



Department
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Office of
Mental Health

Office of Alcoholism and
Substance Abuse Services

Office of Children
and Family Services

Office for People With
Developmental Disabilities

Children's Health and Behavioral Health Medicaid System Transformation

Children's Home and Community Based Services Provider Manual

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Send questions to
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Introduction

Home and Community Based Services (HCBS) are designed to allow children and youth to participate in developmentally and culturally appropriate services through Medicaid. New York State (NYS) is committed to serving individuals in the least restrictive environment possible by providing services and supports to children and their families at home and in the community. HCBS are designed for people who, but for these services, would require the level of care provided in a more restrictive environment such as a long-term care facility or psychiatric inpatient care and for those at risk of elevating to that level of care.

The Children's Medicaid System Transformation for individuals under the age of 21 includes the alignment of the following NY children's waivers previously accessible under the authority of the 1915(c) amendment of the Federal Social Security Act: Office of Children and Family Services (OCFS) Bridges to Health (B2H) Serious Emotional Disturbance (SED), B2H Developmental Disabilities (DD), B2H Medically Fragile (MedF), the Office of Mental Health (OMH) SED Waiver, Office for People With Developmental Disabilities (OPWDD) Care at Home (CAH) IV Waiver, and the Department of Health (DOH) operated Care at Home (CAH) I/II Waiver.

The Office of Alcoholism and Substance Abuse Services (OASAS), OCFS, OMH, OPWDD, and DOH have collaborated to create a newly aligned service array of HCBS benefits for children meeting specific diagnostic and functional criteria. The new 1915(c) Children's Waiver and 1115 Children's Demonstration, with approval from the Centers for Medicare and Medicaid Services (CMS), provides NYS the authority for these HCBS benefits. The waiver includes person-centered planning requirements and specifies transitional coverage requirements for children enrolled in any of the aforementioned 1915(c) waivers at the time of transition.

HCBS eligibility includes: 1) target criteria, 2) risk factors, and 3) functional criteria, and Medicaid eligibility. Level of Care (LOC) has been expanded to include a new needs-based criteria category referred to as Level of Need (LON), allowing more children to access HCBS benefits. This addresses gaps in service for children who may benefit from HCBS but do not meet the LOC criteria, or for children who require continued services to avoid regressing to a higher level of care.

New York State will use the HCBS Eligibility Determination within the Uniform Assessment System (UAS) to confirm HCBS eligibility. In addition, Health Home Care Managers will continue to use the comprehensive Child and Adolescent Needs and Strengths New York (CANS-NY) assessment tool to support person-centered service planning for HCBS eligible children/youth.

This manual defines the specific composition of each service while outlining provider roles and responsibilities. All HCBS benefits are applicable in any home or community setting meeting federal HCBS settings requirements inclusive of the child or family environment, with some exceptions noted in this manual.

VISION AND GOALS

HCBS are designed to offer support and services to children in non-institutionalized settings that enable them to remain at home and in the community. HCBS provides a family-driven, youth guided, culturally, and linguistically appropriate system of care that accounts for the strengths, preferences, and needs of the individual, as well as the desired outcome. Services are individualized to meet the health, developmental, and behavioral health needs of each child or youth. Participants have independent choice among an array of service options and providers. These services are provided in a flexible, complimentary package that evolves over time to meet the changing needs of the child or youth.

HCBS are intended to be provided to a child and family in their home and/or the community. The array of services is intended to assist children in being successful at home, in school, and in their other natural environments to help maintain them in their community and avoid higher levels of care and out-of-home placements.

It is the mission of NYS and its child and family serving agencies to improve health and behavioral health care access and outcomes for individuals served while demonstrating sound stewardship of financial resources.

CRIMINAL HISTORY AND BACKGROUND CHECKS

In accordance with Section 2899-a of the Public Health Law, any entity that provides Home and Community Based Services (HCBS) to enrollees who are under 21 years of age under a demonstration program pursuant to section 1115 of the Federal Social Security Act must request a criminal history record check by the New York State Department of Health (NYSDOH) and the New York State Division of Criminal Justice Services for each prospective employee who will provide HCBS services to such enrollees. Note: this program will operate concurrently with the State's 1115 MRT waiver once approved by CMS.

The term "employee" does not include persons licensed pursuant to Title 8 of the Education Law or Article 28-D of the Public Health Law, provided that such persons are operating within their Title, meaning that such license was required for the position. Volunteers are not subject to this requirement. Part 402 of Title 10 of the Official Compilation of Codes, Rules and Regulations for the State of New York (NYCRR) Part 402 establishes the process for conducting the criminal history record checks and the standards for review by NYSDOH. Each provider must develop and implement written policies and procedures that include protecting the safety of persons receiving services from temporary employees consistent with the NYS statutory requirements and regulations (e.g., appropriate direct observation and evaluation).

Criminal history record checks are finger print-based, national Federal Bureau of Investigation (FBI) criminal history record checks, which require the prospective employee's fingerprints and by two forms of identification. Providers must maintain and retain current records, including a roster of current employees who were so reviewed, to

which NYSDOH shall have immediate and unrestricted access to the determination letters to ensure compliance with these provisions.

Verification of compliance with the criminal history record check regulations is an element of the NYSDOH surveillance process. At the time of surveillance, NYSDOH surveyors utilize a standardized tool to evaluate compliance with the criminal history background record check requirements. If a provider is found out of compliance, a statement of deficiency(ies) is issued, and the provider will be required provide a plan of correction.

Additional information can be found on the NYSDOH webpage [here](#).

HCBS ELIGIBILITY AND ENROLLMENT

To HCBS under Medicaid, a child or youth must be determined eligible based on meeting target population, risk factors, and functional criteria measured by the HCBS Eligibility Determination. Children receiving HCBS through enrollment in a 1915(c) Medicaid waiver will have continued access to HCBS for as long as the child continues to meet the eligibility criteria for the 1915(c) Medicaid waiver.

Children and youth must be under 21 years old and eligible for Medicaid to receive HCBS. HCBS eligibility is comprised of three components: 1) target criteria, 2) risk factors, and 3) functional criteria.

There are two HCBS eligibility groups:

1. Level of Care (LOC): children that meet institutional placement criteria
There are four subgroups within the LOC group:
 - a. Children with Serious Emotional Disturbance (SED) with or without co-occurring Substance Use Disorders (SUD)
 - b. Children with a Developmental Disability in Foster Care
 - c. Children who are Medically Fragile
 - d. Children who are Medically Fragile with a Developmental Disability

2. Level of Need (LON): children who are at risk of institutional placement

- There are two subgroups within the LON group:
- a. Children with Serious Emotional Disturbance (SED) with or without co-occurring Substance Use Disorders (SUD)
 - b. Abuse, Neglect and Maltreatment or Health Home Complex Trauma

The services described in this document are accessible to the child once a Plan of Care (POC) is in place.

Both LOC and LON determinations require the completion of the HCBS Eligibility Determination tool within the Uniform Assessment System (UAS)

The target criteria, risk factors, and functional limits must be documented in the UAS.

Children seeking HCBS who are not otherwise eligible for Medicaid (e.g. income and resources are above Medicaid eligibility allowances) must meet a needs-based criterion for Medicaid eligibility determination via the following process:

- The Independent Entity must complete the HCBS Eligibility Determination.
- The Independent Entity will assist families in completion of the Medicaid application and submission to the Local District of Social Services (LDSS) or New York City (NYC) Human Resources Administration (HRA) to determine Medicaid Eligibility.
- Once Medicaid is established, referral to appropriate care management will be completed.
- Whether a child meets the LOC or the LON criteria, eligible children, youth, and their families will have access to all HCBS services.

SERVICE DEFINITIONS

COMMUNITY HABILITATION

Definition

Community Habilitation covers face-to-face services and supports related to the child's acquisition, maintenance, and enhancement of skills necessary to perform Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), and/or Health-Related Tasks delivered in the community (non-certified) settings.

Acquisition is described as the service available to a child who is seeking greater independence by learning to perform the task for him or herself. There should be a reasonable expectation that the individual will acquire the skills necessary to perform that task within the authorization period.

Maintenance is described as the service available to prevent or slow regression in the child's skill level and to prevent loss of skills necessary to accomplish the identified task.

Enhancement activities are provided to the child through training and demonstration to promote growth and independence with an already acquired skill level and to support the child's goal outside of the training environment.

ADL, IADL, skill acquisition, maintenance, and enhancement are face-to-face services that are determined by the person-centered planning process and must be identified in the child's Plan of Care (POC) on an individual or group basis. These identified services will be used to maximize personal independence and integration in the community, preserve functioning, and prevent the likelihood of future institutional placement. Skill acquisition, maintenance, and enhancement services are appropriate for children who have the capacity to learn to live in the community, with or without support. Community Habilitation may be delivered in individual or group modality.

Service Components

ADL, IADL skill acquisition, maintenance, and enhancement is related to assistance with functional skills and may help a child who has difficulties with these types of skills accomplish tasks related to, but not limited to:

- Self-care
- Life safety
- Medication and health management
- Communication skills
- Mobility
- Community transportation skills
- Community integration
- Appropriate social behaviors
- Problem solving
- Money management

See Appendix E: Community Habilitation Guidelines for additional service recommendations based on age of the child/youth.

Provider and Condition Requirements

ADL, IADL, skill acquisition, maintenance, and enhancement will be performed by a direct care worker, who shall include personal care aides, personal attendants, certified home health aides, direct service professionals who meet the licensure and certification requirements under NYCRR Title 18, or providers approved through the Office for People With Developmental Disabilities (OPWDD) to provide Community Habilitation.

ADL, IADL skill acquisition, maintenance, and enhancement must be provided under the following conditions:

- The need for skills training or maintenance activities has been assessed, determined, and authorized as part of the person-centered planning process.
- Provider agencies of Community Habilitation must develop a Community Habilitation service plan to document the child's goal(s)/outcome(s), health/safety needs required during the delivery of the service, and the necessary staff actions to assist the child reach his/her Community Habilitation goal(s)/outcome(s), and health/safety needs. The activities are for the sole benefit of the child and are only provided to the child receiving HCBS or to the family/caregiver in support of the child.
- The activities are designed to preserve or enhance independence or slow/reduce the loss of independence when the child has a progressive medical condition. The activities provided are consistent with the child's stated preferences and outcomes in the plan of care (POC).
- The activities provided are coordinated with the performance of ADLs, IADLs, and health related tasks.
- Training for skill acquisition, maintenance, and enhancement activities that involve the management of behaviors must use positive enforcement techniques.

- The provider is authorized to perform these services for HCBS recipients and has met any required training, certification, and/or licensure requirements.

Some specific ADL services available for training include, but are not limited to: bathing/personal hygiene, dressing, eating, mobility (ambulation and transferring), and toileting.

Some specific IADL services available for skills training include, but are not limited to: managing finances; assisting with transportation (as indicated in the POC); shopping for food, clothes, and other essentials; preparing meals; assisting with the use of the telephone and/or other communication devices; managing medications; light housekeeping; environmental maintenance such as maintaining safe egress; and laundry.

If the POC indicates that learning how to navigate travel from one location in the community to another is a goal for the child, this service will include the assistance provided by a direct care worker to accompany the child while learning the skill. The face-to-face service time when a direct care worker is assisting or providing transportation to an individual may also be billed as part of the Community Habilitation service.

Health-related tasks are defined as specific tasks related to the needs of a child, which can be delegated or assigned by licensed health-care professionals under state law to be performed by a certified home health aide or a direct service professional. Health-related tasks also include tasks that home health aides or a direct service professional can perform under applicable exemptions from the Nurse Practice Act.

Some specific health-related tasks available for assistance include, but are not limited to: performing simple measurements and tests; assisting with the preparation of complex modified diets; assisting with a prescribed exercise program; pouring, administering, and recording medications; assisting with the use of medical equipment, supplies, and devices; assisting with special skin care; assisting with a dressing change; and assisting with ostomy care.

Modality

- Individual face-to-face service
- Group face-to-face service

Setting

These services can be delivered at any non-certified, community setting. Such a setting might include the child's home, which may be owned or rented, and work setting.

Allowable settings in compliance with Medicaid regulations and the Home and Community Based Settings Final Rule (§441.301(c)(4) and §441.710) (see Appendix B) will exhibit characteristics and qualities most often articulated by the individual

child/youth and family/caregiver as key determinants of independence and community integration. Services should be offered in the setting least restrictive for desired outcomes, including the most integrated home or other community based settings where the beneficiary lives, works, engages in services, and/or socializes. While remaining inclusive of those in the family and caregiver network. Family is broadly defined, and can include families created through birth, foster care, adoption, or a self-created unit.

Limitations/Exclusions

Please note that this service cannot be substituted for vocational rehabilitation services provided under the Rehabilitation Act of 1973 or other Children's HCBS. Approved settings do not include an OPWDD certified residence, congregate or institutional settings, a social day care or health care setting in which employees of the particular setting care for or oversee the child. Foster Care children meeting LOC may receive these services in a home or community based setting where they reside that is not an institution. OCFS Licensed Institutions are defined in New York State Social Services law section 427.2(f) as a facility established for the 24-hour care and maintenance of 13 or more children and operated by a child care agency (Voluntary Foster Care Agency). Only those services not reimbursable under the Community First Choice Option (CFCO) State Medicaid Plan will be reimbursable under this HCBS Waiver.

Children living in certified settings may only receive this service on week days with a start time prior to 3 pm. And are limited to a maximum of six (6) hours of non-residential services (or its equivalent) daily. For school-age children, this service cannot be provided during the school day when a child/youth is participating or enrolled in a school program. Time spent receiving another Medicaid service cannot be counted toward the Community Habilitation billable service time. This service cannot be delivered nor billed while a child is in an ineligible setting, such as in a hospital, ICF/IID, or skilled nursing facility. Community Habilitation services provided under this waiver cannot be duplicative or delivered at the same time as services otherwise available to a child through a local educational agency including those services available under the Individuals with Disabilities Education Act (IDEA) or Rehabilitation Act of 1973.

Certification/Provider Qualifications

Provider Agency Qualifications

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

Practitioners must operate in agencies that have been designated through the NYS Children's Provider Designation Review Team. This requires agencies have appropriate license, certification, and/or approval in accordance with State designation requirements.

- Provider agencies and practitioners must adhere to all Medicaid requirements in this manual and in other applicable provider manuals, regulations, and statutes.
- Provider agencies must adhere to cultural competency guidelines.

- Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
- The provider agency must ensure that staff receive Mandated Reporting training and Personal Safety in the Community training prior to service delivery.
- The provider agency must ensure that practitioners maintain the licensure necessary to provide services under their scope of practice under State law, if applicable.
- The provider agency must ensure that any insurance required by the designating state agency is obtained and maintained.
- The provider agency must ensure that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.

Additional information and application for Children's SPA/HCBS can be found on the DOH website:

https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/provider_design.htm

Individual Staff/Agency Qualifications

Providers must have appropriate license, certification, and/or approval in accordance with State requirements.

OPWDD directs provider agencies to screen staff against the Medicaid Excluded Provider lists maintained by the Department of Health and the HHS Office of the Inspector General.

Direct support professionals must have completed the training stipulated in 14 NYCRR Part 633.8 and the Direct Support Professionals Core Competencies curriculum.

Additional information can be found here:

https://opwdd.ny.gov/opwdd_careers_training/training_opportunities/core_competencies#definition

Training Requirements

Service Type	Trainings Required	Requirement Completion Timeframe
Community Habilitation	<ul style="list-style-type: none"> • Mandated Reporter • Personal Safety/ Safety in the Community • Strength Based Approaches • Suicide Prevention • Domestic Violence Signs and Basic Interventions • Trauma Informed Care 	<ul style="list-style-type: none"> • Prior to Service Delivery • For staff hired before April 1, 2019, training must be completed within six (6) months of the 1915(c) Children's Waiver implementation. • For staff hired on or after April 1, 2019, training must be completed within six (6) months of hire date.

Additional information regarding training requirements can be found in Appendix F.

DAY HABILITATION

Definition

Assistance with acquisition, retention or improvement in self-help, socialization and adaptive skills including communication, and travel that regularly takes place in a non-residential setting, separate from the person's private residence or other residential arrangement. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, community inclusion, relationship building, self-advocacy, and informed choice. Day Habilitation (DH) services may be provided to a child at a NYS certified (e.g., OPWDD certified) setting typically between the daytime hours of 9 a.m. and 3 p.m. However, service delivery may include outings to community (non-certified) settings.

Service Components

Individual Day Habilitation (a one-to-one, individual-to-worker provided service with an hourly unit of service) and Group Day Habilitation services are furnished four or more hours per day on a regularly scheduled basis for one or more days per week or less frequently as specified in the participant's POC. Meals provided as part of these services shall not constitute a "full nutritional regimen" (three meals per day).

A supplemental version of Individual and Group Day Habilitation is available for children who do not reside in a certified setting. The supplemental Day Habilitation is provided outside the 9 a.m. to 3 p.m. weekday time period and includes later afternoon, evenings, and weekends. Day Habilitation and Supplemental Day Habilitation services cannot be delivered at the same time.

All Day Habilitation services (Group and Individual) have the same service description and focus on enabling the participant to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies in the POC. In addition, Day Habilitation services may serve to reinforce skills, behaviors, or lessons taught in other settings. Provider agencies of Day Habilitation must develop a Day Habilitation service plan to document the child's goal(s)/outcomes(s), health/safety needs required during the delivery of the service, and the necessary staff actions to assist the child in reaching his/her Day Habilitation goal(s)/outcomes(s), and health/safety needs.

Modality

- Individual face-to-face service
- Group face-to-face service

Setting

Day Habilitation (DH) services are provided to a child at a NYS certified (e.g., OPWDD certified) setting.

Allowable settings in compliance with Medicaid regulations and the Home and Community Based Settings Final Rule (§441.301(c)(4) and §441.710) (see Appendix B) will exhibit characteristics and qualities most often articulated by the individual child/youth and family/caregiver as key determinants of independence and community integration. Services should be offered in the setting least restrictive for desired outcomes, including the most integrated home or other community based settings where the beneficiary lives, works, engages in services, and/or socializes. While remaining inclusive of those in the family and caregiver network. Family is broadly defined, and can include families created through: birth, foster care, adoption, or a self-created unit.

Limitations/Exclusions

Group and Individual DH cannot be billed as overlapping services. Any child receiving HCBS under this waiver may receive this service. Service necessity criteria for this service requires that the child must have a developmental delay justifying the need for the provision of Day Habilitation, but the child may meet NF, ICF/IID, or Hospital LOC.

Day Habilitation services will not include funding for direct, hands-on physical therapy, occupational therapy, speech therapy, nutrition, or psychology services.

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

Supplemental DH services are those services provided on weekends and/or on weekdays with a service start time after 3 pm. Supplemental DH services are not available to individuals residing in certified residential settings with paid, professional staff, because the certified residential habilitation provider is responsible for the habilitation needs of the individual on weekday evenings and anytime on weekends.

Certification/Provider Qualifications

Provider Agency Qualifications

New York State Office for People With Developmental Disabilities (OPWDD) Regional Office or non-profit organization certified by New York State Office for People With Developmental Disabilities (OPWDD)

- OPWDD Regional Offices may provide Day Habilitation HCBS waiver services directly through its Regional Offices.
- OPWDD directs provider agencies to screen staff against the Medicaid Excluded Provider lists maintained by the Department of Health and the HHS Office of the Inspector General.

Non-Profit Organization

- Certified by the Office for People With Developmental Disabilities (OPWDD) to provide Day Habilitation.
- OPWDD directs provider agencies to screen staff against the Medicaid Excluded Provider lists maintained by the Department of Health and the HHS Office of the Inspector General.
- Non-profit organizations include nonprofit corporations formed under New York State Law or authorized to do business in New York, local government units, or organizations created by an act of the New York State Legislature for charitable purposes, which include providing services to persons with developmental disabilities.
- If the provider agency employs professional clinical staff, that staff person must have the appropriate credentials stipulated by the OPWDD and/or the NYS Department of Education under the following regulations and laws:
 - Nursing (8 NYCRR Part 64 and Education Law Title 8, Article 139)
 - Speech Language Pathologist (8 NYCRR Part 75 and Education Law Title 8, Article 159)
 - Psychology (8 NYCRR Part 72 and Education Law Title 8, Article 153)
 - Social Work (8 NYCRR Part 74 and Education Law Title 8, Article 154)
 - Rehab Counselor (14 NYCRR Part 679.99)
 - Dietetics/Nutrition (8 NYCRR Part 79 and Education Law Title 8, Article 157)
 - Occupational Therapy (8 NYCRR Part 76 and Education Law Title 8, Article 156)
 - Physical Therapy (8 NYCRR part 77 and Education Law Title 8, Article 136)
 - Applied Behavioral Sciences Specialist (8 NYCRR Part 79 and Education Law Title 8, Article 167)
 - Behavioral Intervention Specialist (14 NYCRR part 633-16.b(32))

Practitioners must operate in agencies that have been designated through the NYS Children's Provider Designation Review Team. This requires agencies to have appropriate license, certification, and/or approval in accordance with State designation requirements.

- Provider agencies and practitioners must adhere to all Medicaid requirements in this manual and in other applicable provider manuals, regulations, and statutes.
- Provider agencies must adhere to cultural competency guidelines.
- Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
- The provider agency must ensure that staff receive Mandated Reporting training which is provided throughout New York State and Personal Safety in the Community training prior to service delivery.
- The provider agency must ensure that practitioners maintain the licensure necessary to provide services under their scope of practice under State law, if applicable.

- The provider agency must ensure that any insurance required by the designating state agency is obtained and maintained.
- The provider agency must ensure that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.

Additional information and application for Children's SPA/HCBS can be found on the DOH website:

https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/provider_design.htm

Individual Staff/Agency Qualifications

- Providers must have appropriate license, certification, and/or approval in accordance with State requirements.
- Direct support professionals must have completed the training stipulated in 14 NYCRR Part 633.8 and the Direct Support Professionals Core Competencies curriculum. Additional information can be found here: https://opwdd.ny.gov/opwdd_careers_training/training_opportunities/core_competencies#definition

Training Requirements

Service Type	Trainings Required	Requirement Completion Timeframe
Day Habilitation	<ul style="list-style-type: none"> • Mandated Reporter 	<ul style="list-style-type: none"> • Prior to Service Delivery
	<ul style="list-style-type: none"> • Personal Safety/ Safety in the Community • Strength Based Approaches • Suicide Prevention • Domestic Violence Signs and Basic Interventions • Trauma Informed Care 	<ul style="list-style-type: none"> • For staff hired before April 1, 2019, training must be completed within six (6) months of the 1915(c) Children's Waiver implementation. • For staff hired on or after April 1, 2019, training must be completed within six (6) months of hire date.

Additional information regarding training requirements can be found in Appendix F.

CAREGIVER/FAMILY SUPPORTS AND SERVICES

Definition

Caregiver/Family Supports and Services enhance the child/youth's ability, regardless of disability (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/youth in the home and/or community. Family is broadly defined, and can include families created through birth, foster care, adoption, or a self-created unit.

Note: this service is not the State Plan service of Family Peer Support Services which must be delivered by a certified/credentialed Family Peer with lived experience.

Service Components

Based upon the Caregiver/Family Supports and Services plan developed by the child/youth and caregiver/family team, this service provides opportunities to:

- Interact and engage with family/caregivers and children/youth to offer educational, advocacy, and support resources to develop family/caregivers' ability to independently access community services and activities
- Maintain and encourage the caregivers'/families' self-sufficiency in caring for the child/youth in the home and community
- Address needs and issues of relevance to the caregiver/family unit as the child/youth is supported in the home and community
- Educate and train the caregiver/family unit on available resources so that they might better support and advocate for the needs of the child and appropriately access needed services
- Provide guidance in the principles of children's chronic condition or life-threatening illness

Modality

- Individual face-to-face intervention
- Group face-to-face intervention (no more than three HCBS eligible children/families)

Setting

Allowable settings in compliance with Medicaid regulations and the Home and Community Based Settings Final Rule (§441.301(c)(4) and §441.710) (see Appendix B) will exhibit characteristics and qualities most often articulated by the individual child/youth and family/caregiver as key determinants of independence and community integration. Services should be offered in the setting least restrictive for desired outcomes, including the most integrated home or other community-based settings where the beneficiary lives, works, engages in services, and/or socializes. While remaining inclusive of those in the family and caregiver network, family is broadly defined, and can include families created through: birth, foster care, adoption, or a self-created unit.

Limitations/Exclusions

- This service cannot be delivered nor billed while an enrolled child is in an ineligible setting, including hospitalization
- 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)
- Caregiver Family Supports and Services are limited to three hours per day

Certification/Provider Qualifications

Provider Agency Qualifications

Practitioners must operate in agencies that have been designated through the NYS Children’s Provider Designation Review Team. This requires agencies have appropriate license, certification, and/or approval in accordance with State designation requirements.

- Provider agencies and practitioners must adhere to all Medicaid requirements in this manual and in other applicable provider manuals, regulations, and statutes.
- Provider agencies must adhere to cultural competency guidelines.
- Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
- The provider agency must ensure that staff receive Mandated Reporting training which is provided throughout New York State and Personal Safety in the Community training prior to service delivery.
- The provider agency must ensure that practitioners maintain the licensure necessary to provide services under their scope of practice under State law, if applicable.
- The provider agency must ensure that any insurance required by the designating state agency is obtained and maintained.
- The provider agency must ensure that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.

Additional information and application for Children’s SPA/HCBS can be found on the DOH website:

https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/provider_design.htm

Individual Staff Qualifications

- **Minimum** qualification of a high school diploma, high school equivalency preferred or a State Education Commencement Credential (e.g. SACC or CDOS) with related human service experience.
- **Preferred** experience working with children/youth.

Supervisor Qualifications:

- **Minimum** qualification of a Bachelor’s degree with one year of experience in human services working with children/youth.
- **Preferred** two years’ experience in human services working with children/youth.

Training Requirements

Service Type	Trainings Required	Requirement Completion Timeframe
	<ul style="list-style-type: none"> • Mandated Reporter 	<ul style="list-style-type: none"> • Prior to Service Delivery

Caregiver/Family Supports & Services	<ul style="list-style-type: none"> • Personal Safety/ Safety in the Community • Strength Based Approaches • Suicide Prevention • Domestic Violence Signs and Basic Interventions • Trauma Informed Care 	<ul style="list-style-type: none"> • For staff hired before April 1, 2019, training must be completed within six (6) months of the 1915(c) Children's Waiver implementation. • For staff hired on or after April 1, 2019, training must be completed within six (6) months of hire date.
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Additional information regarding training requirements can be found in Appendix F.

RESPITE

Definition

This service focuses on short-term assistance provided to children/youth, regardless of disability (developmental, physical and/or behavioral), because of the absence of or need for relief of the child or the child's family caregiver. Such services can be provided in a planned mode or delivered in a crisis situation. Respite workers supervise the child/youth and engage the child/youth in activities that support his/her and/ or primary caregiver/family's constructive interests and abilities.

Respite providers offer services with a level of expertise in understanding and implementing behavioral/developmental interventions required to support optimal functioning for children/youth. Respite providers regularly communicate the details of the child/youth's intervention plan so that there is a carryover of skill from the respite source to the caregivers and treatment providers.

Service Components

Planned

Planned Respite services provide planned short-term relief for the child or family/primary caregivers to enhance the family/primary caregiver's ability to support the child/youth's functional, developmental, behavioral health, and/or health care needs. The service is direct care for the child/youth by individuals trained to support the child/youth's needs. This support may occur in short-term increments of time (usually during the day) or on an overnight or longer-term increment. Planned Respite activities support the POC goals and include providing supervision and activities that match the child/youth's developmental stage and continue to maintain the child/youth health and safety.

Crisis

Crisis Respite is a short-term care and intervention strategy for children/youth and their families that helps to alleviate the risk for an escalation of symptoms, a loss of functioning, and/or a disruption in a stable living environment. It may be used when challenging behavioral or situational crises occur that the child/youth and/or family/caregiver is unable to manage without intensive assistance and support. Crisis Respite can also be used for crisis intervention or from visiting the emergency room.

Crisis Respite should be included on the POC to the extent that it is an element of the crisis plan or risk mitigation strategy.

Crisis Respite services may be delivered in a home or residence by qualified practitioners, out-of-home/residence by staff in community-based sites, or in allowable facilities. Services offered may include site-based crisis residence, monitoring for high risk behavior, health and wellness skill building, wellness activities, family/caregiver support, conflict resolution, and other services as needed.

Ongoing communication between child/youth or the family/primary caregiver receiving crisis respite for their child, the crisis respite staff, and the child/youth's established behavioral health and health care providers is required to assure collaboration and continuity in managing the crisis situations and identifying subsequent support and service needs.

At the conclusion of a Crisis Respite period, crisis respite staff, together with the child/youth and family/primary caregiver, and his or her established behavioral health or health care providers when needed, 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.

Modality

Planned Day Respite: This service may be delivered with support of staffing ratios necessary to keep the child, and other children in the environment, safe and as indicated in the child's POC overseen by the respite provider.

Planned Overnight Respite: This service may be delivered with support of staffing ratios necessary to keep the child, and other children in the environment, safe and as indicated in the child's POC overseen by the respite provider.

Crisis Day Respite: This service may be delivered with support of staffing ratios necessary to keep the child, and other children in the environment, safe and as indicated in the child's POC overseen by the respite provider.

Crisis Overnight Respite: This service may be delivered with support of staffing ratios necessary to keep the child, and other children in the environment, safe and as indicated in the child's POC overseen by the respite provider.

Setting

Planned or Crisis Day respite services can be provided in the home of an eligible youth or a community setting.

Planned or Crisis Overnight settings include those licensed or certified by OCFS, OMH, or OPWDD and designated to provide respite services. Please note there is an exemption in the CMS HCBS Final Rule (March 16, 2014) for allowable respite care settings.

- OMH licensed Community Residence (community based or state-operated), including Crisis Residence, which has an OMH Operating Certificate demonstrating compliance with 14 NYCRR 594; OR
- OCFS Licensed agency boarding home, a group home, a group residence, or an institution and certified foster boarding homes; OR
- OPWDD certified residential setting where the individual does not permanently reside (i.e., Family Care Home; Intermediate Care Facility for Individuals with Intellectual and Developmental Disabilities (ICF/IDD); Individualized Residential Alternative (IRA) or Community Residence (CR); or Free-Standing Respite facility under the auspices of OPWDD.)

Limitations/Exclusions

- *Note: Services to children and youth in foster care must comply with Part 435 of 18 NYCRR.* Respite is not an allowable substitute for permanent housing arrangements.
- For respite services that may be provided as crisis or overnight, Federal Financial Participation is not claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.
- It is the responsibility of the Care Coordinator upon referral to ensure that respite providers have adequate training and knowledge to address the individual child/youth's needs (including but not limited to physical and/or medical needs such as medications or technology), *OR* have made arrangements for an appropriately trained and knowledgeable individual to address the individual child/youth's needs (including but not limited to physical and/or medical needs such as medications or technology). Examples include arrangement of an approved Private Duty Nurse for a technology dependent child while in a respite setting.

Certification/Provider Qualifications

Provider Agency Qualifications

Practitioners must operate in agencies that have been designated through the NYS Children's Provider Designation Review Team. This requires agencies have appropriate license, certification, and/or approval in accordance with State designation requirements.

- Provider agencies and practitioners must adhere to all Medicaid requirements in this manual and in other applicable provider manuals, regulations, and statutes.
- Provider agencies must adhere to cultural competency guidelines.

- Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
- The provider agency must ensure that staff receive Mandated Reporting training which is provided throughout New York State and Personal Safety in the Community training prior to service delivery.
- The provider agency must ensure that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable.
- The provider agency must ensure that any insurance required by the designating state agency is obtained and maintained.
- The provider agency must ensure that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.

Additional information and application for Children's SPA/HCBS can be found on the DOH website:

https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/provider_design.htm

For Overnight Planned or Crisis Respite, the designated provider must be one of the following:

- OMH-certified Community Residence: (community based or state operated) including Crisis Residence
- OCFS licensed/certified setting including agency boarding home, a group home, a group residence, or an institution
- OPWDD certified residential setting

Individual Staff Qualifications

- **Provision of service in child's residence or other community based setting (e.g. park, shopping center, etc.)**
 - Respite providers are paraprofessionals with a high school diploma or equivalent and with appropriate skills and training. It is the responsibility of the Care Coordinator to ensure that providers have adequate training and knowledge to address the individual child's needs (including but not limited to physical and/or medical needs such as medications or technology).
 - Experience working with children/youth (preference given to those with experience working with children/youth with special needs)
 - A high school diploma, high school equivalency preferred or a State Education Commencement Credential (e.g. SACC or CDOS)
- **Provision of service outside child's residence and in an allowable licensed/certified setting**
 - In a foster boarding home: Respite providers must be a Licensed Foster Parent pursuant to Part 435 of 18 NYCRR

- In a OCFS licensed/certified setting: Respite providers are paraprofessionals with a high school diploma or equivalent and with appropriate skills and training.
- In an OMH-certified Community Residence: (community based or state operated), including Crisis Residence, which has an OMH Operating Certificate demonstrating compliance with 14 NYCRR 594: Respite workers must be staff of the licensed program.
- In an OPWDD-certified setting: (community based or state operated), Family Care Home, Intermediate Care Facility for Individuals with Intellectual and Developmental Disabilities (ICF/IDD); Individualized Residential Alternative (IRA) or Community Residence (CR); or Free-Standing Respite facility under the auspices of OPWDD: Respite workers must be staff of the certified program.

Supervisor Qualifications

- Minimum qualification is a Bachelor's degree with one year of experience in human services working with children/youth.

Training Requirements

Service Type	Trainings Required	Requirement Completion Timeframe
Respite (Crisis/Planned)	<ul style="list-style-type: none"> ● Mandated Reporter 	<ul style="list-style-type: none"> ● Prior to Service Delivery
	<ul style="list-style-type: none"> ● Personal Safety ● Safety in the Community ● Strength Based Approaches ● OMH-recommended Suicide Prevention ● Domestic Violence Signs and Basic Interventions ● Trauma Informed Care 	<ul style="list-style-type: none"> ● For staff hired before April 1, 2019, training must be completed within six (6) months of the 1915(c) Children's Waiver implementation. ● For staff hired on or after April 1, 2019, training must be completed within six (6) months of hire date.

Additional information regarding training requirements can be found in Appendix F.

PREVOCATIONAL SERVICES

Definition

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 not job-specific, but rather are geared toward facilitating success in any work environment for youth whose disabilities do not permit them access to other prevocational services. The service will be reflected in youth's POC and must be directed to teaching skills rather than explicit employment objectives. In addition, Prevocational Services assist with facilitating appropriate work habits, acceptable job behaviors, and learning job production requirements.

Service Components

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

Prevocational 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.

- Resume writing, interview techniques, role play, and job application completion
- Exploring career options, facilitating appropriate work habits, acceptable job behaviors, and learning job production requirements
- Assisting in identifying community service opportunities that could lead to paid employment
- Helping the youth to connect their educational plans to future career/vocational goals
- Helping youth to complete college, technical school, or other applications to continue formal education/training
- Helping youth to apply for financial aid or scholarship opportunities

Documentation is maintained that the service is not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

Modality

This service may be delivered in a one-to-one session or in a group setting of two or three participants.

Setting

Allowable settings in compliance with Medicaid regulations and the Home and Community Based Settings Final Rule (§441.301(c)(4) and §441.710) (see Appendix B) will exhibit characteristics and qualities most often articulated by the individual child/youth and family/caregiver as key determinants of independence and community integration. Services should be offered in the setting least restrictive for desired outcomes, including the most integrated home or other community based settings where the beneficiary lives, works, engages in services, and/or socializes. While remaining inclusive of those in the family and caregiver network, family is broadly defined, and can include families created through: birth, foster care, adoption, or a self-created unit.

Limitations/Exclusions

Documentation is maintained that the service is not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

Prevocational services will not be provided to an HCBS participant if:

- 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)
- 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)
- Vocational services that are provided in facility-based work settings that are not integrated settings in the general community workforce.

Certification/Provider Qualifications **Provider Agency Qualifications**

Practitioners must operate in agencies that have been designated through the NYS Children's Provider Designation Review Team. This requires agencies have appropriate license, certification and/or approval in accordance with State designation requirements.

- Provider agencies and practitioners must adhere to all Medicaid requirements in this manual and in other applicable provider manuals, regulations, and statutes.
- Provider agencies must adhere to cultural competency guidelines.
- Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
- The provider agency must ensure that staff receive Mandated Reporting training which is provided throughout New York State and Personal Safety in the Community training prior to service delivery.
- The provider agency must ensure that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable.

- The provider agency must ensure that any insurance required by the designating state agency is obtained and maintained.
- The provider agency must ensure that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.

Additional information and application for Children’s SPA/HCBS can be found on the DOH website:

https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/provider_design.htm

Individual Qualifications

- **Minimum** qualifications of an Associate’s degree with one year of human service experience
- **Preferred** qualifications of a Bachelor’s degree with one year of experience in human services working with children/youth

Supervisor Qualifications

- **Minimum** qualification of a Bachelor’s degree with three years of experience in human services
- **Preferred** qualification of a Master’s with one year of experience in human services working with children/youth

Training Requirements

Service Type	Trainings Required	Requirement Completion Timeframe
Prevocational Services	<ul style="list-style-type: none"> • Mandated Reporter 	<ul style="list-style-type: none"> • Prior to Service Delivery
	<ul style="list-style-type: none"> • Personal Safety/ Safety in the Community • Strength Based Approaches • Suicide Prevention • Domestic Violence Signs and Basic Interventions • Trauma Informed Care 	<ul style="list-style-type: none"> • For staff hired before April 1, 2019, training must be completed within six (6) months of the 1915(c) Children’s Waiver implementation. • For staff hired on or after April 1, 2019, training must be completed within six (6) months of hire date.

Additional information regarding training requirements can be found in Appendix F.

SUPPORTED EMPLOYMENT

Definition

Supported Employment services are individually designed to prepare youth with disabilities (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.

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

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

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.

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.

Service Components

Supported employment services may be provided in a variety of settings, particularly work sites. Supported employment services include the following:

- Supervision and training that are not job-related
- Intensive ongoing support
- Transportation to and from the job site
- Interface with employers regarding the individual's disability(ies) and needs related to his/her healthcare issue(s)
- Other activities needed to sustain paid work (e.g., employment assessment, job placement, and/or adaptive/assistive equipment necessary for employment)
- Job finding and development training in work behaviors
- Assessing the interest and fit of an individual for particular job opportunities, staff work with employers and job sites preparing them to be able to make necessary and reasonable accommodations
- On-site support for the individual as they learn specific job tasks
- Monitoring through on-site observation and through communication with job supervisors and employers

Modality

- Individual face-to-face intervention

Setting

Allowable settings in compliance with Medicaid regulations and the Home and Community Based Settings Final Rule (§441.301(c)(4) and §441.710) (see Appendix B) will exhibit characteristics and qualities most often articulated by the individual child/youth and family/caregiver as key determinants of independence and community integration. Services should be offered in the setting least restrictive for desired outcomes, including the most integrated home or other community based settings where the beneficiary lives, works, engages in services, and/or socializes. While remaining inclusive of those in the family and caregiver network, family is broadly defined, and can include families created through: birth, foster care, adoption, or a self-created unit.

Limitations/Exclusions

Medicaid funds may not be used to defray the expenses associated with starting up or operating a business.

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

- 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).
- Vocational rehabilitation services that are otherwise available to the individual through a program funded under section 110 of the Rehabilitation Act of 1973.
- 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.
- 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.
- Supported employment does not include volunteer work. Such volunteer learning and un-paid training activities that prepare a person for entry into the paid workforce are addressed through Pre-Vocational services.

Medicaid funding cannot be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

- Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment; or
- Payments that are passed through to users of supported employment services.

Supported employment is limited to three hours per day.

Certification/Provider Qualifications

Provider Agency Qualifications

Practitioners must operate in agencies that have been designated through the NYS Children's Provider Designation Review Team. This requires agencies have appropriate license, certification, and/or approval in accordance with State designation requirements.

- Provider agencies and practitioners must adhere to all Medicaid requirements in this manual and in other applicable provider manuals, regulations, and statutes.
- Provider agencies must adhere to cultural competency guidelines
- Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
- The provider agency must ensure that staff receive Mandated Reporting training which is provided throughout New York State and Personal Safety in the Community training prior to service delivery.
- The provider agency must ensure that practitioners maintain the licensure necessary to provide services under their scope of practice under State law, if applicable.
- The provider agency must ensure that any insurance required by the designating state agency is obtained and maintained.
- The provider agency must ensure that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.

Additional information and application for Children's SPA/HCBS can be found on the DOH website:

https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/provider_design.htm

Individual Qualifications

- **Minimum** qualifications of an Associate's degree with one year of human service experience
- **Preferred** qualifications of a Bachelor's degree with one year of experience in human services working with children/youth

Supervisor Qualifications

- **Minimum** qualification of a Bachelor's degree with three years of experience in human services
- **Preferred** qualification of a Master's with one year of experience in human services working with children/youth

Training Requirements

Service Type	Trainings Required	Requirement Completion Timeframe
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Supported Employment	<ul style="list-style-type: none"> • Mandated Report 	<ul style="list-style-type: none"> • Prior to Service Delivery
	<ul style="list-style-type: none"> • Personal Safety/ Safety in the Community • Strength Based Approaches • OMH-recommended Suicide Prevention • Domestic Violence Signs and Basic Interventions • Trauma Informed Care 	<ul style="list-style-type: none"> • For staff hired before April 1, 2019, training must be completed within six (6) months of the 1915(c) Children's Waiver implementation. • For staff hired on or after April 1, 2019, training must be completed within six (6) months of hire date.

Additional information regarding training requirements can be found in Appendix F.

COMMUNITY SELF-ADVOCACY TRAINING AND SUPPORTS

Definition

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. Community Self-Advocacy Training and Support is intended to assist the child/youth, family/caregiver, and collateral contacts in understanding and addressing the participant's needs related to their disability(ies).

The use of this service may appropriately be provided to prevent problems in community settings as well as when the child/youth 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/youth. Participating in community events and integrated interests/occupations are important activities for all children/youth, including those with disabilities (developmental, physical, and/or behavioral health in origin). Success in these activities is dependent not only on the child/youth, but on the people who interact with and support the child/youth in these endeavors. Community Self-Advocacy Training and Support improves the child/youth's ability to gain from the community experience and enables the child/youth's environment to respond appropriately to the child/youth's disability and/or health care issues.

Service Components

- Training (one-on-one or group) for the child/youth and/or the family/caregiver regarding methods and behaviors to enable success in the community. Each group must not exceed 12 participants (enrollees and collaterals).
- Direct self-advocacy training in the community with collateral contacts regarding the child/youth's disability(ies) and needs related to his or her health care issues.

- Self-advocacy training for the child/youth and/or family/caregiver, including during community transitions.

Modality

- Individual face-to-face intervention
- Group face-to-face intervention (No more than three HCBS eligible children/youth enrolled may attend a group activity at the same time)

Setting

Allowable settings in compliance with Medicaid regulations and the Home and Community Based Settings Final Rule (§441.301(c)(4) and §441.710) (see Appendix B) will exhibit characteristics and qualities most often articulated by the individual child/youth and family/caregiver as key determinants of independence and community integration. Services should be offered in the setting least restrictive for desired outcomes, including the most integrated home or other community based settings where the beneficiary lives, works, engages in services, and/or socializes. While remaining inclusive of those in the family and caregiver network, family is broadly defined, and can include families created through: birth, foster care, adoption, or a self-created unit.

Limitations/Exclusions

- This service may be provided in group settings but to no more than 12 participants (enrollees and collaterals). No more than three HCBS eligible children/youth may attend a group activity at the same time.
- This service cannot be delivered nor billed while an enrolled child is in an ineligible setting, including hospitalization.
- 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).
- Community Self-Advocacy Training and Supports are limited to three hours a day.

Certification/Provider Qualifications

Provider Agency Qualifications

Practitioners must operate in agencies that have been designated through the NYS Children's Provider Designation Review Team. This requires agencies have appropriate license, certification and/or approval in accordance with State designation requirements.

- Provider agencies and practitioners must adhere to all Medicaid requirements in this manual and in other applicable provider manuals, regulations, and statutes.
- Provider agencies must adhere to cultural competency guidelines.

- Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
- The provider agency must ensure that staff receive Mandated Reporting training which is provided throughout New York State and Personal Safety in the Community training prior to service delivery.
- The provider agency must ensure that practitioners maintain the licensure necessary to provide services under their scope of practice under State law, if applicable.
- The provider agency must ensure that any insurance required by the designating state agency is obtained and maintained.
- The provider agency must ensure that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.

Additional information and application for Children's SPA/HCBS can be found on the DOH website:

https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/provider_design.htm

Individual Staff Qualifications

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

Supervisor Qualifications

- **Minimum** qualifications of a Master's degree with one year of experience in human services working with children/youth
- **Preferred** two years of experience in human services working with children/youth

Training Requirements

Service Type	Trainings Required	Requirement Completion Timeframe
Community Self-Advocacy Training and Supports	<ul style="list-style-type: none"> • Mandated Reporter 	<ul style="list-style-type: none"> • Prior to Service Delivery
	<ul style="list-style-type: none"> • Personal Safety/ Safety in the Community • Strength Based Approaches • Suicide Prevention • Domestic Violence Signs and Basic Interventions • Trauma Informed Care 	<ul style="list-style-type: none"> • For staff hired before April 1, 2019, training must be completed within six (6) months of the 1915(c) Children's Waiver implementation. • For staff hired on or after April 1, 2019, training must be completed within six (6) months of hire date.

Additional information regarding training requirements can be found in Appendix F.

NON-MEDICAL TRANSPORTATION

Definition

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/youth's POC.

Service Components

Examples where this service may be requested include transportation to: HCBS that a child/youth was determined eligible to receive, a job interview, college fair, a wellness seminar, a GED preparatory class, etc. This service will be provided to meet the child/youth's needs as determined by an assessment performed in accordance with the State's requirements and as outlined in the child/youth's POC.

The care manager must document a need for transportation to support an individual's identified goals. The Health Home Care Manager will include justification for this service within the Person-Centered POC. For individuals not enrolled in a Health Home, the Independent Entity or MCO Care Manager will be responsible for completing documentation of which goals in an individual's POC to which the trips will be tied. For each participant utilizing Non-Medical Transportation, the Transportation Manager will provide a monthly report of authorized trips to the State.

Limitations/Exclusions

Generally, the same rules used to determine reimbursement of trips to medical appointments should be followed when considering reimbursement of non-medical trips for eligible participants. Only those services not reimbursable under the Community First Choice Option (CFCO) State Medicaid Plan will be reimbursable under the HCBS Waiver.

The following guidelines apply to Non-Medical Transportation:

- **Transportation must be tied to a goal in the POC**
- Transportation is available for a specified duration
- Individuals receiving residential services are ineligible for Non-Medical Transportation
- Use transportation available free of charge
- Use the medically appropriate mode of transportation
- Travel within the common marketing area
- When possible, trips should be combined
- Justify need for travel outside the common marketing area

Vouchers submitted for personal vehicle mileage reimbursement must be submitted within 90 days of the date of service. Only when there are extenuating circumstances, will the Department allow payment for trips that are submitted after the 90-day time

period. These requests will be considered on a case-by-case basis provided valid justification is given.

Reimbursement for travel can be denied when the destination does not support the participant's integration into the community.

A participant's POC outlines the general parameters of his or her Non-Medical Transportation needs. However, these needs can change or be amended based upon the participant's stated goals and/or successful ongoing integration into the community.

Certification/Provider Qualifications

Agencies interested in providing Non-Medical Transportation must be enrolled in the FFS program as a current Medicaid Transportation Provider. Please see the following links on information on Medicaid Transportation:

- Link to transportation provider manuals:
<https://www.emedny.org/ProviderManuals/Transportation/index.aspx>
- Link to transportation provider enrollment application:
<https://www.emedny.org/info/ProviderEnrollment/transportation/index.aspx>

Roles Related to a Participant's Access to Non-Medical Transportation

The following roles and guidelines serve to inform the Health Home Care Manager, Managed Care Organization (MCO), and the Transportation Manager of the procedures and rules surrounding an eligible participant's access to the Non-Medical Transportation benefit.

Health Home Care Manager Roles

Health Home Care Managers are responsible for conducting and developing the Person-Centered POC. If the care manager determines there is a need for transportation to support an individual's identified goals, the Health Home Care Manager will include justification for this service within the Person-Centered POC. The Health Home Care Manager will complete the ***NYS DOH Plan of Care Grid for Non-Medical Transportation for Children's Home and Community Based Services (HCBS)*** (Grid)¹ with all known information. It is possible that the complete trip destination details may not be known (e.g. exact appointment time and date). This information can be provided by the enrollee to the Transportation Manager upon request of transportation.

The CMA should at a minimum list the goal from the POC; specific activity, support, or task; provider of services (if applicable); start and end date. After completing the POC and the Grid, the Health Home Care Manager will send it to the MCO. If the child/youth

¹ The "NYS BH HCBS Transportation Grid" can be found at <https://www.emedny.org/ProviderManuals/Transportation/index.aspx>

is not yet in a plan the HH Care Manger will send the Grid directly to Department of Health's Medicaid Transportation Manager for review.

Managed Care Organization (MCO) Roles

The MCO is responsible for approving the Person-Centered POC and for forwarding the completed Grid to the Department of Health's Medicaid Transportation Manager.

For individuals not enrolled in a Health Home, the MCO will be responsible for completing the Grid based on the individual's POC and forwarding to the Transportation Manager. The Grid will include documentation for Non-Medical Transportation including documentation of which goals in an individual's POC the trips will be tied to.

The ***NYS DOH Plan of Care Grid for Non-Medical Transportation for Children's Home and Community Based Services (HCBS)*** is completed by the MCO based on the participant's POC and includes the following information:

- Participant information
- HCBS provider information
- Non-Medical Transportation service requested
- Supporting information includes:
 - Goal from the POC
 - HCBS or specific activity/support/task
 - Mode of transportation service needed
 - Trip destination/location
 - Start date/end date
 - Frequency

The MCO will forward the completed Grid with the Transportation Manager any time there are changes to this Grid.

Transportation Manager Roles

The Transportation Manager is responsible for authorizing transportation services in accordance with Medicaid policy, by approved Medicaid Transportation providers, and as supported on the MCO-provided Grid. Once the Grid is received from the MCO, the Transportation Manager should assume that the MCO has reviewed and approved the Non-Medical Transportation included in the individual's POC and that trips included in the Grid are appropriate. The Transportation Manager is responsible for ensuring adherence to the guidelines below for Non-Medical Transportation, which include assigning the most medically appropriate, cost-effective mode of transportation. Enrollees have freedom of choice regarding the transportation provider within the assigned mode (e.g. ambulette, taxi, public transportation, etc.).

Contact Information for Transportation Managers

NYC & Upstate: Medical Answering Services (MAS)

<https://www.medanswering.com/>

<https://www.medanswering.com/enrollee/enrollee-forms-resources/>

https://www.medanswering.com/documents/Doc-MAS_Public_Site--2015-11-11-15-48-44.pdf

Fax number for submitting all forms: (315) 299-2786

Secure email: Harp-info@medanswering.com

(When sending completed Grids: "Attn: Non-Medical Transportation for Children's Home and Community Based Services (HCBS)")

Long Island: LogistiCare Solutions, LLC

<http://www.logisticare.com/>

<http://www.longislandmedicaidride.net/>

<http://www.longislandmedicaidride.net/Portals/51/DOH%20Mileage%20Reimbursement%20Forms-Logisticare.pdf?ver=2015-05-22-123216-000>

Fax number for submitting mileage reimbursement forms: (866) 528-0462

(When sending completed Grids: "Attn: Non-Medical Transportation for Children's Home and Community Based Services (HCBS)")

Additional Contact Information:

NYS Department of Health Transportation Unit: medtrans@health.ny.gov

NYS Office of Mental Health: omh.sm.co.HCBS-Application@omh.ny.gov

ADAPTIVE AND ASSISTIVE EQUIPMENT

Definition

This service provides technological aids and devices identified within the child's Plan of Care (POC) which enable him/her to accomplish daily living tasks that are necessary to support the health, welfare, and safety of the child.

Service Components

Adaptive and Assistive Equipment includes but not limited to: direct selection communicators, alphanumeric communicators, scanning communicators, encoding communicators, speech amplifiers, electronic speech aids/devices; voice activated, light activated, motion activated, and electronic devices; standing boards/frames and therapeutic equipment for the purpose of maintaining or improving the participant's strength, mobility, or flexibility to perform activities of daily living; adaptive switches/devices, meal preparation and eating aids/devices/appliances, specially adapted locks, motorized wheelchairs; guide dogs, hearing dogs, service dogs (as defined in New York Civil Rights Law Article 47-b(4)), and simian aides (capuchin

monkeys or other trained simians that perform tasks for persons with limited mobility); electronic, wireless, solar-powered, or other energy powered devices that demonstrate to the satisfaction of the commissioner, or designee, that the device(s) will significantly enable the participant to live, work, or meaningfully participate in the community with less reliance on paid staff supervision or assistance. Such devices may include computers, observation cameras, sensors, telecommunication screens, and/or telephones and/or other, telecare support services/systems that enable the participant to interact with remote staff to ensure health and safety. Such devices cannot be used for surveillance, but to support the person to live with greater independence including devices to assist with medication administration, including tele-care devices that prompt, teach, or otherwise assist the participant to independently self-administer medication routinely, portable generators necessary to support equipment, or devices needed for the health or safety of the person including stretcher stations.

Adaptive and Assistive Equipment Services include:

- Evaluation of the assistive technology needs of a participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant
- Services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for the participants
- Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices
- Training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant
- Training or technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of participants

Limitations/Exclusions

The adaptive and assistive equipment available through the HCBS authorities including both CFCO and the HCBS authorities cannot duplicate equipment otherwise available through the Medicaid State Plan under 1905(a) of the Social Security Act or other federal/state funding streams. Equipment must be beyond the scope of Durable Medical Equipment (DME). Only those services not reimbursable under the Community First Choice Option (CFCO) State Medicaid Plan will be reimbursable under the HCBS Waiver.

Adaptive Devices are expected to be a one-time only purchase. Replacements, repairs, upgrades, or enhancements made to existing equipment will be paid if documented as a necessity and approved by the State or its designee. Ongoing monitoring associated with telecare support services or other approved systems authorized under this definition may be provided if necessary for health and safety and documented to the satisfaction of the State or designee. The HHCM, IE or MCO care manager will ensure,

that where appropriate, justification from physicians, or other specialists or clinicians has been obtained.

Warranties, repairs, or maintenance on assistive technology only when most cost effective and efficient means to meet the need and are not available through the Medicaid State Plan 1905(a), CFCO, or third-party resources

Cost Limits

All Adaptive and Assistive Equipment costs require prior approval from the LDSS in conjunction with NYSDOH or the MCO. Adaptive and Assistive Equipment is subject to a \$15,000 per calendar year soft limit. The State may consider exceptions when medically necessary, including but not limited to a significant change in the child's needs or capabilities.

Certification/ Provider Qualifications

For Adaptive and Assistive Equipment, the LDSS (for FFS enrollees) or MCO (for managed care enrollees) is the provider of record for billing purposes using the standard bidding process. Services are only billed to Medicaid once the equipment is procured and the amount billed is equal to the purchased value.

LDSS or MCO secures a local vendor qualified to complete the required work.

Health Home Care Managers/C-YES Coordinators will assist in determining the need for the service, identify the expected benefit to the child, the clinical justification (scope of the work), Securing bids and facilitating the completion of the Final Cost Form.

Standard provisions of the NYS Finance Law and procurement policies must be followed to ensure that vendors are qualified, and that State required bidding procedures have been followed. Services are only billed to Medicaid or the MCO once the equipment is verified as received and the amount billed is equal to the contract value.

LDSS or MCO staff verify the qualifications of Adaptive and Assistive Equipment vendor:

- Must be familiar with the Adaptive and Assistive Equipment policies permitted in the waiver program as described in the program manual; the LDSS or MCO should supply the evaluator with a copy of both prior to initiation of the evaluation.
- Must be able to communicate well with all parties involved with the purchase of the equipment and any training needed, e.g. consumers, contractors, and local government officials.
- Must be able to clearly describe in writing, and by design, the proposed purchase. Must have knowledge of assistive technology and specific adaptive equipment appropriate for the child's needs

LDSS in conjunction with NYSDOH or the MCO will determine the most cost effective service that will meet the child's needs.

VEHICLE MODIFICATIONS

Definition

Under this benefit, Vehicle Modifications are allowable (formerly called Home and Vehicle Modifications). This service provides physical adaptations to the primary vehicle of the enrolled child which, per the child's plan of care (POC), are identified as necessary to support the health, welfare, and safety of the child or that enable the child to function with greater independence.

Service Components

Modifications include but are not limited to: portable electric/hydraulic and manual lifts, ramps, foot controls, wheelchair lock downs, deep dish steering wheel, spinner knobs, hand controls, parking break extension, replacement of roof with fiberglass top, floor cut outs, extension of steering wheel column, raised door, repositioning of seats, wheelchair floor, dashboard adaptations and other ancillary equipment or modifications necessary to guarantee full access to, and safety in, a motor vehicle. The LDSS (for FFS enrollees) or MCO (for managed care enrollees) secures a local contractor and/or evaluator qualified to complete the required work. In the case of vehicle modifications, the evaluators and modifiers are approved by the NYS Education Department's Adult Career and Continuing Education Services Rehabilitation (ACCES-VR).

Activities include and are not limited to: determining the need for the service, the safety of the proposed modification, its expected benefit to the child, and the most cost effective approach to fulfill the child's need. In FFS, the LDSS is the provider of record for Vehicle Modifications for billing purposes. The work is done by a contractor who is selected by the LDSS in conjunction with NYSDOH (for FFS) through a standard bid process, following the rules established by the Office of the State Comptroller. Standard provisions of the NYS Finance Law and procurement policies must be followed to ensure that contractors are qualified and that State required bidding procedures have been followed. In managed care, the plan is the payer and may contract with an approved network provider for the service. Services are only billed to Medicaid or the MCO once the contract work is verified as complete and the amount billed is equal to the contract value. Vehicle Modifications are limited to the primary vehicle of the recipient.

Note: This service does not duplicate other services available through the New York Medicaid State Plan. All services require prior authorization by the MCO or the LDSS in conjunction with NYSDOH.

Limitations/Exclusions

Other exclusions include the purchase, installation, or maintenance of items such as cellular phones, global positioning/tracking devices, or other mobile communication

devices; repair or replacement of modified equipment damaged or destroyed in an accident; alarm systems; auto loan payments; insurance coverage; costs related to obtaining a driver's license, title/registration, license plates, emergency road service, or rental vehicles when a vehicle modification is in process.

Repair & Replacement of Modification

In most instances a specific type of Vehicle Modification is a one-time benefit to motor vehicles used by the child. However, in reasonable circumstances determined and approved by the State, a second modification may be considered for funding if the current modifications are in need of repair, worn-out, or unsafe. Replacements, repairs, upgrades, or enhancements made to existing equipment will be paid if documented as a necessity. In addition, when the modification must be replaced or repaired, a depreciation schedule will be used to determine the limit of the amount to be applied to the cost.

Vehicle Modifications are limited to the primary means of transportation for the child. The vehicle may be owned by the child or by a family member or non-relative who provides primary, consistent, and ongoing transportation for the child. All equipment and technology used for entertainment is prohibited. Costs may not exceed current market value of vehicle.

Modification Limits

Only those services not reimbursable under the Community First Choice Option (CFCO) State Medicaid Plan, Medicaid State Plan under 1905(a) of the Social Security Act, or other federal/state funding streams will be reimbursable under the HCBS Waiver.

Contracts for Vehicle modifications may not exceed \$15,000 per calendar year without prior approval from the LDSS in conjunction with NYS DOH or the MCO. The State may consider exceptions when medically necessary, including but not limited to a significant change in the child's needs or capabilities.

Certification/Provider Qualifications

Modification Contractor / Craftsman with licensure appropriate to the trade.

LDSS or MCO staff verify the qualifications of vehicle modification providers present the following knowledge and skills:

- Must be familiar with the vehicle modification policies permitted in the waiver program as described in state guidance; the LDSS/HRA/MCO should supply the evaluator with a copy of both prior to initiation of the evaluation.
- Must be able to communicate well with all parties involved with the development of vehicle modifications, e.g. consumers, contractors, and local government officials.
- Must be able to clearly describe in writing, and by design, the proposed vehicle modification.

- Must know and be able to apply the New York State Building Code, Current Accessibility Standards, and the Federal Accessibility Guidelines found in the Fair Housing Amendment Act (as relevant to any vehicle modification).
- Must have knowledge of assistive technology and specific adaptive equipment appropriate for the child's needs.
- Must have skill in design/drafting in order to clearly describe the proposed modification.
- Must be able to complete all components of an On-Site Evaluation.

Contractors performing any adaptation for a child in the waiver program is required to:

- Be bonded
- Maintain adequate and appropriate licensure
- The ACCES-VR agency verifies the credential of vehicle modification providers pursuant to NYF Fire Prevention and Billing Codes, 00 OMM/ADM 4

Provider qualifications are verified at the beginning of the vehicle modification contract by ACCESVR.

ENVIRONMENTAL MODIFICATIONS

Definition

Environmental Modifications provides internal and external physical adaptations to the home or other eligible residences of the enrolled child which, per the child's plan of care (POC), are identified as necessary to support the health, welfare, and safety of the child or that enable the child to function with greater independence in the home and without which the child would require and institutional and/or more restrictive living setting.

Service Components

Modifications include but are not limited to: installation of ramps, hand rails, and grab-bars; widening of doorways (but not hallways); modifications of bathroom facilities; installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies needed for the welfare of the recipient; lifts and related equipment; elevators when no feasible alternative is available; automatic or manual door openers/bells; modifications of the kitchen necessary for the participant to function more independently in his/her home; medically necessary air conditioning; Braille identification systems; tactile orientation systems; bed shaker alarm devices; strobe light smoke detection and alarm devices; small area drive-way paving for wheel-chair entrance/egress from van to home; safe environment modifications for behaviorally challenged participants require the prior review of a behavioral specialist and include window protections, reinforcement of walls, durable wall finishes, open-door signal devices, fencing, video monitoring systems, and shatter-proof shower doors; and future technology devices that allow the participant to live more safely and independently to avoid possible institutional placement or placement in a more restrictive living environment, which are available at a reasonable cost in comparison to living in a more restrictive residential setting. The scope of environmental modifications

will also include necessary assessments to determine the types of modifications needed.

Note: This service does not duplicate other services available through the New York Medicaid State Plan. All services require prior authorization by the LDSS in conjunction with NYSDOH if exceeding established limits or MCO.

Limitations/Exclusions

Excluded are those adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the child. Adaptations that add to the total square footage of the home's footprint are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair). Also excluded are pools and hot tubs and associated modifications for entering or exiting the pool or hot tub.

Repair & Replacement of Modification

In most instances, a specific type of Environmental Modification is a one-time benefit. However, in reasonable circumstances determined and approved by the State, a second modification may be considered for funding as follows: if a person moves to another home; if the current modifications are in need of repair, worn-out, or unsafe; or if a participant wishes to spend considerable time with a non-cohabitating parent in their home and such modifications are required to ensure health and safety during these periods.

State policy places certain limitations on environmental modifications requested when the home/apartment is a leased space, including property owner sign-off on the modification and limitations on federal/state liability for the cost of removal/replacement/repair of items in public spaces of rental properties.

Modification Limits

Only those services not reimbursable under the Community First Choice Option (CFCO) State Medicaid Plan, Medicaid State Plan under 1905(a) of the Social Security Act, or other federal/state funding streams will be reimbursable under the HCBS Waiver.

All Environmental modifications require prior approval from the LDSS in conjunction with NYS DOH or the MCO. For Environmental Modifications, the LDSS or MCO is the provider of record for billing purposes. Contracts for Environmental Modifications may not exceed \$15,000 per calendar year. The State may consider exceptions when medically necessary, including but not limited to a significant change in the child's needs or capabilities.

Note: This service does not duplicate other services available through the New York Medicaid State Plan. All services require prior authorization by the LDSS in conjunction with NYSDOH if exceeding established limits or MCO.

Certification/Provider Qualifications

Environmental Modification Contractor / Craftsman with licensure appropriate to trade.

LDSS or MCO staff verify the qualifications of home modification providers present the following knowledge and skills:

- Must be familiar with the home adaptation policies permitted in the waiver program as described in state guidance; the LDSS/HRA/MCO should supply the evaluator with a copy of both prior to initiation of the evaluation.
- Must be able to communicate well with all parties involved with the development of home adaptations, e.g. consumers, contractors, and local government officials.
- Must be able to clearly describe in writing, and by design, the proposed home adaptation.
- Must know and be able to apply the New York State Building Code, Current Accessibility Standards, and the Federal Accessibility Guidelines found in the Fair Housing Amendment Act (as applicable to the home modification).
- Must have knowledge of assistive technology and specific adaptive equipment appropriate for the child's needs.
- Must have skill in design/drafting in order to clearly describe the proposed modification.
- Must be able to complete all components of an On-Site Evaluation.

Contractors performing any adaptation for a child in the waiver program is required to:

- Be bonded
- Maintain adequate and appropriate licensure
- Obtain any and all permits required by state and local municipality codes for the modification
- Agree that before final payment is made the contractor must show that the local municipal branch of government that issued the initial permit has inspected the work

Provider qualifications are verified at the beginning of the home modification contract by the LDSS/MCO.

PALLIATIVE CARE – EXPRESSIVE THERAPY

Definition

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 child 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 child'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.

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.

The Health Home Care manager or C-YES will assist the family with obtaining a Doctor's written order including justification for Expressive Therapy from a Physician, Physician Assistant, Nurse Practitioner, Occupational Therapist, Physical Therapist or Psychiatrist, be included with the child/youth's POC and made available to the Managed care plan as needed.

Expressive Therapy (art, music, and play) helps children better understand and express their reactions through creative and kinesthetic treatment.

Expressive therapy helps children to feel empowered in their own creativity, control, and aid in their communication of their feelings when their life and body may be rapidly changing during the stressful time of undergoing a chronic condition and/or life-threatening illness and the trauma that often comes with its treatment. Whether through music, art, and/or play therapy, the child may find an outlet that allows them to express their emotions safely and have a medium where they have complete control to play and explore with abandon. The family can participate as well, whether in the form of memories shared together or by tangible objects made by their child they can hold onto - scrapbooks, paintings, or sculpture - mementos that tell their child's life from their perspective and aid in their family's own journey of grief and loss.

Service Components

- **Expressive Therapy (art, music and play)** helps children better understand and express their reactions through creative and kinesthetic treatment.

Modality

- **Expressive Therapy (art, music and play)** – 1:1

Setting

Allowable settings in compliance with Medicaid regulations and the Home and Community Based Settings Final Rule (§441.301(c)(4) and §441.710) (see appendix B) will exhibit characteristics and qualities most often articulated by the individual child/youth and family/caregiver as key determinants of independence and community integration. Services should be offered in the setting least restrictive for desired outcomes, including the most integrated home or other community based settings where the beneficiary lives, works, engages in services, and/or socializes. While remaining inclusive of those in the family and caregiver network, family is broadly defined, and can include families created through: birth, foster care, adoption, or a self-created unit.

Limitations/Exclusions

Palliative care benefits may not duplicate Hospice or other State Plan benefits accessible to participants.

Limited to the lesser of four appointments per month or 48 units per calendar year. This limit can be exceeded when medically necessary.

Certification/Provider Qualifications

Provider Agency Qualifications

Certified Home Health Agency (CHHA), Hospice Organization or Article 28 Clinic

NOTE: For all staff providing Palliative Care Services, it is expected that they will have a minimum of three years working with the medically fragile population and at least one year of clinical experience with pediatric population, preferably involving end of life care.

Expressive Therapy (art, music, and play): Child Life Specialist with certification through the Child Life Council. A Creative Arts Therapist licensed by the State of New York, a Music Therapist with a Bachelor's Degree from a program recognized by the NYS Education Department, a Play Therapist with a Master's Degree from a program recognized by the New York State Education Department and a current Play Therapist Registration conferred by the Association for Play Therapy (Expressive Therapy (Art, Music, and Play)). Direct service workers must have background checks.

Practitioners must operate in agencies which have been designated through the NYS Children's Provider Designation Review Team. This requires agencies have appropriate license, certification, and/or approval in accordance with State designation requirements.

- Provider agencies and practitioners adhere to all Medicaid requirements in this manual and in other applicable provider manuals, regulations, and statutes.
- Provider agencies adhere to cultural competency guidelines
- Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
- The provider agency ensures that staff receive Mandated Reporting training which is provided throughout New York State and Personal Safety in the Community training prior to service delivery.
- The provider agency ensures that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable.
- The provider agency ensures that any insurance required by the designating state agency is obtained and maintained.
- The provider agency ensures that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.

Additional information and application for Children’s SPA/HCBS can be found on the DOH website:

https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/provider_design.htm

Training Requirements

Service Type	Trainings Required	Requirement Completion Timeframe
Palliative Care	<ul style="list-style-type: none"> • Mandated Reporter 	<ul style="list-style-type: none"> • Prior to Service Delivery
	<ul style="list-style-type: none"> • Personal Safety/ Safety in the Community • Strength Based Approaches • Suicide Prevention • Domestic Violence Signs and Basic Interventions • Trauma Informed Care 	<ul style="list-style-type: none"> • For staff hired before April 1, 2019, training must be completed within six (6) months of the 1915(c) Children’s Waiver implementation. • For staff hired on or after April 1, 2019, training must be completed within six (6) months of hire date.

Additional information regarding training requirements can be found in Appendix F.

PALLIATIVE CARE – MASSAGE THERAPY

Definition

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 child 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 child’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.

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.

The Health Home Care manager or C-YES will assist the family with obtaining a Doctor’s written order including justification for Massage Therapy from a Physician, Physician Assistant, Nurse Practitioner, Occupational Therapist, Physical Therapist or Psychiatrist, be included with the child/youth’s POC and made available to the Managed care plan as needed.

Massage Therapy: To improve muscle tone, circulation, range of motion, and address physical symptoms related to illness as well as provide physical and emotional comfort, pain management, and restore the idea of healthy touch for children and youth who are dealing with treatments that may involve painful interventions and ongoing and/or past trauma.

Service Components

Massage Therapy – To improve muscle tone, circulation, range of motion and address physical symptoms related to their illness.

Modality

- **Massage Therapy** – 1:1

Setting

Allowable settings in compliance with Medicaid regulations and the Home and Community Based Settings Final Rule (§441.301(c)(4) and §441.710) (see appendix B) will exhibit characteristics and qualities most often articulated by the individual child/youth and family/caregiver as key determinants of independence and community integration. Services should be offered in the setting least restrictive for desired outcomes, including the most integrated home or other community based settings where the beneficiary lives, works, engages in services, and/or socializes. While remaining inclusive of those in the family and caregiver network, family is broadly defined, and can include families created through: birth, foster care, adoption, or a self-created unit.

Limitations/Exclusions

Palliative care benefits may not duplicate Hospice or other State Plan benefits accessible to participants.

Limited to no more than 12 appointments per calendar year. This limit can be exceeded when medically necessary.

Certification/Provider Qualifications

Provider Agency Qualifications

Certified Home Health Agency (CHHA), Hospice Organization or Article 28 Clinic

NOTE: For all staff providing Palliative Care Services it is expected that they will have a minimum of three years working with the medically fragile population and at least one year of clinical experience with pediatric population, preferably involving end of life care.

Massage Therapy: Massage Therapist currently licensed by the State of New York. Direct service workers must have background checks.

Practitioners must operate in agencies which have been designated through the NYS Children's Provider Designation Review Team. This requires agencies have appropriate license, certification, and/or approval in accordance with State designation requirements.

- Provider agencies and practitioners adhere to all Medicaid requirements in this manual and in other applicable provider manuals, regulations, and statutes.
- Provider agencies adhere to cultural competency guidelines
- Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
- The provider agency ensures that staff receive Mandated Reporting training which is provided throughout New York State and Personal Safety in the Community training prior to service delivery.
- The provider agency ensures that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable.
- The provider agency ensures that any insurance required by the designating state agency is obtained and maintained.
- The provider agency ensures that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.

Additional information and application for Children’s SPA/HCBS can be found on the DOH website:

https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/provider_design.htm

Training Requirements

Service Type	Trainings Required	Requirement Completion Timeframe
Palliative Care	<ul style="list-style-type: none"> • Mandated Reporter 	<ul style="list-style-type: none"> • Prior to Service Delivery
	<ul style="list-style-type: none"> • Personal Safety/ Safety in the Community • Strength Based Approaches • Suicide Prevention • Domestic Violence Signs and Basic Interventions • Trauma Informed Care 	<ul style="list-style-type: none"> • For staff hired before April 1, 2019, training must be completed within six (6) months of the 1915(c) Children’s Waiver implementation. • For staff hired on or after April 1, 2019, training must be completed within six (6) months of hire date.

Additional information regarding training requirements can be found in Appendix F.

PALLIATIVE CARE – BEREAVEMENT SERVICE

Definition

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 child 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 child'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.

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.

The Health Home Care manager or C-YES will assist the family with obtaining a Doctor's written order including justification for Bereavement Services from a Physician, Physician Assistant, Nurse Practitioner, Occupational Therapist, Physical Therapist or Psychiatrist, be included with the child/youth's POC and made available to the Managed care plan as needed.

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.

Children and youth with chronic conditions and life-threatening illnesses and their families deal with grief and loss in a variety of ways and may need various kinds of support over time including counseling and support groups and other services. Bereavement counseling services are inclusive for those participants who are receiving services with a hospice care provider.

Service Components

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.

Modality

- **Bereavement Service** 1:1 family eligible to participate

Setting

Allowable settings in compliance with Medicaid regulations and the Home and Community Based Settings Final Rule (§441.301(c)(4) and §441.710) (see appendix B) will exhibit characteristics and qualities most often articulated by the individual child/youth and family/caregiver as key determinants of independence and community integration. Services should be offered in the setting least restrictive for desired outcomes, including the most integrated home or other community based settings where the beneficiary lives, works, engages in services, and/or socializes. While remaining inclusive of those in the family and caregiver network, family is broadly defined, and can include families created through: birth, foster care, adoption, or a self-created unit.

Limitations/Exclusions

Palliative care benefits may not duplicate Hospice or other State Plan benefits accessible to participants.

Limited to the lesser of 5 appointments per month or 60 hours per calendar year.

Certification/Provider Qualifications

Provider Agency Qualifications

Certified Home Health Agency (CHHA), Hospice Organization or Article 28 Clinic

NOTE: For all staff providing Palliative Care Services it is expected that they will have a minimum of three years working with the medically fragile population and at least one year of clinical experience with pediatric population, preferably involving end of life care.

Bereavement Service: A Licensed Clinical Social Worker (LCSW), a Licensed Master Social Worker (LMSW), a Licensed Psychologist, or a Licensed Mental Health Counselor, that meet current NYS licensing

Practitioners must operate in agencies which have been designated through the NYS Children's Provider Designation Review Team. This requires agencies have appropriate license, certification, and/or approval in accordance with State designation requirements.

- Provider agencies and practitioners adhere to all Medicaid requirements in this manual and in other applicable provider manuals, regulations, and statutes.
- Provider agencies adhere to cultural competency guidelines
- Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
- The provider agency ensures that staff receive Mandated Reporting training which is provided throughout New York State and Personal Safety in the Community training prior to service delivery.
- The provider agency ensures that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable.
- The provider agency ensures that any insurance required by the designating state agency is obtained and maintained.
- The provider agency ensures that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.

Additional information and application for Children's SPA/HCBS can be found on the DOH website:

https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/provider_design.htm

Training Requirements

Service Type	Trainings Required	Requirement Completion Timeframe
Palliative Care	<ul style="list-style-type: none"> • Mandated Reporter 	<ul style="list-style-type: none"> • Prior to Service Delivery
	<ul style="list-style-type: none"> • Personal Safety/ Safety in the Community • Strength Based Approaches • Suicide Prevention • Domestic Violence Signs and Basic Interventions • Trauma Informed Care 	<ul style="list-style-type: none"> • For staff hired before April 1, 2019, training must be completed within six (6) months of the 1915(c) Children’s Waiver implementation. • For staff hired on or after April 1, 2019, training must be completed within six (6) months of hire date.

Additional information regarding training requirements can be found in Appendix F.

PALLIATIVE CARE – PAIN AND SYMPTOM MANAGEMENT

Definition

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 child 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 child’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.

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.

The Health Home Care manager or C-YES will assist the family with obtaining a Doctor’s written order including justification for Pain and Symptom Management from a Physician, to be included with the child/youth’s POC and made available to the Managed care plan as needed.

Pain and Symptom Management: Relief and/or control of the child’s suffering related to their illness or condition.

Pain and symptom management is an important part of aiding in providing relief from pain and symptoms and/or controlling pain, symptoms, and side effects related to chronic conditions or life-threatening illness a child is enduring. This management is not

only an important part of humanely caring for the child's pain and suffering but helping the child and family cope and preserve their quality of life at a difficult time.

Service Components

Pain and Symptom Management – Relief and/or control of the child's suffering related to their illness or condition.

Modality

- **Pain and Symptom management** – 1:1

Setting

Allowable settings in compliance with Medicaid regulations and the Home and Community Based Settings Final Rule (§441.301(c)(4) and §441.710) (see appendix B) will exhibit characteristics and qualities most often articulated by the individual child/youth and family/caregiver as key determinants of independence and community integration. Services should be offered in the setting least restrictive for desired outcomes, including the most integrated home or other community based settings where the beneficiary lives, works, engages in services, and/or socializes. While remaining inclusive of those in the family and caregiver network, family is broadly defined, and can include families created through: birth, foster care, adoption, or a self-created unit.

Limitations/Exclusions

Palliative care benefits may not duplicate Hospice or other State Plan benefits accessible to participants.

Certification/Provider Qualifications

Provider Agency Qualifications

Certified Home Health Agency (CHHA), Hospice Organization or Article 28 Clinic

NOTE: For all staff providing Palliative Care Services it is expected that they will have a minimum of three years working with the medically fragile population and at least one year of clinical experience with pediatric population, preferably involving end of life care.

Pain and Symptom Management: Pediatrician or Family Medicine Physician, board certified in Pediatrics or Family Medicine licensed by the State of New York, a Nurse Practitioner licensed by the State of New York (Pain and Symptom Management).

Practitioners must operate in agencies which have been designated through the NYS Children's Provider Designation Review Team. This requires agencies have appropriate license, certification, and/or approval in accordance with State designation requirements.

- Provider agencies and practitioners adhere to all Medicaid requirements in this manual and in other applicable provider manuals, regulations, and statutes.
- Provider agencies adhere to cultural competency guidelines
- Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
- The provider agency ensures that staff receive Mandated Reporting training which is provided throughout New York State and Personal Safety in the Community training prior to service delivery.
- The provider agency ensures that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable.
- The provider agency ensures that any insurance required by the designating state agency is obtained and maintained.
- The provider agency ensures that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.

Additional information and application for Children’s SPA/HCBS can be found on the DOH website:

https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/provider_design.htm

Training Requirements

Service Type	Trainings Required	Requirement Completion Timeframe
Palliative Care	<ul style="list-style-type: none"> • Mandated Reporter 	<ul style="list-style-type: none"> • Prior to Service Delivery
	<ul style="list-style-type: none"> • Personal Safety/ Safety in the Community • Strength Based Approaches • Suicide Prevention • Domestic Violence Signs and Basic Interventions • Trauma Informed Care 	<ul style="list-style-type: none"> • For staff hired before April 1, 2019, training must be completed within six (6) months of the 1915(c) Children’s Waiver implementation. • For staff hired on or after April 1, 2019, training must be completed within six (6) months of hire date.

Additional information regarding training requirements can be found in Appendix F.

FAMILY PEER SUPPORTS SERVICES

Effective 7/1/2019 Family Peer Supports Services (FPSS) will be available as a Children and Family Treatment and Support Service. Additional information can be found in the Children and Family Treatment and Support Services (CFTSS) Provider manual, Utilization Management, Standards of Care, a glossary of CFTSS terms, Knowledge Base Skills/Recommendations, Staffing Guidelines, and Cultural Competency and Language Access [here](#).

YOUTH PEER SUPPORTS

Definition

Youth Peer Support and Training (YPST) services are formal and informal services and supports provided to youth, who are experiencing social, medical, emotional, developmental, substance use, and/or behavioral challenges in their home, school, placement, and/or community centered services. These services provide the training and support necessary to ensure engagement and active participation of the youth in the POC process and with the ongoing implementation and reinforcement of skills. Services are delivered in a trauma informed, culturally and linguistically competent manner.

The need for YPST must be determined by a licensed practitioner and included within a POC. Youth Peer Support and Training activities must be intended to develop and achieve the identified goals and/or objectives as set forth in the youth's individualized POC.

The structured, scheduled activities provided by this service emphasize the opportunity for the youth to expand the skills and strategies necessary to move forward in meeting their personal, individualized life goals, develop self-advocacy skills, and to support their transition into adulthood.

NOTE: Youth Peer Supports (YPST) will be authorized under the 1915c array of services upon CMS approvals until authority for this service is covered under the State Plan with an expected implementation date of 1/1/2020 and CMS approvals. Children who meet Level of Care for HCBS will be able to access YPST based on need and appropriateness. Additional information can be found in the Children and Family Treatment and Support Services (CFTSS) Provider manual, including, Utilization Management, Standards of Care, a glossary of CFTSS terms, Knowledge Base Skills/Recommendations, Staffing Guidelines, and Cultural Competency and Language Access [here](#).

Service Components

- **Skill Building:**
 - Developing skills for coping with and managing psychiatric symptoms, trauma, and substance use disorders
 - Developing skills for wellness, resiliency, and recovery support
 - Developing skills to independently navigate the service system
 - Developing goal-setting skills
 - Building community living skills
- **Coaching:** Enhancing resiliency/recovery oriented attitudes, i.e., hope, confidence, and self-efficacy
 - Promoting wellness through modeling.
 - Providing mutual support, hope, reassurance, and advocacy that include

sharing one's own "personal recovery/resiliency story" as the Youth Peer Advocating (YPA) deems appropriate as beneficial to both the youth and themselves. YPA's may also share their recovery with parents to engage parents and help them "see" youth possibilities for future in a new light.

- **Engagement, Bridging, and Transition Support:**
 - Acting as a peer partner in transitioning to different levels of care and into adulthood; helping youth understand what to expect and how and why they should be active in developing their POC and natural supports.

- **Self-Advocacy, Self-Efficacy, and Empowerment:**
 - Developing, linking, and facilitating the use of formal and informal services, including connection to peer support groups in the community.
 - Serving as an advocate, mentor, or facilitator for resolution of issues.
 - Assisting in navigating the service system including assisting with engagement and bridging during transitions in care.
 - Helping youth develop self-advocacy skills (e.g., may attend a Committee on Preschool or Special Education meeting with the youth and parent, coaching the youth to articulate his educational goals).
 - Assisting youth with gaining and regaining the ability to make independent choices and assist youth in playing a proactive role in their own treatment (assisting/mentoring them in discussing questions or concerns about medications, diagnoses or treatment approaches with their treating clinician). The YPA guides the youth to effectively communicate their individual perspective to providers and families.
 - Assisting youth in developing skills to advocate for needed services and benefits and seeking to effectively resolve unmet needs.
 - Assisting youth in understanding their POC and help to ensure the plan is person/family centered

- **Community Connections and Natural Supports:**
 - Connecting youth to community resources and services. The YPA may accompany youth to appointments and meetings for the purpose of mentoring and support but not for the sole purpose of providing transportation for the youth.
 - Helping youth develop a network for information and support from others who have been through similar experiences, including locating similar interest programs, peer-run programs, and support groups.
 - Facilitating or arranging youth peer resiliency/recovery support groups.

Modality

- Individual
- Group
 - Group limit refers to number of child/youth participants, regardless of payor. Groups cannot exceed 8 children/youth.

- Consideration for group limits or the inclusion of an additional group clinician/facilitator, should be based on, but not limited to: the purpose/nature of the group, the clinical characteristics of the participants, age of participants, developmental level and severity of needs of the participants, inclusion of collaterals in group; as well as the experience and skill of the group clinician/facilitator.

Setting

Allowable settings in compliance with Medicaid regulations and the Home and Community Based Settings Final Rule (§441.301(c)(4) and §441.710) (see appendix B) will exhibit characteristics and qualities most often articulated by the individual child/youth and family/caregiver as key determinants of independence and community integration. Services should be offered in the setting least restrictive for desired outcomes, including the most integrated home or other community based settings where the beneficiary lives, works, engages in services, and/or socializes. While remaining inclusive of those in the family and caregiver network, family is broadly defined, and can include families created through: birth, foster care, adoption, or a self-created unit.

Limitations/Exclusions

- A youth with a developmental disability diagnosis without a co-occurring behavioral health condition is ineligible to receive this rehabilitative service.

The following activities are not reimbursable for Medicaid peer support programs:

- 12-step programs run by peers.
- General outreach and education including participation in health fairs, and other activities designed to increase the number of individuals served or the number of services received by individuals accessing services; community education services, such as health presentations to community groups, PTAs, etc.
- Contacts that are not medically necessary.
- Time spent doing, attending, or participating in recreational activities.
- Services provided to teach academic subjects or as a substitute for educational personnel such as, but not limited to, a teacher, teacher's aide, or an academic tutor.
- Time spent attending school (e.g., during a day treatment program), with the exception of attending meetings (e.g. CSE) with a Youth.
- Habilitative services for the beneficiary (youth) to acquire self-help, socialization, and adaptive skills necessary to reside successfully in community settings.
- Child Care services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision.
- Respite care.
- Transportation for the beneficiary (youth) or family. Services provided in the car are considered transportation and time may not be billed under rehabilitation.
- Services not identified on the beneficiary's authorized POC.

- Services not in compliance with the service manual and not in compliance with State Medicaid standards.
- Services provided to children, spouse, parents, or siblings of the eligible beneficiary under treatment or others in the eligible beneficiary's life to address problems not directly related to the eligible beneficiary's issues and not listed on the eligible beneficiary's POC.
- Any intervention or contact not documented or consistent with the approved treatment/recovery plan goals, objectives, and approved services will not be reimbursed.

- Rehabilitative services do not include and FFP (Federal Financial Participation) is not available for any of the following:
 - Educational, vocational, and job training services
 - Room and board
 - Habilitation services such as financial management, supportive housing, supportive employment services, and basic skill acquisition services that are habilitative in nature
 - Services to inmates in public institutions
 - Services to individuals residing in institutions for mental diseases
 - recreational, or custodial (i.e., for the purpose of assisting in the activities of daily living such as bathing, dressing, eating, and maintaining personal hygiene and safety; for maintaining the recipient's or anyone else's safety, and could be provided by persons without professional skills or training).
 - Services that must be covered under other Medicaid authorities (e.g. services within a hospital outpatient setting).
 - Services also do not include services, supplies or procedures performed in a nonconventional setting including: resorts, spas, therapeutic programs, and camps.

Certification/Provider Qualifications

Must operate within a child serving agency that is licensed, certified, designated and/ or approved by OCFS, OMH, OASAS, or DOH or its designee, in settings permissible by that designation.

Individual Qualifications:

YPST is delivered by a New York State Youth Peer Advocate Credential. To be eligible for the Youth Peer Advocate Professional Credential, an individual must:

- Be an individual 18 to 30 years old who has self-identified as a person who has first-hand experience with social, emotional, medical, developmental, substance use, and/or behavioral challenges.
- Be able to use lived experience with a disability, mental illness, juvenile justice, special education, substance use disorder, and/or foster care to assist in supporting youth in their resiliency/recovery and wellness.
- At a minimum, have a high school diploma, high school equivalency preferred or a State Education Commencement Credential. This educational requirement can

be waived by the certifying agency if the person has demonstrated competencies and has relevant life experience sufficient for the peer certification.

- Complete Level One (online component) and Level Two (online and in-person) training of the Youth Peer Support Services Advisory Council recommended and State approved training for YPAs followed by a minimum of three consultation calls.
- Submit three letters of reference attesting to proficiency in and suitability for the role of an YPA including one from YPAs supervisor.
- Agree to practice according to the Youth Peer Advocate Code of Ethics.
- Document 600 hours of experience providing Youth Peer Support services.
- Complete *20 hours* of continuing education *every 2 years*.
- Demonstrate qualities of leadership, including:
 - Knowledge of advocacy
 - Group development and/or facilitation of peer-to-peer groups or activities
- Be supervised by a credentialed YPA with four years direct service experience or an individual who meets the criteria for a “qualified mental health staff person” found in 14 NYCRR 591 or 14NYCRR 595.

A YPA may obtain a provisional credential that will allow services they provide to be billed if the applicant:

- Is an individual 18 to 30 years old who has self-identified as a person who has first-hand experience with social, emotional, medical, developmental, substance use, and/or behavioral challenges.
- Be able to use lived experience with a disability, mental illness, juvenile justice, special education, substance use disorder, and/or foster care to assist in supporting youth in their resiliency/recovery and wellness.
- Has a high school diploma, high school equivalency preferred or a State Education Commencement Credential. This educational requirement can be waived by the certifying agency if the person has demonstrated competencies and has relevant life experience sufficient for the peer certification.
- Has completed Level One of the Youth Peer Support Services Advisory Council recommended and State approved training for YPAs.
- Submits two letters of reference attesting to proficiency in and suitability for the role of a YPA.
- Agrees to practice according to the Youth Peer Advocate Code of Ethics.
- Demonstrates qualities of leadership, including:
 - Knowledge of advocacy
 - Group development and/or facilitation of peer-to-peer groups or activities
- Is supervised by a credentialed YPA with four years direct service experience OR an individual who meets the criteria for a “qualified mental health staff person” found in 14 NYCRR 591 or 14NYCRR 595 (refer to Appendices for criteria).

A YPA with a provisional credential must complete all other requirements of the full credential within 18 months of employment as an YPA.

OR

A Certified Recovery Peer Advocate – To be eligible as a certified recovery peer advocate, an individual must be 18 to 30 years of age and has the following:

- Lived experience defined as having been impacted or affected by substance use disorders and/or be in recovery from substance use disorders.
- A high school diploma, high school equivalency preferred or a State Education Commencement Credential.
- Completed a minimum of 46 hours of content specific training, covering topics of: advocacy, mentoring/education, recovery/wellness support, and ethical responsibility.
- Documented 1,000 hours of relative work experience, or document at least 500 hours of related work experience if they:
 - Have a Bachelor's Degree, is certified by OASAS as a CASAC or CASAC trainee or Prevention Professional or completed the 30-hour Recovery Coach Academy training.
- Provide evidence of at least 25 hours of supervision specific to the performance domains of advocacy, mentoring/education, recovery/wellness, and ethical responsibility. Supervision must be provided by an organization documented and qualified to provide supervision per job description.
- Pass the NYCB/IC&RC Peer Advocate Exam or other exam by an OASAS designated certifying body.
- Submitted two letters of recommendation.
- Demonstrated a minimum of 16 hours specifically related to Youth Peer Support Completed 20 hours of continuing education earned every two years, including 6 hours of ethics.

The youth requires education, support, coaching, and guidance in age-appropriate behaviors, interpersonal communication, problem-solving, and conflict resolution, and relating appropriately to others to address daily living, social, and communication needs.

Supervisor Qualifications: for Credentialed Youth Peer Advocates/Certified Recovery Peer Advocates:

- 1) A credentialed YPA/CRPA, as appropriate, with four years of direct YPST service experience with access to clinical consultation as needed. The clinical supervision may be provided by a staff member or through a contract with another organization.

OR

- 2) A credentialed FPA/CRPA-F, as appropriate, with four years of experience providing FPSS that has been trained in YPST services and the role of YPAs, and efforts are made as the YPST service gains maturity in NYS to transition to supervision by experienced credentialed YPAs/CRPA within the organization.

OR

- 3) A “qualified mental health staff person” found in 14 NYCRR 594 or 14 NYCRR 595 that has training in YPST services and the role of YPAs/CRPA and efforts are made as the YPST service gains maturity to transition to supervision by an experienced credentialed YPA/CRPA within the organization.

Additional Supervision Guidance:

- It is required that one hour of supervision be delivered for every 40 hours of Peer Support and Training duties performed.
- The individual providing consultation, guidance, mentoring, and on-going training need not be employed by the same agency. Supervision of these activities may be delivered in person or by distance communication methods.

Training Requirements

Youth Peer Advocates (YPAs) must complete the Youth Peer Support Services Council recommended and State Approved Level One and Level Two YPA training or comparable training that has been approved by the Youth Peer Support Services Council and State.

OR

For the Credentialed Youth Peer Advocates: Complete a minimum of 46 hours of content specific training, covering the topics: advocacy, mentoring/education, recovery/wellness support, and ethical responsibility and 16 hours in the area of Youth Peer Support.

Specific components of Level One and Level Two can be found on the Families Together in NYS web site (www.ftnys.org) or CTAC (www.ctacny.org)

Other Required Training: Mandated Reporter Other Recommended Trainings: Practitioners are encouraged to review knowledge base and skills the State recommended for providers who will be delivering the new State Plan services to children in order to demonstrate competency (See Appendix B in the CFTSS Provider Manual [here](#)).

CRISIS INTERVENTION

Definition

Crisis Intervention (CI) services are mobile services provided to children/youth under age 21 who are identified as experiencing an acute psychological/emotional change which results in a marked increase in personal distress and which exceeds the abilities and the resources of those involved (e.g. family, provider, community member) to effectively resolve it.

CI services are designed to interrupt or ameliorate the crisis experience and result in immediate crisis resolution. The goals of CI are engagement, symptom reduction,

stabilization, and restoring child/youth to a previous level of functioning, or promoting coping mechanisms within the family unit to minimize or prevent crises in the future.

CI is a face-to-face intervention that can occur in a variety of settings, including community locations where the child/youth lives, attends school, engages in services (e.g., office settings), socializes, and/or works. CI services are delivered in a person-centered, family-focused, trauma-informed, culturally and linguistically responsive manner.

CI includes engagement with the child/youth, family/caregiver and other collateral sources (e.g., school personnel) as needed, to determine level of safety, risk, and plan for the next level of services. All activities must be delivered within the context of a potential or actual behavioral health crisis with a desired outcome of diverting an emergency room visit and/or inpatient admission, when appropriate.

CI services are provided through a multi-disciplinary team to enhance engagement and meet the unique needs of the child/youth and family. Teams are encouraged to include a range of service providers as defined below (see: *Individual Qualifications*) to promote the multi-disciplinary approach, such as, the inclusion of a Credentialed Family Peer Advocate or CASAC. The team should be comprised of at least two professionals for safety purposes. One member of a two-person crisis intervention team must be a licensed behavioral health professional and have experience with crisis intervention service delivery including: Psychiatrist, Physician, Licensed Psychoanalyst, Licensed Clinical Social Worker, Licensed Master Social Worker, Licensed Mental Health Counselor, Licensed Psychologist, Licensed Marriage and Family Therapist, or Nurse Practitioner with experience/background in treatment of mental health and/or substance use disorders. The team may also be comprised of non-licensed behavioral health professionals to include: Certified Alcoholism and Substance Abuse Counselor, Credentialed Family Peer Advocate with lived experience as a family member, Certified Recovery Peer Advocate-Family, Certified Rehabilitation Counselor, or a Registered Professional Nurse. If one member of the team is a Peer Advocate, the Peer Advocate must have a credential/certification as either an OMH established Family Peer Advocate Credential or an OASAS established Certified Recovery Peer Advocate-Family.

If determined through triage only one team member is needed to respond to a psychiatric crisis, that team member must be a behavioral health professional and have experience with crisis intervention. If determined through triage only one team member is needed to respond to a substance use disorder (SUD) crisis, the team member may be a Credentialed Alcoholism and Substance Abuse Counselor (CASAC) and a licensed behavioral health professional must be available via phone. A Peer Support specialist may not respond alone.

Substance use should be recognized and addressed in an integrated way as it elevates risk and impacts both the crisis intervention being delivered and the planning for ongoing care, further demonstrating the necessity of a multi-faceted team approach. As

such, crisis services cannot be denied based upon substance use and crisis team members should be trained on screening for substance use disorders.

Referrals for CI service may be made through a number of sources such as: family members, school social worker, provider agencies, primary care doctors, law enforcement, etc. Upon receiving a call/request for crisis services, a preliminary assessment of risk and mental status is conducted. The preliminary assessment will determine if crisis services are necessary to further evaluate, resolve, and/or stabilize the crisis. This determination can be made by the following practitioners of the healing arts, operating within their scope of practice, who may or may not be part of the crisis team: Psychiatrist, Physician, Licensed Psychoanalyst, Registered Professional Nurse, Nurse Practitioner, Clinical Nurse Specialist, LCSW, LMFT, LMHC, or a licensed Psychologist.

CI must provide 24/7/365 availability and respond within one (1) hour of the completion of the initial call to the crisis provider and upon the determination an in-person contact is required. A crisis intervention episode begins with the provider's initial face to face contact with the child.

The CI team uses methods and techniques to engage and promote symptom reduction and stabilization to restore the child/ youth to a previous level of functioning. Relevant information is gathered from the child, family, and/or other collateral supports to assess the risk of harm to self or others and to develop a crisis plan to address safety/mitigate risk. The crisis plan is developed in collaboration with the child/family and should follow to the extent possible, any established crisis plan already developed for the child/youth if it is known to the team.

Care coordination is provided and must include, at a minimum, a follow up contact either by phone or in person, to assure the child's continued safety and confirm that linkage to needed services has taken place. Follow up may, however, include further assessment of mental status and needs, continued supportive intervention (face to face or by phone, as clinically indicated), coordination with collateral providers, linkage to services or other collateral contacts. The end of the CI episode will be defined by the resolution of the crisis and alleviation of the child/youth's acute symptoms, and/or upon transfer to the recommended level of care. The crisis intervention and follow up should not exceed 72 hours. If exceeding 72 hours, it shall be considered a new CI episode and should be transferred to longer-term rehabilitative supports and services.

CI services must be documented in the individual's case record in accordance with Medicaid regulations. The child/youth's case record must reflect resolution of the crisis which marks the end of the episode. Warm handoff to follow up services (such as CPST, or other identified supports) with a developed plan should be clearly identified in the case record.

NOTE: CRISIS INTERVENTION will be authorized under the 1915c array of services upon CMS approvals until authority for this service is covered under the

State Plan with an expected implementation date of 1/1/2020 and CMS approvals. Children who meet Level of Care for HCBS will be able to access CI based on need and appropriateness Additional information can be found in the Children and Family Treatment and Support Services (CFTSS) Provider manual, , Utilization Management, Standards of Care, a glossary of CFTSS terms, Knowledge Base Skills/Recommendations, Staffing Guidelines, and Cultural Competency and Language Access [here](#).

Service Components

Crisis Intervention may include the following components:

1. Assessment of risk, mental status, and need for further evaluation and/or other health/behavioral health services.
2. Crisis Planning. The crisis planning minimally addresses:
 - Immediate safety/ risk concerns
 - Prevention of future crises
 - Signing of appropriate consent for releases for follow up referrals to services and/or collaboration with existing providers of recipients.
3. Care Coordination, including:
 - Consultation with a physician or other licensed practitioner of the healing arts to assist with the child's specific crisis and planning for future service access.
 - Contact with collaterals focusing on the child's needs.
 - Follow-up with the child and family/caregiver within 24 hours of initial contact/response, including informing existing supports/providers of the developed crisis plan.
 - Documentation of follow-up services.
4. Crisis resolution and debriefing (counseling) with child and/or family/caregiver and treatment provider.
5. Peer Support, assisting in the resolution of issues through instilling confidence and support.

Modality

- All service components are meant to be provided by individual face-to-face intervention with the child and their caregiver/collaterals.
- Follow-up may be conducted in person or by phone.

Setting

Allowable settings in compliance with Medicaid regulations and the Home and Community Based Settings Final Rule (§441.301(c)(4) and §441.710) (see appendix B) will exhibit characteristics and qualities most often articulated by the individual child/youth and family/caregiver as key determinants of independence and community

integration. Services should be offered in the setting least restrictive for desired outcomes, including the most integrated home or other community based settings where the beneficiary lives, works, engages in services, and/or socializes. While remaining inclusive of those in the family and caregiver network, family is broadly defined, and can include families created through: birth, foster care, adoption, or a self-created unit.

Limitations/Exclusions

- Rehabilitative services do not include and FFP (Federal Financial Participation) is not available for any of the following:
 - Educational, vocational, and job training services
 - Room and board
 - Habilitation services such as financial management, supportive housing, supportive employment services, and basic skill acquisition services that are habilitative in nature
 - Services to inmates in public institutions
 - Services to individuals residing in institutions for mental diseases
 - Recreational or custodial (i.e., for the purpose of assisting in the activities of daily living such as bathing, dressing, eating, and maintaining personal hygiene and safety; for maintaining the recipient's or anyone else's safety, and could be provided by persons without professional skills or training).
 - Services that must be covered under other Medicaid authorities (e.g. services within a hospital outpatient setting).
- Services also do not include services, supplies, or procedures performed in a nonconventional setting including: resorts, spas, therapeutic programs, and camps.

Certification/Provider Qualifications

Provider Agency Qualification:

- CI practitioners must work within in a child serving agency or agency with children's behavioral health and health experience that is licensed, certified, designated, and/or approved by OMH, OASAS, OCFS, or DOH or its designee to provide comparable and appropriate crisis services.

Individual staff qualifications:

Staff qualifications are categorized in accordance with CI Service Components.

Qualifications for service components 1-3 (Assessment, Crisis Planning, Care Coordination):

Psychiatrist, Physician, Licensed Psychoanalyst, Licensed Clinical Social Worker (LCSW), Licensed Master Social Worker (LMSW), Licensed Mental Health Counselor, Licensed Psychologist, Licensed Marriage and Family Therapist, or Nurse Practitioner with experience/background in treatment of mental health and/or substance use

disorders, Certified Alcoholism and Substance Abuse Counselor, Certified Rehabilitation Counselor, or a Registered Professional Nurse.

Qualifications for service component 4 (Crisis Resolution and Debriefing):

Psychiatrist, Physician, Licensed Psychoanalyst, Licensed Clinical Social Worker (LCSW), Licensed Master Social Worker (LMSW), Licensed Mental Health Counselor, Licensed Psychologist, Licensed Marriage and Family Therapist, or Nurse Practitioner with experience/background in treatment of mental health and/or substance use disorders, Certified Alcoholism and Substance Abuse Counselor, Credentialed Family Peer Advocate with lived experience as a family member, Certified Recovery Peer Advocate-family, Certified Rehabilitation Counselor, or a Registered Professional Nurse.

Qualifications for service component 5 (Peer Support):

NYS Credentialed Family Peer Advocate (FPA) or a Certified Recovery Peer Advocate-Family

- A Peer Advocate may not respond alone.
 - If one member of the crisis intervention team is a Peer Advocate, the Peer support provider must have a credential/certification as either: 1) an OMH established Family Peer Advocate, or 2) an OASAS established Certified Recovery Peer Advocate-Family.
- Services should be provided by a competent, trauma-informed, and linguistically responsive multidisciplinary team, for programmatic and safety purposes.

NOTE: Individual staff qualifications for Credential Family Peer Advocate or Certified Peer Advocate can be found in Family Peer Support Service Section of this manual.

Supervisor Qualifications:

- The supervisor must provide regularly scheduled supervision and have the qualifications of at least a Licensed Clinical Social Worker (LCSW), Licensed Mental Health Counselor, Licensed Creative Arts Therapist, Licensed Marriage and Family Therapist, Licensed Psychoanalyst, Licensed Psychologist, Physician's Assistant, Psychiatrist, Physician, Registered Professional Nurse, or Nurse Practitioner operating within the scope of their practice, with at least 2-3 years of work experience. Supervisors must also be aware of and sensitive to trauma informed care and the cultural needs of the population of focus and how to best meet those needs, and be capable of training staff regarding these issues.

Training Requirements

Required Training: All members of the Crisis Intervention Team are required to have training in First Aid, Narcan training, CPR, Mandated Reporter, Crisis De-escalation, Resolution and Debriefing, Suicide Prevention (e.g. SafeTALK), and Crisis Plan Development. For the trainings listed that require refreshers to remain current, retraining must be provided at the required frequency to maintain qualifications.

Recommended Trainings: Practitioners are encouraged to review knowledge base and skills the State recommended for providers who will be delivering the new State Plan

services to children in order to demonstrate competency (See Appendix B in the CFTSS Provider Manual [here](#)).

APPENDICES

APPENDIX A: GLOSSARY OF TERMS

Cultural Competency: Is defined as attributes of a behavioral healthcare organization that describe the set of congruent behaviors, attitudes, skills, policies, and procedures that are promoted and endorsed to enable caregivers at all levels of the organization to work effectively and efficiently with persons and communities of all cultural backgrounds. An important element of cultural competence is the capacity to overcome structural barriers in healthcare delivery that sustain health and healthcare disparities across cultural groups.

Developmental Disability: Section 1.03(22) of the New York State Mental Hygiene Law is the legal base for eligibility determination and defines Developmental Disability as: A disability of a person that: (a)(1) Is attributable to an intellectual disability cerebral palsy, epilepsy, neurological impairment, familial dysautonomia, Prader-Willi syndrome or autism; (2) Is attributable to any other condition of a person found to be closely related to an intellectual disability because such condition results in similar impairment of general intellectual functioning or adaptive behavior to that of intellectually disabled persons or requires treatment and services similar to those required for such persons; or (3) Is attributable to dyslexia resulting from a disability described in (1) or (2); (b) Originates before such person attains age twenty-two; (c) Has continued or can be expected to continue indefinitely; and (d) Constitutes a substantial handicap to such person's ability to function normally in society.

Evidence-Based: Services must utilize evidence-based practices where appropriate and provide or enable continuing education activities to promote uptake of these practices.

Family: Family is defined as the primary caregiving unit and is inclusive of the wide diversity of primary caregiving units in our culture. Family is a birth, foster, adoptive, or self-created unit of people residing together, with significant attachment to the individual, consisting of adult(s) and/or child(ren), with adult(s) performing duties of parenthood/caregiving for the child(ren) even if the individual is living outside of the home.

“Family of One”: A commonly used phrase to describe a child that becomes eligible for Medicaid through use of institutional eligibility rules for certain medically needy individuals. These rules allow a budgeting methodology for children to meet Medicaid financial eligibility criteria as a “family of one,” using the child’s own income and disregarding parental income.

Home or Community Setting: Home setting or community setting means the setting in which children primarily reside or spend time, as long as it is not a hospital nursing facility, Intermediate Care Facility (ICF), or psychiatric nursing facility. Note: this is distinguished from a Home *and* Community based setting.

Licensed Practitioner of the Healing Arts: An individual professional who is a Licensed psychoanalyst, Licensed psychologist, Licensed Clinical Social Worker, Nurse Practitioner, Physician, Physician Assistant or Psychologist and practicing within the scope of their State license. LPHAs who sign off on the HCBS Attestation form must be able to diagnose within their scope of practice.

- a. **Licensed Psychologist** is an individual who is currently licensed and currently registered as a psychologist by the New York State Education Department from the New York State Education Department and who possesses a doctoral degree in psychology.
- b. **Licensed Clinical Social Worker (LCSW)** is an individual who is currently licensed and registered as a Clinical Social Worker by the New York State Education Department.
- c. **Nurse Practitioner** is an individual who is currently certified as a nurse practitioner by the New York State Education Department.
- d. **Physician** is an individual who is licensed and currently registered as a physician by the New York State Education Department.
- e. **Physician Assistant** is an individual who is currently registered as a physician assistant by the New York State Education Department.
- f. **Psychiatrist** is an individual who is licensed and currently registered to practice medicine in New York State, who (i) is a diplomat of the American Board of Psychiatry and Neurology or is eligible to be certified by that Board, or (ii) is certified by the American Osteopathic Board of Neurology and Psychiatry or is eligible to be certified by that Board.

Institutionalization: Admission to a hospital (medical or psychiatric), RTF, ICF/IID or nursing facility

Integrated: Success for children requires both integrated and effective treatment. Initial and on-going collaboration between providers and natural supports is fundamental to enhancing resiliency, meeting the imperatives of developmental stages, and promoting wellness for each child and their family.

Licensed Occupational Therapist: is an individual who is licensed and currently registered as an Occupational Therapist by the New York State Education Department

Medicaid Eligible Child: Any child in New York State who is eligible for Medicaid, whether eligible via income consideration, medically needy definitions or categorical eligibility (e.g., foster care).

Medically Fragile: For the purposes of this manual and Children's HCBS a "medically fragile child" is defined as an individual who is under 21 years of age whose target population, risk factors, and functional criteria align with the Medically Fragile or Medically Fragile and DD LOC criteria.

Multisystem involved: two or more child systems including child welfare, juvenile justice, OASAS clinics or residential treatment facilities or institutions, OMH clinics or residential facilities or institutions, OPWDD services or residential facilities or institutions, or having an established IEP through the school district.

Natural Supports: Natural supports are individuals and informal resources that a family/caregiver can access, independent of formal services. These supports are a significant source of culturally relevant emotional support and caring friendships for children and families. Natural supports can be short-term or long-term and are usually sustainable and available to the child and family/caregiver after formal services have ended.

Out of Home placement: RRSY, RTF, RTC, or other congregate care setting, such as SUD residential treatment facilities, group residencies, institutions in the OCFS system or hospitalization.

Person-Centered Care: Services should reflect a child and family's goals and emphasize shared decision-making approaches that empower families, provide choice, and minimize stigma. Services should be designed to optimally treat illness, improve clinical and psychosocial outcomes, and emphasize wellness and attention to the family's overall well-being and the child's full community inclusion. To be person-centered, services must be culturally appropriate, child/youth guided, and relevant.

Physical Disability: "Disability" under Social Security is based on one's inability to work. A person is considered disabled under Social Security rules if: they cannot do work that s/he did before; SSA decides that s/he cannot adjust to other work because of his/her medical condition(s); and his/her disability has lasted or is expected to last for at least one year or to result in death.

Recovery-Oriented: Services should be provided based on the principle that all individuals have the capacity to recover from mental illness and/or substance use disorders. Specifically, services should support the acquisition of living, vocational, and social skills and be offered in home and community-based settings that promote hope and encourage each person to establish an individual path towards recovery.

Restoration: Returning to a previous level of functioning.

School Setting: The place in which a child/youth attends school.

Serious Emotional Disturbance (SED): A designated mental illness diagnosis according to the most current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) for a child or adolescent who has experienced functional limitations due to emotional disturbance over the past 12 months on a continuous or intermittent basis. The functional limitations must be moderate in at least two of the following areas or severe in at least one of the following areas:

- Ability to care for self (e.g. personal hygiene; obtaining and eating food; dressing; avoiding injuries); or
- Family life (e.g. capacity to live in a family or family like environment; relationships with parents or substitute parents, siblings and other relatives; behavior in family setting); or
- Social relationships (e.g. establishing and maintaining friendships; interpersonal interactions with peers, neighbors and other adults; social skills; compliance with social norms; play and appropriate use of leisure time); or
- Self-direction/self-control (e.g. ability to sustain focused attention for a long enough period of time to permit completion of age-appropriate tasks; behavioral self-control; appropriate judgment and value systems; decision-making ability); or
- Ability to learn (e.g. school achievement and attendance; receptive and expressive language; relationships with teachers; behavior in school).

Service Goal: A general statement of outcome relating to the identified need for the specific intervention provided.

Service Provider: Individuals/organizations that provide and are paid to provide services to the youth and family/caregiver.

Substance Use Disorder (SUD): A diagnosis of a substance use disorder is based on a pathological pattern of behaviors related to the use of the substance. The diagnosis of a substance use disorder is based on criteria defined in the current Diagnostic and Statistical Manual of Mental Disorders (DSM) and can be applied to all ten classes of drugs including: alcohol; cannabis; hallucinogens; inhalants; opioids; sedatives, hypnotics, anxiolytics; stimulants; tobacco; and other (or unknown) substances.

Trauma-Informed: Trauma-informed services are based on an understanding of the vulnerabilities or triggers experienced by trauma survivors that may be exacerbated through traditional service delivery approaches so that these services and programs can be modified to be more supportive and avoid re-traumatization. All programs should engage all individuals with the assumption that trauma has occurred within their lives (SAMHSA, 2014).

Youth: Individuals generally 14 years of age and older.

APPENDIX B: HCBS SETTINGS OVERVIEW

The CMS Final Rule (§441.301(c)(4) and §441.710) defines the qualities that all home and community-based settings must possess in order to be in compliance with the rule. In the final rule, CMS also clarifies which settings do NOT qualify as home and community-based settings.

According to CMS, settings that DO NOT MEET the definition of being home and community based are:

- A nursing facility;
- An institution for mental diseases;
- An intermediate care facility for individuals with intellectual disabilities;
- A hospital; or
- Any other locations that have qualities of an institutional setting, as determined by the Secretary.

In addition, the final rule 441.301(c)(5)(v) specifies that the following settings are presumed to have the qualities of an institution (and therefore likely do not meet the HCBS standard without documentation to support otherwise):

- Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment,
- Any setting that is located in a building on the grounds of, or immediately adjacent to, a public institution, or
- Any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS.

CMS has created a Settings Requirements Compliance Toolkit that may be found here: <https://www.medicaid.gov/medicaid/hcbs/index.html>

Included in the toolkit are exploratory questions to assist in the assessment of residential settings, found here:

<https://www.medicaid.gov/medicaid/hcbs/downloads/exploratory-questions-re-settings-characteristics.pdf>

Additionally, there are exploratory questions to assist in the assessment of non-residential settings, found here: <https://www.medicaid.gov/medicaid/hcbs/downloads/exploratory-questions-non-residential.pdf>

APPENDIX C: PRIOR/CONCURRENT AUTHORIZATION GRID

Home and Community Based Services (HCBS)	Prior Authorization	Concurrent Authorization	Additional Guidance
Caregiver/Family Supports and Services	No	Yes	Eligibility determination and plan of care (POC) are the only required elements for initial authorization. MMCPs will reimburse for initial authorization of 96 units or a total of 24 hours of service for a period of 60 days from the time that the MMCP receives notification from the HCBS provider.
Community Self-Advocacy Training and Support	No	Yes	Eligibility determination and POC are the only required elements for initial authorization. MMCPs will reimburse for initial authorization of 96 units or a total of 24 hours of service for a period of 60 days from the time that the MMCP receives notification from the HCBS provider.
Community Habilitation	No	Yes	Eligibility determination and POC are the only required elements for initial authorization. MMCPs will reimburse for initial authorization of 96 units or a total of 24 hours of service for a period of 60 days from the time that the MMCP receives notification from the HCBS provider.
Day Habilitation	No	Yes	Eligibility determination and POC are the only required elements for initial authorization. MMCPs will reimburse for initial authorization of 96 units or a total of 24 hours of service for a period of 60 days from the time that the MMCP receives notification from the HCBS provider.
Prevocational Services	No	Yes	Eligibility determination and POC are the only required elements for initial authorization. MMCPs will reimburse for initial authorization of 96 units or a total of 24 hours of service for a period of 60 days from the time that the MMCP receives notification from the HCBS provider.
Supported Employment	No	Yes	Eligibility determination and POC are the only required elements for initial authorization. MMCPs will reimburse for initial authorization of 96 units or a total of 24 hours of service for a period of 60 days from the time that the MMCP receives notification from the HCBS provider.
Accessibility Modifications	Yes		To be addressed in separate guidance.
Adaptive and Assistive Equipment	Yes		To be addressed in separate guidance.
Palliative Care	Yes	Yes	To be addressed in separate guidance.

Planned Respite	No	Yes	<p>Eligibility determination and POC must include Planned Respite based on child and or family needs. Billing for Respite must be based on face-to-face interactions with the Waiver child.</p> <p>Respite billing is limited to six (6) hours (24 units) per child per day (Individual. The maximum of six (6) hours (24 units) is equivalent to a daily individual per diem rate. Group Respite billing is limited to (4) hours (16 units) per child per day. . Planned Respite will be authorized for utilization for no more than 7 days per calendar year. Anything beyond this utilization will require concurrent review.</p>
Crisis Respite	No	Yes	<p>No prior authorization is needed; MCO may require a notification of care and require concurrent review if utilization exceeds 72 hour stay.</p>

APPENDIX D: UTILIZATION MANAGEMENT/MEDICAL NECESSITY GUIDELINES FOR CHILDREN'S ALIGNED HOME AND COMMUNITY BASED SERVICES

Admission Criteria	Continued Stay Criteria	Discharge Criteria²
<p>All of the following criteria must be met:</p> <ol style="list-style-type: none"> 1. The child/youth must meet Level of Care (LOC) Eligibility Determination criteria to be eligible for HCBS. 2. The child/youth must meet risk and functional criteria as evidenced by the completion and affirmative outcome of the HCBS Eligibility Determination tool or the ICF-IDD Level of Care determination. 3. The HCBS supports the child/youth's efforts to maintain the child in the home, community, and school and is reflected in the Plan of Care (POC). 4. The child/youth must be willing to receive HCBS. 5. There is no alternative level of care or co-occurring service that would better address the child/youth's clinical and functional needs. 6. The child/youth must live in an appropriate setting in accordance with Federal and State guidance. 	<p>All of the following criteria must be met:</p> <ol style="list-style-type: none"> 1. Child/youth continues to meet admission criteria and an alternative service would not better serve the child/youth. 2. A POC has been developed, informed and signed by the child/youth, Health Home care manager or Independent Entity, and others responsible for implementation. 3. Interventions are timely, need-based and consistent with evidence based/best practice and provided by a designated HCBS provider. 4. Child/youth is making measurable progress towards a set of clearly defined goals Or There is evidence that the POC and/or provider treatment plan are modified to address the barriers in treatment progression Or Continuation of services is necessary to maintain progress already achieved and/or prevent deterioration. 5. Family/guardian/caregiver is participating in treatment, where appropriate. 	<p>Criteria #1, 2, 3, 4, 5 or 6 are suitable; criteria #7 is recommended, but optional:</p> <ol style="list-style-type: none"> 1. Child/youth no longer meets admission criteria and/or meets criteria for another, more appropriate service, either more or less intensive. 2. Child/youth or parent/guardian withdraws consent for treatment. 3. Child/youth is not participating in the POC development and/or utilizing referred services. 4. Child/youth's needs have changed and current services are not meeting these needs. 5. Child/youth's goals would be better served with an alternate service and/or service level. 6. Child/youth's POC goals have been met. 7. Child/youth's support system is in agreement with the aftercare service plan.

² As described in the NYS 1115 MRT Waiver, 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.

APPENDIX E: COMMUNITY HABILITATION GUIDELINES

Guidelines for Medical Necessity Criteria

Person Centered Planning will define areas of skill & areas of need or support and may be defined in a Health Home Comprehensive Plan of Care (POC) or a Home and Community Based Service POC

*NOTE: The ranges outlined below should be considered guidance for general support needs. Unique situations occur and upon justification the top of the recommended range can be exceeded. **

<p>Child/youth is 0-2</p>	<p>*Average/typical hours per week = 0</p> <ul style="list-style-type: none"> • Skill building typically met through parental support/natural caregivers & use of services such as Early Intervention (EI) and educational/school programs. Services necessary at this age typically are provided by licensed practitioners including OT, PT, and ST. • CH will only be authorized if clear documentation exists of a lack of availability of EI services, EI Respite and/or OPWDD Respite and natural supports (e.g., parent has a disability and the provision of Community Habilitation supports the child and parent skill development or the family has significant stressors that impact ability to support child).
<p>Child/youth is ages 3-9</p>	<p>*Average/typical hours per week = 3</p> <ul style="list-style-type: none"> • Supports to facilitate community inclusion, relationship building, & adaptive/social skill development. May include social skills groups, music or art programs where the child is working to develop specific goals on their person-centered plan such as appropriate social interaction and mimicking others. • Average hours and need for CH typically increase over the years to support a growing level of developmental independence • Not allowed during school/educational hours.
<p>Child/youth is ages 10-13</p>	<p>*Average/typical hours per week = 10</p> <ul style="list-style-type: none"> • Supports to facilitate community inclusion, relationship building, & adaptive/social skill development • Average hours and need for CH typically increase over the years to support a growing level of developmental independence Not allowed during school/educational hours
<p>Child/youth is ages 14-17</p>	<p>*Average/typical hours per week = 15</p> <ul style="list-style-type: none"> • Focus on transition activities including increased independence/life skill building including skills such as riding the bus, grocery shopping, using the library, understanding health issues, personal appearance, and hygiene, • Not allowed during school/education hours • If graduates/discontinues K-12 education services, CH can increase to meet additional need for skill building. (Utilize adult guidelines)

<p>Child/youth is ages 18 up to 21st birthday</p>	<p>*Average/typical hours per week = 20</p> <ul style="list-style-type: none">• Focus on increased independence/life skill building including skills such as riding the bus, grocery shopping, using the library, personal appearance and hygiene, understanding health issues, assist in teaching skills for personal advocacy, buying healthy meals, spending money, and coping skills.• Allows for additional training and skill development for transition into adult services including work and education• If graduates/discontinues K-12 education services, CH can increase to meet additional need for skill building including developing adult educational or work skills and providing mentorship and personal support and practical assistance when needed. For example, assistance managing anxiety after graduation in new locations, seeking assistance with new situations and interacting with peers. assist the participant in learning to utilize resources when needed, teaching the participant how to schedule, organize materials, time management, planning and participation in activities and programs (Utilize adult guidelines)
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APPENDIX F: TRAINING GRID

Providers must have the following in place:

- written policies and procedures that describe staff orientation,
- mandatory training and other offered trainings for staff.
- staff have the required training to provide care that is trauma informed, culturally competent, and appropriate to the developmental level of the population served.
- maintain documentation of staff completion of required trainings in accordance with the Children's HCBS Provider Manual and be able to provide training records to the State upon request to review. Additional information on State reviews will follow.

Mandatory training components can be delivered in one training or a series of trainings. The HCBS provider will need to maintain training records and training curriculum as evidence of meeting the requirements. Providers can seek community training available to them, partner with another agency and/or develop a training within their organization to address the required training components.

<ul style="list-style-type: none"> • For staff hired before April 1, 2019, training must be completed within six (6) months of the 1915(c) Children's Waiver implementation. • For staff hired on or after April 1, 2019, training must be completed within six (6) months of hire date. 	
Training Required	Training Components Required
Personal Safety/ Safety in the Community	<ul style="list-style-type: none"> • Safety Awareness/Office and Community Safety • Prevention/Risk assessment for the Field Visits • Use of Safety Technology (e.g. Use of Mobile Phones) • Transporting Children/Youth/Families • Safety Training/Self-protection strategies • De-escalation techniques • Emergency protocols and resources (includes agency policies that address emergency procedures while delivering HCBS in the community and resources available to staff in the event of an emergency e.g. 911, on-call supervision) • Post incident reporting and response (includes agency policies that address incident reporting and procedures for staff providing HCBS in the community) • To ensure safety and protection of child/ youth, trainings will address professional boundaries, relationship boundaries, trauma, and a code of ethics for staff working with children/ youth.
Strength Based Approaches	<ul style="list-style-type: none"> • What are Strength-based approaches? • Person-centered planning/Strength based information gathering • Collaboration with child/youth/family and community (e.g. family-guided, youth-driven, etc.) • Identifying strengths, Protective Factors and Assets • Cultural and linguistic competence
Suicide Prevention	<ul style="list-style-type: none"> • Myths and Misconceptions of Suicide • Risk Factors • High risk populations • Warning Signs • How to Help (assess for risk of suicide and harm, encourage appropriate professional help) • Action/Safety Planning identify resources in the community (i.e., emergency services and mental health professionals))

Domestic Violence Signs and Basic Interventions	<ul style="list-style-type: none">• What is Domestic Violence?• Prevalence• Types of Abuse• Cycle of Violence/Pattern of Abuse• Domestic Violence Effects on Children• How to Help• Action/Safety Planning
Trauma Informed Care	<ul style="list-style-type: none">• What is trauma?• Prevalence/Findings (e.g. ACES)• Impact of Trauma• Trauma informed care Approach (i.e., strength-based, person and family centered, culturally aware, meeting language needs, performing collaborative and coordinated care, etc.).