations**)

A social history, psychosocial report, or other background report that shows that the person became disabled before age 22 years (background information is still needed if the person is a child or adolescent)

In some cases, the DDSO will not be able to decide whether someone is eligible based on the reports that are provided. In those cases, the DDSO may request further information or different reports, and will either recommend where these tests can be done, or arrange for them to be done.

Acceptable Measures of Intellectual and Adaptive Behavior

Any of the following measures of intellectual functioning are accepted:*

Kaufman Assessment Battery for Children

Leiter International Performance Scale

The Stanford-Binet Scales

The Wechsler series of Intelligence Scales

Other intelligence tests are acceptable if they are comprehensive, structured, standardized, and have up-to date general population norms

-- Brief or partial administration of comprehensive intellectual measures may be utilized only in circumstances where standardized administration is impossible

-- **Abbreviated measures of intelligence (e.g., WASI or KBIT) alone are not acceptable**

-- **Language-free instruments (e.g., the Leiter or CTONI), in combination with the performance items of a comprehensive IQ test, will be considered for individuals who are non-English speaking, deaf or nonverbal**

-- **Intellectual measures standardized in English that have been administered by translation into another language are not acceptable for eligibility determinations**

Any of the following measures of adaptive behavior are accepted:*

AAMR Adaptive Behavior Scale, School Version **only** (for use with children)

Adaptive Behavior Assessment System

Comprehensive Test of Adaptive Behavior

Scales of Independent Behavior

Vineland Adaptive Behavior Scales

Other adaptive behavior measures are acceptable if they are comprehensive, structured, standardized, and have up-to-date general population norms

Adaptive behavior measures should be completed to reflect the person's typical behavior, not their best behavior under best circumstances.

Adaptive behavior measures should be completed and scored by professionals trained in their use, according to professional standards established for each scale in its respective manual.

**Updated or current evaluations of intellectual functioning and adaptive behavior must be based upon the most recent version of the particular instrument used.*

Appendix N: OMRDD Transmittal for Determination of Developmental Disability

Page 1 of 2

NYS Office of Mental Retardation and Developmental Disabilities

Form # ELL-01 (7/2006)

Transmittal for Determination of Developmental Disability

Verification of an individual's qualifying developmental disability is required for determination of eligibility for OMRDD services. Complete this form and submit it to your local DDSO. (See Instructions on page 2).

Documentation demonstrating a disability prior to age 22 must be attached.

Contact your local DDSO if you have questions or require assistance in filling out this form.

Please Type or Print Legibly. An * indicates required information.

***Section 1. Individual's Information**

*Name:		TABS ID (if known):		*SS#:	
*Date of Birth: / /	Medicaid #:	*County of Residence:		*Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
*Home Address:			Mailing Address (if different):		
*City:	*State:	*Zip:	City:	State:	Zip:
*Phone: ()			*Also Known As :		

*Send information to (Check as many as desired):

1. Self -Home 2. Self - Mailing Address
3. Parent/Advocate 1 (Complete Section 2 – P/A1 Name & Address) **Note:** Do not check 3 or 4 if the Advocate is the Agency listed in Section 3.
4. Parent/Advocate 2 (Complete Section 2 – P/A2 Name & Address)

Section 2: Involved Parents or Advocates - Use address where mail is received. Optional unless 3 or 4 is checked above.

P/A1 Name:			P/A2 Name:		
Address:			Address:		
City:	State:	Zip:	City:	State:	Zip:
Phone: ()		Country:	Phone: ()		Country:

Section 3: Referring Agency Information (if applicable) - Automatically receives information if completed.

Agency Name:			
Agency Code (if known):		Street Address:	
Agency Contact:			
Phone: ()		City:	State: Zip:

***Section 4: Check the services you are interested in receiving if determined eligible**

1. Developmental Disability Determination only – No services requested at this time.

2. Individualized Support Services (ISS) 3. Respite Center 4. Residential Habilitation – IRA

5. Residential Habilitation – At Home 6. Intermediate Care Facility (ICF) 7. Day Habilitation

8. Day Treatment 9. Pre-Vocational services 10. Supported Work (SEMP) 11. Care at Home

12. FET – Family Education & Training 13. CSS – Consolidated Supports & Services

14. Case Management, e.g. MSC 15. Env. Modifications/Adap. Devices 16. Art. 16 Clinic

Family Support Services: 17. Respite 18. Other Family Supports

19. Other (Specify): _____

*Completed By (Name): _____ *Date: _____

Print Legibly

*Form Completed by: 1. Self 2. Parent/Advocate 3. Agency

Following to be completed by DDSO Staff Only:

Date Received by DDSO: / /		Intake Staff Name:	
Individual's TABS ID #:	Date entered in TABS: / /	By (initials):	

Appendix N: OMRDD Transmittal for Determination of Developmental Disability

Page 1 of 2

NYS Office of Mental Retardation and Developmental Disabilities

Form # ELL-01 (7/2006)

Transmittal for Determination of Developmental Disability

Verification of an individual's qualifying developmental disability is required for determination of eligibility for OMRDD services. Complete this form and submit it to your local DDSO. (See Instructions on page 2).

Documentation demonstrating a disability prior to age 22 must be attached.

Contact your local DDSO if you have questions or require assistance in filling out this form.

Please Type or Print Legibly. An * indicates required information.

***Section 1. Individual's Information**

*Name:		TABS ID (if known):	*SS#:		
*Date of Birth: / /	Medicaid #:	*County of Residence:	*Sex: <input type="checkbox"/> M <input type="checkbox"/> F		
*Home Address:		Mailing Address (if different):			
*City:	*State:	*Zip:	City:	State:	Zip:
*Phone: ()		*Also Known As :			

*Send information to (Check as many as desired):

1. Self -Home 2. Self - Mailing Address
 3. Parent/Advocate 1 (Complete Section 2 – P/A1 Name & Address) **Note:** Do not check 3 or 4 if the Advocate is the Agency listed in Section 3.
 4. Parent/Advocate 2 (Complete Section 2 – P/A2 Name & Address)

Section 2: Involved Parents or Advocates - Use address where mail is received. Optional unless 3 or 4 is checked above.

P/A1 Name:			P/A2 Name:		
Address:			Address:		
City:	State:	Zip:	City:	State:	Zip:
Phone: ()	Country:		Phone: ()	Country:	

Section 3: Referring Agency Information (if applicable) - Automatically receives information if completed.

Agency Name:			
Agency Code (if known):		Street Address:	
Agency Contact:			
Phone: ()	City:	State:	Zip:

***Section 4: Check the services you are interested in receiving if determined eligible**

<input type="checkbox"/> 1. Developmental Disability Determination only – No services requested at this time. <input type="checkbox"/> 2. Individualized Support Services (ISS) <input type="checkbox"/> 3. Respite Center <input type="checkbox"/> 4. Residential Habilitation – IRA <input type="checkbox"/> 5. Residential Habilitation – At Home <input type="checkbox"/> 6. Intermediate Care Facility (ICF) <input type="checkbox"/> 7. Day Habilitation <input type="checkbox"/> 8. Day Treatment <input type="checkbox"/> 9. Pre-Vocational services <input type="checkbox"/> 10. Supported Work (SEMP) <input type="checkbox"/> 11. Care at Home <input type="checkbox"/> 12. FET – Family Education & Training <input type="checkbox"/> 13. CSS – Consolidated Supports & Services <input type="checkbox"/> 14. Case Management, e.g. MSC <input type="checkbox"/> 15. Env. Modifications/Adap. Devices <input type="checkbox"/> 16. Art. 16 Clinic <u>Family Support Services:</u> <input type="checkbox"/> 17. Respite <input type="checkbox"/> 18. Other Family Supports <input type="checkbox"/> 19. Other (Specify): _____	
--	--

*Completed By (Name): _____ *Date: _____

Print Legibly

*Form Completed by: 1. Self 2. Parent/Advocate 3. Agency

Following to be completed by DDSO Staff Only:

Date Received by DDSO: / /		Intake Staff Name:	
Individual's TABS ID #:	Date entered in TABS: / /	By (initials):	

Appendix O: Interaction of the B2H Waiver Program and Child Welfare Training Outline

INTERACTION OF THE B2H WAIVER PROGRAM AND CHILD WELFARE: AN OUTLINE OF KEY POINTS

The following are the basic content components for the Interaction of B2H and Child Welfare Training curriculum.

I. THE CHILD WELFARE SYSTEM IS COMPOSED OF A NUMBER OF AREAS WHICH NCLUDE:

- A. Prevention;
- B. Child Protection;
- C. Foster Care;
- D. Adoption

II. KEY CHARGES OF THE CHILD WELFARE SYSTEM INCLUDE:

- A. Safety, Health and Well-being: Title IV-E of the Social Security Act, as amended by the federal Adoption and Safe Families Act of 1997, reflects five key principles that are also reflected in New York State standards: 1) Safety of children is the paramount concern that must guide all child welfare services; 2) Foster care is a temporary setting and not a place for children to grow up; 3) Permanency planning efforts for children should begin as soon as a child enters foster care and should be expedited by the provision of services to families; 4) The child welfare system must focus on results and accountability; 5) Innovative approaches are needed to achieve the goals of safety, permanency and well-being.
- B. State Supervised/Locally Administered: Generally NYS has a state supervised, locally administered child welfare system. The State Office of Children and Family Services (OCFS) sets the policy, promulgates regulations and provides oversight and monitoring, while the local Departments of Social Services (LDSSs) provide most of the oversight the actual service delivery.
- C. Division of Juvenile Justice and Opportunities for Youth: OCFS has direct responsibilities for the juvenile justice population through the Division of Juvenile Justice and Opportunities for Youth (DJJOY) and operates public facilities for this juvenile justice population.
- D. For each child in need of a permanent family, an adoptive family shall be sought in which he/she may have the opportunity for growth and development through loving care, parental guidance and the security of a permanent home, (per 18 NYCRR 421.2). Adoption or other permanency options are pursued in cases where the parent is unable or unwilling to provide a safe and permanent home for the child; the parent surrenders the child for adoption or the court directs efforts to terminate parental rights and place the child. The ASFA requirements for Termination of Parental Rights must be met as well.
- E. Child Protective Services/Licensure: Local districts (LDSSs), via the Child Protective Services units, are also responsible for conducting child protective investigations. LDSS are also responsible for certifying foster boarding homes; approving kinship or relative family foster care homes and approving adoptive homes.
- F. Preventive Services: The child welfare system is responsible to provide preventive services, which are defined at Social Services Law Section 409 as supportive and rehabilitative services provided to children and their families for the purpose of:
 - averting an impairment or disruption of a family which will or could result in the placement of a child in foster care;
 - enabling a child who has been placed in foster care to return to his family at an earlier time than would otherwise be possible; **or**

Appendix O: Interaction of the B2H Waiver Program and Child Welfare Training Outline

- reducing the likelihood that a child who has been discharged from foster care would return to such care.

G. Voluntary Agencies: These agencies provide foster care, adoption services and preventive services under a contract with one or more local Departments of Social Services.

The voluntary agencies may certify or approve foster homes and approve adoptive homes if they have such programs or they may operate congregate care facilities, such as institutions, group homes, group residences, agency operated boarding homes and supervised independent living programs.

Except for voluntary agencies participating in the Improved Outcomes for Children (IOC) initiative in New York City, if a child is placed in a voluntary authorized agency, a worker from LDSS is the case manager and the voluntary authorized agency worker is the case planner.

The IOC initiative in New York City shifts case management responsibilities from ACS to the voluntary agencies. B2H providers in New York City should understand how IOC interfaces with the B2H Waiver Program.

H. Case Managers and Case Planners:

A Case manager is an employee of the social services district with responsibility to authorize the provision of services; to approve the client eligibility determination and to approve the family assessments and service plans.

A Case planner is the caseworker on staff of an authorized child care agency or LDSS with the primary responsibility for providing or coordinating and evaluating the provision of child welfare services to the family. Case planning includes referring the child and his or her family to providers of services, as needed, and delineating the roles of the various service providers. The case planner must collaborate with all caseworkers assigned to the case so that a single family assessment and service plan is developed for a child. This collaboration also includes working with the HCI.

III. KEY ELEMENTS OF THE BRIDGES TO HEALTH (B2H) WAIVER:

The B2H Waiver Program: provides services for children who, at the time of enrollment, are placed in foster care and post foster care. Children in care experience higher rates of physical and emotional problems than those in the general population. Trainings should address these issues and help service providers understand how B2H Waiver services can support child welfare mandates, including service planning and permanency planning. Training should cover the following general points:

- How B2H supports permanency planning and related goals
- How B2H Team Meetings and Service Plan Reviews relate to one another
- Look at how B2H is supplemental to foster care and adoption services and review the ways that B2H supports the work being done in foster care and post adoption

More specific points to be covered include:

A. Role of the LDSS case manager: authorizes provider child welfare services, determines eligibility, and reviews and monitors the Family Assessment and Service Plan (FASP). Trainings should also address the relationship to the voluntary agency case planner including:

- Explanation of the roles of the case manager at the LDSS (or ACS in NYC), the case planner, DJJOY Community Services Team (CST) Case Manager
- Reinforcement that the LDSS staff have final approval of program eligibility as well as Individualized Health Plans (IHP), including any changes to IHPs

Appendix O: Interaction of the B2H Waiver Program and Child Welfare Training Outline

- Explanation that the LDSS case manager may become the child's medical consentor in certain circumstances, which will vary by practice and policies for each LDSS throughout NYS.

B. Role of foster/adoptive parents or staff of foster care congregate facilities: caregivers receive training by LDSS and voluntary authorized child care agencies. Trainings should address the important role of these caregivers and encourage their active involvement and cooperation so that the B2H Waiver services benefit the child.

- Reinforcement of the importance that providers must understand that foster/adoptive parents can become overwhelmed by staff entering their homes to work with the foster/adopted children in the B2H Program, so it is important that WSPs promote and encourage positive relationships with foster/adoptive parents
- Emphasis that WSPs should be respectful towards the foster/adoptive parents and families regarding their homes, lives, and their time
- Encouragement of the WSPs to partner with foster/adoptive parents as they work collectively to assist and support the child

C. Role of the Health Care Integrator (HCI): assess, educate, coordinate, consult, stabilize, advocate, and provide linkages to services. The HCI is the staff person who provides health care integration services for the child enrolled in the B2H Waiver Program and, as such, is the primary architect of the child's plan. Trainings should address roles and responsibilities of various individuals and entities. (B2H Program Manual, page 14-1).

- Reinforcement that the HCI is the liaison between the enrolled child, LDSS and service providers

IV. RESPONSIBILITIES OF THE HEALTH CARE INTEGRATOR:

Once a child has been referred to an HCIA by the LDSS for assessment and completion of an Application for Enrollment Packet, the HCI directs the preparation of the packet. This process must begin by meeting with the child/medical consentor, and other caregivers to discuss the B2H Waiver Program, philosophy, and services available. Information gathering is both a formal and informal process, and should be done with the goal of obtaining the fullest and clearest picture of the child and the child's life. Case planners and case managers should be included in information gathering. (B2H Program Manual, page 6-4).

A. Team Meetings and Required Contacts:

- Within 30 days of enrollment, the HCI must hold a team meeting to discuss and document any changes that may have occurred since preparation of the Preliminary IHP and complete the Initial IHP.
- The purpose of a team meeting is to allow collaboration and planning among service providers, the medical consentor, and the child regarding the child's current needs and to support the health, welfare and permanency of the child. The LDSS case manager, other representatives of the case planner's agency representatives, and anyone the child/medical consentor chooses may be involved. The LDSS remains responsible for coordinating the B2H Waiver Program with foster care services, and child welfare services in general, and works with the HCI to coordinate the FASP schedule and the IHP. (B2H Program Manual, page 4-13)
- The HCI must schedule and meet with the child at least two times a month in meetings of at least 45 minutes in duration to determine that the services are meeting the child's needs and that the child/medical consentor are satisfied with the services being provided. At least one of these meetings must be in the child's primary residence. It is suggested that the child's caregiver be present at these meetings. These meetings may occur more frequently, if needed, throughout the child's enrollment in the B2H Waiver Program. In addition, while the child is in foster care, the HCI must have at least two contacts per month with the child's case planner to determine if there have been any changes in the child's life that would require revisions to the IHP and/or the FASP. (B2H Program Manual page 6-7)

Appendix O: Interaction of the B2H Waiver Program and Child Welfare Training Outline

- The following chart details the participants for Team Meetings and attendance requirements.

Must attend	Must be invited and expected to attend	May be invited and may attend
<ul style="list-style-type: none"> Health Care Integrator Medical Consenter Informed Waiver Service Provider (WSP) <p>representative(s) for each service the child receives – must attend the first meeting (within 30 days of enrollment) and at least every 6 months thereafter.</p>	<ul style="list-style-type: none"> a representative from the LDSS or DJJOY a representative from the HCIA beyond the HCI a representative from the voluntary case planning agency if the child is in foster care family members and caregivers a representative from the Office of Mental Retardation and Developmental Disabilities/ Developmental Disabilities Service Office (DDSO) (on a case specific basis) the OCFS QMS (on a case specific basis) 	<ul style="list-style-type: none"> the child anyone the child or medical consenter wishes to have participate

B. The Individualized Health Plan:

- It is the responsibility of the HCIA to verify that the HCI has completed the IHP as stipulated in Chapter 9 of the B2H Program Manual, The Individualized Health Plan. The HCIA must also verify that B2H Waiver services can appropriately support the child’s health and welfare. The HCI must gather necessary data, either from records or interviews, and record information in person-centered language and in a way that gives proper voice to the child’s valued outcomes and goals. This includes seeking information and input from the case planner and case manager. (B2H Program Manual, page 5-4) Prior to submission of any IHP to the LDSS, there should be ongoing communication between the HCI and the LDSS regarding the B2H Waiver Services and the contents of the IHP. (B2H Program Manual, page 4-10)

C. Documentation:

- Progress Notes (OCFS-8019) are the documentation that captures all contacts, including Team Meetings, beyond the Service Summary that the HCIs or WSPs have on behalf of or with the child, and/or family/caregiver. Progress Notes concisely summarize all relevant information about the case, updating any interactions with the child and family/caregiver, and are completed whether or not the information is needed to support billing; Progress Notes are submitted every month, or more frequently as needed, to the HCI for review. Copies of Progress Notes are maintained in the B2H case record.

Note: The HCI(s), as having an assigned role in CONNECTIONS, has to document significant information relevant to the case planner/case manager via CONNECTIONS Progress Notes (B2H Program Manual, page 6-8).

**Appendix P: Agreement to Accept Services Form
Bridges to Health
Agreement to Accept Services**

CHILD'S NAME (LAST, FIRST, M.I.)		DATE OF BIRTH (MM/DD/YYYY)
SEX: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	CHILD'S CIN #	WAIVER TYPE : <input type="checkbox"/> SED <input type="checkbox"/> MEDF <input type="checkbox"/> DD

INSTRUCTIONS: This form may be used to inform the foster parent/group home staff/caregiver of their role(s) and responsibilities relevant to B2H and should be signed and witnessed.

The Bridges to Health (B2H) Home and Community-Based Medicaid Waiver Program is designed to provide children in foster care who have qualifying diagnoses of Serious Emotional Disturbance (SED), Developmental Disability (DD), or Medical Fragility (MedF), with necessary services that will enable them to reside in the community. In this program children are served in the least restrictive, most home-like setting possible.

The involvement of the foster parent/group home staff/caregiver in B2H remains crucial throughout enrollment in the B2H Waiver Program. Foster parents/group home staff/caregivers are strongly encouraged to participate with the medical consentor, whenever possible, to express their preferences and program goals over the span of the child's enrollment in the B2H Waiver Program. It is recognized that there may be instances when participation is not possible. However, their active involvement and cooperation is critical to maximizing the B2H Waiver Program benefits for the child.

Role and Responsibilities

- ◆ Participate in initial meeting with child, medical consentor, and Local Department of Social Services (LDSS) or Division of Juvenile Justice and Opportunities for Youth (DJJOY) staff.
- ◆ Support necessary services for the child, including allowing B2H service providers access to the residence for provision of all home-based services, and providing transportation to or facilitating the child's attendance at appointments for community-based services. Participate in and allow any other persons or children residing in the home who are involved with the B2H child to participate in B2H services, as appropriate, which may include:

*Health Care Integration	*Family/Caregiver Supports	*Skill Building
*Day Habilitation	*Prevocational Services	*Special Needs Community Advocacy
*Supported Employment	*Planned and Crisis Respite	*Crisis Avoidance, Management and Training
*Immediate Crisis Response	*Intensive In-home Supports	*Adaptive and Assistive equipment
*Accessibility Modifications		
- ◆ Actively participate in Individualized Health Plan (IHP) reviews and team meetings.
- ◆ Promptly notify the Health Care Integration Agency (HCIA) if the child is hospitalized, detained, incarcerated, returned to a DJJOY or other residential facility or absent without consent (AWOC).
- ◆ Promptly notify the HCIA if there are any problems or concerns with service provision or with a Waiver Service Provider (WSP), such as the child not receiving the services specified in the IHP.

I have read the above list of responsibilities and understand what is requested of me. I agree to fulfill these responsibilities. I understand that there may be instances in which I am asked to undertake additional roles and/or responsibilities with respect to the B2H program. Furthermore, if I am unable to fulfill any of these responsibilities, or if I have any questions regarding my role, I will promptly notify the Health Care Integrator (HCI) and LDSS/DJJOY worker. I understand that my roles and responsibilities as a foster parent/group home staff/caregiver for a child enrolled in the B2H program will not affect my rate of reimbursement or pay.

SIGNATURE OF FOSTER PARENT//GROUP HOME STAFF /CAREGIVER	DATE
PRINTED NAME / RELATIONSHIP TO CHILD	FOSTER PARENT/ GROUP HOME STAFF /CAREGIVER PHONE NUMBER
WITNESS NAME	DATE

Appendix Q: OCFS Letter for Claiming Instructions



New York State
Office of
Children & Family
Services

www.ocfs.state.ny.us

David A. Paterson
Governor
Gladys Carrión, Esq.
Commissioner

Capital View Office Park
52 Washington Street
Rensselaer, NY 12144



An Equal Opportunity Employer

April 21, 2008

Dear Commissioner:

The purpose of this letter is to provide the claiming instructions for the program and the administrative costs related to the Bridges to Health (B2H) Medicaid Waiver.

Claiming Program Costs for the B2H Medicaid Waiver Program

The program related expenditures will be paid through the standard eMedNY payment process. Program expenses cannot begin until the District's B2H program is operational. The B2H funding is open-ended; locals will not have an allocation. The Federal, State and Local District shares will also be reported through the current eMedNY reporting process.

Children included in the Waiver will be encoded with the following B2H Waiver Codes within the Welfare Management System's (WMS) Restriction/Exception Subsystem:

- 72 – Bridges to Health – Seriously Emotionally Disturbed
- 73 – Bridges to Health – Developmentally Disabled
- 74 – Bridges to Health – Medically Fragile

The eMedNY reporting process is being enhanced to identify a child as being included within the Waiver. Further information will be provided when those enhancements are included on the eMedNY reports.

Claiming Administrative Costs for the B2H Medicaid Waiver Program

Local districts will use the following instructions to claim administrative costs associated with the B2H Medicaid Waiver Program. These instructions have been modified since the original letter providing B2H claiming instructions, dated August 7, 2007, were issued.

Districts must have received approval into the B2H program prior to claiming expenditures. Once approval is received, Districts can begin incurring administrative expenditures immediately. The claim form will show reimbursement rates as 50% Federal, 25% State and 25% local. Allowable administrative costs are the basic costs allowed under the F4 function. Districts will accumulate their administrative expenditures in the F17 function on the Schedule D, DSS Administrative Expenses Allocation

Appendix Q: OCFS Letter for Claiming Instructions

-2-

and Distribution by Function and Program LDSS-2347 and carry them forward to the LDSS-3274 form entitled Schedule D-17, Distribution of Allocated Costs to Other Reimbursable Programs. Employee counts for this program are assigned to the F17 function for Schedule D-17 reporting purposes. Any employee who is assigned part-time to other programs or projects must complete an ongoing time study and have their salary, fringe benefits and person count apportioned to the applicable program/project. These time studies should be completed for one full pay period during the first month of each quarter and applied to salary costs related to each month of the same quarter. If your district participates in the Random Moment Study (RMS), the staff would be excluded from the RMS pool.

These expenditures will support an LDSS-3922, Reimbursement Claim for Special Projects that is labeled as B2H in the project name box. The expenditures should be reported in the Administrative Cost column on the appropriate lines and claimed for normal reimbursement shares of 50% Federal share, 25% State share and 25% Local share. As the funds are Title XIX Medical Assistance, the State will reimburse the local share to the District. The State must track the local share separately as part of the Medical Assistance CAP process.

Please refer to Fiscal Reference Manual (FRM), Volume 2, Chapter 3 for further LDSS-3922 instructions. Instructions for the Schedules D and D-17 are found in Volume 3 (Volume 4 for NYC) of the FRM in Chapters 7 and 18 respectively. The FRM is available on-line at <http://otda.state.ny.net/bfdm/>.

Contact Information

Claiming questions can be directed to the Office of Temporary and Disability Assistance (OTDA) Bureau of Financial Services by contacting:

- Regions 1 through 4 – James Carroll at 1-800-343-8859 ext. 4-7549, or via e-mail at James.Carroll@otda.state.ny.us.
- Region 5 – Michael Borenstein at (631) 854-9704, or via e-mail at Michael.Borenstein@otda.state.ny.us.
- Region 6 – Ms. Marian Borenstein at (212) 961-8250, or via e-mail at Marian.Borenstein@otda.state.ny.us.

Appendix Q: OCFS Letter for Claiming Instructions

-3-

Program questions related to the B2H Waiver should be directed to the Bureau of Waiver Management at (518) 408-4064.

Sincerely,



Susan A. Costello
Director for Financial Management

cc: Virginia Scala, OTDA
Mimi Weber

APPENDIX R: NYC B2H Pre-Referral Process and Request for Services (R4S)

Bridges to Health (B2H) Home and Community Based Waiver Program Overview (SIDE A)

- What is the B2H Waiver Program:
 - A program that serves children in foster care diagnosed with the 3 following disabilities: Serious Emotional Disturbances (SED), Developmental Disabilities (DD) and Medical Fragility (MedF).
- Who is Eligible:
 - **Age Requirements:** SED – under 19 DD and MedF – under 21. Once enrolled, services may continue until age 21 as long as the child is otherwise eligible. (Note: Referral must be initiated 6 months prior to the 19th or 21st birthday).
 - **Residency:** in 2008 must live in Rochester Region, Albany Region or 5 boroughs of NYC. In 2009: B2H expands to the Syracuse and Lower Hudson Valley regions. In 2010, all NYS counties will be participating in B2H.
 - **Foster Care Status:** In foster care at time of enrollment.
 - **Setting:** Living in a setting of 12 or fewer beds, includes group homes and foster homes.
 - **Discharge:** Once enrolled in the B2H program, eligible children may continue to receive services if they are adopted, discharged home, or discharged to a permanent resource or self.
- Services:
 - B2H services are available to all enrolled children regardless of which B2H waiver type they are enrolled in.
 - B2H services supplement and compliment, but do not replace, existing Medicaid and child welfare services.
 - B2H services are intended to serve children and their support network, including birth families, foster and adoptive families.
- The 14 B2H services are:

<ul style="list-style-type: none"> – Health Care Integration – Family/Caregiver Supports and Services – Intensive In-Home Supports and Services – Special Needs Community Advocacy & Support – Immediate Crisis Response Services – Crisis Avoidance, Management and Training – Adaptive and Assistive Equipment 	<ul style="list-style-type: none"> – Planned Respite – Skill Building – Day Habilitation – Crisis Respite – Prevocational Services – Supported Employment – Accessibility Modifications
---	--
- All documents can be found on Docushare as well as the ACS web site at:
<http://www.nyc.gov/html/acs/html/staff/bridges2health.shtml>
- B2H Slots:
 - Year 1 (2008): 360 total new slots: 288 SED, 63 DD, 9 MedF.
 - Year 2 (2009): 360 total new slots: 288 SED, 63 DD, 9 MedF.
 - 720 total slots: 576 SED, 126 DD, 18 MedF.
 - Year 3 (2010): 1144 total new slots: 915 SED, 200 DD, 29 MedF.
 - 1864 total slots: 1491 SED, 326 DD, 47 MedF.

APPENDIX R: NYC B2H Pre-Referral Process and Request for Services (R4S)

Bridges to Health (B2H) Home and Community Based Waiver Program Referral and Enrollment Information (SIDE B)

REFERRAL

Case Planning Agency Initiates Referral:

- **Documentation required:**
 - Administration for Children's Services (ACS) New Request for Services (R4S) Form
 - **SED referrals:** psychosocial and psychiatric evaluations **within 4 months**, comprehensive physical/medical evaluation **within one year**.
 - **DD referrals:** psychosocial **within 4 months**; psychological evaluations with adaptive scales testing **within one year** and physical/medical evaluation **within one year**.
 - **MedF referrals:** psychosocial and physical/medical evaluations **within one year**.
 - Current Individualized Education Plans (I.E.P.) for all children in Special Education only
- Case planner assists the Medical Consenter with selecting a Health Care Integration Agency and introduces and discusses the B2H program prior to submitting all documentation.
- Medical consenter signs Authorization for Release of Information Form (OCFS-8001).
- Foster parent/residential home staff signs the Foster Parent Agreement to Accept Services Form.
- Case Planner submits two copies of the referral packet by mail including the New R4S Referral Form signed and dated by the Medical Consenter and all the original consent forms to:

Administration for Children's Services (ACS)

B2H Unit at 150 William Street, 4th floor, New York, NY 10038

- ACS will Confirm Medicaid and foster care status prior to sending the referral to the selected HCIA.
- All Valid DD referrals are sent to OPWDD to be reviewed by an eligibility coordinator at the local DDSO. OPWDD make eligibility determinations and notify ACS of the edibility status and forward an Level of Care (LOC) certificate to ACS.
- ACS reviews eligibility and verifies the Selection of the HCIA and completes the referral Form (OCFS-8004), assigns HCIA a role in CONNECTIONS, and submits referral packet to selected HCIA.

HCIA Completes Application for Enrollment Packet:

- The HCIA has *up to* 60 days to complete and return the Application for Enrollment Packet to ACS for approval and authorization.
- This Packet includes numerous forms and documentation as outlined in Chapter 5 of the B2H Program Manual.
- HCIA sends completed Application for Enrollment Packet to ACS.

ENROLLMENT

ACS Processes the Application for Enrollment Packet:

- Upon receipt of complete enrollment packet, ACS reviews documentation, budget and approves or denies the child for services.
- Upon denial: parties notified via the Notice of Decision Denial of Enrollment (OCFS-8010A) including information about the Fair Hearing process.
- Upon approval: CONNECTIONS is updated, all parties including the HCIA are notified via the Notice of Decision Authorization (OCFS-8009)
- Child is enrolled in B2H and services commence.
- Waitlists: Up to 10% of the available slots.

Special Note about Discharge: Cases will remain open in the B2H unit even after discharge from care. Connections cases must remain open except for adoption cases which are force closed, however - FASPs will not be due.

Contact us: Jodi A. Saitowitz, LCSW-R
Director-Bridges to Health (B2H)
Division of Family Permanency
Administration for Children Services
150 William Street, 4O-5
New York NY 10038
212-341-2743– telephone
917-551-7510 Direct Fax
212-442-5839 – Main fax
b2hacs@dfa.state.ny.us or
Jodi.saitowitz2@dfa.state.ny.us

Download all HCIA Brochures and Application forms by visiting us on the internet at:

<http://www.nyc.gov/html/acs/html/staff/bridges2health.shtml>



APPENDIX R: NYC B2H Pre-Referral Process and Request for Services (R4S)



NEW YORK CITY
ADMINISTRATION FOR CHILDREN'S SERVICES

Request For Services (R4S) Form

BRIDGES TO HEALTH (B2H) HOME & COMMUNITY BASED SERVICES MEDICAID WAIVER PROGRAM

PLEASE TYPE OR PRINT NEATLY- Please submit TWO copies of the ENTIRE package by mail.

DATE OF REFERRAL: ___ / ___ / ___				
CHILD'S NAME, (LAST, FIRST, MI.) (Include any alias, nicknames or other names the child may be known by):				
CHILD'S CURRENT ADDRESS:				
CITY:	STATE:	ZIP:	COUNTY:	MEDICAID CIN #:
DATE OF BIRTH: / /	SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female	CASE NAME:		ACS CASE #:
SOCIAL SECURITY #:		CASE PLANNING AGENCY NAME:		
IS CHILD LEGALLY FREED? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF NO, HAS PERMISSION TO OVERRIDE PARENTAL CONSENT BY ACS BEEN APPROVED?		
MEDICAL CONSENTER'S NAME:		RELATIONSHIP TO CHILD:	E-MAIL ADDRESS:	
MEDICAL CONSENTER ADDRESS:		CITY:	STATE:	ZIP CODE: PHONE #:
IS CAREGIVER FLUENT IN ENGLISH? <input type="checkbox"/> YES <input type="checkbox"/> NO IF NOT, WHICH LANGUAGE?	IS CHILD FLUENT IN ENGLISH? <input type="checkbox"/> YES <input type="checkbox"/> NO IF NOT, WHICH LANGUAGE?	ARE THERE ANY REASONABLE ACCOMMODATION'S AND/OR UNDUE HARDSHIP'S UNDER THE AMERICANS WITH DISABILITIES ACT TO BE CONSIDERED WHEN WORKING WITH THIS CHILD OR FAMILY?		
B2H WAIVER TYPE (Check one only) <input type="checkbox"/> B2H Serious Emotional Disturbance (SED) Waiver <input type="checkbox"/> B2H Developmental Disabilities (DD) Waiver <input type="checkbox"/> B2H Medically Fragile (MedF) Waiver		REFERRAL TYPE (Check one only) <input type="checkbox"/> Initial Referral <input type="checkbox"/> Subsequent Referral: completed if child was Withdrawn or Denied previously.		
SIBLING INFO (Check ALL that Apply) <input type="checkbox"/> Sibling is enrolled in B2H-Name of Sibling(s): <input type="checkbox"/> A referral for another sibling is also being submitted- Name of Sibling(s):				
LEGAL STATUS OF CHILD: <input type="checkbox"/> IN CARE <input type="checkbox"/> ON TRIAL DISCHARGE <input type="checkbox"/> PINS <input type="checkbox"/> TPR PENDING <input type="checkbox"/> CALENDARED FOR ADOPTION?				
DATE OF PENDING ADOPTION: ___ / ___ / ___ DATE OF ANTICIPATED FINAL DISCHARGE: ___ / ___ / ___				
NOTE: If child is discharged from care prior to being ENROLLED, they will NO longer be eligible for B2H.				
IS CHILD CURRENTLY IN AN ELIGIBLE SETTING? (12 BEDS or LESS) <input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, HAS AN ELIGIBLE SETTING BEEN IDENTIFIED FOR CHILD? (FBH or SETTING OF 12 BEDS or LESS) <input type="checkbox"/> YES <input type="checkbox"/> NO DATE OF INTENDED DISCHARGE or STEP DOWN DATE: ___ / ___ / ___				
IS CHILD RECEIVING SPECIAL EDUCATION? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES PLEASE SUBMIT A CURRENT IEP WITHIN THE CURRENT YEAR.				
IS CHILD CURRENTLY RECEIVING ANY OTHER SUPPORTIVE SERVICES (i.e. OMH or CSPOA)? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES PLEASE DESCRIBE:				

PLEASE CALL 212-676-6406 IF YOU NEED ASSISTANCE WITH THIS FORM

ORIGINAL MUST BE Mailed to- ACS 150 William Street, 4th Floor New York, NY 10038 **ATTENTION: (B2H) UNIT**
FAXES will **NOT** be accepted!



APPENDIX R: NYC B2H Pre-Referral Process and Request for Services (R4S)



NEW YORK CITY
ADMINISTRATION FOR CHILDREN'S SERVICES

Request For Services (R4S) Form

BRIDGES TO HEALTH (B2H) HOME & COMMUNITY BASED SERVICES MEDICAID WAIVER PROGRAM

PLEASE TYPE OR PRINT NEATLY- Please submit TWO copies of the ENTIRE package by mail.

The **Freedom of Choice Act** (H.R. 1964/S. 1173) Federal Law states that an individual have been informed that they may be eligible for services provided through either the B2H Medicaid Waiver Program or a medical institution It prohibits a federal, state, or local governmental entity from denying or interfering with a person's right to exercise such choices; or discriminating against the exercise of those rights in the regulation or provision of benefits, facilities, services, or information. Provides that such prohibition shall apply retroactively.

TO BE COMPLETED BY THE MEDICAL CONSENTER

I have chosen to **(Check one only)**:

- Apply for the B2H Medicaid Waiver
- NOT** apply for services through the B2H Medicaid Waiver Program at this time.

A LIST AND BROCHURES OF HEALTH CARE INTEGRATION AGENCIES (HCIA) WAS PROVIDED TO THE CHILD/MEDICAL CONSENTER. THE CHILD/MEDICAL CONSENTER HAS SELECTED THE FOLLOWING HCIA: **(CHECK BOX BELOW)**

(CHECK ONE ONLY):

NYC (5 BOROUGHES)

- ABBOTT HOUSE
- CATHOLIC GUARDIAN SOCIETY AND HOME BUREAU
- CARDINAL MCCLOSKEY SERVICES (CMS)
- GRAHAM WINDHAM
- NEW ALTERNATIVES FOR CHILDREN (NAC)
- NY FOUNDLING
- JEWISH CHILD CARE ASSOCIATION (JCCA)
- SCO FAMILY OF SERVICES

LOWER HUDSON VALLEY

- CHILDREN'S VILLAGE
- ASTOR SERVICES FOR CHILDREN AND FAMILIES

LONG ISLAND (NASSAU AND SUFFOLK COUNTY)

- LITTLE FLOWERS
- SCO

OTHER: _____

(TO BE COMPLETED ONLY IF HCIA IS NOT IN THESE THREE REGIONS)

My signature BELOW verifies that I have exercised my **Freedom of Choice** rights to choose my Health Care Integration Agency without any influences. I acknowledge that I understand that I have the right to change my HCIA at any time by contacting ACS at 212-676-6406 or my HCIA.

MEDICAL CONSENTER NAME:		MEDICAL CONSENTER SIGNATURE: X		DATE:	
FOSTER PARENT NAME:		FOSTER PARENT HOME PHONE:		FOSTER PARENT CELL PHONE:	
FOSTER PARENT ADDRESS:		CITY:	COUNTY:	STATE:	ZIP CODE:
NAME OF RESIDENTIAL SETTING IF NOT IN A FOSTER HOME: (THIS INCLUDES HOSPITAL)		NAME OF CONTACT PERSON AT RESIDENTIAL SETTING IF NOT IN A FOSTER HOME: (THIS INCLUDES HOSPITAL)			
PHONE # OF RESIDENTIAL SETTING IF NOT IN A FOSTER HOME: (THIS INCLUDES HOSPITAL)		E-MAIL ADDRESS OF RESIDENTIAL SETTING IF NOT IN A FOSTER HOME: (THIS INCLUDES HOSPITAL)			
AGENCY REPRESENTATIVE NAME:		RELATIONSHIP TO CHILD: (e.g. Case Planner, Case Worker, Therapist)			
AGENCY REPRESENTATIVE'S TITLE:		AGENCY REPRESENTATIVE'S E-MAIL ADDRESS:			
AGENCY REPRESENTATIVE'S ADDRESS:		CITY:	COUNTY:	STATE:	ZIP CODE:
AGENCY REPRESENTATIVE'S OFFICE PHONE #:		AGENCY REPRESENTATIVE'S CELL PHONE #:			
SUPERVISOR'S NAME:		SUPERVISOR'S E-MAIL ADDRESS:			
SUPERVISOR'S OFFICE PHONE #:		SUPERVISOR'S CELL PHONE #:			
DIRECTOR'S NAME:		DIRECTOR'S E-MAIL ADDRESS:			
DIRECTOR'S OFFICE PHONE #:		DIRECTOR'S CELL PHONE #:			
NAME OF PERSON COMPLETING THIS FORM:		SIGNATURE: X		DATE:	

PLEASE CALL 212-676-6406 IF YOU NEED ASSISTANCE WITH THIS FORM

ORIGINAL MUST BE Mailed to- ACS 150 William Street, 4th Floor New York, NY 10038 **ATTENTION: (B2H) UNIT**
FAXES will **NOT** be accepted!



APPENDIX R: NYC B2H Pre-Referral Process and Request for Services (R4S)



NEW YORK CITY
ADMINISTRATION FOR CHILDREN'S SERVICES

Request For Services (R4S) Form

BRIDGES TO HEALTH (B2H) HOME & COMMUNITY BASED SERVICES MEDICAID WAIVER PROGRAM

PLEASE TYPE OR PRINT NEATLY- Please submit TWO copies of the ENTIRE package by mail.

CHECK THAT ALL DOCUMENTS ARE INCLUDED IN THIS PACKET BEFORE SUBMITTING TO ACS. (Only completed packets will be reviewed for eligibility)					
✓	Document Type	SED	DD	MedF	Date Requirements/Directions
<input type="checkbox"/>	Psychosocial	X	X	X	Evaluation must be completed within the past (4) months of date of referral
<input type="checkbox"/>	Psychiatric	X			Evaluation must be completed within the past (4) months of date of referral
<input type="checkbox"/>	Psychological		X		Evaluation must be completed within the past twelve (12) months of date of referral
<input type="checkbox"/>	Adaptive Scales		X		Evaluation must be completed within the past twelve (12) months of date of referral
<input type="checkbox"/>	Medical/Physical	X	X	X	Evaluation must be completed within the past twelve (12) months of date of referral
<input type="checkbox"/>	IEP-Special Ed ONLY	X	X	X	Evaluation must be completed within the past twelve (12) months of date of referral- Only if child is in Special Education.
<input type="checkbox"/>	Foster Parents Agreement to Accept	X	X	X	To be completed by the Foster Parent (when applicable)
<input type="checkbox"/>	Authorization For Release of Health information (OCFS-8001)	X	X	X	To be completed by Biological Parent or medical Consenter if Permission for Override has been obtained or child is Legally Freed.

TO BE COMPLETED BY ACS STAFF ONLY		
Date Medical Consenter contacted: 1st attempt ___ / ___ / ___ 2nd attempt ___ / ___ / ___ 3rd attempt ___ / ___ / ___		
Verification of Freedom of Choice: <input type="checkbox"/> Confirmed (Medical Consenter exercised their Freedom of Choice willingly without any influences?) <input type="checkbox"/> Yes <input type="checkbox"/> No		
Comments: 		
Date R4S Returned to Agency if incomplete: ___ / ___ / ___		
Date R4S sent to HCIA: ___ / ___ / ___		
Date R4S received (Time Stamp here) 		
ACS STAFF NAME:	ACS STAFF SIGNATURE: X	DATE:

PLEASE CALL 212-676-6406 IF YOU NEED ASSISTANCE WITH THIS FORM

ORIGINAL MUST BE Mailed to- ACS 150 William Street, 4th Floor New York, NY 10038 **ATTENTION: (B2H) UNIT**
FAXES will **NOT** be accepted!

NEW YORK CITY
ADMINISTRATION FOR CHILDREN'S SERVICES

Referral Process for B2H Developmental Disability (DD) Waiver
BRIDGES TO HEALTH (B2H) HOME & COMMUNITY BASED SERVICES MEDICAID WAIVER PROGRAM

- I. Foster Care Case Planning agencies identify potentially eligible children and initiate referrals by forwarding the following documentation to the ACS B2H unit:
 - a. New Request for Services Form (R4S) (See Attached);
 - b. Psychological evaluation/early intervention evaluation (with cognitive and adaptive scales included within 1 year);
 - c. Psychosocial evaluation - within 4 months;
 - d. Medical Assessment - within 1 year;
 - e. IEP (if child is enrolled in Special Education) - within 1 year.
 - f. Authorization for Release of Health Information (OCFS-8001)
 - g. Foster Parents Agreement to Accept Services Form

- II. ACS reviews the referral information and provides the local Developmental Disabilities Services Office¹ (DDSO) with the supporting information and the OPWDD Transmittal for Determination of Developmental Disability for the initial Level of Care (LOC) determination. The DDSO may request additional information such as updated testing tools. In these cases, ACS notifies the case planning agency of the request for additional information. The DDSO completes the eligibility determination using the OMRDD ICF/MR- Level of Care Eligibility Determination Form (02-02-97).
 - ❖ If the DDSO determines that the child is not eligible for B2H DD, the DDSO forwards ACS an OPWDD Letter of Determination. ACS notifies the case planner and forwards the OPWDD Letter of Determination to the case planning Agency.

 - ❖ If child is determined eligible for B2H DD, ACS will forward the entire referral packet including the LOC and Letter of Eligibility to the selected HCIA
 - a. Freedom of Choice Form (OCFS-8003)
 - b. Health Care Integrator Selection Form (OCFS-8007)

- III. See the B2H Program Manual for next steps.

¹ The State Office of People with Developmental Disabilities (OPWDD) regional entities responsible for the organization and certification of regional voluntary providers. The DDSO's evaluate the Level of Care assessment for a potential developmentally disabled enrollee's initial entry into the B2H DD waiver.

**Appendix T: OMRDD Administrative Memorandum #2009-05 ICF/MR
Level of Care Eligibility Form (LCED) Qualified Mental Retardation
Professional (QMRP) Authorized to sign Annual LCED Forms**



David A. Paterson, Governor
Diana Jones Ritter, Commissioner

Policy & Enterprise Solutions

Gary Lind, Deputy Commissioner

44 Holland Avenue
Albany, NY 12229-0001

TEL: 518-473-9697
FAX: 518-473-0054
TTY: 866-933-4889

omr.state.ny.us

Memorandum

To: Executive Directors of Voluntary Provider Agencies
Executive Directors of MSC Vendors
DDSO Directors

From: Gary Lind, Deputy Commissioner
Division of Policy and Enterprise Solutions

A handwritten signature in blue ink that reads 'Gary R. Lind'.

Subject: Clarifying Information
Administrative Memorandum #2009-05: ICF/MR Level of Care Eligibility
Determination Form (LCED) Qualified Mental Retardation Professional (QMRP)
authorized to sign annual LCED forms

Date: March 2, 2010

Suggested Distribution:

DDSO Medicaid Service Coordination (MSC) Service Coordinators and Supervisors
DDSO Home and Community Based Services (HCBS) Waiver Coordinators
MSC Service Coordinators and Supervisors
Residential Supervisors

Purpose:

This Memorandum provides clarification related to Administrative Memorandum (ADM) #2009-05, ICF/MR Level of Care Eligibility Determination Form (LCED) Qualified Mental Retardation Professional (QMRP) authorized to sign annual LCED forms. ADM #2009-05 authorizes an optional change in the requirements related to the review and signature on the ICF/MR level of care eligibility determination (LCED) forms for HCBS waiver participants undergoing an annual redetermination.

Appendix T: OMRDD Administrative Memorandum #2009-05 ICF/MR Level of Care Eligibility Form (LCED) Qualified Mental Retardation Professional (QMRP) Authorized to sign Annual LCED Forms

March 2, 2010, Page 2 of 4

Applicability:

ADM #2009-05 specifies that effective December 14, 2009, a QMRP who is familiar with the waiver participant's functional level, may review and sign the annual LCED redetermination form in place of a physician (or physician's assistant or nurse practitioner if so authorized by a physician) for all individuals enrolled in the HCBS waiver except residents of Community Residences (Supervised and Supportive Community Residences).

This optional change is available for individuals who live in the following HCBS waiver appropriate living arrangements:

- The person's own home or apartment or the home/apartment of a relative;
- Supervised and Supportive Individualized Residential Alternatives (IRAs); and,
- Family Care Homes

This change is not available at this time for individuals who live in Supervised and Supportive Community Residences.

Applicability of the Optional Change for Willowbrook Class Members:

We have received a number of inquiries related to the applicability of the optional change for Willowbrook Class Members. The optional change is available to all HCBS waiver participants, including Willowbrook Class Members, unless the HCBS waiver participant resides in a Supervised or Supportive Community Residence (as noted above). The availability of this optional change does not alter or modify any obligations or entitlements for services to class members as stipulated in the Willowbrook Permanent Injunction.

Definition of QMRP:

OMRDD has received a large number of inquiries regarding the definition of **Qualified Mental Retardation Professional (QMRP)** as referred to in ADM #2009-05. To clarify, because the Level of Care Eligibility Determination is a Federal requirement for individuals enrolled in the HCBS Waiver, the Federal definition of a QMRP is controlling.

To be designated a QMRP for the purpose of completing an annual redetermination of Level of Care Eligibility, an individual **must** meet the definition set forth in federal regulations at 42 CFR 483.430(a):

- (1) Has a least one year of experience working directly with persons with mental retardation or other developmental disabilities; **and**

**Appendix T: OMRDD Administrative Memorandum #2009-05 ICF/MR
Level of Care Eligibility Form (LCED) Qualified Mental Retardation
Professional (QMRP) Authorized to sign Annual LCED Forms**

March 2, 2010, Page 3 of 4

- (2) Is one of the following:
- (i) A doctor of medicine or osteopathy.
 - (ii) A registered nurse.
 - (iii) An individual who holds **at least a Bachelor's Degree** in a professional category specified in paragraph 42 CFR 483.430(b)(5).

Please Note: A Licensed Practical Nurse (LPN), a Certified Occupational Therapy Assistant, or a Physical Therapy Assistant would not qualify as a QMRP unless they held a Bachelor's Degree in a human service field and have the necessary year of experience.

Please see the attachment to this memo for a listing of the professional categories contained in 42 CFR 483.430(b)(5).

**Appendix T: OMRDD Administrative Memorandum #2009-05 ICF/MR
Level of Care Eligibility Form (LCED) Qualified Mental Retardation
Professional (QMRP) Authorized to sign Annual LCED Forms**

March 2, 2010, Page 4 of 4

ATTACHMENT (based on 42 CFR 483.430(b)(5))

Qualified Mental Retardation Professionals (QMRPs) must have at least one year of experience working directly with persons with mental retardation or other developmental disabilities AND be:

- 1) a doctor of medicine or osteopathy;
- 2) a registered nurse; or
- 3) professional program staff with at least a **Bachelor's Degree** in one of the following professional categories and who are licensed, certified or registered as applicable, to provide professional services by New York State. Those professional program staff who do not fall under the jurisdiction of New York State licensure, certification, or registration requirements must meet the following qualifications:
 - i. An Occupational Therapist must be eligible to be certified by the American Occupational Therapy Association or another comparable body;
 - ii. An Occupational Therapy Assistant must be eligible to be certified as an Occupational Therapy Assistant by the American Occupational Therapy Association or another comparable body*;
 - iii. A Physical Therapist eligible for certification by the American Physical Therapy Association or another comparable body;
 - iv. A Physical Therapy Assistant eligible for registration by the American Physical Therapy Association or be a graduate of a two-year College-level program approved by the American Physical Therapy Association or another comparable body*.
 - v. A Psychologist with at least a Master's Degree in Psychology from an accredited school;
 - vi. A Social Worker who must: hold a Graduate Degree from a school of Social Work accredited or approved by the Council on Social Work Education or another comparable body; or, hold a Bachelor of Social Work Degree from a college or university accredited or approved by the Council on Social Work Education or another comparable body.
 - vii. A Speech/Language Pathologist or Audiologist who must: be eligible for a Certificate of Clinical Competence in Speech/Language Pathology or Audiology granted by the American Speech/Language-Hearing Association or another comparable body; or meet the educational requirements for certification and be in the process of accumulating the supervised experience required for certification.
 - viii. A professional recreation staff member who must have a Bachelor's Degree in Recreation or in a specialty area such as art, dance, music or Physical Education;
 - ix. A professional dietician eligible for registration by the American Dietetics Association; or,
 - x. A human services professional who must have at least a Bachelor's Degree in a human services field, including but not limited to: Sociology, Special Education, Rehabilitation Counseling and Psychology.

**Note: A Certified Occupational Therapy Assistant or a Physical Therapy Assistant would not qualify as a QMRP unless they held a Bachelor's Degree in a human service field and have the necessary year of experience*

Appendix T: OMRDD Administrative Memorandum #2009-05 Clarifying
Information Administrative Memorandum



NYS Office of Mental Retardation and Developmental Disabilities

Putting People First



David A. Paterson, Governor
Diana Jones Ritter, Commissioner

Policy & Enterprise Solutions

Gary Lind, Deputy Commissioner

44 Holland Avenue
Albany, NY 12229-0001

TEL: 518-473-9697
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omr.state.ny.us

ADMINISTRATIVE MEMORANDUM #2009-05

TO: Executive Directors of Voluntary Provider Agencies
Executive Directors of MSC Vendors
DDSO Directors

FROM: Gary Lind, Deputy Commissioner
Division of Policy and Enterprise Solutions

SUBJECT: ICF/MR Level of Care Eligibility Determination Form (LCED)
Qualified Mental Retardation Professional (QMRP) authorized to sign annual
LCED forms

DATE: December 14, 2009

Suggested Distribution:

DDSO Medicaid Service Coordination Service Coordinators and Supervisors
DDSO Home and Community Based Services (HCBS) Waiver Coordinators
MSC Service Coordinators and Supervisors
Residential Supervisors

Applicability:

This information is applicable for all individuals enrolled in OMRDD's Home and Community Based Services (HCBS) waiver except individuals residing in Community Residences.

Background:

The purpose of this memorandum is to notify you of an **optional** change in the requirements related to the review and signatures on the ICF/MR level of care eligibility determination (LCED) annual redetermination forms for HCBS waiver participants. This optional change is made possible as a result of OMRDD's recent HCBS waiver renewal.

**Appendix T: OMRDD Administrative Memorandum #2009-05 Clarifying
Information Administrative Memorandum**

ADM #2009-05
December 14, 2009

Optional Change: Effective immediately, a Qualified Mental Retardation Professional (QMRP) who is familiar with the HCBS waiver participant's functional level may review and sign the annual LCED redetermination form in place of a physician (or physician's assistant or nurse practitioner if so authorized by a physician) for all individuals enrolled in the HCBS waiver except residents of Community Residences. Community Residences are subject to OMRDD regulation 14 NYCRR Section 671.4(b)(1)(ii), which requires the signature of a physician or physician's assistant/nurse practitioner on the LCED.

Notes:

Redetermination only: This optional change is applicable only for LCED redeterminations. This change is not applicable for the initial LCED which must continue to be reviewed, signed, and dated by a physician.

QMRP: See 42 CFR 483 for the definition of QMRP. Also defined in 14 NYCRR Section 690.99 (See "Professional, qualified). The QMRP signing in place of the physician/physician's assistant or nurse practitioner, should sign on the line designated for the QMRP's Signature (at the bottom of the form).

Required Medical Evaluations: 14 NYCRR Section 633.10 (a)(2)(iii) requires the annual evaluation of a person's need for a medical examination or specific medical services by a physician or registered physician's assistant for all individuals residing in an OMRDD certified residential facility (e.g., IRA, CR, Family Care).

Willowbrook class members: This change does not alter or modify OMRDD's obligations on behalf of Willowbrook class members.

OMRDD is in the process of clarifying and updating the instructions for annual completion of the ICF/MR Level of Care Eligibility Form for HCBS waiver participants. Once this process is completed, the revised instructions and form will be distributed to HCBS waiver and MSC providers. In the meantime, except for the optional change indicated above, the form and directions outlined in The Key to Individualized Services, The Home and Community Based Services Waiver (OMRDD, 1997) remain in effect.

Questions on this optional change may be directed to OMRDD's Waiver Management Bureau at (518) 474-5647.

cc: Provider Associations
Ms. Broderick
Ms. Gentile
Mr. Moran
Mr. Whitehead

Appendix U: B2H Personnel Record Checklists for Health Care Integrators and Waiver Service Providers

Bridges to Health (B2H) Personnel Record Checklist for Health Care Integrators (HCIs)

Employee Name: _____ HCIA: _____

B2H Services Start Date: _____

Name, Title, and Signature of HCIA staff completing this form: _____

Instruction: Complete all required information below.

Qualifications	Documentation	Date
Master's degree in social work, psychology, or other related field, or licensed Health Care Practitioner, Registered Nurse or Special Education teacher & 1 yr exp. in service coordination OR Bachelor's degree in social work, psychology, or other related field & 4 yrs exp. in service coordination		

Background Checks	Documentation	Date
NYS DCJS Sex Offender Registry (Level 1, 2, and 3)		
Attestation of complete Criminal History		
Statewide Central Register (SCR)		

Training	Documentation	Date
Training prior to providing services		
Mandated Reporting Training		
B2H Overview of Documentation Requirements Training		
First Aid		
CPR		
CANS B2H Training		
Training within 3 Months of providing services		
Recognizing & Understanding Cultural Differences & Diversity		
Communication Skills & Behavioral Support		
Interaction of B2H Waiver Program & Child Welfare		
Child & Adolescent Development		
Training prior to supervising for HCI supervisor and within 6 months for HCI		
Health Care Integrators & Supervisors Training		

OCFS recommendations:

OCFS staff initials and date: _____

Bridges to Health (B2H) Personnel Record Checklist for Waiver Service Providers (WSPs)

Employee Name: _____ Agency: _____
 Name, Title, and Signature of Agency staff completing this form: _____

Instruction: Complete all required information below.

Qualifications – check service provided and date began providing service	Documentation	Date began providing service
<input type="checkbox"/> Family/Caregiver Supports & Services: HS diploma/equiv. & approp.skills & training		
<input type="checkbox"/> Skill Building: HS diploma/equiv. & approp. skills & training		
<input type="checkbox"/> Day Habilitation: Individual employed by an OPWDD-certified, day hab. provider		
<input type="checkbox"/> Special Needs Community Needs Community Advocacy and Support (SNCAS): Masters in ed./human services & 1 yr exp. OR Bachelor's & 2 yrs exp.		
<input type="checkbox"/> Prevocational Services: Bachelors & 2 yrs exp. OR Associate's & 2 yrs exp.		
<input type="checkbox"/> Supported Employment: same as Prevocational Services		
<input type="checkbox"/> Crisis Avoidance Management and Training (CAMT): Master's degree in social work, psy., or master's in related human svc. field & 1 yr app. exp. OR Bachelor's degree & 2 yrs related exp.		
<input type="checkbox"/> Immediate Crisis Response Services (ICRS): same as CAMT		
<input type="checkbox"/> Intensive In Home Supports and Services (IIHS): same as CAMT		
<input type="checkbox"/> Crisis Respite: High school diploma/equiv. & approp. skills & trng., & part 435 of 18 NYCRR as applicable		
<input type="checkbox"/> Planned Respite: same as Crisis Respite		

Background Checks	Documentation	Date
DCJS fingerprinting required only for Planned & Crisis Respite part 435 of 18 NYCRR		
NYS DCJS Sex Offender Registry (Level 1, 2, and 3)		
Attestation of complete Criminal History		
Statewide Central Register (SCR)		

Training	Documentation	Date
Required Prior to Providing Services		
Mandated Reporting Training		
B2H Overview of Documentation Requirements Training		
First Aid		
CPR		
Training w/in 3 months of providing services		
Recognizing & Understanding Cultural Differences & Diversity		
Communication Skills & Behavioral Support		
Interaction of B2H Waiver Program & Child Welfare		
Child & Adolescent Development		
WSP Training w/in 6 months of providing services (WSP supervisors w/in 3 months)		
B2H Service	Training Module	
All WSPs	Module #1: Documentation Module #2: Building Resilience Module #3: Safety in the Community Module #4: Essential Elements for Service Provision OR B2H Documentation and Working in a Family's Home*	
Family/Caregiver Supports & Services	Family/Caregiver Supports & Services OR Parenting Skills*	
Skill Building	Skill Building OR Teaching, Modeling and Mentoring*	
SNCAS	SNCAS OR Community and Academic Advocacy *	
Prevocational Services & Supported Employment	Prevocational & Supported Employment Services OR Job Readiness*	
CAMT, ICRS, IIHS	Crisis Services OR Safety Planning and Response*	
Planned and Crisis Respite	Planned & Crisis Respite	

*former name of training.

OCFS recommendations:

OCFS staff initials and date: _____

Appendix V: Bridges to Health (B2H) Performance Measures to meet Centers for Medicare and Medicaid Services' (CMS) Six Assurances

Bridges to Health (B2H) Performance Measures to meet Centers for Medicare and Medicaid Services' (CMS) Six Assurances

Performance Measure #1: Level of Care	
Sub-Assurance	Performance Measure to meet sub-assurance, data source
A. An evaluation for Level of Care is provided to all applicants for whom there is reasonable indication that services may be needed in the future	1. Number and percent of new enrollees who had a Level of Care indicating need for institutional Level of Care (e.g., nursing home, Residential Treatment Facility, ICF/MR) prior to receipt of services. Data Source: B2H Case Record Review
B. The Levels of Care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.	1. Number and percent of waiver participants who received an annual re-determination of eligibility within 12 months of their initial Level of Care evaluation or within 12 months of their last annual Level of Care evaluation. Data Source: B2H Case Record Review
C. The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant Level of Care.	1. Number and percent of participants' initial (or annual, or both) Level of Care determinations forms/instruments that were completed as required by the state. Data Source: B2H Case Record Review 2. Number and percent of Level of Care determinations made by a qualified evaluator. Data Source: B2H Case Record Review

Performance Measure #2: Service Plans	
Sub-Assurance	Performance Measure to meet sub-assurance, data source
A. Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.	1. Number and percent of participants reviewed who had service plans that were adequate and appropriate to their needs (including health care needs) as indicated in the assessment(s). Data Source: B2H Case Record Review 2. Number and percent of service plans that address participants' goals as indicated in the assessment(s). Data Source: B2H Case Record Review
B. The State monitors service plan development in accordance with its policies and procedures.	1. Number and percent of service plan development activities that are completed as described in the waiver application: who participates in the plan development process; Service plan content follows state requirements regarding completion of the Child and Adolescent Needs and Strengths Assessment tool; plan development provides for assignment of responsibilities to implement and monitor the plan. Data Source: B2H Case Record Review
C. Service plans are updated/ revised at least annually or when warranted by changes in the waiver participant's needs.	1. Number and percent of service plans that were reviewed, and revised as warranted, on or before waiver participants' annual review date. Data Source: B2H Case Record Review 2. Number and percent of waiver participants reviewed whose service plans were revised, as needed, to address changing need. Data Source: B2H Case Record Review
D. Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.	1. Number and percent of participant survey respondents reporting they received all the services in their plan. Data Source: B2H Satisfaction Survey

<p>E. Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.</p>	<p>1. Number and percent of waiver participant records reviewed with an appropriately completed and signed freedom of choice form that specified choice was offered between institutional care and waiver services. Data Source: B2H Case Record Review</p> <p>2. Number and percent of participant records reviewed with an appropriately completed and signed freedom of choice form that specifies choice was offered among waiver services and providers. Data Source: B2H Case Record Review</p>
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Performance Measure #3: Health and Welfare	
Sub-Assurance	Performance Measure to meet sub-assurance, data source
<p>A. The State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.</p>	<p>1. Number and percent of participant records reviewed where the participant (and/or family or legal guardian) received information/education about how to report abuse, neglect, exploitation and other critical incidents as specified in the approved waiver. Data Source: B2H Case Record Review</p> <p>2. Number and percent of critical incidents that were reported within required time frames as specified in the approved waiver. Data Source: B2H Serious Reportable Incident Database</p> <p>3. Number and percent of critical incident reviews/investigations that were initiated within required time frames as specified in the approved waiver. Data Source: B2H Serious Reportable Incident Database</p> <p>4. Number and percent of critical incident reviews/investigations that were completed within required time frames as specified in the approved waiver. Data Source: B2H Serious Reportable Incident Database</p> <p>5. Number and percent of critical incidents requiring review/investigation where the state adhered to the follow-up methods as specified in the approved waiver. Data Source: B2H Serious Reportable Incident Database</p> <p>6. Number of substantiated complaints. Data Source: Complaint database</p> <p>7. Number and percent of complaints addressed within required timeframe. Data Source: Complaint database</p>

Performance Measure #4: Qualified Providers	
Sub-Assurance	Performance Measure to meet sub-assurance, data source
<p>A. The State verifies that providers <u>initially</u> and <u>continually</u> meet required licensure and certification standards and adhere to other standards prior to their furnishing services.</p>	<p>1. Number and percent of new provider applications, by provider type, for which the provider obtained appropriate licensure/certification in accordance with State law and waiver provider qualifications prior to service provision. Data Source: OCFS Contract Management System</p> <p>2. Number and percent of providers, by provider type, continuing to meet applicable licensure/certification following initial enrollment. Data Source: B2H Administrative Review</p> <p>3. Number and percent of agency providers whose direct support staff had timely criminal background and registry checks. Data Source: B2H Administrative Review</p>

B. The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.	1. Number and percent of providers, by provider type, meeting provider training requirements. Data Source: B2H Administrative Review
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Performance Measure #5: Financial Accountability	
Sub-Assurance	Performance Measure to meet sub-assurance, data source
A. State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.	<p>1. Number and percent of waiver claims reviewed that were submitted using the correct rate as specified in the waiver application. Data Source: OCFS Audit and Quality Control (A&QC) Audits</p> <p>2. Number and percent of waiver service claims reviewed that were submitted for participants who were enrolled in the waiver on the date that the service was delivered. Data Source: OCFS A&QC Audits</p>

Performance Measure #6: Administrative Authority	
Sub-Assurance	Performance Measure to meet sub-assurance, data source
A. The State Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.	<p>1. Percent of provider reviews (surveys) conducted with the frequency required in the agreement with the State Medicaid Agency. Data Source: B2H Database</p> <p>2. Number of Quality Assurance record reviews conducted each month/year as compared to what was specified in the agreement with the State Medicaid Agency. Data Source: B2H Database</p> <p>3. The State Medicaid Agency must ensure that provider agreements/contracts for different types of services are <u>uniformly</u> developed and executed throughout all geographic areas covered by the waiver. Number and percent provider agreements/contracts that adhered to the State's uniform agreement/contract requirements (specific to service provider type). Data Source: B2H Provider Agreements and B2H Model Subcontracts</p> <p>4. The State Medicaid Agency must ensure that there is equitable distribution of waiver openings in all geographic areas covered by the waiver, consistent with its description in the approved waiver. Number and percent of new openings that have been allocated according to State policies and procedures (that insure equitable distribution of waiver openings). Data Source: B2H Enrollment Database</p>