

Section 1115 New York Medicaid Redesign Team Waiver Children's Amendment

May 8, 2017

Section I - Program Description

This section should contain information describing the goals and objectives of the Demonstration, as well as the hypotheses that the Demonstration will test. In accordance with 42 CFR 431.412(a)(i), (v) and (vii), the information identified in this section must be included in a state's application in order to be determined complete. Specifically, this section should:

- 1. Provide a summary of the proposed Demonstration program, and how it will further the objectives of title XIX and/or title XXI of the Social Security Act (the Act).**

The State is submitting this amendment to its current 1115 New York Medicaid Redesign Team (NY MRT) Waiver (Demonstration) to create a children's model of care that enables qualified Managed Care Organizations (MCOs) in Mainstream Medicaid Managed Care (MMMC) and HIV Special Needs Plans (SNPs) throughout the State to comprehensively meet the needs of children and youth under 21 years of age with Behavioral Health(BH) and Home and Community Based Services (HCBS) needs, specifically, medically fragile children, children with behavioral health diagnosis(es) and children in Foster Care (FC) with developmental disabilities. On January 1, 2018, this amendment requests authority to:

- *Incorporate Medicaid State Plan behavioral health services into the MMMC and HIV SNP contracts for enrolled children with an implementation date of July 1, 2018.*
- *Transition the six children's Section 1915(c) HCBS waivers to the 1115 Demonstration authority¹:*
 - *Office of Mental Health (OMH) Serious Emotional Disturbance (SED) waiver #NY.0296.*
 - *Department of Health (DOH) Care At Home (CAH) I/II waiver #NY.4125.*
 - *Office for People With Developmental Disabilities (OPWDD) Care At Home (CAH) waiver #NY.40176*
 - *Office of Children and Families (OCFS) Bridges to Health (B2H) SED waiver #NY.0469.*

¹ Maintenance of Effort under the ACA requires New York to continue eligibility for medically needy children with a waiver of 1902(a)(10)(C)(i)(III) under the current 1915(c) waivers. These children are referred to as "LOC Family of One" HCBS children in the Demonstration.

- OCFS B2H Developmental Disability (DD) waiver #NY.0470.
 - OCFS B2H Medically Fragile waiver #NY.0471.
- Remove the exemption from mandatory enrollment into MMMC and HIV SNPS for children in the above HCBS waivers effective July 1, 2018.
- Provide HCBS under this 1115 Demonstration through the MMMC and HIV SNP delivery system, for children who are not exempt or excluded from enrollment effective July 1, 2018. Children who receive HCBS and who are exempt or excluded from MMMC and HIV SNP enrollment will receive HCBS through the Fee for Service (FFS) delivery system under the Demonstration.
- Provide Health Home care management for children eligible for HCBS under this 1115 Demonstration.
- Include medically needy children under age 21 (42 CFR 435.308) with income at or below the monthly income standard or spenddown if they are eligible for HCBS in the demonstration.
- Streamline children's HCBS benefits and administration to have more consistent eligibility processes and benefits across all populations.
- Offer a single HCBS benefit package to all children meeting institutional level of care (LOC) functional criteria. This includes offering State Plan Community First Choice Option (CFCO) services to children who are otherwise eligible for CFCO services but who become eligible for Medicaid solely because of receipt of HCBS (i.e., Family of One children not eligible under the State Plan but who meet institutional admission criteria and receive HCBS).
- Offer an HCBS benefit package identical to the 1115 HCBS package to children at risk of institutionalization but not meeting institutional LOC functional criteria. The children must meet targeting criteria of behavioral health or having experienced abuse, neglect and maltreatment or meeting Health Home complex trauma targeting criteria, risk factors and having functional needs at-risk of institutional care under the Demonstration. These services will be added no earlier than January 1, 2019 for children who are already eligible for Medicaid under community eligibility rules.² These at-risk HCBS Level of Need (LON) services do not include State Plan CFCO services because the children do not meet institutional LOC criteria.
- Expand Medicaid eligibility for children with parental income waived to those meeting at-risk HCBS LON targeting criteria, risk factors, and functional status to offer an HCBS benefit package identical to the HCBS package for other at-risk LON children under the Demonstration. This LON Family of One children's expansion population will be added no earlier than January 1, 2019.
- Include children placed in a Voluntary Foster Care Agency (VFCA) in MMMC or HIV SNPs no earlier than January 1, 2019.
- Transition HCBS to risk-based reimbursement no earlier than July 1, 2020.

² Children who are already eligible for Medicaid under community eligibility rules include both Categorically Needy and Medically Needy children who are eligible without considering the child under Family of One or institutional eligibility rules.

This Demonstration amendment provides further detail on the requirements for the children's behavioral health and HCBS populations and services being integrated into the Demonstration and Mainstream Medicaid MCOs and HIV SNPs.

The goals of the children's managed care model are to improve clinical and recovery outcomes for children and youth with BH and HCBS needs, (e.g., medically fragile children, those having BH needs, and children with developmental disabilities in FC); reduce the growth in costs through a reduction in unnecessary emergency and inpatient care; addressing needs early in childhood and before they escalate and become more costly and complex in adulthood; integrate the delivery and care planning of behavioral health, health services and community supports; and increase network capacity to deliver community-based recovery-oriented services and supports. To ensure MCOs are equipped to meet the needs of the HCBS and BH population, the plans will be reviewed and qualified against new health and BH specific administrative, performance and fiscal standards. Implementation will be staggered, as noted in the timeline in Section 1, question 6.

2. Include the rationale for the Demonstration.

As part of Governor Andrew Cuomo's efforts to "conduct a fundamental restructuring of (the) Medicaid program to achieve measurable improvement in health outcomes, sustainable cost control, and a more efficient administrative structure," the Governor appointed a Medicaid Redesign Team (MRT). The MRT created several work groups to review and provide recommendations in key areas, including BH. The 22 members of the work group included State commissioners, advocates, providers, insurers, and other stakeholders from the New York Behavioral Health community. A Children's Behavioral Health Subcommittee was formed to focus on the unique needs of children and families. Through the work group's six meetings and those of the subcommittee, a series of recommendations were adopted. The MRT adopted recommendations from its BH work group and children's subcommittee concerning the development of specialty BH managed care. Meetings and stakeholder engagement will continue throughout implementation and oversight processes.

The State is submitting this amendment to its current 1115 MRT Waiver to implement the recommendations adopted by the Children's MRT Behavioral Health Subcommittee, to develop a children's managed care model that improves clinical and recovery outcomes for children and youth with BH and HCBS needs (e.g., medically fragile children, children with BH needs, and children with developmental disabilities in FC).

This Demonstration package is part of a package of children's reform and redesign initiatives developed in collaboration with the MRT Subcommittee and stakeholder engagement.

The effective date of the MRT Waiver Amendment for Children will be January 1, 2018 and reflects an anticipated timeline for implementation that begins July 1, 2018 and runs

through January 1, 2019. Depending on the timeframes for acquiring any necessary approvals, these dates may be modified accordingly. The provisions of the 1115 MRT Waiver are part of a package of children's reform and redesign initiatives, which includes two separately proposed State Plan Amendments (SPAs) to implement six new State plan services, and collectively constitutes the MRT Children's Redesign Plan. A seventh State Plan amendment, which is related to the transition of the foster care population included in the MRT Children's Redesign Plan, will also be submitted at a later date.

The timely and collective implementation and approval of the State Plans and Demonstration amendment is necessary to ensure that all children in New York receive comparable services under the Demonstration. Because these services permit the delivery of community evidence-based practices consistent with CMS guidance³, the approval of the State Plan Amendments is linked to the approval of this Demonstration amendment and ensuring that comprehensive coordination of physical health and behavioral health within Health Homes as well as appropriate utilization review over these new services within FFS and managed care occurs.

- o Two State Plan Amendments have been submitted to implement the six new EPSDT services described above: Other Licensed Practitioners.*
- o Crisis Intervention.*
- o Youth Peer Support and Training.*
- o Family Peer Support Services.*
- o Community Psychiatric Support and Treatment.*
- o Psychosocial Rehabilitation Supports.*

The following prevention SPA will be separately submitted.

- Residential Supports and Services is a new EPSDT Prevention SPA service related to foster care providers that will be included in the MMMC and HIV SNP benefit packages once approved in the State Plan for an effective date of January 1, 2019.*

The 1115 MRT waiver will also implement the Health Home model in the provision of HCBS services. The Health Home model, as recently expanded to serve children, was also developed in collaboration with the MRT Subcommittee and stakeholder engagement.

3. Describe the hypotheses that will be tested/evaluated during the Demonstration's approval period and the plan by which the State will use to test them.

³ CMCS-IB dated March 27, 2013, "Prevention and Early Identification of Mental Health and Substance Use Conditions"; Joint CMCS and SAMHSA Informational Bulletin dated May 7, 2013, "Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions"; State Medicaid Director Letter, July 11, 2013, "Trauma Informed care for Children"; Joint CMCS and SAMHSA Informational Bulletin dated January 26, 2015, "Coverage of Behavioral Health Services for Youth with Substance Use Disorders".

Goal 1: Improve the health outcomes for eligible HCBS individuals under 21 (HCBS Child/Youth) with access to the Medicaid managed care delivery system.

	Research Question
1	Access to care: What are the consequences of targeting availability of HCBS to a more narrowly defined population than the criteria in the State Plan?
2	Costs: What are the PMPM costs of HCBS for Children enrollees who receive services and how have they improved health outcomes?
3	To what extent are new populations (i.e., Medically Needy under age 21 and Foster Care) satisfied with their access to primary care services, including dental services?

Goal 2: Improve timely access to the additional EPSDT benefits that address early behavioral health needs and health needs of children will demonstrate improved health outcomes and long term financial savings.

	Research Question
1	To what extent are MMMC enrollees accessing community based behavioral specialty services in a timely manner?
2	Access to Care: To what extent are MMMC enrollees accessing community based health care or integrated health/behavioral health care in a manner that results in improved health care outcomes?

Goal 3: Increase appropriate access to the uniform HCBS benefit package for children who meet Level of Care and/or Level of Need criteria to achieve improved health outcomes while recognizing that children's needs change over time along with the duration, scope and frequency of services.

	Research Question
1	How has enrollment in HCBS increased over the length of the Demonstration?
2	What are the demographic, social, functional and clinical characteristics of the HCBS population? Are they changing over time?

Goal 4: Increase access to LON HCBS under the Demonstration and reduce the number of children being referred and diverted to more costly institutional level of care. More children will remain in the community and be diverted from institutional services if delivered prior to the child meeting an institutional level of care.

	Research Question
1	Access to Care: To what extent has the Demonstration improved availability of Home and Community Based Services for Children? What are their health outcomes and have they been able to remain in the community?
2	Costs: To what extent are HCBS cost effective? What are the PMPM costs of inpatient psychiatric services, SUD ancillary withdrawal, hospital-based detox and emergency room services for the Children's HCBS population? Are these costs decreasing over time?

Goal 5: Improve access to the integrated Health Home model for all children to improve the coordination of care for children and increase access to available services.

	Research Question
1	To what extent are Health Home/HCBS enrollees accessing primary care?
2	Access to Care: To the extent there is capacity for HCBS services, to what extent are Health

	Home/HCBS enrollees accessing community based health care or integrated health/behavioral health care?
3	Quality of Care: Are Health Home/HCBS enrollees accessing necessary services such as health monitoring and prevention services? Are chronic health and behavioral health conditions being managed appropriately?

Goal 6: Improve the integration of care for children exempted or excluded from MMMC or HIV SNPs in the Demonstration.

	Research Question
1	Are the health outcomes of children not in managed care different than children in managed care under the Demonstration?

Goal 7: Improve continuity of care for youth as they transition into the adult Medicaid services system, specifically to the HARP from the children's Mainstream managed care benefits.

	Research Question
1	Are chronic health and behavioral health conditions for young adults who transition to adult HCBS and other Medicaid services (e.g., 21–25) in the Demonstration being managed appropriately?

4. Describe where the Demonstration will operate, i.e., statewide, or in specific regions within the State.

The Demonstration will operate statewide after completion of a phase-in schedule. See the proposed statewide phase-in of the new children's populations and services below in item 6 and presented more fully in Section V.

5. If the Demonstration will not operate statewide, please indicate the geographic areas/regions of the State where the Demonstration will operate;

N/A

6. Include the proposed timeframe for the Demonstration;

The Demonstration effective date is January 1, 2018. Implementation of Phase 1 o will begin July 1, 2018 with the consolidation of the six HCBS children's waivers under the 1115, and the inclusion of existing and new BH services for children enrolled in MMMC and HIV SNPs. Children receiving HCBS and currently enrolled in the 1915(c) Waivers and exempted or excluded from managed care are also included in the Demonstration and will continue to receive HCBS through FFS Medicaid until transitioned into managed care. A complete description of the proposed implementation timeline is found in Section V.

High-Level Timeline		
1	Waiver effective date	1/1/18
2	Children meeting HCBS institutional LOC criteria and enrolled in the six 1915(c)	7/1/18

High-Level Timeline		
	<p>waivers as of 7/1/18 will transition to the 1115 Demonstration.</p> <ul style="list-style-type: none"> • Children eligible under community and institutional (Family of One) Medicaid rules who are not otherwise excluded from enrollment will be enrolled in MMMC and HIV SNPs except for Children in Voluntary Foster Care on July 1, 2018. • The HCBS benefits will be aligned and eligibility evaluations will transition to the 1115 demonstration on July 1, 2018 for all six waivers. • Transitional care policies for children with LTSS will be in effect for 180 days following the date of transition for an individual. Existing HCBS Plans of Care utilization, services and HCBS providers for the population transitioning to MMMC or HIV SNP will remain unchanged unless additional services/utilization/provider changes are requested by the beneficiary for not less than 180 days, during which time, a new Plan of Care (POC) is to be developed and approved by the MMMC Plans or HIV SNPs through the Health Homes. POCs for children in FFS Medicaid will remain in effect until the next Medicaid recertification or POC review, whichever comes first. • On July 1, 2018, care coordination and care coordination staff for all children receiving services under the current six HCBS waivers will transition to Health Home. Children new to Medicaid requesting HCBS and those Medicaid children newly determined eligible for HCBS will also receive Health Home care management. HCBS benefits will be delivered under the MMMC or HIV SNPs or through FFS Medicaid for children exempted or excluded from MMMC or HIV SNP enrollment. 	
3	<p>Beginning no earlier than January 1, 2019, the following will occur:</p> <ul style="list-style-type: none"> • Medicaid-eligible children, who meet at-risk LON criteria may receive HCBS. • Children in Voluntary Foster Care Agencies transition to MMMC and HIV SNPs. • Medicaid eligibility is expanded to children who meet at-risk LON criteria and are determined Medicaid eligible through Family of One and receive HCBS. 	1/1/2019
4	HCBS for children transition to risk-based reimbursement.	7/1/2020

7. Describe whether the Demonstration will affect and/or modify other components of the State's current Medicaid and CHIP programs outside of eligibility, benefits, cost sharing or delivery systems.

The Demonstration Amendment will affect only Medicaid eligibility, benefits and delivery systems. Cost sharing will not be affected and components of the State's current Medicaid and CHIP programs outside of the areas listed will not be affected.

Section II - Demonstration Eligibility

This section should include information on the populations that will participate in the Demonstration, including income level. In accordance with 42 CFR 431.412(a)(ii), the

information identified in this section must be included in a state's application in order to be determined complete. Specifically, this section should:

- 1. Include a chart identifying any populations whose eligibility will be affected by the Demonstration (an example is provided below; note that populations whose eligibility is not proposed to be changed by the Demonstration do not need to be included). Please refer to Medicaid Eligibility Groups: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/List-of-Eligibility-Groups.pdf> when describing Medicaid State Plan populations, and for an expansion eligibility group, please provide the state name for the groups that is sufficiently descriptive to explain the groups to the public.**

Eligibility Chart for Children/Youth

Eligibility will not change for the Children/Youth under age 21 eligible under community Medicaid rules. Children who are otherwise excluded from MMMC or HIV SNP enrollment will be included in the Demonstration in the fee-for-service Medicaid delivery system until the point they will transition to MMMC or HIV SNP enrollment.⁴

⁴ LOC HCBS other than CFCO services will be "pass-through" services (Demonstration services 16). CFCO HCBS for State Plan eligibles are covered under the State Plan and will be in the MEG for State Plan services. Family of One LOC children formerly covered under the 1915(c) waivers under a waiver of Section 1902(a)(10)(C)(i)(III) of the Social Security Act will be a "pass through" population (Demonstration population 12). HCBS LON Family of One HCBS populations and services will be an "Expansion Population under CNOM" with a waiver of Section 1902(a)(10)(C)(i)(III) of the Social Security Act. (Demonstration population 13).

Mandatory Medicaid Eligibility

The following populations are eligible under the current Medicaid State Plan for children.

<i>Eligibility Group Name</i>	<i>Group Name and Delivery System</i>	<i>Service Package and Delivery System</i>	<i>Medicaid Eligibility Group (MEG): Demonstration Services or Demonstration Population</i>
<i>Children eligible for Medicaid under community eligibility rules (Categorially and Medically Needy) including children meeting targeting, risk and institutional LOC and at-risk LON functional criteria and receiving HCBS.</i>	<i>Medicaid children eligible for managed care will receive services through MMMC or HIV SNPs. Children with Medicaid excluded or exempted from the MMMC or HIV SNP delivery system will receive services via FFS.</i>	<p><i>State Plan benefits and HCBS benefits. All children will receive all State Plan services and, if in managed care, Demonstration services (Outpatient/residential Addiction, Crisis Intervention, and LBHP).</i></p> <p><i>Children meeting LOC will also receive State Plan CFCO HCBS services, if eligible, and 1115 HCBS children's services (See attachment 1: Benefit Descriptions).</i></p> <p><i>Children meeting LON will also receive 1115 HCBS children's services (See attachment 1).</i></p>	<p><i>1115 HCBS other than CFCO HCBS into MEG for Demonstration Services 16.</i></p> <p><i>All other State Plan services including CFCO into MEG for State Plan eligibility group for which the beneficiary already qualifies.</i></p>

Optional Medicaid Eligibility

The following populations are eligible under current 1915(c) waivers for children.

Eligibility Group Name	SSA and CFR Citations	Income Level	Group Name and Delivery System	Service Package	MEG: Demonstration Services or Demonstration Population
<p><i>LOC Family of One - children who would be eligible for Medicaid under institutional rules and receiving services under the state's current 1915(c) waivers specifically:</i></p> <ul style="list-style-type: none"> • <i>OMH SED waiver #NY.0296</i> • <i>CAH I/II waiver #NY.4125</i> • <i>OPWDD CAH waiver #40176</i> • <i>B2H SED waiver #NY.0469</i> • <i>B2H DD waiver #NY.0470</i> • <i>B2H Medically Fragile waiver #NY.0471</i> 	<p><i>Medically needy children with a waiver of 1902(a)(10)(C)(i)(III) meeting institutional LOC.</i></p>	<p><i>Income that does not exceed the medically needy income standard for an individual or who have a spenddown; For SSI-related medically needy only, resources that do not exceed the medically needy resource standard for an individual (there is no resource test for children who are not SSI-related); Individuals must meet institutional functional criteria requirements.</i></p> <p><i>Use institutional income and resource rules for the medically needy meeting institutional LOC.</i></p>	<p><i>"LOC Family of One" children's HCBS group (i.e., Family of One child where the child meets institutional functional eligibility criteria and receives HCBS).</i></p> <p><i>Fully eligible Family of One children will be in managed care unless otherwise exempted or excluded. Children exempted or excluded from managed care will receive services through the FFS delivery system.</i></p>	<p><i>State Plan benefits including CFCO HCBS benefits and 1115 HCBS benefits.</i></p> <p><i>If children are in managed care, they will receive Demonstration services (Outpatient/residential Addiction, Crisis Intervention, and LBHP).</i></p>	<p><i>Demonstration Population 12.</i></p>

Expansion Eligibility

Eligibility Group Name	Social Security Act and CFR Citations	Income Level	Group Name and delivery system	Service Package	MEG
<p><i>New HCBS program for children meeting behavioral health or abuse and neglect targeting criteria, including children with complex trauma. All children in these target populations are at risk of institutionalization and meet risk factors and needs-based criteria but do not meet institutional LOC.</i></p>	<p><i>Medically needy children with a waiver of 1902(a)(10)(C)(i)(III) meeting needs-based criteria for HCBS.</i></p>	<p><i>Income that does not exceed the medically needy income standard for an individual or who have a spenddown. For SSI-related medically needy, resources that do not exceed the medically needy resource standard for an individual (there is no resource test for non SSI-related children).</i></p>	<p><i>“LON Family of One” at-risk HCBS children (i.e., the child meets at-risk LON HCBS eligibility criteria so parental income is waived and the child receives HCBS as a Family of One).</i></p> <p><i>Fully eligible Family of One children will be in managed care unless otherwise exempted or excluded. Children exempted or excluded from managed care will receive services through the FFS delivery system.</i></p>	<p><i>State Plan benefits and 1115 HCBS benefits Note: CFCO benefits are not provided to these children.</i></p> <p><i>If children are in managed care, they will receive Demonstration services (Outpatient/residential Addiction, Crisis Intervention, and LBHP).</i></p>	<p><i>Demonstration population 13.</i></p>

A. Targeting and Functional Criteria for Children Meeting institutional Level of Care (LOC)

Note: to transition children's coverage and services under the six children's Section 1915(c) HCBS waivers to the 1115 Demonstration, the targeting and functional criteria from the following six waivers are included below and requested to be added to the 1115 STCs:

- Office of Mental Health (OMH) Serious Emotional Disturbance (SED) waiver #NY.0296;*
- Department of Health (DOH) Care At Home (CAH) I/II waiver #NY.4125;*
- Office for People With Developmental Disabilities (OPWDD) Care At Home (CAH) waiver #NY.40176*
- Office of Children and Families (OCFS) Bridges to Health (B2H) SED waiver #NY.0469;*
- OCFS B2H Developmental Disability (DD) waiver #NY.0470;*
- OCFS B2H Medically Fragile waiver #NY.0471*

The following LOC populations are the combined eligibility of the six HCBS waivers above. Individuals must meet institutional and functional eligibility criteria for LOC as indicated by a face-to-face assessment using the assessment tool determining LOC for that population under the Demonstration: 1) the Child and Adolescent Needs and Strengths (CANS)-NY tool for children with Serious Emotional Disturbance, 2) the State designated assessment protocols and tools for Children who are Medically Fragile and 3) the Office for People with Developmental Disabilities (OPWDD) eligibility tool for FC children with DD.

Under the Demonstration, the 1115 will be administered by the Department of Health – not multiple sister agencies. The Department of Health through MMMCs, HIV SNPs and a State Independent Entity for FFS will utilize Health Homes to administer all assessments through the Uniform Assessment System which will have algorithms (except for the FC DD and OPWDD CAH MF DD population as noted below) to determine functional eligibility criteria. In addition, the HH will ensure that the child meets all other eligibility criteria for HCBS (i.e., a child must live in a setting meeting HCBS settings criteria to be eligible for HCBS under either LOC and LON criteria).

The SED diagnosis below encompasses the OMH and B2H criteria in the former 1915(c) waivers. The medically fragile determination encompasses the CAH and B2H criteria in former 1915(c) waivers. B2H DD current diagnosis and functional standards remain the same as under the current waiver. These requirements combined with the coordination/transition assurances for current children will ensure New York does not violate the Maintenance of Effort requirements for children under the Accountable Care Act. LOC continues to equal the medical institutional admission criteria into that institution in NY (hospital for SED, hospital or nursing facility for Medically Fragile, and ICF/IDD for the DD population). Note: Only children with DD in FC or children with DD who are MF and Family of One are served under this authority. Children with DD who are not in FC or who are not MF are served under other OPWDD authorities.

Children currently in receipt of HCBS and currently enrolled in the 1915(c) Waivers and exempt or excluded from enrollment in MMMC and HIV SNP are also included in the Demonstration to

continue to receive HCBS through FFS Medicaid until those children can transition into managed care.

Children that are currently on the 1915(c) waiver at the time of transition under the 1115 waiver will continue to receive HCBS as long as they meet either the 1115 Demonstration LOC or LON criteria. This will ensure that children on HCBS will remain in HCBS as long as they qualify under the Demonstration because it can be demonstrated that the child would have met LOC criteria under the former six HCBS waivers. This exception will also remain in place for new Family of One LOC children until such time as the LON criteria is implemented to ensure that ACA Maintenance of Effort requirements are met. Because new assessment tools and criteria are being implemented to create consistency between the children's HCBS populations, until the LON populations are implemented, the Department of Health or its designee may place in HCBS a new Community Eligible Medicaid child meeting targeting and risk criteria who in absence of HCBS would be institutionalized.

1. Serious Emotional Disturbance (SED) LOC population:

a. Target Criteria

- i. Ages 0 to their 21st birthday*
- ii. Serious emotional disturbance means a child or adolescent has a designated mental illness diagnosis according to the most current Diagnostic and Statistical Manual of Mental Disorders (DSM). Designated mental illness means a disruption of normal cognitive, emotional, or behavioral functioning, which can be classified and diagnosed using the current edition of the DSM, other than:
 - 1. Substance-related and addictive disorders without a co-occurring diagnosis*
 - 2. Neurodevelopmental disorders except: attention-deficit/hyperactivity disorder and tic disorders*
 - 3. Neurocognitive disorders*
 - 4. Other conditions that may be a focus of clinical attention (V – codes in ICD-9 or Z codes in ICD-10) except: V61.20 (Z62.820) parent-child relational problem*
 - 5. Other mental disorders**

b. Risk Factors

- i. Currently in an out-of-home placement, including psychiatric hospital, or*
- ii. Has been in an out-of-home placement, including psychiatric hospital within the past six months, or*
- iii. Has applied for an out-of-home placement, including placement in psychiatric hospital within the past six (6) months, or*
- iv. Currently is multi-system involved and needs complex services/supports to remain successful in the community and*
- v. A licensed practitioner of the healing arts (LPHA) who has the ability to diagnose within his or her scope of practice under state law has*

determined in writing that the child, in the absence of HCBS, is at risk of institutionalization. The LPHA has submitted written clinical documentation to support the determination.

2. *Medically Fragile LOC population:*

a. *Target Criteria*

- i. *Ages 0 to their 21st birthday⁵*
- ii. *The child must have a documented physical disability following state demonstration protocols.*

b. *Risk Factor*

- i. *A LPHA who has the ability to diagnose within his or her scope of practice under state law has determined in writing that the child, in the absence of HCBS, is at risk of institutionalization. The LPHA has submitted written clinical documentation to support the determination.*

3. *Developmental Disability LOC population:*

a. *Target Criteria*

- i. *Ages 0 to their 21st birthday*
- ii. *A child having a developmental 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.*

b. *Risk Factor*

- i. *The child must be either: 1) Medically Frail using the risk factor under 2b above and Family of One eligible; or 2) a FC child who enrolled in HCBS originally while in the care and custody of Local Departments of Social Services (counties and New York City) (LDSS) or a child in the custody of OCFS Division of Juvenile Justice and Opportunities for Youth (DJJOY). For the second risk factor, once enrolled, eligibility can continue after the child is discharged from LDSS and OCFS DJJOY custody so long as the child*

⁵ MF children may optionally transition to MLTC on their 18th birthday. Once enrolled, eligibility for a child in custody of OCFS can continue after the child is discharged from LDSS custody up to the 21st birthday so long as the child continues to meet targeting, risk, and functional criteria with no break in eligibility.

continues to meet targeting, risk and functional criteria (no break in coverage permitted). This risk factor continues Maintenance of Effort for children up through, but not including, their 21st birthday (B2H Waiver reference).

B. Targeting and Functional Criteria for Children Meeting At-risk Needs-based Criteria Level of Need (LON)

The following two populations are at-risk populations who will be eligible for HCBS during the second implementation phase. Individuals must meet functional needs-based criteria less than an institutional admission criteria using the CANS-NY assessment for children with serious emotional disturbance and abuse, neglect, maltreatment and complex trauma. Generally, the child does not meet the need for institutional level of care but does have extended impairment in functioning demonstrated by the child experiencing functional limitations. An individual is eligible for LON services if he or she has a need for HCBS services as indicated by a face-to-face assessment with at least “moderate” levels of need as indicated by a State designated score on the HCBS eligibility assessment tool. The HCBS functional eligibility for LON is based on a subset of questions from the Child and Adolescent Needs and Strengths - New York (CANS-NY).

1. SED LON population:

a. Target Criteria

- i. Ages 0 to their 21st birthday*
- ii. Serious emotional disturbance means a child or adolescent has a designated mental illness diagnosis according to the most current DSM. Designated mental illness means a disruption of normal cognitive, emotional, or behavioral functioning, which can be classified and diagnosed using the current edition of the DSM, other than:
 - 1. Substance-related and addictive disorders only (i.e., not co-occurring)*
 - 2. Neurodevelopmental disorders except: attention-deficit/hyperactivity disorder and tic disorders*
 - 3. Neurocognitive disorders*
 - 4. Other conditions that may be a focus of clinical attention (V –codes in ICD-9 or Z codes in ICD-10) except: V61.20 (Z62.820) parent-child relational problem*
 - 5. Other mental disorders**
- iii. A child may not solely have a developmental disorder (299.xx.315.xx.319.xx.) or Organic Brain syndrome (290.xx.293.xx.294xx) or Autism spectrum disorder 299.00 (F84.0) (unless if co-occurring with SED) and may not be enrolled in an OPWDD waiver*

b. Risk Factors

- i. The child has a reasonable expectation of benefiting from HCBS and*

- ii. The child requires HCBS to maintain stability, to improve functioning, to prevent relapse to an acute inpatient level of care and/or to maintain residence in the community and*
- iii. A LPHA who has the ability to diagnose within his or her scope of practice under state law has determined in writing that the child, in the absence of HCBS, is at risk of treatment in a more restrictive setting. The LPHA has submitted written clinical documentation to support the determination.*

2. Abuse, Neglect and Maltreatment or Health Home Complex Trauma LON population:

a. Target Criteria

- i. Ages 0 to their 21st birthday*
- ii. Children who have experienced physical, emotional, or sexual abuse or neglect, or maltreatment and are in the custody of LDSS or complex trauma (as defined by in the Health Home State Plan).*

b. Risk Factors:

- i. The child must meet the following risk factors (a and (b or c) and d and e):*
 - a. The child has a reasonable expectation of benefiting from HCBS and either b or c.*
 - b. The child requires HCBS to maintain stability, improve functioning, prevent relapse to an acute inpatient level of care and maintain residence in the community or*
 - c. The child who, but for the provision of HCBS, would be at risk for a more restrictive setting and*
 - d. A LPHA who has the ability to diagnose within his or her scope of practice under state law has determined in writing that the child, in the absence of HCBS, is at risk of treatment in a more restrictive setting. The LPHA has submitted written clinical documentation to support the determination.*
- e. And one of the following risk factors (ii or iii):*
 - ii. Medicaid Community Eligible children such as a TANF child or a child in the care and custody of LDSS; or*
 - iii. A former FC child who was enrolled in HCBS originally while in the care and custody of LDSS with no break in eligibility.*

1. Describe the standards and methodologies the state will use to determine eligibility for any populations whose eligibility is changed under the Demonstration, to the extent those standards or methodologies differ from the State Plan.

Medically Needy children under age 21 (42 CFR 435.308) who receive HCBS will be included under the demonstration. With the exception pertaining to deeming of income and resources discussed below, the standards and methodologies of that eligibility group will not differ from the State Plan. Both TANF (Child under age 21) and SSI-Related Medically Needy children with income at or below the monthly income standard and children with spenddown will be included under the demonstration if they are eligible to receive HCBS services under the demonstration.

For the Family of One populations under this Demonstration amendment, the State wants to waive deeming of income and resources (if applicable) for all medically needy children (both SSI-related and non SSI-related) who meet targeting criteria, risk factors, and institutional level of care and needs based criteria for HCBS. Note: post eligibility rules do not apply to these populations.

For LOC Family of One HCBS children (Optional Medicaid eligibility group): Income that does not exceed the medically needy income standard for an individual or who have a spenddown; for SSI-related children, resources that do not exceed the medically needy resource standard for an individual; Individuals must meet institutional functional criteria requirements. These LOC Family of One groups were previously included under the State's existing 1915(c) waivers #0296, #0469, #0470, #0471, #40176 and #4125.

For LON Family of One at-risk HCBS children (Expansion eligibility group): Income that does not exceed the medically needy income standard for an individual or who have a spenddown; for SSI-related children, resources that do not exceed the medically needy resource standard for an individual; do not count income and/or resources from parents as being available to children who otherwise meet the requirements for eligibility as medically needy.

2. Specify any enrollment limits that apply for expansion populations under the Demonstration.

Under the 1115 Demonstration, the State of New York will not maintain waiting lists for children's HCBS for children who meet institutional LOC.

However the following mechanisms will be available to New York if the projections of the LON population and services under the Demonstration exceed resources available.

- *New York will project the number of individuals who are expected to be eligible for HCBS under LON and submit the actual number served each year. If the actual enrollment exceeds the projection, the state may modify the non-financial needs-based eligibility criteria for the LON population without prior approval by CMS following a 60-day*

notification process. Existing individuals on the LON authority will continue to be served through grandfathered eligibility for as long as the at-risk LON HCBS eligibility option is authorized.

Projected Number of Unduplicated LON Member Months To Be Served Annually. (Specify for year one-five):⁶

<i>Annual Period</i>	<i>From</i>	<i>To</i>	<i>Projected Number of Community Eligible LON Member Months</i>	<i>Projected Number of Family of One LON Member Months</i>
Year 1/DY19	4/1/2018	3/31/2019		
Year 2/DY 20	4/1/2018	3/31/2019	36,918	483
Year 3/DY 21	4/1/2019	3/31/2020	97,476	9,660
Year 4/DY 22	4/1/2020	3/31/2021	110,604	19,344
Year 5/DY 23	4/1/2021	3/31/2022	131,220	36,744

- *The State will limit the number of expansion children who are “LON Family of One” at-risk HCBS children (i.e., Expansion Population - Family of One child where the child meets at-risk level of need HCBS eligibility criteria and receives HCBS when parental income is disregarded) to the number of children projected by the New York State Department of Health to be supported by the State’s annual global spending cap. If the actual enrollment exceeds the projection, the state may institute a wait list managed by DOH for the LON Family of One at risk HCBS children. Existing individuals on the Demonstration under LON Family of One continue to be served through grandfathered eligibility for as long as at-risk LON HCBS eligibility option is authorized.*
- 3. Provide the projected number of individuals who would be eligible for the Demonstration, and indicate if the projections are based on current state programs (i.e., Medicaid State Plan, or populations covered using other waiver authority, such as 1915(c). If applicable, please specify the size of the populations currently served in those programs.**

⁶ *Note: This chart and the budget neutrality estimates with this submission reflect originally proposed implementation dates of various aspects of this demonstration and range between October 1, 2017, and January 1, 2020. The State is in the process of updating the budget neutrality estimates and this chart to reflect the updated proposed effective date of this amendment of January 1, 2018 through January 1, 2020, subject to the CMS approval, through the end of the Demonstration, consistent with the remaining demonstration years of the current renewal.*

New populations to the Demonstration will include the following individuals currently eligible for Medicaid:

1. *Medically needy children under age 21 (42 CFR 435.308) with income at or below the monthly income standard or spenddown if they are eligible for HCBS under the demonstration.*
2. *FC children served in voluntary FC agencies.*
3. *Children in receipt of HCBS benefits and exempt or excluded from managed care (will be in FFS delivery system).*
4. *The new Demonstration Expansion Population which is the at-risk HCBS LON population under Family of One provisions (e.g., LON Family of One).*

It is not anticipated that a large un-served population exists and will become Medicaid eligible under this amendment. Some new children may become eligible for Medicaid under the LON Family of One at risk HCBS population.

The current children’s HCBS waivers had the following enrollment in CY 2014(in member months)

Waiver	CY2014 Member Months
OMH SED 1915(c) waiver (NY.0296)	20,266
B2H SED 1915(c) waiver (NY.0469)	34,054
CAH I/II 1915(c) waiver (NY.4125)	15,194
OPWDD CAH 1915(c) waiver (NY.40176)	4,548
B2H Medically Fragile 1915(c) waiver (NY.0471)	1,511
B2H DD 1915(c) waiver (NY.0470)	6,095
Total	81,668

With the elimination of waiting lists from HCBS for children meeting institutional LOC, the number of children receiving HCBS is expected to grow. In addition, adding the at-risk LON HCBS to the Demonstration will increase the number of children receiving HCBS. LON Family of One at-risk HCBS children will be added to the Medicaid population up to the projections supported under the Demonstration (see explanation at Section II, item 2 above).

Current children’s HCBS waivers in CY2014 compared to future enrollment projected for DY23 (April 1, 2021 – March 31, 2022)

HCBS Population	Children’s Member Months Served in HCBS waivers prior to Demonstration in CY 2014	Children’s Member Months proposed to be eligible for HCBS under Demonstration in DY23

HCBS Population	Children's Member Months Served in HCBS waivers prior to Demonstration in CY 2014	Children's Member Months proposed to be eligible for HCBS under Demonstration in DY23
<i>Medicaid Children meeting LOC under Community Eligibility rules</i>	65,064	147,869
<i>Medicaid Children meeting LOC under Family of One rules</i>	16,604	18,363
<i>Medicaid Children meeting at-risk HCBS LON under Community Eligibility rules</i>	N/A	131,220
<i>New Medicaid Children meeting at-risk HCBS LON under Family of One rules</i>	N/A	36,744
Total	81,668	334,196

4. **To the extent that long term services and supports are furnished (either in institutions or the community), describe how the Demonstration will address post-eligibility treatment of income, if applicable. In addition, indicate whether the Demonstration will utilize spousal impoverishment rules under section 1924, or will utilize regular post-eligibility rules under 42 CFR 435.726 (SSI State and section 1634) or under 42 CFR 435.735 (209b State);**

HCBS will be provided for children under the Demonstration meeting targeting, risk, and functional criteria. The Medically Needy children meeting either of the two following criteria may become eligible for Medicaid under the institutional financial criteria with a waiver deeming income and resources for all children (both SSI-related and non SSI-related).

- *LOC Family of One HCBS children group (as of 7/1/2018)*
- *LON Family of One at-risk HCBS children group (as of 1/1/2019 with statewide implementation)*

Medically Needy children may have their parent's income waived and resources (if SSI-related) if they meet the targeting, risk and functional HCBS eligibility criteria only.⁷ Note: Post-eligibility treatment of income rules do not apply to this Family of One population.

⁷ Consistent with the State Medicaid Director letter dated July 25, 2000, Olmstead letter number three, the earliest date for which Federal financial participation (FFP) can be claimed when a person's Medicaid eligibility is predicated upon receipt of Medicaid HCBS under a waiver is the date on which all of criteria in the letter are met. The provisional plan of care developed for Family of One children will include a referral to HH or the State Independent Entity for the face to face assessment and development of the final plan of care.

5. Describe any changes in eligibility procedures the state will use for populations under the Demonstration, including any eligibility simplifications that require 1115 authority (such as continuous eligibility or express lane eligibility for adults or express lane eligibility for children after 2013).

N/A

6. If applicable, describe any eligibility changes that the state is seeking to undertake for the purposes of transitioning Medicaid or CHIP eligibility standards to the methodologies or standards applicable in 2014 (such as financial methodologies for determining eligibility based on modified adjusted gross income), or in light of other changes in 2014.

N/A

Section III – Demonstration Benefits and Cost Sharing Requirements

This section should include information on the benefits provided under the Demonstration as well as any cost sharing requirements. In accordance with 42 CFR 431.412(a)(ii), the information identified in this section must be included in a state's application in order to be determined complete. Specifically, this section should:

1. Indicate whether the benefits provided under the Demonstration differ from those provided under the Medicaid and/or CHIP State Plan:

Yes, services under the Demonstration will differ from services under the State Plan.

First, children meeting HCBS targeting, risk and functional criteria under the Demonstration may receive HCBS as noted in #6 below.

Children meeting institutional LOC criteria who also meet CFCO eligibility and who are eligible for Medicaid under Community Eligibility rules will be eligible for CFCO services under the State Plan. Children eligible for Medicaid under Family of One institutional rules who also meet CFCO eligibility will be eligible for CFCO services under this 1115 Demonstration amendment. A complete listing of CFCO HCBS is in #6 below.

Demonstration Services for Behavioral Health provided under MMMC or HIV SNP which will be placed into the State Plan in order to be provided to children in the FFS delivery system.

- *Outpatient and residential addiction services are already included in the MMMC and HIV SNP benefit package under the 1115. A State Plan for adults and children with an effective date of July 1, 2016 was submitted September 30, 2016.*

- *Licensed Behavioral Health Practitioner (LBHP) and Crisis Intervention services are already included in the MMMC and HIV SNP benefit package under the 1115. Two EPSDT State Plan Amendments with effective dates of March 1, 2017 and October 1, 2017 were submitted on December 30, 2016 as EPSDT Other Licensed Practitioners and EPSDT Crisis Intervention. Note: these effective dates will be modified to July 1, 2018.*

**2. Indicate whether the cost sharing requirements under the Demonstration differ from those provided under the Medicaid and/or CHIP State Plan:
No (if no, please skip questions 8 – 11).**

No

3. If changes are proposed, or if different benefit packages will apply to different eligibility groups affected by the Demonstration, please include a chart specifying the benefit package that each eligibility group will receive under the Demonstration (an example is provided).

Only HCBS will vary by population (e.g., only LOC HCBS populations who meet CFCO eligibility may receive CFCO services).

Benefit Package Chart

Eligibility Group	Benefit Package
<i>Children not meeting HCBS targeting, risk factors and functional criteria</i>	<i>All State Plan and Demonstration services (Outpatient/residential Addiction, Crisis Intervention, and LBHP).</i>
<i>Children meeting HCBS targeting, risk factors, and functional criteria for institutional LOC</i>	<i>All State Plan services including CFCO services – Note: Family of One institutional LOC children will receive CFCO services under the Demonstration, 1115 HCBS children’s services (See attachment 1) and Demonstration services (Outpatient/residential addiction, crisis intervention, and LBHP).</i>
<i>Children meeting HCBS targeting, risk factors and at-risk LON functional criteria</i>	<i>All State Plan services (not eligible for CFCO services), 1115 HCBS children’s services (See Attachment 1) and Demonstration services (Outpatient/residential addiction, crisis intervention, and LBHP).</i>

The State Plan and Demonstration behavioral health benefits listed below are a comprehensive list of behavioral health services in the MMMC and HIV SNP plans for children under age 21 who are not otherwise exempted or excluded from managed care enrollment. Children exempted or excluded from MMMC and HIV SNP will receive the State Plan and HCBS benefits via the FFS delivery system.

From Attachment A of the Standard Terms and Conditions

<i>For individuals 21 and older</i>	<i>Now also applicable to Children/Youth under age 21</i>
State Plan Inpatient and Outpatient Behavioral Health Services in MMMCs for individuals 21 and older, excluding rehabilitation services for residents of community residences	X
Clinic: Medically supervised outpatient withdrawal	X
Clinic: OASAS outpatient and opioid treatment program (OTP) services	X
Rehabilitation: OASAS outpatient rehabilitation programs	X
Clinic: Licensed clinic services (OMH services)	X
Outpatient Hospital: Comprehensive psychiatric emergency program including Extended Observation Bed (EOB)	X
Clinic: Continuing day treatment	X (minimum age is 18 for medical necessity)
Clinic: Partial hospitalization	X
Rehabilitation: Personalized Recovery Oriented Services	X (minimum age is 18 for medical necessity)
Rehabilitation: Intensive Psychiatric Rehabilitation Treatment	X
Rehabilitation: Assertive Community Treatment	X (minimum age is 18 for medical necessity)
Targeted Case Management (being phased out) including Intensive case management/supportive case management	X
Inpatient Hospital: Medically Managed detoxification (hospital based)	X
Inpatient Hospital: Medically supervised inpatient detoxification	X
Inpatient hospital: Inpatient treatment	X
Inpatient Hospital: Inpatient psychiatric services	X
Rehabilitation: Services for residents of community residences <i>Note: these services are currently excluded from the behavioral health integration. Will be phased into MMMC via contract amendments at a later date.</i>	X

Child Specific Behavioral Health services

The State Plan and Demonstration behavioral health benefits below are being included in the MMMC plans for Children/Youth under age 21 according to the implementation phase in.

- **Children's Day Treatment** – *Note: these services are currently excluded from the behavioral health integration. Will be phased into MMMC via contract amendments at a later date.*

- **RTFs** – *Note: these services are currently excluded from the behavioral health integration. Will be phased into MMMC via contract amendments at a later date.*
- **Inpatient BH Services in OMH operated facilities** – *Note: these services are currently excluded from the behavioral health integration. Will be phased into MMMC via contract amendments at a later date.*
- **Residential Rehabilitation Services for Youth (RRSYs)** – *Note: these services are currently excluded from the behavioral health integration. Will be phased into MMMC via contract amendments at a later date.*
- **Teaching Family Home-** *Note: these services are currently excluded from the behavioral health integration. Will be phased into MMMC via contract amendments at a later date.*

Demonstration Services which will be placed in State Plan as noted above.

- *Outpatient and residential addiction services are already included in the MMMC and HIV SNP benefit package under the 1115. A State Plan for adults and children (#16-004) with an effective date of 7/1/2016 was submitted 9/30/2016. For addiction services and the delivery system changes associated with the new demonstration services and resulting state Plan amendments including changes under the CMS Innovation Accelerator Program (IAP), the state may require the MCOs through their contracts, as approved by CMS, to adopt system-wide changes and rates, also approved by CMS, to ensure that the innovations are adopted in a consistent manner statewide.*
- *Licensed Behavioral Health practitioner (LBHP) and Crisis Intervention services are already included in the MMMC and HIV SNP benefit package under the 1115. Two EPSDT State Plan Amendments with effective dates of March 1, 2017 and October 1, 2017 were submitted December 30, 2016 as EPSDT Other Licensed Practitioners and EPSDT Crisis Intervention. Note: these effective dates will be modified to July 1, 2018.*

New State Plan Services

The following four new EPSDT SPA services will also be included in the MMMC and HIV SNP benefit packages with behavioral health services once approved in the State Plan. This EPSDT State Plan Amendment was submitted with the EPSDT Rehabilitation State Plans above for an effective date of October 1, 2017, on December 30, 2016. Note: these effective dates will be modified to July 1, 2018.

- *Youth Peer Support and Training.*
- *Family Peer Support Services.*
- *Community Psychiatric Support and Treatment.*
- *Psychosocial Rehabilitation Supports.*

The following prevention SPA will be separately submitted.

- *Residential Supports and Services is a new EPSDT Prevention SPA service that will be included in the MMMC and HIV SNP benefit packages once approved in the State*

Plan for an effective date of January 1, 2019 and will be submitted no later than March 31, 2019.

4. If electing benchmark-equivalent coverage for a population, please indicate which standard is being used:

N/A

5. In addition to the Benefit Specifications and Qualifications form: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Interim1115-Benefit-Specifications-and-Provider-Qualifications.pdf>, please complete the following chart if the Demonstration will provide benefits that differ from the Medicaid or CHIP State Plan, (an example is provided).

See Attachment 1 to this amendment.

6. Indicate whether Long Term Services and Supports will be provided.

New York will provide the following services to children meeting HCBS targeting, risk and functional criteria if medically necessary and listed on the child's person-centered POC. See attachment 1 for a description of each children's HCBS service. These children's HCBS are available to all children's HCBS populations under the Demonstration and descriptions vary from the adult BH HCBS.

- *Health Home (if not otherwise eligible under the State Plan).*
- *Habilitation.*
- *Caregiver/Family Supports and Services.*
- *Respite.*
- *Prevocational Services.*
- *Supported Employment.*
- *Community Self-Advocacy Training and Support.*
- *Non-Medical Transportation.*
- *Adaptive and Assistive Equipment.*
- *Accessibility Modifications.*
- *Palliative Care.*
- *Financial Management services for the Customized Goods and Services pilot.*
- *Customized Goods and Services (pilot).*

Children meeting institutional LOC criteria who also meet CFCO eligibility and who are eligible for Medicaid under Community Eligibility rules will be eligible for these CFCO

services under the State Plan. Children eligible for Medicaid under Family of One institutional rules who also meet CFCO eligibility will be eligible for these CFCO services under the 1115 Demonstration:

- *Assistive Technology.*
- *Community Transitional services.*
- *Durable Medical Equipment/Medical Supplies.*
- *Environmental Modification.*
- *Community Habilitation.*
- *Supervision and/or Cueing.*
- *Home Delivered/Congregate Meals.*
- *Home Health Care (Aide).*
- *Homemaker/Housekeeper.*
- *Moving Assistance.*
- *Personal Care/Consumer Directed Personal Assistance Program.*
- *Personal Emergency Response.*
- *Transportation -Non-Emergency, Medical.*
- *Transportation -Non-Emergency, Social.*
- *Vehicle Modification.*

See the State's approved CFCO State Plan for service definitions. SPA #13-0035 approved October 23, 2015 and 15-0060 approved 10/23/2015.

7. Indicate whether premium assistance for employer sponsored coverage will be available through the Demonstration.

This amendment does not modify any premium assistance for employer sponsored coverage available under the New York Medicaid program and its existing 1115 MRT waiver.

8. If different from the State Plan, provide the premium amounts by eligibility group and income level (if additional space is needed, please supplement your answer with a Word attachment).

N/A

9. Include a table if the Demonstration will require copayments, coinsurance and/or deductibles that differ from the Medicaid State Plan.

N/A

10. Indicate if there are any exemptions from the proposed cost sharing.

N/A

Section IV – Delivery System and Payment Rates for Services

This section should include information on the means by which benefits will be provided to Demonstration participants. In accordance with 42 CFR 431.412(a)(ii), a description of the proposed healthcare delivery system must be included in a state's application in order to be determined complete. Specifically, this section should:

1. Indicate whether the delivery system used to provide benefits to Demonstration participants will differ from the Medicaid and/or CHIP State Plan:

Children currently in the Demonstration and enrolled in MMMC or HIV SNPs will not change delivery systems or providers.

Children receiving HCBS but not yet eligible for managed care enrollment will remain in FFS until phased into managed care. Children receiving HCBS will be enrolled in and receive care management from the Health Home program authorized under the existing Health Home State Plan. Children that choose not to enroll in Health Home care management and receive HCBS and are enrolled in MMMC or HIV SNPs will receive HCBS care management from the MMMC or HIV SNPs. Children eligible for HCBS and Medicaid under Family of One and also eligible for managed care will be assessed by a State Independent Entity to determine HCBS/Medicaid eligibility prior to being enrolled in a Health Home. Children that choose not to enroll in Health Home care management and receive HCBS and are exempted or excluded from MMMC or HIV SNP will receive HCBS care management from a State Independent Entity.

Children receiving HCBS will be enrolled under the Demonstration in one of two ways:

- 1. Children who are not otherwise excluded or exempt from enrollment in MMMC or HIV SNP will receive coverage through the managed care delivery systems.*
- 2. Children exempted or excluded from MMMC or HIV SNP will remain in fee-for-service Medicaid delivery systems.*

2. Describe the delivery system reforms that will occur as a result of the Demonstration, and if applicable, how they will support the broader goals for improving quality and value in the health care system. Specifically, include information on the proposed Demonstration's expected impact on quality, access, cost of care and potential to improve the health status of the populations covered by the Demonstration. Also include information on which populations and geographic areas will be affected by the reforms;

The MMMC and HIV SNP delivery system will not change under this amendment, other than the addition of performance measures for children's behavioral health and HCBS populations and operations specific to the children's HCBS populations and services.

3. Indicate the delivery system that will be used in the Demonstration by checking one or more of the following boxes:

- X **Managed Care Organization (MCO).** *Children in Managed Care will be enrolled in Health Homes, if eligible. All children in Managed Care receiving HCBS will be enrolled in and receive Health Home care management. Children that choose not to enroll in Health Homes will receive HCBS case management from State Independent Entity (if eligible under HCBS Family of One rules) and the MCO.*
- X **Health Homes.** *Children will be enrolled in Health Homes, if eligible under the State Plan, regardless of whether they are enrolled in Managed Care or FFS delivery systems or eligible for HCBS. Children formerly enrolled in 1915(c) waivers will transition to Health Home Care management.*
- X **Other (please describe):** *Children that choose not to enroll in Health Home Care management and receive HCBS and are exempted or excluded from MMMC or HIV will receive HCBS care management from a State Independent Entity. Note: for all children, HCBS Non-Medical Transportation (NMT) is paid through the State's transportation broker.*

Consistent with the approved 1115 renewal - All children utilizing long term services and supports will have a person centered individual service plan maintained at the MCO or, if in FFS, at the Health Home or State Independent entity. Person-centered planning includes consideration of the current and unique psycho-social and medical needs and history of the enrollee, as well as the person's functional level, and support systems. The person centered plan is developed by the enrollee with the assistance of the MCO, Health Home or State Independent Entity and individuals the enrollee chooses to include

When a service provider is an approved State Plan Health Home provider and also a HCBS provider, this entity may conduct person-centered service planning, care coordination, and provision of HCBS provision as long as firewalls are constructed between the service planning, care coordination, and service provision. A home and community-based service provider who is not also an approved State Plan Health Home provider may not conduct person-centered service planning with individuals who they also provide HCBS, unless that service provider is the only qualified and willing entity available to conduct the service planning. If a service provider is the only willing and qualified entity to conduct service planning, the state must require such provider to establish firewalls between the service provision and planning functions. The person

centered plan is developed in accordance with 42 CFR 441.301(c)(4)(F)(1) through (8).

Health home program will have administrative safeguards in place when providing person-centered planning and care coordination and services that have transitioned from 1915(c) waivers to eligible health home individuals. In addition, the state agrees to meet all health home requirements including reporting annually on quality and utilization measures. In addition, each child will receive the beneficiary protections granted under Medicaid including notices of denials and the right to grieve and file appeals when denied HCBS enrollment or receiving a denial or limitation for a requested service.

4. **If multiple delivery systems will be used, please include a table that depicts the delivery system that will be utilized in the Demonstration for each eligibility group that participates in the Demonstration (an example is provided). Please also include the appropriate authority if the Demonstration will use a delivery system (or is currently seeking one) that is currently authorized under the State Plan, section 1915(a) option, section 1915(b) or section 1932 option.**

<i>Delivery System Chart Eligibility Group</i>	<i>Delivery System</i>	<i>Authority</i>
<i>Children not otherwise excluded from MMMC or HIV SNPs including children in direct Foster Care and/or receiving HCBS</i>	<i>Managed care – MCO Health Home Care Management or the MCO care management if decline Health Home care management Note: HCBS NMT will be provided outside of the MCO by the State’s transportation broker</i>	<i>1115 Demonstration and State Plan</i>
<i>Children with HCBS exempted or excluded from MMMC or HIV SNPs</i>	<i>FFS and Health Home care management or care management by State Independent Entity if Health Home care management is declined. Note: HCBS NMT will be provided by the State’s transportation broker</i>	<i>1115 Demonstration and State Plan</i>

5. **If the Demonstration will utilize a managed care delivery system:**
 - a. **Indicate whether enrollment be voluntary or mandatory. If mandatory, is the state proposing to exempt and/or exclude populations (if additional space is needed, please supplement your answer with a Word attachment).**

Mandatory. All current population exemptions and exclusions will continue to apply as outlined in the STCs with the exceptions of the populations noted in the right hand column of the charts below.

Individuals Excluded from MMMC (including HARP and HIV SNP)

Currently in STC 3 p. 18 - Table 2	Proposed to remain in STCs after Children's Amendment
<i>Individuals who become eligible for Medicaid only after spending down a portion of their income</i>	X
<i>Residents of state psychiatric facilities and residents of Residential Treatment Facilities for Children and Youth</i>	<i>As the RTF services are phased into managed care through contract amendments, the children in RTFs will phase into the demonstration</i>
<i>Individuals under age 21 who are permanent residents of Residential Health Care Facilities or temporary residents of Residential Health Care Facilities at time of enrollment</i>	X
<i>Medicaid eligible infants living with incarcerated mothers</i>	X
<i>Individuals with access to comprehensive private health insurance</i>	X
<i>Foster care children in the placement of a voluntary agency</i>	
<i>Certified blind or disabled children living or expected to live separate and apart from their parents for 30 days or more</i>	X
<i>Individuals expected to be Medicaid eligible for less than 6 months (except for pregnant women)</i>	X
<i>Individuals receiving hospice services (at time of enrollment)</i>	X
<i>Individuals with a "county of fiscal responsibility" code of 97, except for individuals in the New York Office of Mental Health family care program, who other than their residence in district 97, would be eligible to enroll in MMMC.</i>	X
<i>Individuals with a "county of responsibility" code of 98 (Individuals in an Office for People with Developmental Disabilities/OPWDD facility or treatment center)</i>	X
<i>Youth in the care and custody of the commissioner of the Office of Family & Children Services</i>	<i>Youth in OCFS facilities and in the care and custody of the Office of Family and Children Services</i>
<i>Individuals who are under 65 years of age (screened and require treatment) in the Centers for Disease Control and Prevention breast, cervical, colorectal or prostate cancer, and who are not otherwise covered under creditable health coverage</i>	X

Currently in STC 3 p. 18 - Table 2	Proposed to remain in STCs after Children's Amendment
<i>Individuals who are eligible for Emergency Medicaid</i>	X
<i>Aliessa Court Ordered Individuals*</i>	X
<i>Medicare recipients</i>	X
<i>Residents of Assisted Living Programs</i>	X

*Aliessa Aliens are not excluded from Managed Care but are excluded from FFP.

Individuals who may be exempted from MMMC (including HARP and HIV SNP)

Currently in STC 3 p. 19 - Table 3	Proposed to remain in STCs after Children's Amendment
<i>Individuals with chronic medical conditions who have been under active treatment for at least 6 months with a sub-specialist who is not a network provider for any Medicaid MCO in the service area or whose request has been approved by the New York State Department of Health Medical Director because of unusually severe chronic care needs. Exemption is limited to six months</i>	X
<i>Child and Youth residents of alcohol/substance abuse long term residential treatment programs</i> <i>Note: this item was in the 7/29/2015 Amendment STCs and removed in the renewal STCs.</i>	<i>Child and Youth residents of Residential Rehabilitation Services for Youth (RRSYs)</i> <i>As the RRSY services are phased into managed care through contract amendments, the children in RRSYs will mandatorily phase into the demonstration</i>
<i>Individuals designated as participating in OPWDD-sponsored programs</i>	X
<i>Individuals with a developmental or physical disability receiving services through a Medicaid home and community based services (HCBS) waiver authorized under section 1915(c) of the Act</i>	<i>Individuals with a developmental or physical disability receiving services through a Medicaid home and community based services (HCBS) waiver authorized under section 1915(c) of the Act except for children formerly under the CAH I/II, B2H MF, B2H DD, and CAH DD waivers which are subsumed into the Demonstration.</i>
<i>Native Americans</i>	X
<i>Individuals in the following Section 1915(c) waiver programs: Traumatic Brain Injury (TBI) and Nursing Home Transition & Diversion (NHTD)</i>	X
<i>Individuals in the Office for People with Developmental Disabilities Home and Community Based Services Comprehensive (OPWDD HCBS) Section 1915 (c) waiver program</i>	X

- b. Indicate whether managed care will be statewide, or will operate in specific areas of the state (if additional space is needed, please supplement your answer with a Word attachment).**

Managed care already operates statewide. The new populations and services will be implemented based on the phase-in schedule above in Section 1 #6.

- c. Indicate whether there will be a phased-in rollout of managed care (if managed care is not currently in operation or in specific geographic areas of the state. If additional space is needed, please supplement your answer with a Word attachment).**

Statewide: according to the implementation timeline listed Section 1 #6, above.

- d. Describe how the state will assure choice of MCOs, access to care and provider network adequacy (if additional space is needed, please supplement your answer with a Word attachment).**

The process for MMMC and HIV SNP plan selection will remain as it is under the approved Demonstration. Building on the process completed for the adult behavioral health and HARP transition, the State will conduct readiness reviews of the MMMC and HIV SNP plans to verify access to care and provider network for the new children's benefits and populations prior to the transition dates.

- e. Describe how the managed care providers will be selected/procured (if additional space is needed, please supplement your answer with a Word attachment).**

The existing MMMC and HIV SNPs will be utilized and their existing contracts will be amended to include these populations and services. The State will expand benefits covered by existing MMMC and HIV SNP plans. DOH will execute a contract amendment to include these new services and populations. An MCO Qualification Standard Document, which builds on some of the foundational elements already implemented under the transition of adult behavioral health benefits to managed care, will be issued by the State. The MCO Qualification Standard Document will be circulated for public comment and stakeholder input. The MCO Qualification Standard Document will serve as the basis of the desk review and in-person readiness reviews ensuring that the specific requirements of this contract amendment are met prior to implementation and transition.

- 6. Indicate whether any services will not be included under the proposed delivery system and the rationale for the exclusion (if additional space is needed, please supplement your answer with a Word attachment).**

All children continue to be eligible for all State Plan services. All MMMC and HIV SNP services under the currently approved STCs in Attachment A will be included. See complete listing of additional children's services added to the Demonstration above in Section III.

- 7. If the Demonstration will provide personal care and/or long term services and supports, please indicate whether self-direction opportunities are available under the Demonstration. If yes, please describe the opportunities that will be available, and also provide additional information with respect to the person-centered services in the Demonstration and any financial management services that will be provided under the Demonstration (if additional space is needed, please supplement your answer with a Word attachment).**

A self-direction pilot for Customized Goods and Services will be available to HCBS eligible children/youth enrollees. The program will take effect no earlier than January 2019 and be in effect for no more than 24 months and is anticipated to include no more than eight pilot sites phased in over the demonstration. Customized Goods and Services are defined as items or services that may be purchased by an individual receiving HCBS services to help meet their person centered needs and care plan goals. It is anticipated funding shall not exceed \$2,000 annually per participant.

Participation in the Customized Goods and Services pilot is voluntary, and participants may opt out at any time. The State will notify eligible enrollees about the option to Customized Goods and Services. The State will develop a waiting list for the pilot site for enrollees who wish to participate in the pilot, should the demand exceed capacity.

Customized Goods and Services pilot participants will have a Fiscal Intermediary and Management Services provider within the service center. Each participant will have the choice of provider and location for Customized Goods and Services. There will be an RFP for FMS services under the Demonstration for adults in MMMC. The children will use the same FMS as the adults in MMMC.

- 8. If fee-for-service payment will be made for any services, specify any deviation from State Plan provider payment rates. If the services are not otherwise covered under the State Plan, please specify the rate methodology (if additional space is needed, please supplement your answer with a Word attachment).**

FFS payment will be made for children who are eligible for, but not yet enrolled in MMMC or HIV SNPs, and for services excluded from MMMC or HIV SNP contracts (e.g., in the State Plan but not in Attachment A of the STCs, and for HCBS provided to children who are exempt or excluded from MMMC or HIV SNPs.) The State Plan rates and State HCBS FFS fee schedule will be utilized for payment of these services.

- 9. If payment is being made through managed care entities on a capitated basis, specify the methodology for setting capitation rates, and any deviations from the payment and contracting requirements under 42 CFR Part 438 (if additional space is needed, please supplement your answer with a Word attachment).**

All MMMC and HIV SNP payments will be set consistent with actuarial soundness requirements at 42 CFR 438.6(c) and the new 42 CFR 438.4 and the already approved Demonstration. No variation is expected. Costs for all 1905(a) State Plan services will be included in the capitated rates. All reimbursement for HCBS covered in the managed care benefit package will be non-risk for 24 months of the Demonstration subject to the non-risk UPL at 42 CFR 447.362. A contract amendment will be submitted when the HCBS become part of the capitation rates in 24 months. The MCO must pay the FFS fee schedule for non-risk services as long as the HCBS are non-risk (i.e., 24 months). For essential State Plan services/providers, the MCOs must pay at least the FFS fee schedule for 24 months for the new EPSDT SPA services including [Other Licensed Practitioner (OLP), Crisis Intervention, Community Psychiatric Support and Treatment (CPST), Psychosocial Rehabilitation (PSR), Family and Youth Peer Support, and the Preventive Residential Supports], OASAS clinics (Article 32 certified programs), OMH Clinics (Ambulatory Article 31 licensed programs). A fee schedule transition for OCFS voluntary FC agencies for at least 24 months will be developed.

Providers who historically provided care management services under one of the 1915(c) waivers that are eliminated and who will provide services that are being transitioned to Health Home under this 1115 waiver may receive a transitional rate. The transitional rate may be paid for an appropriate number of care management slots in place immediately prior to the providers' transition to this waiver, for no more than 24 months. The rates will be as financially equivalent as practical to the interim rates (and as reconciled) established under the former waivers and in place immediately prior to their transition to Health Home.

- 10. If quality-based supplemental payments are being made to any providers or class of providers, please describe the methodologies; including the quality markers that will be measured and the data that will be collected (if additional space is needed, please supplement your answer with a Word attachment).**

New York will utilize the same Value-Based Purchasing strategies for children as adults under the already approved guidelines for the larger Demonstration.

Section V – Implementation of Demonstration

This section should include the anticipated implementation date, as well as the approach that the State will use to implement the Demonstration. Specifically, this section should:

- 1. Describe the implementation schedule. If implementation is a phase-in approach, please specify the phases, including starting and completion dates by major component/milestone (if additional space is needed, please supplement your answer with a Word attachment).**

The Demonstration amendment will be implemented effective January 1, 2018.

- *Pre-implementation or Non-Demonstration Activities*
Prior to the effective date of the Demonstration, the following key activities will occur:
 - *July 1, 2016 – OASAS Addiction SPA effective date.*
 - *October 2016 – Eligible children are authorized to be enrolled in Health Homes (excluding children enrolled in 1915(c) Waivers).*
- *July 1, 2018 – Start date for following children’s new EPSDT State Plan services.*
 - *Other Licensed Practitioner (OLP) State Plan service*
 - *Crisis Intervention.*
 - *Community Psychiatric Support and Treatment.*
 - *Psychosocial Rehabilitation.*
 - *Family Peer Support.*
 - *Youth Peer Support and Training.*

Demonstration Amendment Effective Date – January 1, 2018.

- *July 1, 2018 – The six children’s Section 1915(c) HCBS waiver benefit packages and eligibility, and behavioral health services including the new State Plan services transition to the 1115 Demonstration.*
- *July 1, 2018 – The new populations (Children/Youth in receipt of HCBS) receive HCBS, and BH services including the new State Plan behavioral health services, in MMMC or HIV SNP unless otherwise excluded or exempt from managed care enrollment.*
 - *MCOs are reimbursed on a non-risk basis for HCBS. State Plan services are at-risk under the capitated rates.*
 - *Children receiving HCBS who are excluded or exempt and choose not to enroll in MMMC or HIV SNP, will continue to receive coverage through the FFS delivery system under the Demonstration.*
- *July 1, 2018 – HCBS children meeting targeting, risk and institutional criteria are incorporated into Health Homes.*
- *January 1, 2019 – Earliest date for children with Medicaid under community eligibility rules meeting at-risk LON HCBS criteria to receive HCBS services.*
- *January 1, 2019 – Children in Voluntary Foster Care Agencies transition to MMMC and HIV SNPS.*

- *January 1, 2019 – Earliest date for children meeting at-risk LON HCBS criteria with family income waived to become Medicaid eligible as “LON Family of One”.*
- *July 1, 2020 – Earliest date for HCBS for children to transition to risk-based reimbursement.*

2. Describe how potential Demonstration participants will be notified/enrolled into the Demonstration (if additional space is needed, please supplement your answer with a Word attachment).

The current MMMC and HIV SNP enrollment process will be utilized for all children not otherwise excluded and who are eligible for Medicaid under community rules.

Modifications to the enrollment process will be made for children eligible for Medicaid using waiver of parental income (e.g., the LOC Family of One and the LON Family of One populations) to ensure that the children’s families are given a choice of MCOs during the HCBS Eligibility Evaluation process and Plan of Care process. Specifically, the following process will be followed for Family of One children:

The State will select an Independent Entity (IE) that will be responsible for various activities relating to children not already enrolled in Medicaid, including:

- *Conducting the HCBS Eligibility Evaluation screen,*
- *Developing the provisional POC,*
- *Determination of HCBS preliminary eligibility,*
- *Educating the family and facilitating Medicaid financial application,*
- *Referral to enrollment broker for plan selection, when not otherwise exempt or excluded, and*
- *Referral to a HH for a full assessment and final POC.*

3. If applicable, describe how the state will contract with managed care organizations to provide Demonstration benefits, including whether the state needs to conduct a procurement action (if additional space is needed, please supplement your answer with a Word attachment).

The State will expand benefits covered by existing MMMC and HIV SNP plans. DOH will execute a contract amendment to include these new services and populations. An MCO Qualification Standards document will be issued by the State, which will serve as the basis of the contract amendment and a desk review of required components of the children’s transition. The MCO Qualification Standard Document will be circulated for public comment and stakeholder input. The desk review will be followed by in-person readiness reviews, to ensure that the specific requirements of this Qualification Standards document are met prior to implementation and transition.

Section VI – Demonstration Financing and Budget Neutrality

This section should include a narrative of how the Demonstration will be financed as well as the expenditure data that accompanies this application. The State must include five years of historical data, as well as projections on member month enrollment. In accordance with 42 CFR 431.412(a)(iii) and (iv), historical and projected expenditures as well as projected enrollment for the proposed Demonstration project must be included in a state's application in order to be determined complete. The additional information requested will be needed before the application can be acted upon.

Please complete the Demonstration financing and budget neutrality forms, respectively and include with the narrative discussion.

The Financing Form: <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Interim1115-Demo-Financing-Form.pdf> includes a set of standard financing questions typically raised in new section 1115 Demonstrations; not all will be applicable to every Demonstration application.

The Budget Neutrality form and spreadsheet: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Interim1115-Budget-Neutrality-Form.pdf> includes a set of questions with respect to historical expenditure data as well as projected Demonstration expenditures.

Budget Neutrality Overview

This section presents the State's approach for showing budget neutrality for the amendment to New York's 1115 MRT waiver (Demonstration) and the data and assumptions used in the development of the cost and caseload estimates supporting this 1115 waiver amendment request.

Budget neutrality estimates for this amendment request include expenditures for all tenets of the proposed Demonstration amendment. The proposed amendment expands the services covered by MMMC and HIV SNPs, adds new existing Medicaid populations to the Demonstration, and also expands the Medicaid eligibility to some children who receive HCBS services. Subsequent sections of this narrative provide additional information on the impact on budget neutrality for the relevant amendment provisions.

The budget neutrality estimates with this submission reflect originally proposed implementation dates of various aspects of this demonstration and range between October 1, 2017, and January 1, 2020. The details of this budget neutrality narrative also recognize the original demonstration years impacted by the various changes. The State is in the process of updating the budget neutrality estimates and narrative below to reflect the updated proposed effective date of this amendment of January 1, 2018 through January 1, 2020 (see Section 1), subject to the CMS approval, through the end of the Demonstration, consistent with the remaining demonstration years of the current renewal.

Budget Neutrality Approach

This amendment request intends to add additional cost estimates related to the amendment services and Medicaid eligibles to the applicable per member per month (PMPM) amounts in the budget neutrality agreement of the current demonstration. In addition, this amendment includes the creation of two additional Medicaid eligibility groups (MEG), MEG 12 and MEG 13, as well as the creation of Demonstration Services 16. This amendment request does not propose to modify the manner in which the State is currently at risk for the per capita costs for demonstration eligibles (but not for the number of demonstration eligibles under the existing MEGs) under the budget neutrality agreement of the current demonstration.

Because the amendment incorporates current Medicaid populations who were not previously included in the Demonstration, caseload estimates for the Medicaid eligibles in MEGs within the current demonstration have also been updated. As such, this amendment request adds additional monies related to the amendment programs and services to the approved PMPMs of the current budget neutrality agreement and additional member months to the caseload estimates, while still reflecting the same growth rates applicable to the current demonstration. The results of this process and the adjusted PMPMs and caseload estimates proposed by this amendment request are located in the summary of budget neutrality section below.

The impact of the majority of this amendment request is expected to be cost neutral in terms of budget neutrality. That is, cost estimates for most aspects of this amendment are assumed to be the same for both without waiver costs and with waiver costs. Specifically, both Demonstration Services 16 and MEG 12 are populations or services that could be covered under the Medicaid State Plan authority and are considered to be “pass-through populations”. However, MEG 13 is an Expansion Population requiring “Costs not otherwise Matchable (CNOM)”.

The State is assuming the budget neutrality agreement is in terms of total computable so that the State is not hindered by future changes to the federal medical assistance percentage rate on services.

Methodology for Determining Budget Neutrality Estimates

This section provides background information about the methods and data sources used to develop the proposed demonstration amendment estimates.

Time Periods

The budget neutrality in this submission reflects cost estimates for the demonstration amendment request for the last half of Demonstration Year (DY) 19 through DY 23, as the first changes of the amendment are effective on October 1, 2017 and DY 19 covers the time period from April 1, 2017 through March 31, 2018. Updated budget neutrality estimates are being prepared to reflect the proposed July 1, 2018 and January 1, 2019 implementation dates. Due to the staggered implementation dates of certain populations in the Demonstration, DY 20 also includes the addition of various services and eligibles for different lengths of time within the

year. However, all adjustments have been made to incorporate the impact across the full year. Lastly, new Family of One and new Community Eligible populations are assumed to gradually enroll into Medicaid. Therefore, the caseload estimates for all years reflect the assumed ramp-up of these populations.

Waiver Eligibility Groups and Caseload Estimates

Temporary Assistance for Needy Children (TANF) Child and SSI 0-64 MEGs

The following changes of the amendment impact the existing TANF Child and SSI 0-64 MEGs in the current demonstration, which currently only include children enrolled in MMMC or HIV SNPs. Some of these current managed care enrollees also meet HCBS institutional LOC criteria and are enrolled in the six 1915(c) waivers for children. Because these populations are exempted from managed care enrollment, the children would have had to voluntarily enroll in MMMC or HIV SNP plans.

- *The budget neutrality calculations in this submission reflect that children meeting HCBS institutional LOC criteria and enrolled in the six 1915(c) waivers as of September 30, 2017, will transition into the 1115 demonstration on October 1, 2017 (NYC and Nassau, Suffolk and Westchester counties) or January 1, 2018 (Rest of State counties) (the submission will be updated to reflect July 1, 2018 statewide implementation). The DY caseload estimates have been updated accordingly, with all subsequent demonstration years reflecting four quarters of this population. The caseload estimates are based on current enrollment in the 1915(c) waivers.*
- *All children meeting HCBS institutional LOC criteria who are enrolled in the six 1915(c) waivers, will transition to the 1115 demonstration. Children meeting HCBS institutional LOC criteria and are enrolled in the six affected children's 1915(c) waivers, may continue in the fee-for-service (FFS) delivery system under the Demonstration if they meet one of the managed care exemption or exclusion reasons (e.g., with comprehensive Third Party Health Insurance (TPHI)). Therefore, populations who remain in the FFS delivery system with HCBS must be reflected in budget neutrality. The caseload estimates for these HCBS recipients are included in budget neutrality for all years of the demonstration.*
- *The budget neutrality calculations in this submission reflect that Medicaid-eligible children who meet at-risk LON criteria may begin to receive HCBS services starting on July 1, 2018 (the submission will be updated to reflect January 1, 2019). While it is expected that some of these children are already enrolled in MMMC or HIV SNPs and therefore, already included in the current demonstration, it is also expected that there may be some Medicaid eligible but not yet enrolled children enrolling and meeting at-risk LON criteria as a result of publicity and outreach surrounding this new initiative. These estimates have been included in the caseload estimates for the applicable portion of DY 20, as well as subsequent demonstration years.*
- *As also outlined in Section 1, Children in VFCA will transition to MMMC and HIV SNPs on January 1, 2019. As both of these changes impact the last quarter of the DY 20 calculations, caseload estimates have been included for these populations in the applicable portion of DY 20, as well as subsequent demonstration years.*

Eligibility Group 12

Upon inclusion of the 1915(c) waiver populations into the 1115 demonstration, there are current Medicaid eligibles who were eligible under the existing 1915(c) waivers who are not reflected in the current Demonstration. This group will come into the demonstration and will enroll in MMMC or HIV SNPs, unless otherwise exempted or excluded from managed care. The children in this group are all currently eligible for Medicaid under the eligibility criteria for medically needy children with a waiver of 1902(a)(10)(C)(i)(III) meeting institutional LOC (i.e., Family of One). These populations will be reflected in MEG 12. The caseload estimates for this population are based on estimates for this population who are currently eligible as a Family of One population within one of the six 1915(c) waivers, as well as estimates of current Medicaid eligibles who are also expected to meet LOC criteria and be eligible under Family of One criteria. The caseload estimates for this population are reflected in the appropriate demonstration years.

Eligibility Group 13

On January 1, 2019, Medicaid eligibility and HCBS eligibility is expanded to children who meet at-risk LON criteria and are determined Medicaid eligible through institutional eligibility criteria and Family of One deeming of parental income (e.g., Medically needy children with a waiver of 1902(a)(10)(C)(i)(III) meeting needs-based criteria for HCBS). This population is an expansion population and will be included in MEG 13. Caseload estimates for this population have been included starting in the last quarter of DY 20 and continuing in all subsequent demonstration years. The expected ramp-up of this population is reflected throughout these demonstration years.

Demonstration Services 16

The caseload estimates for Demonstration Services 16 reflects the following:

- *Medicaid Community Eligible⁸ children meeting HCBS institutional LOC criteria and enrolled in the six 1915(c) waivers, who are voluntarily enrolled in MMMC or HIV SNPs, expected to be enrolled in MMMC or HIV SNPs, or expected to remain in the FFS delivery system due to other MMMC and HIV SNP population exclusions. Note: There are no CAH DD children who are community eligible under waiver #40176. That waiver currently only serves 409 children who are not otherwise eligible for Medicaid except under Family of One because they receive HCBS services.*
- *Medicaid Community Eligible Children meeting HCBS at-risk LON criteria.*

Cost Estimates

This section presents the sources and methodologies used for the estimates associated with each of the services and new Demonstration eligibles of this waiver amendment request.

⁸ Community Eligible children include children who are eligible for Medicaid under community rules including categorically and medically needy children. It does not include children who are eligible for Medicaid due to the waiving of parental income and are Medically needy children with a waiver of 1902(a)(10)(C)(i)(III) meeting institutional or needs-based criteria for HCBS.

State Plan Services New to Managed Care

The current demonstration PMPMs reflect only the services included in the MMMC or HIV SNP capitation rates. As part of the demonstration, other Medicaid BH services currently provided through the FFS delivery system will be incorporated into managed care. Based on current spend in FFS for the MMMC and HIV SNP populations, the PMPMs for the TANF Child and SSI 0-64 MEGs have been adjusted accordingly. See Section III, item 3 for a list of the State Plan services new to managed care for children.

For MEG 12 and MEG 13, the base PMPM was developed by estimating the spend in MMMC or HIV SNPs prior to the inclusion of BH services currently provided through the FFS delivery system. This estimation was based on the PMPM for similar populations within the current demonstration. The adjustment for existing BH services provided through the FFS delivery system was also based on the PMPM cost for populations within the current demonstration.

New State Plan/Demonstration Services

As described in Section III of this amendment, new BH services will be available to all children included in this demonstration amendment through inclusion in this Demonstration or submission and approval of State Plan Amendments. Some of these services are currently provided through the State's children's 1915(c) waivers and will be placed into the State Plan. It is also expected that new providers will begin to provide these additional BH services to children who do not meet HCBS eligibility criteria. Based on expected utilization and cost of these new services, adjustments were developed for all children's MEGs, including MEGs 12 and 13, to reflect the expected cost of these services.

Home- and Community-Based Services

For the Community Eligible MEGs (TANF Child and SSI 0-64), the HCBS services authorized under the Demonstration for eligible Medicaid Community Eligible populations are reflected in Demonstration Services 16. Some of the services within the current 1915(c) waivers will be covered by the State's Community First Choice Option (CFCO) program. Costs for CFCO services to Community Eligible Medicaid eligibles will remain in the TANF Child and SSI 0-64 MEGs. Based on a review of current HCBS utilization, an estimate for utilization under CFCO has been made, due to the fact that the FMAP is different for CFCO. The CFCO expected cost has been included within the TANF Child and SSI 0-64 MEG PMPMs. For the remaining HCBS services, current utilization within the 1915(c) waivers has been used to estimate the PMPM for Demonstration Services 16. Upon HCBS eligibility for the at-risk LON children, the PMPM for Demonstration Services 16 also reflects the expected utilization of these services for the LON children, which is also based on the utilization for existing 1915(c) enrollees.

For MEGs 12 and 13, the expected PMPM cost for HCBS services, as well as CFCO services for children meeting LOC (MEG 12 only), was based on utilization of current 1915(c) waiver enrollees. The expected cost of these services is included in the overall PMPM for these MEGs (i.e., HCBS services are not separated for these MEGs like they are for Community Eligible MEGs in Demonstration Services 16).

Health Home

As described in this amendment, care coordination provided under the existing 1915(c) waivers will transition to Health Homes concurrent with transition of the waivers into the 1115 demonstration. The cost estimates for Health Home are based on the current expenditures for existing populations. For individuals anticipated to meet the LOC or LON criteria under this amendment, the cost estimate for Health Home was also based on the current expenditures for existing populations.

Summary of Budget Neutrality

The attached budget neutrality summary spreadsheets reflect all changes discussed above for the current years of the Demonstration.

Section VII – List of Proposed Waivers and Expenditure Authorities

This section should include a preliminary list of waivers and expenditures authorities related to Title XIX and XXI authority that the State believes it will need to operate its Demonstration. In accordance with 42 CFR 431.412(a)(vi), this section must be included in a state's application in order to be determined complete. Specifically, this section should:

1. Provide a list of proposed waivers and expenditure authorities.
2. Describe why the state is requesting the waiver or expenditure authority, and how it will be used.

Please refer to the list of title XIX and XXI waivers and expenditure authorities found at:

<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/List-of-Waivers-and-Expenditure-Authorities.pdf> (the state can reference this to help complete this section). CMS will work with the State during the review process to determine the appropriate waivers and expenditures needed to ensure proper administration of the Demonstration.

Waivers Requested for this amendment

1. *Staterwideness Section 1902(a)(1). To permit New York to geographically phase in Behavioral Health (BH) services and Home and Community Based Services (HCBS) for children enrolled in MMMC and HIV SNPs.*
2. *Income Comparability Section 1902(a)(17). To allow the state to use institutional income and resource rules for the medically needy children under age 21 receiving HCBS in the same manner as it did for the terminated 1915(c) waiver children's populations that were subsumed under the 1115 MRT Waiver and the new LON Family of One HCBS populations. Section 1902(a)(10)(C)(i)(III) of the SSA.*
3. *Service Comparability (Amount, Duration & Scope) Section 1902(a)(10)(B). To enable New York to provide HCBS, as a Demonstration benefit, to targeted populations that may not be consistent with the targeting authorized under the*

approved State Plan, in amount, duration and scope that exceeds those available to eligible individuals not in those targeted populations.

4. *Freedom of Choice Section 1902(a)(23)(A). To the extent necessary to enable New York to require beneficiaries to enroll in managed care plans, including the Mainstream Medicaid Managed Care (MMMC) and HIV SNPs, in order to obtain benefits offered by those plans. Beneficiaries shall retain freedom of choice of family planning providers.*
5. *Direct Payment to Providers Section 1902(a)(32). To the extent necessary to permit participants to self-direct expenditures for Children's HCBS and supports.*

Expenditure Authority

Demonstration-Eligible Populations – expenditures for healthcare related costs for the following populations that are not otherwise eligible under the Medicaid State Plan.

1. *Demonstration Population 12 and 13 (HCBS Expansion). Medically needy children under age 21 with a waiver of 1902(a)(10)(C)(i)(III) who are receiving HCBS, and who are medically needy as individuals rather than as children with parents whose income and resources would normally be considered available to the child when determining eligibility. Only the income and resources of the child counted for eligibility.*
2. *Targeted children's HCBS. Expenditures for the provision of HCBS that are not otherwise available under the approved State Plan for children enrolled in MMMC or HIV SNPs.*
3. *Demonstration Services for addiction service. Provided to children under MMMC. Expenditures for provision of residential and outpatient addiction services, crisis intervention and licensed behavioral health practitioner services to MMMC enrollees only and are not provided under the State Plan. This includes addiction services and the delivery system changes associated with the new demonstration services and resulting State Plan amendments including changes under the CMS Innovation Accelerator Program (IAP), the state may require the MCOs through their contracts, as approved by CMS, to adopt system-wide changes and rates, also approved by CMS, to ensure that the innovations are adopted in a consistent manner statewide.*

Section VIII – Public Notice

The MRT BH Work Group began meeting on June 30, 2011 in New York City and the subcommittee for children's BH was subsequently formed. Since 2014, the Children's MRT Health and Behavioral Health Subcommittee has met quarterly. Meeting dates and materials can be found at:

http://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health_reform.htm.

DOH, OASAS, OCFS and OMH continue to regularly meet with Managed Care Plans, Provider Associations, parents and constituents regarding this important BH Transition from FFS to Medicaid Managed Care.

The proposed amendment was placed on public notice on September 21, 2016 for 30 days. This amendment incorporates changes and suggestions by the public from that process (note: no comments were received from the public notice. However, comments from the MRT and other public meetings were incorporated).

Section IX – Demonstration Administration

Please provide the contact information for the state’s point of contact for the Demonstration application.

Name and Title: Lana Earle, NYSDOH, Deputy Director, Division of Program Development and Management

Email Address: lana.earle@health.ny.gov

Attachment 1: Benefit Descriptions

Benefit	Eligibility Criteria	Description of Amount, Duration and Scope of Services
<i>Health Home Care Management</i>	<i>Health Home Care Management for children meeting HCBS eligibility criteria including CFCO who are not eligible for Health Homes under the State Plan</i>	<p><i>Health Home Care Management, as defined by the State Plan and implemented, including the six core functions, and the provisions of required care plans for HCBS services. This is for children receiving HCBS including CFCO but not eligible for Health Homes (e.g., children with developmental disabilities (DD) and enrolled in Foster Care or HCBS under the Demonstration until such time as the HH SPA is expanded to include DD chronic conditions). Regular FMAP will be claimed on this Demonstration service because these populations are not approved under the Health Home SPA.</i></p> <p><i>For children who opt out of Health Homes, the MCO or a State Independent Entity for FFS enrolled children will conduct the HCBS assessment, plan of care development and on-going monitoring of the POC.</i></p>
<i>Habilitation</i>	<i>Children meeting HCBS eligibility criteria</i>	<p><i>These services focus on helping children with developmental, medical and behavioral disabilities who are eligible for HCBS to be successful in the home, community and school by acquiring both social and environmental skills associated with his/her current developmental stage. This service assumes that the child has never had the skills being acquired. Habilitation services assist children who have never acquired a particular skill 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. This service may be delivered in an individual or group setting. Habilitation is provided to the child and the child's family/caregiver to support the development and maintenance of skills sets.</i></p> <p><i>Habilitation services support, guide, mentor, coach and/or train the child and/or family/caregiver in successful functioning in the home and community. Habilitation utilizes an individualized, strength based approach in assisting the child in recognizing his/her functional assets/strengths and those that need developing.</i></p> <p><i>Through a variety of techniques, skills will be taught and practiced with the child and family/caregiver. 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. This may take the form of role play, modeling, step-by-step instruction, etc. with the goal of skill attainment and growth.</i></p> <p><i>Habilitation may occur through a variety of settings meeting HCBS settings requirements including the</i></p>

Benefit	Eligibility Criteria	Description of Amount, Duration and Scope of Services
		<p><i>community, home or provider owned day habilitation facilities for children with medical, behavioral or DD. Examples of these settings could encompass: a grocery or clothing store (teaching the young person how to shop for food, or what type of clothing is appropriate for the weather, school, interview, work), apartment complexes (to seek out housing opportunities), laundromats (how to wash their clothes), or day habilitation provider sites.</i></p> <p><i>Habilitation services includes assistance with acquiring, retaining, or improving skills related to:</i></p> <ul style="list-style-type: none"> • <i>Personal grooming and cleanliness</i> • <i>Bed making and household chores</i> • <i>Eating and/or preparing food</i> • <i>Social and adaptive skills</i> • <i>Transportation</i> • <i>Participating in community activities</i> • <i>Safety skills</i> • <i>Managing money</i> • <i>Making informed choices</i> • <i>Task completion (i.e., completing homework (excludes tutoring))</i> • <i>Problem solving</i> • <i>Socialization skills such as receiving a compliment, asking for help, etc.</i> • <i>Communication skills, such as communicating effectively one's needs and feelings</i> • <i>Sensory/motor development ("diet"/modulation, through the development of play skills and imagination)</i> • <i>Organizational skills to manage day-to-day living</i> • <i>Interpersonal behavior including peer relationships</i> • <i>Life coaching to prepare a youth for transition to adulthood, including money management and housekeeping skills</i> • <i>Conducting activities of daily living (ex. developing Independent living skills to assist children who, are or will be, transitioning to adulthood with support in acquiring, retaining and improving self-help)</i> • <i>Use of transportation (accessing public transportation, learning to drive, obtaining insurance)</i> • <i>Participating in social and emotional skills development to support community inclusion such as recovery oriented activities and living</i> • <i>Eliminating or decreasing maladaptive behaviors</i>
<i>Caregiver/Family</i>	<i>Children meeting</i>	<i>Caregiver/family supports and services enhance the child's ability, regardless of disability</i>

Benefit	Eligibility Criteria	Description of Amount, Duration and Scope of Services
<p><i>Supports & Services</i></p>	<p><i>HCBS eligibility criteria</i></p>	<p><i>(developmental, physical and/or behavioral), to function as part of a caregiver/family unit and enhance the caregiver/family’s ability to care for the child in the home and/or community.</i></p> <p><i>Note: this service differs from the State Plan service of Family Peer Support Services, which is delivered by a credentialed/certified Family Peer Specialist with lived experience.</i></p> <p><i>Based upon the caregiver/family supports and service plan developed by the child and caregiver/family team, this service provides opportunities to:</i></p> <ul style="list-style-type: none"> <i>• Interact and engage with caregivers/family and children to offer self-advocacy, and support resources to develop caregiver/family’s ability to independently access community services and activities</i> <i>• Maintain and encourage the caregivers/families’ self-sufficiency in caring for the child in the home and community</i> <i>• Address needs and issues of relevance to the caregiver/family unit as the child is supported in the home and community</i> <i>• Educate and train the caregiver/family unit on resource availability so that they might better support and advocate for the needs of the child and appropriately access needed services</i> <i>• Direct instruction and guidance in the principles of the children’s chronic condition or life threatening illness</i>
<p><i>Respite</i></p>	<p><i>Children meeting HCBS eligibility criteria</i></p>	<p><i>This service focuses on short-term assistance and/or relief for children with disabilities (developmental, physical and/or behavioral), and family/caregivers which can be provided in a planned mode or delivered in a crisis environment. To the extent that skilled nursing is provided as a form of respite, this service has to be ordered by a physician.</i></p> <p><i><u>Planned</u></i></p> <p><i>Planned respite services provide planned short-term relief for family/caregivers that are needed to enhance the family/caregiver’s ability to support the child’s functional, mental health/substance use disorder, developmental, and/or health care issues. This service may be provided in a one-to-one, individual session or group session. The service is direct care for the child by staff trained to support the child’s needs while providing relief from caregiver activities for the family/caregiver. This may occur on a fifteen minute basis or a per diem basis (i.e., over 4 hours). Planned Respite Services support the Plan of Care goals and lead to skill development. Planned Respite activities include providing supervision and</i></p>

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		<p><i>pro-social activities that match the child's developmental stage to maintain the participant's health and safety.</i></p> <p><u><i>Crisis</i></u></p> <p><i>Crisis Respite is a short-term care and intervention strategy for children and their families as a result of a child's behavioral health, developmental, medical crisis or trauma that creates a risk for an escalation of symptoms without supports and/or a loss of functioning. It may be used when acutely challenging emotional or medical crisis occur which the child is unable to manage without intensive assistance and support. For children determined HCBS eligible, the need for Crisis Respite may be identified as a result of a Medicaid State Plan crisis intervention or may come from referrals from the emergency room, the community, LDSS/LGU/SPOA, school, self-referrals, or as part of a step-down plan from an inpatient setting. Crisis Respite should be included on the POC to the extent that it is an element of the crisis plan, or risk mitigation strategy.</i></p> <p><i>Crisis Respite services may be delivered in home by qualified practitioners or out of home by staff in community-based sites. Services offered may include: site-based crisis residence, monitoring for high risk behavior, health and wellness coaching, wellness activities, family/caregiver support, conflict resolution and other services as needed.</i></p> <p><i>Ongoing communication between child or family/caregiver receiving crisis respite, crisis respite staff, and the child's established behavioral health and health care providers is required to assure collaboration and continuity in managing the crisis situation and identifying subsequent support and service needs. At the conclusion of a Crisis Respite period, crisis respite staff, together with the child and family/caregiver and his or her established behavioral health or health care providers, will make a determination as to the continuation of necessary care and make recommendations for modifications to the child's POC. Children are encouraged to receive crisis respite in the most integrated and cost-effective settings appropriate to meet their respite needs. Out of home Crisis Respite is not intended as a substitute for permanent housing arrangements.</i></p>
<i>Prevocational Services</i>	<i>Children meeting HCBS eligibility criteria ages 14 or older</i>	<i>Prevocational services are individually designed to prepare a youth age 14 or older to engage in paid work, volunteer work or career exploration. Prevocational services are structured around teaching concepts such as compliance, attendance, task completion, problem solving, and safety based on a</i>

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		<p><i>specific curriculum related to youth with disabilities (developmental, physical and/or behavioral). In addition, prevocational services assist with facilitating appropriate work habits, acceptable job behaviors, and learning job production requirements.</i></p> <p><i>Prevocational services may include volunteer work, such as learning and training activities that prepare a person for entry into the paid workforce. Prevocational services should enable each participant to attain the highest level of work in the most integrated setting and with the job matched to the participant's interests, strengths, priorities, abilities, and capabilities, while following applicable federal wage guidelines from the U.S. Department of Labor. Services are intended to develop and teach general skills. Examples include, but are not limited to: ability to communicate effectively with supervisors, co-workers and customers; generally accepted community workplace conduct and dress; ability to follow directions; ability to attend to and complete tasks; punctuality and attendance; appropriate behaviors in and outside the workplace; workplace problem solving skills and strategies; mobility training; career planning; proper use of job-related equipment and general workplace safety. Services include activities that are not primarily directed at teaching skills to perform a particular job, but at underlying habilitative goals (e.g., attention span, motor skills, interpersonal relations with co-workers and supervisors) that are associated with building skills necessary to perform work and optimally to perform competitive, integrated employment.</i></p> <p><i>Prevocational services are not job-specific, but rather are geared toward facilitating success in any work environment for children whose disabilities do not permit them access to other prevocational services. The service will be reflected in participant's service plan directed to teaching skills rather than explicit employment objectives.</i></p> <p><i>Services are expected to occur over a defined period of time which is determined based upon a person-centered planning process. Prevocational service will not be provided to an HCBS participant if:</i></p> <ul style="list-style-type: none"> <i>i. Special education and related services that are otherwise available to the individual through a local educational agency, under the provisions of the Individuals with Disabilities Education Act (IDEA).</i> <i>ii. Vocational rehabilitation services that are otherwise available to the individual through a program funded under section 110 of the Rehabilitation Act of 1973 (Access VR).</i> <i>iii. Vocational services that are provided in facility based work settings that are not</i>

Benefit	Eligibility Criteria	Description of Amount, Duration and Scope of Services
		<p><i>integrated settings in the general community workforce.</i></p> <p><i>The waiver participant may receive up to 12 months of prevocational services. This service may be delivered in a one-to-one session or in a group setting of two or three participants.</i></p>
<p><i>Supported Employment</i></p>	<p><i>Children meeting HCBS eligibility criteria ages 14 or older</i></p>	<p><i>Supported employment services are individually designed to prepare individuals with disabilities (developmental, physical and/or behavioral) age 14 or older to engage in paid work. Supported employment services provide assistance to participants with disabilities as they perform in a work setting.</i></p> <p><i>Supported Employment provides ongoing supports to participants who, because of their disabilities, need intensive on-going support to obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals.</i></p> <p><i>Supported employment services are individualized and may include any combination of the following services: vocational/job-related discovery or assessment, person-centered employment planning, job placement, job development, negotiation with prospective employers, job analysis, job carving, training and systematic instruction, job coaching, benefits support, training and planning, transportation, career advancement services, and other workplace support services including services not specifically related to job skill training that enable the participant to be successful in integrating into the job setting.</i></p> <p><i>Supported employment services may also include services and supports that assist the participant in achieving self-employment through the operation of a business including home-based self-employment. However, Medicaid funds are not used to defray the expenses associated with starting up or operating a business.</i></p> <p><i>In addition to the need for an appropriate job match that meets the individual's skills and interests, individuals may also need long term employment support to successfully maintain a job due to the ongoing nature of the HCBS participant's support needs, changes in life situations, or evolving and changing job responsibilities.</i></p>

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		<p><i>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.</i></p> <p><i>Supported employment services include the following:</i></p> <ul style="list-style-type: none"> • <i>Supervision and training that are not job-related</i> • <i>Intensive ongoing support</i> • <i>Transportation to and from the job site</i> • <i>Interface with employers regarding the child's disability(ies) and needs related to his or her healthcare issue(s)</i> • <i>Other activities needed to sustain paid work (e.g., employment assessment, job placement, adaptive/assistive equipment necessary for employment)</i> • <i>Job finding and development training in work behaviors</i> • <i>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</i> • <i>On-site support for the child as they learn specific job tasks</i> • <i>Monitoring through on-site observation through communication with job supervisors and employers</i> <p><i>Supported Employment service will not be provided to HCBS participant if:</i></p> <ol style="list-style-type: none"> i. <i>Special education and related services that is otherwise available to the individual through a local educational agency, under the provisions of the Individuals with Disabilities Education Act (IDEA).</i> ii. <i>Vocational rehabilitation services that are otherwise available to the individual through a program funded under section 110 of the Rehabilitation Act of 1973.</i> iii. <i>Supported employment does not include facility based, or other similar types of vocational services furnished in specialized facilities that are not a part of the general workplace.</i> iv. <i>Supported employment does not include payment for supervision, training, support and adaptations typically available to other workers without disabilities filling similar positions in the business.</i> v. <i>Supported employment does not include volunteer work. Such volunteer learning and</i>

Benefit	Eligibility Criteria	Description of Amount, Duration and Scope of Services
		<p><i>un-paid training activities that prepare a person for entry into the paid workforce are addressed through pre-vocational and pre-employment services.</i></p> <p><i>Federal financial participation cannot be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:</i></p> <ul style="list-style-type: none"> <i>• Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment</i> <i>• Payments that are passed through to users of supported employment services</i>

Benefit	Eligibility Criteria	Description of Amount, Duration and Scope of Services
<p><i>Community Advocacy Training and Support</i></p>	<p><i>Children meeting HCBS eligibility criteria</i></p>	<p><i>Participating in community events and integrated interests/occupations are important activities for all youth, including children with disabilities (developmental, physical and/or behavioral). Success in these activities is dependent not only on the youth but on the people who interact with and support the youth in these endeavors. Community self-advocacy training and support improves the child's ability to gain from the community experience and enables the child's environment to respond appropriately to the child's disability and/or health care issues.</i></p> <p><i>Community training and support is intended to assist the child, family/caregiver, and collateral contacts in understanding and addressing the participant's needs related to their disability(ies).</i></p> <p><i>Community self-advocacy training and support provides family, caregivers, and collateral contacts with techniques and information not generally available so that they can better respond to the needs of the participant. The use of this service may appropriately be provided to prevent problems in community settings as well as when the child is experiencing difficulty. The POC 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.</i></p> <p><i>This service may be provided in an individual session or in a group setting. The service includes:</i></p> <ul style="list-style-type: none"> <i>• Training (one-on-one or group) for the child and/or the family/caregiver regarding methods and behaviors to enable success in the community</i> <i>• Direct self-advocacy training in the community with collateral contacts regarding the child's disability(ies) and needs related to his or her health care issues</i> <i>• Self-advocacy training for the child and/or family/caregiver, including during community transitions</i>
<p><i>Non-Medical Transportation</i></p>	<p><i>Children meeting HCBS eligibility criteria</i></p>	<p><i>Non-Medical Transportation services are offered, in addition to any medical transportation furnished under the 42 CFR 440.17(a) in the State Plan. Non-medical Transportation services are available for individuals to access authorized HCBS and destinations that are related to a goal included on the child's POC. Examples where this service may be requested include transportation to: HCBS that a child was</i></p>

Benefit	Eligibility Criteria	Description of Amount, Duration and Scope of Services
		<p><i>determined eligible to receive, a job interview, college fair, a community integration activity, a habilitation activity such as learning how to use the grocery store or public transportation, etc. This service will be provided to meet the child's needs as determined by an assessment performed in accordance with Department requirements and as outlined in the child's POC.</i></p>
<p><i>Adaptive and Assistive Equipment</i></p>	<p><i>Children meeting HCBS eligibility criteria</i></p>	<p><i>This service provides technological aids and devices that can be added to the home, vehicle, or other 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 HCBS cannot duplicate equipment otherwise available through the Medicaid State Plan or other federal/state funding streams. 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. Combined five year spending threshold of \$30,000 with the ability to consider exceptions when medically necessary, including but not limited to a significant change in the child's needs or capabilities.</i></p>
<p><i>Accessibility Modifications</i></p>	<p><i>Children meeting HCBS eligibility criteria</i></p>	<p><i>This service provides internal and external physical adaptations to the home or other 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 federal/state funding streams, and enable the child to function with greater independence related to the child's disability and/or health care issues and prevent medical institutionalization. All equipment and technology used for entertainment is prohibited. Combined five year spending threshold of \$30,000 with the ability to consider exceptions when medically necessary, including but not limited to a significant change in the child's needs or capabilities.</i></p>
<p><i>Palliative Care</i></p>	<p><i>Children meeting HCBS eligibility criteria and with a serious illness</i></p>	<p><i>Palliative care is specialized medical care focused on providing relief from the symptoms and stress of a chronic condition or life threatening illness. The goal is to improve quality of life for both the patient and the family. Palliative care is provided by a specially-trained team of doctors, nurses, social workers and other specialists who work together with a patient's doctors to provide an extra layer of support. It is appropriate at any stage of a chronic condition or life threatening illness and can be provided along with curative treatment.</i></p> <p><i>Children must meet LOC functional criteria and suffer from the symptoms and stress of chronic medical conditions OR illnesses that put individuals at risk for death before age 21.</i></p>

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		<p><i>Types of activities included: bereavement service; pain and symptom management; expressive therapy (art, music and play); and massage therapy:</i></p> <p><i>Bereavement Service – Help for participants and their families to cope with grief related to the participant’s end-of-life experience. Bereavement counseling services are inclusive for those participants in receipt of hospice care through a hospice provider. All others are limited to the lesser of 5 appointments per month or 60 hours per calendar year.</i></p> <p><i>Pain and Symptom Management – Relief and/or control of the child’s suffering related to their illness or condition. No limit; as required by participant’s physician.</i></p> <p><i>Expressive Therapy (art, music and play) – Help children better understand and express their reactions through creative and kinesthetic treatment. Limited to the lesser of four appointments per month or 48 hours per calendar year. This limit can be exceeded when medically necessary.</i></p> <p><i>Massage Therapy – To improve muscle tone, circulation, range of motion and address physical symptoms related to their illness. Limited to no more than 12 appointments per calendar year. This limit can be exceeded when medically necessary.</i></p>

The following services and supports are available to participants in the Customized Goods and Services pilot:

Benefit	Eligibility Criteria	Description of Amount, Duration and Scope of Services
<i>Fiscal Management Services (FMS):</i>	<i>Children meeting HCBS eligibility criteria and participating in the self-direction pilot</i>	<i>FMS assists individuals with exercising budget authority. This is a requirement for assistance with understanding billing and documentation, performing payroll and employer-related duties, purchasing approved goods & services, tracking and monitoring expenditures.</i>
<i>Customized Goods and Services</i>		<p><i>Customized Goods and Services are services, equipment, or supplies not otherwise provided through this demonstration or through the Medicaid State Plan, that are available under a pilot program and address an identified need in the service plan. The item or service must:</i></p> <ul style="list-style-type: none"> <i>Decrease the need for other Medicaid services</i>

Benefit	Eligibility Criteria	Description of Amount, Duration and Scope of Services
		<ul style="list-style-type: none"> • <i>Promote inclusion in the community</i> • <i>Increase the child/youths safety in the home or community environment</i> <p><i>To be an eligible service:</i></p> <ul style="list-style-type: none"> • <i>The participant must lack funds to purchase the item or service, OR</i> • <i>The service is not available through another source.</i> <p><i>Customized Goods and Services should be used as the funding source of last resort – only for those costs that cannot be covered by any other source and that are vital to the implementation of the POC. Funding shall not exceed \$2,000 annually per participant.</i></p> <p><i>Services Ineligible for Customized Goods and Services include:</i></p> <ul style="list-style-type: none"> • <i>Experimental or prohibited treatments</i> • <i>Purchases for or from third parties who are family members, friends or significant others;</i> • <i>Room and board in a residential facility, including assisted living facilities</i> • <i>Tobacco products, alcohol products, firearms, contraband or illegal items</i> • <i>Pornographic materials, prostitution services, escort services</i> • <i>Payment of court-ordered costs, attorney fees, fines, restitution, or similar debts</i> • <i>Credit card payments of any kind, or similar debts</i> • <i>Items purchased for the purpose of resale</i> • <i>Gift cards or prepaid debit cards</i> • <i>Services or goods that are recreational in nature</i> • <i>Goods and services that a household does not include a person with a disability would not be expected to pay for as household expenses (e.g. subscription to a cable television service).</i>