



United Behavioral Health

## Supplemental Clinical Criteria: New York Medicaid Home and Community Based Services (HCBS) & Health and Recovery Plan (HARP)

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### INTRODUCTION & INSTRUCTIONS FOR USE

The following *State or Contract Specific Clinical Criteria*<sup>1</sup> defined by state regulations or contractual requirements are used to make medical necessity determinations, mandated for members of behavioral health plans managed by Optum and U.S. Behavioral Health Plan, California (doing business as OptumHealth Behavioral Solutions of California (“Optum-CA”)).

Other *Clinical Criteria*<sup>2</sup> may apply when making behavioral health medical necessity determinations for members of behavioral health plans managed by Optum®<sup>3</sup>. These may be externally developed by independent third parties used in conjunction with or in place of these Clinical Criteria when required, or when state or contractual requirements are absent for certain covered services. When deciding coverage, the member’s specific benefits must be referenced.

All reviewers must first identify member eligibility, the member-specific benefit plan coverage, and any federal or state regulatory requirements that supersede the member’s benefits prior to using these Clinical Criteria. If the requested service or procedure is limited or excluded from the benefit, is defined differently or there is otherwise a conflict between this Clinical Criteria and the member’s specific benefit, the member’s specific benefit supersedes these Clinical Criteria.

These Clinical Criteria are provided for informational purposes and do not constitute medical advice.

## **Ambulatory Behavioral Health Services (Adult)**

<sup>1</sup> **Clinical Criteria (State or Contract Specific):** Criteria used to make medical necessity determinations for mental health disorder benefits when there are explicit mandates or contractual requirements.

<sup>2</sup> **Clinical Criteria**

**(Level of Care Utilization System-LOCUS)** Standardized level of care assessment tool developed by the American Association of Community Psychiatrists used to make medical necessity determinations and placement decisions for adults ages 19 and older.

**Child and Adolescent Level of Care Utilization System/Child and Adolescent Service Intensity Instrument (CALOCUS-CASII)** Standardized assessment tool developed by the American Association of Community Psychiatrists and the American Academy of Child and Adolescent Psychiatry used to make clinical determinations and to provide level of service intensity recommendations for children and adolescents ages 6-18.

**(Early Childhood Service Intensity Instrument-ECSII)** - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry used to make medical necessity determinations and to provide level of service intensity recommendations for children ages 0-5.

**(LOCADTR Criteria)** Criteria used to make medical necessity determinations for substance-related disorder benefits.

<sup>3</sup> Optum is a brand used by United Behavioral Health and its affiliates.

## PERSONALIZED RECOVERY ORIENTED SERVICES (PROS) – ADULTS

**PROS:** PROS is a comprehensive recovery-oriented program for individuals with severe and persistent mental illness. Through a single plan of care, the program model integrates treatment, support, and rehabilitation in a manner that facilitates the individual's recovery. The PROS model is person-centered, strength based, and comprised of a menu of group and individual services designed to assist a participant to overcome mental health barriers and achieve a desired life role. As PROS is individualized, a person can participate in one service or multiple services as needed. Examples of goals for program participants are to: improve functioning, reduce inpatient utilization, reduce emergency services, reduce contact with the criminal justice system, increase employment, attain higher levels of education, and secure preferred housing.

PROS programs offer combinations of the following 4 service components:

1. Community Rehabilitation and Support (CRS): includes services designed to engage and assist individuals in managing their illness and restoring those skills and supports necessary for living successfully in the community.
2. Intensive Rehabilitation (IR) consists of four different services:
  - a. Intensive Rehabilitation Goal Acquisition to help an individual attain a specific goal within a certain area such as education, housing or employment.
  - b. Intensive Relapse Prevention includes targeted interventions to reduce the risk of hospitalization or involvement in the criminal justice system.
  - c. Family Psychoeducation
  - d. Integrated Dual Disorder Treatment (IDDT) (includes smoking cessation)
3. Ongoing Rehabilitation and Support (ORS): ORS, as a service, provides supports to assist individuals in managing their symptoms in the competitive workplace. OMH recommends that PROS programs use the Individual Placement & Support evidence-based model for employment services.
4. Clinical Treatment: an optional component of a PROS program, Clinical Treatment provides a recovery-focused, disability management approach with medication management, health assessment, clinical counseling and therapy, symptom monitoring, and treatment for co-occurring disorders. PROS participants can choose to receive their Clinical Treatment through PROS program or from another provider. As of 2015, 87 of the 90 NYS PROS programs offer the Clinical Treatment component and 78% of PROS recipients receive their clinical treatment at their PROS program.

### Admission Criteria

- The member is 18 years of age or older;
- The member has been diagnosed with a mental illness diagnosis;
- The member has a functional disability due to the severity and duration of mental illness; and
- The member has been recommended for admission by a Licensed Practitioner of the Healing Arts.
- Pre-Admission begins with initial visit and ends when Initial Service Plan (ISR) is submitted to MMCO/HARP.
- Admission begins when ISR is approved by MMCO/HARP. IRP must be developed within 60 days of admission date.
- Active Rehabilitation begins when the IRP is approved by the MMCO/HARP.
- Individualized Recovery Plan (IRP) is developed within 60 days of admission
- The IRP is reviewed and updated, at a minimum, every 6 months
- For individuals receiving Intensive Rehabilitation (IR) or Ongoing Rehabilitation and Supports (ORS), the IR or ORS services identified in the IRP shall be assessed for continued need, at a minimum, every 3 months

### Continuing Stay Criteria

- Concurrent review and authorizations should occur at 3-month intervals for IR and ORS services and at 6-month intervals for Community Rehabilitation and Support (CRS) and Clinic Treatment services. Continuing stay criteria may include:
  - The member has an active recovery goal and shows progress toward achieving it; OR
  - The member has met and is sustaining a recovery goal, but would like to pursue a new goal; OR

- The member requires a PROS level of care in order to maintain psychiatric stability and there is not a less restrictive level of care that is appropriate; OR without PROS services the individual would require a higher level of care.

### **Discharge Criteria**

- Any one of the following must be met:
  - The member has sustained recovery goals for 6-12 months and a lower level of care is clinically indicated.
  - The member has achieved current recovery goals and can identify no other goals that would require additional PROS services.
  - The member is not participating in a recovery plan, is not making progress toward any goals, extensive engagement efforts have been exhausted, and no significant benefit is expected from continued participation.
  - The member can live, learn, work and socialize in the community with supports from natural and/or community resources.

### **Service Delivery**

- PROS services are offered in 3 phases that are defined based upon the pace of service planning and the specific service components offered: Pre-Admission, Admission, and Active Rehabilitation. NYS issued guidance on prior and concurrent review authorization for ambulatory services on May 14, 2015, which lists authorization and review requirements for each of the 3 phases. A person-centered approach is key when applying level of care criteria for PROS. The 3 phases of PROS include:
  - Pre-Admission: This phase begins with the initial visit and ends when the PROS provider submits an Initial Service Recommendation (ISR) to the MMCO/HARP. PROS providers bill a monthly Pre-Admission rate but add-ons for Intensive Rehabilitation, Ongoing Rehabilitation and Supports, and Clinical Treatment are not allowed. The Pre-Admission phase is open-ended to allow flexibility for recipients who may be ambivalent about participation or who may need an extended period of time to develop an initial goal. Although there is no time limit, PROS providers may not bill the Pre-Admission rate for more than 2 consecutive months. For example, a PROS provider may bill for month A but not month B because the recipient did not participate in month B. If the recipient returns and receives Pre-Admission services in months C and D, the PROS provider may bill for months C and D but may not bill for month E. If the recipient still has not decided to enroll and the provider has not submitted an Initial Service Recommendation, the recipient can remain in Pre-Admission status and the PROS provider could bill for month F and G (but not month H) if the recipient attends the program, etc.
  - Admission begins when the ISR is approved by the MMCO/HARP. Upon admission, providers may offer additional services and bill add-on rates accordingly for:
    - Intensive Rehabilitation (IR);
    - Ongoing Rehabilitation and Supports (ORS); or
    - Clinical Treatment.
- Prior authorization for the Admission phase will ensure that individuals are not receiving duplicate services from other clinical or HCBS providers. An Individualized Recovery Plan (IRP) must be developed within 60 days of the admission date.
- Active Rehabilitation begins when the IRP is approved by MMCO/HARP. Concurrent review and authorizations should occur at 3-month intervals for IR and ORS services and at 6-month intervals for Base/ Community Rehabilitation and Support (CRS) and Clinic Treatment services.

## **Crisis Residences**

**CRISIS RESIDENCE PROGRAMS** stabilize psychiatric crisis symptoms and prevent unnecessary inpatient admissions by restoring a level of functioning and stability that supports transition to community-based services, supports and resources. Crisis Residence services mobilize resources and natural supports to address ongoing treatment and recovery needs to prevent future crises, reduce the intensity and duration of crises, and provide a safe and therapeutic environment where services are delivered through a trauma-informed approach consistent with the member's conditions and needs.

**There are three (3) types of Crisis Residence:**

### **Children's Crisis Residence (Under 21)**

Children's Crisis Residence services ensure linkages and connections to community-based services and medication management are made. Children can continue to attend their school, continue to receive services they have already been receiving in the community, and engage in new services as needed to prevent an escalation of symptoms.

Members do not need a mental health diagnosis to receive Children's Crisis Residence. Services are typically provided in programs with up to 8 beds.

### **Residential Crisis Support (18 and Over)**

Residential Crisis Support provides voluntary, short term residential crisis support services to individuals experiencing a mental health crisis. Members may also be experiencing challenges in daily life that create a risk for an escalation of symptoms that cannot be managed in the individual's home and community without onsite supports. Peer support is a critical component of the Residential Crisis program. Members may continue to receive previously authorized community-based outpatient services or new outpatient services identified as part of the member's Crisis Residence service plan.

Members do not need a diagnosis to receive Residential Crisis Support. Services are typically provided for up to 28 days in programs with 3-16 beds.

### **Intensive Crisis Residence (18 and Over)**

Intensive Crisis Residence is voluntary short-term residential treatment service for individuals experiencing a mental health crisis in order to evaluate, resolve and/or stabilize crisis symptoms. Co-occurring conditions may also be addressed in addition to medication therapy. An interdisciplinary team includes licensed and paraprofessionals as well as New York Certified Peers.

Members have been diagnosed with a primary mental health diagnosis. Intensive Crisis Residence services are typically provided for up to 28 days in programs with 3-16 beds.

### **Medical Necessity Criteria**

To determine whether services are medically necessary please consider the above service definitions in combination with the LOCUS/CASII/ECSII. Crisis Residence Services are consistent with Level 5 of each of the following placement criteria:

- **Level of Care Utilization System (LOCUS) for adults**
  - Residential Crisis Support
  - Intensive Crisis Residence
- **Child and Adolescent Service Intensity Instrument (CASII) for children 6-18 years of age; and**
- **Early Childhood Service Intensity Instrument (ECSII) for children under 6**
  - Children's Crisis Residence

### **Service Delivery**

- Individuals may still receive previously authorized community-based outpatient services or new outpatient services identified as part of the individual's Crisis Residence service plan. Authorization of these services cannot be restricted because of a Crisis Residence admission.
- Collaboration with Crisis Residence providers occurs to share relevant information supporting the member's treatment, care coordination, and discharge planning.
- If there are barriers to discharge, a discussion with the Crisis Residence provider can identify strategies to resolve them. The frequency of communication should reflect the complexity of the member's treatment and care coordination needs.

## **HARP Home and Community Based Services (HCBS) (Adult 21 +)**

### **COMMUNITY PSYCHIATRIC SUPPORTS AND TREATMENT (CPST) - ADULT AND CHILD**

**CPST – Adult includes time-limited goal-directed supports and solution-focused interventions intended to achieve identified person-centered goals or objectives as set forth in the individual's Plan of Care and CPST Individual Service Plan.**

The following activities under CPST are designed to help individuals with serious mental illness to achieve stability and functional improvement in the following areas: daily living, finances, housing, education, employment, personal recovery and/or resilience, family and interpersonal relationships and community integration. CPST is designed to provide mobile treatment and rehabilitation services to individuals who have difficulty engaging in site-based programs who can benefit from off-site rehabilitation or who have not been previously engaged in services, including those who had only partially benefited from traditional treatment or might benefit from more active involvement of their family of choice in their treatment.

#### **Admission Criteria**

- Services are intended to help engage individuals with mental health and/or a substance use diagnosis who are unable to receive site-based care or who may benefit from community-based services, including those who had only partially benefited from traditional treatment or might benefit from more active involvement of their family in their treatment. In addition, this service is intended for individuals who are being discharged from inpatient units, jail or prisons, and with a history of non-engagement in services; individuals who are transitioning from crisis services; and, for individuals who have disengaged from care.

#### **Limitations/Exclusions**

Community treatment for eligible individuals can continue as long as needed, within the limits, based on the individual's needs. The intent of this service is to eventually transfer the care to a place based clinical setting.

The total combined hours for CPST, Psychosocial Rehabilitation (PSR) and Habilitation are limited to no more than a total of 500 hours in a calendar year.

**CPST - Child: CPST services are goal-directed supports and solution-focused interventions intended to address challenges associated with a behavioral health need and to achieve identified goals or objectives as set forth in the child/youth's treatment plan. This includes the implementation of interventions using evidenced-based techniques, drawn from cognitive-behavioral therapy and/or other evidenced-based psychotherapeutic interventions approved by New York State.**

CPST includes the following components: Rehabilitative Psychoeducation, Intensive Interventions, Strengths Based Treatment Planning, Rehabilitative Supports, Crisis Avoidance, and Intermediate Term Crisis Management.

CPST is designed to provide community-based services to children and families who may have difficulty engaging in formal office settings but can benefit from community based rehabilitative services. CPST allows for delivery of services within a variety of permissible settings including community locations where the member lives, works, attends school, engages in services (e.g., provider office sites), and/or socializes.

#### **Admission Criteria**

- The child/youth has a behavioral health diagnosis that demonstrates symptoms consistent or corresponding with the DSM OR the child/youth is at risk of development of a behavioral health diagnosis; AND
- The child/youth is expected to achieve skill restoration in one of the following areas:
  - Participation in community activities and/or positive peer support networks;
  - Personal relationships;
  - Personal safety and/or self-regulation;
  - Independence/productivity;
  - Daily living skills;
  - Symptom management;
  - Coping strategies and effective functioning in the home, school, social or work environment; AND
- The child/youth is likely to benefit from and respond to the service to prevent the onset or the worsening of symptoms; AND
- The services are recommended by the following Licensed Practitioners of the Health Arts operating within the scope of their practice under state license:
  - Licensed Master Social Worker
  - Licensed Clinical Social Worker
  - 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

### **Continuing Stay Criteria**

- The child/youth continues to meet admission criteria; AND
- The child/youth shows evidence of engagement toward resolution of symptoms but has not fully reached established service goals and there is expectation that if the service continues, the child/youth will continue to improve; AND
- The child/youth does not require an alternative and/or higher, more intensive level of care or treatment; AND
- The child/youth is at risk of losing skills gained if the service is not continued; AND
- Treatment planning includes family/caregiver(s) and/or other support systems, unless not clinically indicated or relevant.

### **Discharge Criteria**

- The child/youth no longer meets admission criteria and/or meets criteria for another level of care, either more or less intensive; OR
- The child/youth has successfully met the specific goals outlined in the treatment plan for discharge; OR
- The child/youth or parent/caregiver(s) withdraws consent for services; OR
- The child/youth is not making progress on established service goals, nor is there expectation of any progress with continued provision of services; OR
- The child/youth is no longer engaged in the service, despite multiple attempts on the part of the provider to apply reasonable engagement strategies; OR
- The child/youth and/or family/caregiver(s) no longer needs this service as he/she is obtaining a similar benefit through other services and resources.

### **Limitations/Exclusions**

- The provider agency will assess the child prior to developing a treatment plan for the child.
- Treatment services must be part of the treatment plan including goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visits.
- A child with a developmental disability diagnosis without a co-occurring behavioral health condition is ineligible to receive this rehabilitative service.

- Group face-to-face may occur for Rehabilitative Supports
- Group should not exceed more than 6-8 members. Consideration may be given to a smaller limit of members if participants are younger than eight years of age.

## EDUCATION SUPPORT SERVICES

**Education Support Services** are provided to assist individuals with mental health or substance use disorders who want to start or return to school or formal training with a goal of achieving skills necessary to obtain employment. Services may also include classes, vocational training, and tutoring to receive a Test Assessing Secondary Completion (TASC) diploma, as well as support to the participant to participate in an apprenticeship program.

## HABILITATION AND RESIDENTIAL SUPPORT SERVICES - ADULT

**Habilitation and Residential Support Services:** Habilitation services are provided on a 1:1 basis and are designed to assist individuals with a behavioral health diagnosis (i.e. SUD or mental health) in acquiring, retaining and improving skills such as communication, self-help, domestic, self-care, socialization, fine and gross motor skills, mobility, personal adjustment, relationship development, use of community resources and adaptive skills necessary to reside successfully in home and community-based settings.

These services assist individuals with developing skills necessary for community living and, if applicable, to continue the process of recovery from an SUD disorder. Services include things such as: instruction in accessing transportation, shopping and performing other necessary activities of community and civic life including self-advocacy, locating housing, working with landlords and roommates and budgeting. Services are designed to enable the participant to integrate full into the community and ensure recovery, health, welfare, safety and maximum independence of the participant.

### Admission Criteria

- The individual requires habilitation and onsite services that may include but are not limited to cognition (cognitive skills), functional status (ADLs), and recovery-oriented community support.
- Providers who did not apply for both PSR and Habilitation are encouraged to apply for both of these services. Programs without a joint designation will not be allowed to serve individuals having both a PSR and Habilitation goal in their Plan of Care. The state will work with these programs to facilitate this process.

### Limits/Exclusions

The total combined hours for Psychosocial Rehabilitation, Community Psychiatric Support and Treatment and Habilitation are limited to no more than a total of 500 hours in a calendar year. Time limited exceptions to this limit for individuals transitioning from institutions are permitted if prior authorized and found to be part of the cost-effective package of services provided to the individual compared to institutional care.

## INTENSIVE CRISIS RESPITE – ADULT

**Intensive Crisis Respite (ICR):** a short-term, residential care and clinical intervention strategy for individuals who are facing a behavioral health crisis, including individuals who are suicidal, express homicidal ideation, or have a mental health or co-occurring diagnosis and are experiencing acute escalation of mental health symptoms. In addition, the person must be able to contract for safety.

Individuals in need of ICR are at imminent risk for loss of functional abilities and may raise safety concerns for themselves and others without this level of care. The immediate goal of ICR is to provide supports to help the individual stabilize and return to previous level of functioning or as a step-down from inpatient hospitalization.

### Admission Criteria

- Individuals who may be a danger to self or others and are experiencing acute escalation of mental health symptoms and/or at imminent risk for loss of functional abilities and raise safety concerns for themselves and others but can contract for safety.
- Experiencing symptoms beyond what can be managed in a short-term crisis respite.
- Individual does not require inpatient admission or can be used as an alternative to inpatient admission if clinically indicated and person can contract for safety.



## Limitations/Exclusions

- 7 days maximum
- Intensive Crisis Respite services include a limit of 21 days per year. Individuals requiring Intensive Crisis Respite for longer periods than those specified may be evaluated on an individual basis and approved for greater length of stay based on medical necessity.
- Have an acute medical condition requiring higher level of care.

## PREVOCATIONAL- ADULT AND CHILD

**Prevocational Services – Adult:** time-limited services that prepare an individual for paid or unpaid employment. This service specifically provides learning and work experiences where the individual with mental health and/or disabling substance use disorders can develop general, non-job-task-specific strengths and soft skills that contribute to employability in competitive work environment as well as in the integrated community settings. Pre-vocational services occur over a defined period of time and with specific person centered goals to be developed and achieved, as determined by the individual and his/her employment specialist and support team and ongoing person-centered planning process as identified in the individual's person-centered Plan of Care, Pre-vocational services provide supports to individuals who need ongoing support to learn a new job and/or maintain a job in a competitive work environment or a self-employment arrangement. The outcome of this pre-vocational activity is documentation of the individual's stated career objective and a career plan used to guide individual employment support.

### Admission Criteria

- Individuals must have a clear desire to work in competitive employment.

### Limitations/Exclusions

The total combined hours (for pre-vocational services and transitional supported employment) are limited to no more than a total of 250 hours and duration of 9 months of service in a calendar year.

For all employment supports services, documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.). Federal financial participation is not 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 a supported employment program
- Payments that are passed through to users of supported employment programs
- Payments for training that is not directly related to an individual's supported employment program

When Pre-vocational services are provided at a work site where individuals are competitively employed, payment is made only for the adaptations, supervision, and training required by individuals receiving services as a result of their disabilities but does not include payment for the supervisory activities rendered as a normal part of the business setting or work environment.

**Prevocational Services - Child:** structured around teaching concepts based on a specific Plan related to youth with disabilities. Services include activities that are not primarily directed at teaching skills to perform a certain job, but at underlying habilitative goals (e.g., attention span, motor skills, interpersonal relations with co-workers and supervisors) that are associated with building skills necessary to perform work and optimally to perform competitive, integrated employment such as:

- facilitating appropriate work habits;
- learning job production requirements;
- ability to communicate effectively with supervisors, co-workers and customers;
- generally accepted community workplace conduct and dress;
- ability to follow directions;
- ability to attend to and complete tasks;
- punctuality and attendance;
- appropriate behaviors in and outside the workplace;
- workplace problem solving skills and strategies;
- mobility training;

- career planning;
- proper use of job-related equipment and general workplace safety.

## PSYCHOSOCIAL REHABILITATION - CHILDREN

**Psychosocial Rehabilitation (PSR):** Psychosocial Rehabilitation Services (PSR) are designed for children/youth and their families/caregivers to assist with implementing interventions outlined in the treatment plan to compensate for or eliminate functional deficits and interpersonal and/or behavioral health barriers associated with a child/youth's behavioral health needs. The intent of PSR is to restore, rehabilitate, and support a child/youth's functional level as possible and as necessary for the integration of the child/youth as an active and productive member of their community and family with minimal ongoing professional interventions. Activities included must be intended to achieve the identified goals or objectives as set forth in the child/youth's individualized treatment plan. Please refer to "Children's Health and Behavioral Health Services Transformation-Medicaid State Plan Provider Manual for Children's BH Early and Periodic Screening and Diagnostic Treatment (EPSDT) Services" for additional information regarding this service. This service is available for children from birth to 21 years of age.

### Admission Criteria

- The child/youth has a behavioral health diagnosis that demonstrates symptoms consistent or corresponding with the DSM; AND
- The child/youth is likely to benefit from and respond to the service to prevent the onset or the worsening of symptoms; AND
- The service is needed to meet rehabilitative goals by restoring, rehabilitating, and/or supporting a child/youth's functional level to facilitate integration of the child/youth as participant of their community and family AND
- The services are recommended by the following Licensed Practitioners of the Healing Arts operating within the scope of their practice under State License:
  - Licensed Master Social Worker
  - Licensed Clinical Social Worker
  - 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

### Continued Stay Criteria

- The child/youth continues to meet admission criteria; AND
- The child/youth shows evidence of engagement toward resolution of symptoms but has not fully reached established service goals and there is expectation that if the service continues, the child/youth will continue to improve; AND
- The child/youth does not require an alternative and/or higher, more intensive level of care or treatment; AND
- The child/youth is at risk of losing skills gained if the service is not continued; AND
- Treatment planning includes family/caregiver(s) and/or other support systems, unless not clinically indicated or relevant.

### Discharge Criteria

- The child/youth no longer meets admission criteria and/or meets criteria for another level of care, either more or less intensive; OR
- The child/youth has successfully met the specific goals outlined in the treatment plan for discharge; OR
- The child/youth or parent/caregiver(s) withdraws consent for services; OR
- The child/youth is not making progress on established service goals, nor is there expectation of any progress with continued provision of services; OR
- The child/youth is no longer engaged in the service, despite multiple attempts on the part of the provider to apply reasonable engagement strategies; OR
- 6. The child/youth and/or family/caregiver(s) no longer needs this service as he/she is obtaining a similar benefit through other services and resources.

#### **Limitations/Exclusions:**

- The provider agency will assess the child prior to developing a treatment plan for the child. A licensed CPST practitioner or OLP must develop the treatment plan, with the PSR worker implementing the intervention identified on the treatment plan.
- A child with a developmental disability diagnosis without a co-occurring behavioral health condition is ineligible to receive this rehabilitative service.
- Group limit refers to number of child/youth participants, regardless of payor. Groups cannot exceed 8 children/youth. Ratio of facilitator to participants should be 1:4.
- 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
- Treatment services must be a part of a treatment plan including goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visits.

### **SHORT-TERM CRISIS RESPITE SERVICES - ADULT**

**Short-Term Crisis Respite:** a short-term care and intervention strategy for individuals who have a mental health or co-occurring diagnosis and are experiencing challenges in daily life that create risk for an escalation of symptoms that cannot be managed in the individual's home and community environment without onsite supports including:

- A mental health or co-occurring diagnosis and are experiencing challenges in daily life that create imminent risk for an escalation of symptoms and/or a loss of adult role functioning but who do not pose an imminent risk to the safety of themselves or others
- A challenging emotional crisis occurs which the individual is unable to manage without intensive assistance and support
- When there is an indication that an individual's symptoms are beginning to escalate

Referrals to Crisis Respite may come from the emergency room, the community, self-referrals, a treatment team, or as part of a step-down plan from an inpatient setting. Crisis respite is provided in site-based residential settings. Crisis Respite is not intended as a substitute for permanent housing arrangements.

#### **Admission Criteria**

- All individuals receiving this service must be experiencing a crisis, and be:
  - Willing to voluntarily stay at a Crisis Respite
  - Willing to be assessed by a treating professional including undergo a BH HCBS assessment
  - Willing to authorize release of medical records by relevant treating providers
  - Have a mental health or co-occurring diagnosis and are experiencing challenges in daily life that create imminent risk for an escalation of symptoms and/or a loss of adult role functioning but who do not pose an imminent risk to the safety of themselves or others.

#### **Limitations/Exclusions**

- Diagnosis of dementia, organic brain disorder or TBI
- Those with an acute medical condition requiring higher level of care
- At imminent risk to self or others that requires higher level of care
- Displays symptoms indicative of active engagement in substance use manifested in a physical dependence or results in aggressive or destructive behavior

- Is not willing or able to respect and follow the guest agreement during his/her stay
- Is not willing to sign necessary registration documentation
- Is not willing to participate in the wellness process during his/her stay
- No longer than 1 week per episode, not to exceed a maximum of 21 days per year. Individual stays of greater than 72 hours require prior authorization. Individuals requiring crisis respite for longer periods may be evaluated on an individual basis and approved for greater length of stay based on medical necessity.

## SUPPORTED EMPLOYMENT – ADULT AND YOUTH

**Intensive Supported Employment (ISE) – Adult:** Services that assist recovering individuals with MH/SUDs to obtain and keep competitive employment. These services consist of intensive supports that enable individuals to obtain and keep competitive employment at or above the minimum wage. This service uses evidence-based principles of the Individual Placement and Support (IPS) model.

This service is based on Individual Placement Support (IPS) model which is an evidence-based practice of supported employment. It consists of intensive employment supports that enable individuals for whom competitive employment at or above the minimum wage is unlikely, absent the provision of supports, and who, because of their clinical and functional needs, require supports to perform in a regular work setting.

Individual employment support services are individualized, person-centered services that provide supports to individuals who need ongoing support to learn a new job and maintain a job in a competitive employment or self-employment arrangement. Individuals in a competitive employment arrangement receiving Individual Employment Support Services are compensated at or above the minimum wage and receive 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 activity is documentation of the individual's stated career objective and a career plan used to guide individual employment support.

### Admission Criteria

- In order to achieve a successful outcome in ISE, an individual must have made a clear decision to work in competitive employment in the community.
- The basic tenet of ISE is that all individuals are capable of working in competitive employment in the community even without prior training and all individuals interested in employment should be given the opportunity.
- The ongoing level of care criteria including service duration, intensity and effectiveness should be reviewed by the BH HCBS provider and/or the MCO at least quarterly.

### Limitations/Exclusions

250 hours per calendar year. For all employment supports services, documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.). Federal financial participation is not 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 a supported employment program,
- Payments that are passed through to users of supported employment programs, and
- Payments for training that is not directly related to an individual's supported employment program.

When employment support services are provided at an integrated work site where individuals without disabilities are employed, payment is made only for the adaptations, supervision, and training required by OMH participants who receive services as a result of their disabilities but does not include payment for the supervisory activities rendered in as a normal part of the regular business setting.

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

Supported employment services are individualized and may include any combination of the following services:

- Vocational/job-related discovery or assessment;
- Person-centered employment planning;
- Job placement;
- Job development;
- Negotiation with prospective employers;
- Job analysis;
- Job carving;
- Training and systematic instruction;
- Job coaching;
- Benefits support;
- Training and planning;
- Transportation;
- Career advancement services; and
- Other workplace support services including services not specifically related to job skill training that enable the waiver participant to be successful in integrating into the job setting.

## TRANSITIONAL EMPLOYMENT - ADULT

**Transitional Employment:** This service is designed to strengthen the participant's work record and work skills toward the goal of achieving assisted or unassisted competitive employment at or above the minimum wage paid by the competitive sector employer. This service is provided, instead of individual supported employment, only when the person specifically chooses this service and may only be provided by clubhouse, psychosocial club program certified provider or recovery center. This service specifically provides learning and work experiences where the individual with behavioral health and/or substance use disorders can develop general, non-job-task-specific strengths and soft skills that contribute to employability in the competitive work environment in integrated community settings paying at or above minimum wage. The outcome of this activity is documentation of the participant's stated career objective and a career plan used to guide individual employment support.

### Admission Criteria

- An individual must have made a clear decision to work in competitive employment in the community regardless of limited or unsuccessful work history, or present status of sobriety and/or abstinence.
- The basic tenet of Transitional Employment is that all individuals are capable of working in competitive employment in the community even without prior training and all individuals interested in employment should be given the opportunity.

### Limitations/Exclusions

The total combined hours for pre-vocational and transitional supported employment) are limited to no more than a total of 250 hours and duration of 9 months of service in a calendar year.

Additionally, Transitional Employment placements should be part-time and time-limited, usually 15-20 hours/week from 6-9 months in duration.

For all employment supports services, documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.). Federal financial participation is not 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 a supported employment program,
- Payments that are passed through to users of the state VR supported employment programs, and
- Payments for training that is not directly related to an individual's supported employment program.

When employment support services are provided in a competitive and integrated work site where individuals without disabilities are employed, payment is made only for the adaptations, supervision, and training required by individuals who receive services as a result of their disabilities and does not include payment for the supervisory activities rendered as a normal part of the business setting.

## **Home and Community Based Services (HCBS) (Children 0-20)**

### **ADAPTIVE AND ASSISTIVE EQUIPMENT**

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

#### **Service Components**

Adaptive and Assistive Equipment includes but not limited to:

- Direct selection communicators, alphanumeric communicators, scanning communicators, and encoding communicators
- Speech amplifiers and 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)) (for additional guidance regarding service dogs, please refer to Appendix N)
- Electronic, wireless, solar-powered, or other energy powered devices that demonstrate to the satisfaction of the commissioner, or designee, that the device(s) will significantly enable the participant to live, work, or meaningfully participate in the community with less reliance on paid staff supervision or assistance
  - Such devices may include computers, observation cameras, sensors, telecommunication screens, and/or telephones and/or other telecare support services/systems that enable the participant to interact with remote staff to ensure health and safety
  - Such devices cannot be used for 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 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); please reference the DME Manual.

Adaptive Devices are expected to be a one-time only purchase. Replacements, repairs, upgrades, and/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, C-YES, or MMCP will ensure, that where appropriate, justification from physicians or other specialists or clinicians has been obtained.

Warranties, repairs, and/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) or third-party resources.

### Cost Limits

All Adaptive and Assistive Equipment costs require prior approval from the LDSS in conjunction with DOH or the MMCP. 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.

## CAREGIVER/FAMILY SUPPORTS AND SERVICES

**Caregiver/Family Supports and Services** are individual and group face to face interventions that 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.

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.

### Services 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

When outlined in the child/youth's POC, the service can be delivered to multiple family members or other identified resources for the child/youth by more than one practitioner to address the child/youth's needs by educating, engaging, and guiding their families to ensure that the child/youth and family's needs are met. In instances where two practitioners are required to meet the needs of the child/family, and the encounters occur at the same date and time, the agency can bill for both practitioners in one claim by adding the time the service was delivered by each practitioner into a combined claim. If one practitioner delivers the services to a child/youth and/or multiple family members/ resources at the same date and time, the claim should reflect the exact time spent as a single encounter. For additional billing information please see the NYS Children's Health and Behavioral Health Billing and Coding Manual, and any subsequent updates.

### **Limitations/Exclusions**

- This service cannot be delivered nor billed while an enrolled child/youth 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

## **COMMUNITY SELF ADVOCACY**

**Community Self-Advocacy Training and Support** are individual and group face to face interventions that provide 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 healthcare issues.

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.

### **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



## 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 in-eligible 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

## COMMUNITY HABILITATION

**Community Habilitation** covers face-to-face services and supports related to the child/youth'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/youth 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/youth'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/youth'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/youth's 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/youth 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/youth 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

### Service Requirements

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/youth's goal(s)/outcome(s), health/safety needs required during the delivery of the service, and the necessary staff actions to assist the child/youth reach his/her Community Habilitation goal(s)/outcome(s), and health/safety needs; the activities are for the sole benefit of the child/youth and are only provided to the child receiving HCBS or to the family/caregiver in support of the child/youth
- The activities are designed to preserve or enhance independence or slow/reduce the loss of independence when the child/youth has a progressive medical condition; the activities provided are consistent with the child/youth's stated preferences and outcomes in the 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

### **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/youth. Foster Care children/youth 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 childcare 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/youth living in certified settings may only receive this service on weekdays with a start time prior to 3 pm and are limited to a maximum of six hours of non-residential services (or its equivalent) daily. For school-age children/youth, 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/youth 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/youth through a local educational agency including those services available under the Individuals with Disabilities Education Act (IDEA) or Rehabilitation Act of 1973.

### **DAY HABILITATION**

**Day Habilitation** provides 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/youth 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.

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.

## 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/youth 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/youth's goal(s)/outcomes(s), health/safety needs required during the delivery of the service, and the necessary staff actions to assist the child/youth in reaching his/her Day Habilitation goal(s)/outcomes(s), and health/safety needs.

## Limitations/Exclusions

Group and Individual DH cannot be billed as overlapping services. Any child/youth receiving HCBS under this waiver may receive this service. Service necessity criteria for this service requires that the child/youth must have a developmental delay justifying the need for the provision of Day Habilitation, but the child/youth 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/youth 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 p.m. on weekdays.

Supplemental DH services are those services provided on weekends and/or on weekdays with a service start time after 3 p.m. 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.

## ENVIRONMENTAL MODIFICATIONS

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

## Service Components

Modifications include but are not limited to:

- Installation of ramps, handrails, 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. These may also include 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.

### **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/youth. 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 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 DOH or the MMCP. For Environmental Modifications, the LDSS or MMCP 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/youth's needs or capabilities.

## **NON-MEDICAL TRANSPORTATION**

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 MMCP 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 the child/youth's 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.

### **PALLIATIVE CARE – EXPRESSIVE THERAPY**

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/youth 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/youth'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/youth 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. This written order is to be included with the child/youth's POC and made available to the MMCP as needed.

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

Expressive therapy helps children/youth 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/youth 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 the child/youth they can hold onto - scrapbooks, paintings, or sculpture - mementos that tell their child/youth's life from their perspective and aid in their family's own journey of grief and loss.

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.

### **Service Components**

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

### **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.

## **PALLIATIVE CARE – BEREAVEMENT SERVICES**

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/youth 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/youth'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/youth 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. The written order is to be included with the child/youth's POC and made available to the MMCP 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/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.

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.

### **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.

### **Limitations/Exclusions**

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

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

## **PALLIATIVE CARE – PAIN AND SYMPTOM MANAGEMENT**

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/youth 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/youth’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/youth 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. The written order is to be included with the child/youth’s POC and made available to the MMCP as needed.

Pain and Symptom Management: Relief and/or control of the child/youth’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/youth is enduring. This management is not only an important part of humanely caring for the child/youth’s pain and suffering but helping the child/youth and family cope and preserve their quality of life at a difficult time.

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.

### **Service Components**

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

### **Limitations/Exclusions**

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

**Prevocational Services – Adult:** time-limited services that prepare an individual for paid or unpaid employment. This service specifically provides learning and work experiences where the individual with mental health and/or disabling substance use disorders can develop general, non-job-task-specific strengths and soft skills that contribute to employability in competitive work environment as well as in the integrated community settings. Pre-vocational services occur over a defined period of time and with specific person centered goals to be developed and achieved, as determined by the individual and his/her employment specialist and support team and ongoing person-centered planning process as identified in the individual's person-centered Plan of Care, Pre-vocational services provide supports to individuals who need ongoing support to learn a new job and/or maintain a job in a competitive work environment or a self-employment arrangement. The outcome of this pre-vocational activity is documentation of the individual's stated career objective and a career plan used to guide individual employment support.

### **Admission Criteria**

- Individuals must have a clear desire to work in competitive employment.

### **Limits/Exclusions**

The total combined hours (for pre-vocational services and transitional supported employment) are limited to no more than a total of 250 hours and duration of 9 months of service in a calendar year.

For all employment supports services, documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.). Federal financial participation is not 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 a supported employment program
- Payments that are passed through to users of supported employment programs
- Payments for training that is not directly related to an individual's supported employment program

When Pre-vocational services are provided at a work site where individuals are competitively employed, payment is made only for the adaptations, supervision, and training required by individuals receiving services as a result of their disabilities but does not include payment for the supervisory activities rendered as a normal part of the business setting or work environment.

**Prevocational Services - Child:** structured around teaching concepts based on a specific Plan related to youth with disabilities. Services include activities that are not primarily directed at teaching skills to perform a certain job, but at underlying habilitative goals (e.g., attention span, motor skills, interpersonal relations with co-workers and supervisors) that are associated with building skills necessary to perform work and optimally to perform competitive, integrated employment such as:

- facilitating appropriate work habits;
- learning job production requirements;
- ability to communicate effectively with supervisors, co-workers and customers;
- generally accepted community workplace conduct and dress;
- ability to follow directions;
- ability to attend to and complete tasks;
- punctuality and attendance;
- appropriate behaviors in and outside the workplace;
- workplace problem solving skills and strategies;
- mobility training;
- career planning;
- proper use of job-related equipment and general workplace safety.



## RESPITE

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/youth or the child/youth'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.

Planned or Crisis Day Respite services can be provided in the home of an eligible child/youth or a community setting. Community settings may include areas where a child/youth lives, attends school, works, engages in services and/or socializes and is in compliance with CMS Final Rule (§441.301(c)(4) and (§441.710), HCBS Settings Rule (Appendix B).

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
- OCFS Licensed agency boarding home, a group home, a group residence, or an institution and certified foster boarding homes
- 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)

### **Service Components**

#### *Planned*

Planned Respite services provide planned short-term relief for the child/youth 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.

Respite services may be delivered in a home or residence by qualified practitioners, out-of-home/residence by staff in community-based sites (e.g. community centers, camps, parks), or in allowable facilities.

#### *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 healthcare 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/youth 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.

### **Limitations/Exclusions**

- Services to children/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/youth while in a respite setting.

## **SUPPORTED EMPLOYMENT – ADULT AND YOUTH**

**Intensive Supported Employment (ISE) – Adult:** Services that assist recovering individuals with MH/SUDs to obtain and keep competitive employment. These services consist of intensive supports that enable individuals to obtain and keep competitive employment at or above the minimum wage. This service uses evidence-based principles of the Individual Placement and Support (IPS) model.

This service is based on Individual Placement Support (IPS) model which is an evidence-based practice of supported employment. It consists of intensive employment supports that enable individuals for whom competitive employment at or above the minimum wage is unlikely, absent the provision of supports, and who, because of their clinical and functional needs, require supports to perform in a regular work setting.

Individual employment support services are individualized, person-centered services that provide supports to individuals who need ongoing support to learn a new job and maintain a job in a competitive employment or self-employment arrangement. Individuals in a competitive employment arrangement receiving Individual Employment Support Services are compensated at or above the minimum wage and receive 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 activity is documentation of the individual's stated career objective and a career plan used to guide individual employment support.

### **Admission Criteria**

- In order to achieve a successful outcome in ISE, an individual must have made a clear decision to work in competitive employment in the community.
- The basic tenet of ISE is that all individuals are capable of working in competitive employment in the community even without prior training and all individuals interested in employment should be given the opportunity.
- The ongoing level of care criteria including service duration, intensity and effectiveness should be reviewed by the BH HCBS provider and/or the MCO at least quarterly.

## Limitations/Exclusions

250 hours per calendar year. For all employment supports services, documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.). Federal financial participation is not 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 a supported employment program,
- Payments that are passed through to users of supported employment programs, and
- Payments for training that is not directly related to an individual's supported employment program.

When employment support services are provided at an integrated work site where individuals without disabilities are employed, payment is made only for the adaptations, supervision, and training required by OMH participants who receive services as a result of their disabilities but does not include payment for the supervisory activities rendered in as a normal part of the regular business setting.

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

Supported employment services are individualized and may include any combination of the following services:

- Vocational/job-related discovery or assessment;
- Person-centered employment planning;
- Job placement;
- Job development;
- Negotiation with prospective employers;
- Job analysis;
- Job carving;
- Training and systematic instruction;
- Job coaching;
- Benefits support;
- Training and planning;
- Transportation;
- Career advancement services; and

Other workplace support services including services not specifically related to job skill training that enable the waiver participant to be successful in integrating into the job setting.

## VEHICLE MODIFICATIONS

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/youth which, per the child/youth's POC, are identified as necessary to support the health, welfare, and safety of the child/youth or that enable the child/youth to function with greater independence.

### Services Components

Modifications include but are not limited to:

- Portable electric/hydraulic and manual lift
- Ramps
- Foot controls
- Wheelchair lock downs/wheelchair floor
- Deep dish steering wheel
- Spinner knobs
- Hand controls

- Parking brake extension
- Replacement of roof with fiberglass top
- Floor cut outs
- Extension of steering wheel column
- Raised door
- Repositioning of seats
- Dashboard adaptations
- Other ancillary equipment or modifications necessary to guarantee full access to, and safety in, a motor vehicle.

The LDSS (for FFS enrollees) or MMCP (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/youth, and the most cost-effective approach to fulfill the child/youth'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 DOH (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 MMCP 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.

### **Limitations/Exclusions**

Other exclusions include the purchase, installation, and/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/youth. 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/youth. The vehicle may be owned by the child/youth or by a family member or non-relative who provides primary, consistent, and ongoing transportation for the child/youth. 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 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 DOH or the MMCP. The State may consider exceptions when medically necessary, including but not limited to a significant change in the child's needs or capabilities.

## **Additional State Plan Behavioral Health Services (Children under 21)**

### **CRISIS INTERVENTION - CHILDREN**

**Crisis Intervention:** Crisis Intervention (CI) Services are provided to children/youth 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. collateral, provider, community member) to effectively resolve it. A child/youth in crisis may be referred by a family member or other collateral contact who has knowledge of the child/youth's capabilities and functioning. The goals of CI are engagement, symptom reduction, stabilization, and restoring individuals to a previous level of functioning or developing the coping mechanisms to minimize or prevent the crisis in the future. Please refer to "Children's Health and Behavioral Health Services Transformation-Medicaid State Plan Provider Manual for Children's BH Early and Periodic Screening and Diagnostic Treatment (EPSDT) Services" for additional information regarding this service. This service is available for children from birth to 21 years of age.

#### **Admission Criteria**

- The child/youth experiencing 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. collateral, provider, community member) to effectively resolve it; AND
- The child/youth demonstrates at least one of the following:
  - Suicidal/assaultive/destructive ideas, threats, plans or actions that represent a risk to self or others; or
  - Impairment in mood/thought/behavior disruptive to home, school, or the community or
  - Behavior escalating to the extent that a higher intensity of services will likely be required; AND
- The intervention is necessary to further evaluate, resolve, and/or stabilize the; AND
- The services are recommended by the following Licensed Practitioners of the Healing Arts operating within the scope of their practice under State License:
  - Psychiatrist
  - Physician
  - Licensed Psychoanalyst
  - Registered Professional Nurse
  - Nurse Practitioner
  - Clinical Nurse Specialist
  - Licensed Clinical Social Worker
  - Licensed Marriage and Family Therapist
  - Licensed Mental Health Counselor or
  - Licensed Psychologist

#### **Discharge Criteria:**

- The child/youth no longer meets admission criteria (demonstrates symptom reduction, stabilization, and restoration, or developing the coping mechanisms to pre-crisis levels of functioning) and/or meets criteria for another level of care, either more or less intensive; OR
- The child/youth or parent/caregiver(s) withdraws consent for services

#### **Limits/Exclusions:**

- Within the 72 hour time-frame of a crisis, de-escalation techniques are utilized in an attempt to calm the child; information is gathered from the child, family, and/or other collateral supports on what may have triggered the crisis; information is gathered on the child's history; review of medications occurs, as appropriate, and a crisis plan is developed with the child/family. Warm handoff to providers of needed services should also be occurring following these expectations.
- The following activities are excluded: financial management, supportive housing, supportive employment services, and basic skill acquisition services that are rehabilitative in nature.

- Services may not be primarily educational, vocational, 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 also do not include services, supplies or procedures performed in a nonconventional setting including resorts, spas, therapeutic programs, and camps. Once the current crisis episode and follow up exceeds 72 hours, then it shall be considered a new crisis intervention episode or will be transferred to a longer-term service for rehabilitation skill-building such as CPST. An episode is defined as starting with the initial face to face contact with the child.
- The child/youth's chart must reflect resolution of the crisis which marks the end of the episode. Warm handoff to follow up services with a developed plan should follow.
- Substance Use should be recognized and addressed in an integrated fashion as it may add to the risk and increase the need for engagement in care. Crisis services cannot be denied based upon substance use. Crisis Team members should be trained on screening for substance use disorders. family peer support services (FPSS) – Children

**Family Peer Support Services (FPSS):** Family Peer Support Services (FPSS) are an array of formal and informal activities and supports provided to families caring for/raising a child who is experiencing social, emotional, medical, developmental, substance use, and/or behavioral challenges in their home, school, placement, and/or community. FPSS provide a structured, strength-based relationship between a Family Peer Advocate (FPA) and the parent/family member/caregiver for the benefit of the child/youth. The service is needed to allow the child the best opportunity to remain in the community. Activities included must be intended to achieve the identified goals or objectives as set forth in the child/youth's treatment plan. This service is needed to achieve specific outcome(s), such as: strengthening the family unit, building skills within the family for the benefit of the child, promoting empowerment within the family, and strengthening overall supports in the child's environment Please refer to "Children's Health and Behavioral Health Services Transformation-Medicaid State Plan Provider Manual for Children's BH Early and Periodic Screening and Diagnostic Treatment (EPSDT) Services" for additional information regarding this service. This service is available for children from birth to 21 years of age.

### **Admission Criteria**

- The child/youth has a behavioral health diagnosis that demonstrates symptoms consistent or corresponding with the DSM OR
- The child/youth displays demonstrated evidence of skill(s) lost or undeveloped as a result of the impact of their physical health diagnosis; AND
- The child/youth is likely to benefit from and respond to the service to prevent the onset or the worsening of symptoms; AND
- The child/youth's family is available, receptive to and demonstrates need for improvement in the following areas such as but not limited to:
  - strengthening the family unit
  - building skills within the family for the benefit of the child
  - promoting empowerment within the family
  - strengthening overall supports in the child's environment; AND
- The services are recommended by the following Licensed Practitioners of the Healing Arts operating within the scope of their practice under State License:
  - Licensed Master Social Worker
  - Licensed Clinical Social Worker
  - 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

### **Continued Stay**

- The child/youth continues to meet admission criteria; AND
- The child/youth is making progress but has not fully reached established service goals and there is a reasonable expectation that continued services will increase the Child/youth meeting services goals; AND
- Family/caregiver(s) participation in treatment is adequate to meaningfully contribute to the child/youth's progress in achieving service goals; AND
- Additional psychoeducation or training to assist the family/caregiver understanding the child's progress and treatment or to care for the child would contribute to the child/youth's progress; AND
- The child/youth does not require an alternative and/or higher, more intensive level of care or treatment; AND
- The child/youth is at risk of losing skills gained if the service is not continued; AND
- Treatment planning includes family/caregiver(s) and/or other support systems, unless not clinically indicated or relevant.

### **Discharge Criteria**

- The child/youth and/or family no longer meets admission criteria OR
- The child/youth has successfully met the specific goals outlined in the treatment plan for discharge; OR
- The family withdraws consent for services; OR
- The child/youth and/or family is not making progress on established service goals, nor is there expectation of any progress with continued provision of services; OR
- The child/youth and/or family is no longer engaged in the service, despite multiple attempts on the part of the provider to apply reasonable engagement strategies; OR
- The family/caregiver(s) no longer needs this service as they are obtaining a similar benefit through other services and resources.

### **Limitations/Exclusions:**

- The provider agency will assess the child prior to developing the treatment plan for the child.
- Treatment services must be part of the treatment plan including goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visits.
- A child with a developmental disability diagnosis without a co-occurring behavioral health condition is ineligible to receive this rehabilitative service.
- A group cannot exceed more than 12 individuals in total.

### **Medicaid family support programs will not reimburse for the following:**

- 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).
- Habilitative services for the beneficiary (child) 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 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 treatment plan.
- 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 treatment plan.
- Any intervention or contact not documented or consistent with the approved treatment/recovery plan goals, objectives, and approved services will not be reimbursed.

#### INTENSIVE IN-HOME – CHILDREN

**Intensive In-Home (IIH):** Services that support the child's social and emotional development and learning. IIH supports the child and family in implementing both the Treatment Plan (from the clinical provider) and the Waiver Service Plan (established by the Waiver program). Strategies are designed to be sensitive to the culture and values of each individual family and may include:

- anger management,
- psychoeducation,
- post crisis de-briefing,
- re-enforcing the integration of safety plans in the home,
- parent-child relationship building,
- teaching parenting skills,
- providing support in emotional self-regulation in situational contexts including anger management,
- encouraging supportive sibling relationships with the Waiver child,
- developing healthy coping mechanisms,
- making healthy choices,
- building self-esteem,
- clarifying identity issues, etc.

#### OTHER LICENSED PRACTITIONER – CHILDREN

**Other Licensed Practitioner:** OLP service is delivered by a Non-physician licensed behavioral health practitioner (NP-LBHP) who is licensed in the state of New York operating within the scope of practice defined in State law and in any setting permissible under State practice law. OLP does not require a DSM diagnosis in order for the service to be delivered. NP-LBHPs include individuals licensed and able to practice independently as a:

- Licensed Psychoanalyst
- Licensed Clinical Social Worker (LCSW)
- Licensed Marriage & Family Therapist; or
- Licensed Mental Health Counselor

An NP-LBHP also includes the following individuals who are licensed under supervision or direction of a licensed Clinical Social Worker (LCSW), a Licensed Psychologist, or a Psychiatrist:

- Licensed Master Social Worker (LMSW)

In addition to licensure, service providers that offer addiction services must demonstrate competency as defined by state law and regulations. Any practitioner above 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.

#### Admission Criteria

- The child/youth is being assessed by the NP-LBHP to determine the need for treatment. The NP-LBHP develops a treatment plan for goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visits that:
- Corrects or ameliorates conditions that are found through an EPSDT screening; OR
- Addresses the prevention, diagnosis, and/or treatment of health impairments; the ability to achieve age-appropriate growth and development, and the ability to attain, maintain, or regain functional capacity.

#### Continuing Stay Criteria

- The child/youth is making some progress but has not fully reached established service goals and there is expectation that if the child/youth continues to improve, then the service continues; OR
- Continuation of the service is needed to prevent the loss of functional skills already achieved.



- The child/youth continues to meet admission criteria AND
- The child/youth and/or family/caregiver(s) continue to be engaged in services AND
- An alternative service(s) would not meet the child/youth needs AND
- The treatment plan has been appropriately updated to establish or modify ongoing goals.

### **Discharge Criteria**

- The child/youth no longer meets continued stay criteria OR
- The child/youth has successfully reached individual/family established service goals for discharge; OR
- The child/youth or parent/caregiver(s) withdraws consent for services; OR
- The child/youth is not making progress on established service goals, nor is there expectation of any progress with continued provision of services; OR
- The child/youth is no longer engaged in the service, despite multiple attempts on the part of the provider to apply reasonable engagement strategies; OR
- The child/youth and/or family/caregiver(s) no longer needs OLP as he/she is obtaining a similar benefit through other services and resources.

### **Limits/Exclusions**

- Groups must not exceed more than 6-8 members. Consideration may be given to a smaller limit of participants are younger than eight years of age.
- Evidence Based Practices (EBPs) require prior approval, designations, and fidelity reviews on an ongoing basis as determined necessary by New York State.
- Inpatient hospital facilities are allowed for licensed professional other than social workers if a Preadmission Screening and Resident Review (PASRR) indicate it is medically necessary treatment. Social worker visits are included in the Nursing Facility Visit and may not be billed separately.
- Visits to Intermediate Care Facilities for individuals with Mental Retardation (ICF-MR) are not covered.
- All NP-LBHP services provided while the person is a resident of an institution for Mental Disease, such a free-standing psychiatric hospital or psychiatric residential treatment facility, are part of the institutional service and not otherwise reimbursable by Medicaid.
- If a child requires medically necessary services that are best delivered in the school setting by a community provider, the service needs to be detailed on the treatment plan.
- If a child needs assistance in the schools (educationally necessary) and a school employee will be providing the service, the service must be on the child's Individualized Education Plan (IEP) (504 plan services are not reimbursable by Medicaid).
- Evidence based practices (EBP) require approval, designations, and fidelity reviews on an ongoing basis as determined necessary by New York State. Treatment services must be a part of a treatment plan including goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visits.

## **PERSONALIZED RECOVERY ORIENTED SERVICES (PROS) – ADULTS**

**PROS:** PROS is a comprehensive recovery-oriented program for individuals with severe and persistent mental illness. Through a single plan of care, the program model integrates treatment, support, and rehabilitation in a manner that facilitates the individual's recovery. The PROS model is person-centered, strength based, and comprised of a menu of group and individual services designed to assist a participant to overcome mental health barriers and achieve a desired life role. As PROS is individualized, a person can participate in one service or multiple services as needed. Examples of goals for program participants are to: improve functioning, reduce inpatient utilization, reduce emergency services, reduce contact with the criminal justice system, increase employment, attain higher levels of education, and secure preferred housing.

PROS programs offer combinations of the following 4 service components:

1. Community Rehabilitation and Support (CRS): includes services designed to engage and assist individuals in managing their illness and restoring those skills and supports necessary for living successfully in the community.
2. Intensive Rehabilitation (IR) consists of four different services:

- a. Intensive Rehabilitation Goal Acquisition to help an individual attain a specific goal within a certain area such as education, housing or employment.
- b. Intensive Relapse Prevention includes targeted interventions to reduce the risk of hospitalization or involvement in the criminal justice system.

IR also includes two evidence-based practices:

- c. Family Psychoeducation
- d. Integrated Dual Disorder Treatment (IDDT) (includes smoking cessation)

3. Ongoing Rehabilitation and Support (ORS): ORS, as a service, provides supports to assist individuals in managing their symptoms in the competitive workplace. OMH recommends that PROS programs use the Individual Placement & Support evidence-based model for employment services.

4. Clinical Treatment: an optional component of a PROS program, Clinical Treatment provides a recovery-focused, disability management approach with medication management, health assessment, clinical counseling and therapy, symptom monitoring, and treatment for co-occurring disorders. PROS participants can choose to receive their Clinical Treatment through PROS program or from another provider. As of 2015, 87 of the 90 NYS PROS programs offer the Clinical Treatment component and 78% of PROS recipients receive their clinical treatment at their PROS program.

### **Admission Criteria**

- The member is 18 years of age or older;
- The member has been diagnosed with a mental illness diagnosis;
- The member has a functional disability due to the severity and duration of mental illness; and
- The member has been recommended for admission by a Licensed Practitioner of the Healing Arts.
- Pre-Admission begins with initial visit and ends when Initial Service Plan (ISR) is submitted to MMCO/HARP.
- Admission begins when ISR is approved by MMCO/HARP. IRP must be developed within 60 days of admission date.
- Active Rehabilitation begins when the IRP is approved by the MMCO/HARP.
- Individualized Recovery Plan (IRP) is developed within 60 days of admission
- The IRP is reviewed and updated, at a minimum, every 6 months
- For individuals receiving Intensive Rehabilitation (IR) or Ongoing Rehabilitation and Supports (ORS), the IR or ORS services identified in the IRP shall be assessed for continued need, at a minimum, every 3 months

### **Continuing Stay Criteria**

- Concurrent review and authorizations should occur at 3-month intervals for IR and ORS services and at 6-month intervals for Community Rehabilitation and Support (CRS) and Clinic Treatment services. Continuing stay criteria may include:
  - The member has an active recovery goal and shows progress toward achieving it; OR
  - The member has met and is sustaining a recovery goal, but would like to pursue a new goal; OR
  - The member requires a PROS level of care in order to maintain psychiatric stability and there is not a less restrictive level of care that is appropriate; OR without PROS services the individual would require a higher level of care.

### **Discharge Criteria**

- Any one of the following must be met:
  - The member has sustained recovery goals for 6-12 months and a lower level of care is clinically indicated.
  - The member has achieved current recovery goals and can identify no other goals that would require additional PROS services.
  - The member is not participating in a recovery plan, is not making progress toward any goals, extensive engagement efforts have been exhausted, and no significant benefit is expected from continued participation.
  - The member can live, learn, work and socialize in the community with supports from natural and/or community resources.

## Service Delivery

- PROS services are offered in 3 phases that are defined based upon the pace of service planning and the specific service components offered: Pre-Admission, Admission, and Active Rehabilitation. NYS issued guidance on prior and concurrent review authorization for ambulatory services on May 14, 2015, which lists authorization and review requirements for each of the 3 phases. A person-centered approach is key when applying level of care criteria for PROS. The 3 phases of PROS include:
    - Pre-Admission: This phase begins with the initial visit and ends when the PROS provider submits an Initial Service Recommendation (ISR) to the MMCO/HARP. PROS providers bill a monthly Pre-Admission rate but add-ons for Intensive Rehabilitation, Ongoing Rehabilitation and Supports, and Clinical Treatment are not allowed. The Pre-Admission phase is open-ended to allow flexibility for recipients who may be ambivalent about participation or who may need an extended period of time to develop an initial goal. Although there is no time limit, PROS providers may not bill the Pre-Admission rate for more than 2 consecutive months. For example, a PROS provider may bill for month A but not month B because the recipient did not participate in month B. If the recipient returns and receives Pre-Admission services in months C and D, the PROS provider may bill for months C and D but may not bill for month E. If the recipient still has not decided to enroll and the provider has not submitted an Initial Service Recommendation, the recipient can remain in Pre-Admission status and the PROS provider could bill for month F and G (but not month H) if the recipient attends the program, etc.
    - Admission begins when the ISR is approved by the MMCO/HARP. Upon admission, providers may offer additional services and bill add-on rates accordingly for:
      - Intensive Rehabilitation (IR);
      - Ongoing Rehabilitation and Supports (ORS); or
      - Clinical Treatment.
  - Prior authorization for the Admission phase will ensure that individuals are not receiving duplicate services from other clinical or HCBS providers. An Individualized Recovery Plan (IRP) must be developed within 60 days of the admission date.
  - Active Rehabilitation begins when the IRP is approved by MMCO/HARP. Concurrent review and authorizations should occur at 3-month intervals for IR and ORS services and at 6-month intervals for Base/ Community Rehabilitation and Support (CRS) and Clinic Treatment services.
- THERAPEUTIC FOSTER CARE - CHILD

**Therapeutic Foster Care:** Therapeutic Foster Care provides a structured home environment in which specifically trained foster parents teach social, behavioral, and emotional skills to children and adolescents who are at risk of placement, or who have complex and significant behavioral health problems which cannot be managed at home. The course of treatment is focused on addressing the member's condition to the point that the member's condition can be safely, efficiently and effectively treated in a less intensive level of care or no longer requires treatment. The member's condition includes consideration of the acute and chronic symptoms in the member's history and presentation, including co-occurring behavioral health or medical conditions, informed by information collected by the provider following evaluation and treatment planning as described in Common Clinical Best Practices.

Placements in a therapeutic foster home are usually limited to two youths per family. Whenever appropriate, Therapeutic Foster Care supports family permanence by also training the parent(s)/guardian(s) to manage the member's needs and behavior, and by providing case management.

Therapeutic Foster Care varies in intensity and duration in order to support the member's ability to manage functional difficulties and enhance the member's resiliency.

## Admission Criteria

- The member's condition indicates that the member cannot be suitably cared for in the member's home. Examples include:
  - The member is at risk for placement.
  - The member has complex and significant behavioral health problems that cannot be managed by the member's family or caregiver.

## Service Delivery

- The responsible Therapeutic Foster Care provider evaluates the member's needs as well as the needs of the family or caregiver upon admission.
- The responsible Therapeutic Foster Care provider, in conjunction with the member and/or member's family or caregiver, develops a plan that includes a description of the following:
  - The goal of Therapeutic Foster Care;
  - Objectives aimed at achieving the goal(s) of Therapeutic Foster Care, including interventions aimed at promoting effective parenting skills as appropriate.
- The plan includes instructions for accessing behavioral health services.

## YOUTH PEER SUPPORT AND TRAINING - YOUTH

**Youth Peer Support and Training:** 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 treatment planning process and with the ongoing implementation and reinforcement of skills. 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 treatment plan. 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.

### Admission Criteria

- The youth has a behavioral health diagnosis that demonstrates symptoms consistent or corresponding with the DSM; OR
- The youth displays demonstrated evidence of skill(s) lost or undeveloped as a result of the impact of their physical health diagnosis; AND
- The youth requires involvement of a Youth Peer Advocate to implement the intervention(s) outlined in the treatment plan, AND
- The youth demonstrates a need for improvement in the following areas such as but not limited to:
  - Enhancing youth's abilities to effectively manage comprehensive health needs
  - Maintaining recovery
  - Strengthening resiliency, self-advocacy
  - Self-efficacy and empowerment
  - Developing competency to utilize resources and supports in the community
  - Transition into adulthood or participate in treatment; AND
- The youth is involved in the admission process and helps determine service goals; AND
- The youth is available and receptive to receiving this service; AND
- The services are recommended by the following Licensed Practitioners of the Healing Arts operating within the scope of their practice under State License:
  - Licensed Master Social Worker
  - Licensed Clinical Social Worker
  - 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

### Continuing Stay Criteria

- The youth continues to meet admission criteria; AND

- The youth shows evidence of engagement toward resolution of symptoms but has not fully reached established service goals and there is expectation that if the service continues, the youth will continue to improve; AND
- The youth does not require an alternative and/or higher, more intensive level of care or treatment; AND
- The youth is at risk of losing skills gained if the service is not continued.; AND
- Treatment planning includes family/caregiver(s) and/or other support systems, unless not clinically indicated.

### **Discharge Criteria**

- The youth no longer meets admission criteria; OR
- The youth has successfully met the specific goals outlined in the treatment plan for discharge; OR
- The youth or parent/caregiver withdraws consent for services; OR
- The youth is not making progress on established service goals, nor is there expectation of any progress with continued provision of services; OR
- The youth is no longer engaged in the service, despite multiple attempts on the part of the provider to apply reasonable engagement strategies; OR
- The youth no longer needs this service as they are obtaining a similar benefit through other services and resources.

### **Limitations/Exclusions**

- The provider agency will assess the child prior to developing the treatment plan for the child.
- Treatment services must be part of the treatment plan including goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visits.
- A youth with a developmental disability diagnosis without a co-occurring behavioral health condition is ineligible to receive this rehabilitative service.
- A group is composed of two or more youth and cannot exceed more than 12 individuals total.
- The intervention plan should identify the medical or remedial services intended to reduce the identified condition as well as the anticipated outcomes of the individual. The intervention plan must specify the amount, duration and scope of services. The intervention plan must be signed by the licensed mental health practitioner or physician responsible for developing the plan with the participant (or authorized representative) also signing to note concurrence with the treatment plan. The plan will specify a timeline for reevaluation of the plan that is at least a quarterly review. The reevaluation should involve the individual, family and providers and include a reevaluation of plan to determine whether services have contributed to meeting the stated goals. A new treatment plan should be developed if there is no measurable reduction of disability or restoration of functional level. The new plan should identify different rehabilitation strategies with revised goals and services.
- 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).
- Habilitative services for the beneficiary (child) 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 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 treatment plan.
- 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 treatment plan.
- Any intervention or contact not documented or consistent with the approved treatment/recovery plan goals, objectives, and approved services will not be reimbursed.
- The state assures that rehabilitative services do not include and FFP is not available for any of the following in accordance with section 1905(a)(13) of the Act.
  - Educational
  - Room and board
  - Habilitation services
  - Services to inmates in public institutions as defined in 42 CFR 435.1010;
  - Services to individuals residing in institutions for mental disease as described in 42 CFR 435.1010
  - Recreational and social activities
  - Services that must be covered elsewhere in the state Medicaid plan

#### YOUTH PEER ADVOCATE - YOUTH

**Youth Peer Advocate (YPA):** This service will promote skills for coping and managing psychiatric symptoms. YPA service will facilitate the use of natural and community resources. In addition, YPA service promotes wellness through modeling and will assist waiver participants with gaining and regaining the ability to make independent choices and playing a proactive role in their own treatment. This service may be delivered in either a one-to-one session or a group setting of 2 or 3 waiver participants.

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

#### SKILL BUILDING - CHILD

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

#### TRANSITIONAL CASE MANAGEMENT - CHILD

**Transitional Case Management (TCM):** designed to provide coordination and continuity of care by supporting youth and family/natural support system in transition from an inpatient or residential setting to a community setting. TCM provides case management to youth enrolled in Waiver that require temporary inpatient care.

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

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

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

## REFERENCES

New York State Guidelines for New York City Medicaid Managed Care Organizations and Health and Recovery Plans regarding utilization management for Assertive Community Treatment, 2015.

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New York Office of Mental Health, Crisis Residence Benefit Medicaid Managed Care Implementation, October 15, 2020.

## REVISION HISTORY

Date	Action/Description
12/17/2018	• Version 1
08/19/2019	• Version 2
01/31/2020	• Version 3: Added Evidence-Based Practice Criteria section, updated with LOCUS/CASII/ECSII language.
02/15/2021	• Version 4: Annual Review and addition of Crisis Residence
04/15/2022	• Version 5: Annual Review