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MEDICAID HOME and COMMUNITY BASED WAIVER SERVICES IN NEW YORK STATE

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BY

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HOME AND COMMUNITY BASED WAIVER SERVICES IN NEW YORK STATE

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HCBS WAIVERS: FEDERAL LANDSCAPE

Introduction – 1915(c) Waivers

Medicaid home and community-based services [HCBS] are available through waiver programs to groups of individuals who would be eligible for Medicaid if institutionalized and, but for the services, would be institutionalized in a hospital or nursing facility.[1] Under section 1915(c) of the Social Security Act, the federal government grants waivers of requirements that are otherwise applicable to Medicaid "state plan" services.

Congress enacted section 1915(c) of the Social Security Act in the Omnibus Reconciliation Act (OBRA) of 1981.[2] Until then, comprehensive long-term care services through Medicaid were available only in institutional settings. Although mandatory home health services and optional personal care services were available as Medicaid benefits before OBRA 1981, states had largely restricted their use and limited the amount of services - New York being an exception with its personal care program and the Lombardi or Long Term Home Health Care Program (LTHHCP), which was established by Chapter 895 of the New York Laws of 1977. In fact, Congress reportedly modeled 1915(c) waivers in part on New York's experience with the Lombardi program.

In waiver programs, CMS waives key requirements that apply to Medicaid "state plan" services – those provided to all Medicaid recipients in the state. State plan services are either "mandatory" or "optional," meaning that a State may elect to include them in the state plan. Once elected by a state, an optional service must still comply with all of the federal requirements. For a waiver, however, waivers of the "statewideness" or "comparability" requirements of federal Medicaid law allow states to create waiver programs that target only a particular population -- limited by age, diagnosis, or geographic area of the state, or that limit the number of waiver slots available.[3] Waiver of the financial eligibility requirements allow states to include individuals who would normally not meet Medicaid's income/resource guidelines.

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[1] 42 U.S.C. 1396a(a)(10)(A)(ii)(VI), 1396n(b) - (e).

[2] Cynthia Shirk, *Rebalancing Long Term Care: The Role of the Medicaid HCBS Waiver Program*, Georgetown University National Health Policy Forum, 2006, posted at http://www.nhpf.org/library/details.cfm/2510 and reprinted as addendum with permission.

[3] 42 U.S.C. 1396n(b), (d)(3), (e)(3). *See also* n 2, supra. Limitation of the number of waiver slots is among the most litigated issues. Waiting lists are forbidden in regular Medicaid "state plan" services but are permissible in HCBS waiver programs. The seminal *Olmstead v LC* case, 527 U.S. 581, 144 L.Ed.2d 540, 119 S. Ct. 2176 (1999), held that such waiting lists are limited by requirements of the Americans with Disabilities Act.

Waivers vs. State Plan Services

Waivers have grown nationally with the momentum to "rebalance" long term care services from institutional care to care in the communities. However, they are not the only Medicaid home care services -- Medicaid programs offer "state plan" services which are part of the state's statewide Medicaid plan, offered to all people of all ages and diagnoses in the state, if eligible. Unlike waiver services, state plan services may not have a waiting list. New York State has long led the nation in these two state plan services:

1. **Personal Care** - also known as "home attendant" in NYC, and includes the Consumer Directed Personal Assistance Program.

   OPTIONAL service - 31 states opt to provide this service, which is not mandatory under federal Medicaid law.[4] In 2006, nearly 10 percent of all personal care recipients nationally lived in NYS (82,038 out of 881,762). About 25 percent of all Medicaid dollars spent nationally on personal care in 2006 were spent in NYS ($2.1 billion out of $8.5 billion). This is because New York provides the most comprehensive service package -- the most hours per day, with an average expenditure per recipient per day of $25,896 compared to New Jersey, for example with average $11,998 or Florida, with average of $2,390.

2. **Certified Home Health Care - (CHHA)** -

   MANDATORY service under federal law, but most states limit the amount and type of services available. Like personal care, New York State leads the nation, spending nearly one-third of all dollars spent nationally on this service ($1.5 billion out of $4.6 billion in 2006), with about one-eighth of all CHHA recipients nationally living in NYS (111,698 out of 873,600 individual recipients.) As for personal care, NYS provides a more expansive service, including round-the-clock home health aide services if needed. *Kaiser HCBS Update*, supra.[5]

While New York may spend more than all other states on personal care and certified home health services, on a national level, Medicaid spending on HCBS waivers in 2006 was $25

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[4] Kaiser Commission on Medicaid and the Uninsured, *Medicaid Home and Community-Based Service Programs: Data Update*, (November 2009), posted at <http://www.kff.org/medicaid/7720.cfm> (based on data 1999 - 2006)(hereinafter "*Kaiser HCBS Update*"). For more information on New York State's personal care program, see Selfhelp Community Services, Inc, *Medicaid Personal Care Services in NYS*, posted at http://wnylc.com/health/entry/7/

[5] For more information on New York State's Certified Home Health care program, see Selfhelp Community Services, Inc, *Medicaid Certified Home Health Agency Services in NYS*, posted at http://wnylc.com/health/entry/76/

billion, nearly double the amount spent together on personal care ($8.5 billion) and home health services ($4.6 billion). *Kaiser HCBS Update*, supra, at 7. Only seven percent of all HCBS waiver participants nationally are in New York (2006) – 81,101 out of 1,107,358**.** Id. at 19 (Table 1D). About 15 percent of waiver dollars spent nationally are spent in NYS, about $3.8 billion out of $25 billion. Id. at 26 (Table 2D).

Table 1 -- Comparison of National and NYS Medicaid Spending on Community-Based vs. Institutional Long-Term Care

	Medicaid Expenditures 2006		**No. of Medicaid Participants**	
	US$	**NYS**	**US**	**NYS**
Personal Care	$8.5 billion	$2.1 billion	881,762	82,038
Home Health Care	$4.6 billion	$1.5 billion	873,600	111,698
HCBS Waiver Programs	$25.0 billion	$3.8 billion	1,107,358	81,101
Subtotal Community-Based Care	**38.1 billion**	**$7.4 billion**	Total number not accurate because some some individuals receive more than one service in a year, counted twice	
Nursing Home	**$53.7 billion**	**$7.75 billion**	1,588,454 (2002)	96,776 (average monthly)

Based on Kaiser HCBS Update, *supra,* except for nursing home data from Kaiser Commission, *Medicaid Facts: Medicaid Long Term Care Services and Supports* (Feb. 2009)<http://kff.org/medicaid/upload/2186_06.pdf>; NYS Dept of Health, *Medicaid Quarterly Reports of Beneficiaries, Expenditures and Units of Service*, 2006 http://www.health.state.ny.us/nysdoh/medstat/quarterly/aid/quarterly.htm; Kaiser Comm'n., *Medicaid's Long -Term Care Beneficiaries: An Analysis of Spending Patterns* (Nov. 2006) http://kff.org/medicaid/upload/7576.pdf

Two Main Waiver Requirements – Avoid Institutionalization and Cost Neutrality

States must give two main assurances when they apply for a waiver from CMS, which must be renewed every five years. First, waiver eligibility is limited to those who would otherwise be in nursing homes, intermediate are facilities for the developmentally disabled, or in hospitals. Second, the waiver must be "cost neutral" -- the cost of HCBS services, combined with the other Medicaid "state plan" services, must be less than the cost of providing services to a comparable population in a nursing home. The state must spend less per capita under the waiver than without the waiver.[6] From this requirement, states may choose to set an individual cost cap, such as in the Lombardi program in NYS, in which services must cost less than 75 percent of the regional nursing home cost. Alternately, an "aggregate cost cap" is used in the NYS Nursing Home Transition & Diversion Waiver, in which the cost of providing services to all of the participants in that waiver in a region of the state are less than the cost if a comparable population was institutionalized in that region.

Individuals who participate in HCBS waiver programs receive the full range of services available under the state's Medicaid plan in addition to a set of supplemental services defined by the state and provided under the waiver. States may also make available through HCBS waivers services that would not normally be considered "medical services" -- case management; social adult day health care, habilitation, accessibility modifications to a home, and respite care—and permits the Secretary to approve other services at his or her discretion.[7]

MEDICAID HCBS WAIVER PROGRAMS IN NYS

New York State operates a number of waivers for adults and children, which will be discussed below.[8]

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[6] Cost neutrality for populations under age 65 is defined in 42 U.S.C. 1396n(c)(2)(D), 13096n(e)(2)(B). In HCBS waivers for people age 65+, states must keep expenditures under a cap, based on a complex formula. 42 U.S.C. 1396n(d)(5)(B). See also Cynthia Shirk, *Medicaid Waivers and Budget Neutrality*, Georgetown University National Health Policy Forum, 2009, posted at http://www.nhpf.org/library/details.cfm/2754.

[7] 42 C.F.R. 440.180, 440.181

[8] In March, 2010, the State issued a new booklet briefly describing these programs, oriented to consumers. http://www.health.state.ny.us/health_care/medicaid/publications/docs/gis/10oltc-001attbooklet.pdf

HOME AND COMMUNITY BASED WAIVER SERVICES IN NEW YORK STATE

ADULTS - DISABLED UNDER 65 OR ELDERLY

- Long-Term Home Health Care Program (LTHHC or Lombardi),
- Traumatic Brain Injury (TBI) (under age 65)
- Office of Mental Retardation and Developmental Disabilities (OMRDD), and
- Nursing Home Transition and Diversion (NHTD).

CHILDREN --

- Care at Home for Disabled Children,
- OMH waiver for children with serious emotional disturbance,
- Bridges to Health (B2H)

The following table places New York's waivers in the context of waiver programs nationally. Note that the table does not include the Nursing Home Transition & Diversion Waiver, begun in 2008, for which enrollment as of April 2010 is only about 450.

TABLE 2: COMPARISON OF NYS AND NATIONAL ENROLLMENT, EXPENDITURES, AND WAITING LISTS FOR HCBS WAIVERS

	MR/DD	**Aged/Disabled** (Lombardi in NY)	**Children**	**TBI**	**HIV/AIDS/ Mental Health**	**Total**
Medicaid Expenditures 2006 (in $ thousands)						
US	$18,144,257	$6,252,930	$219,798	$364,351	$65,598	$25,046,934
NY	$3,696,404	$34,059	$26,668	$65,234	0	$3,822,364
Number of Participants (2006)						
US	443,058	616,831	20,479	11,679	15,311	1,107,358
NY	54,395	22,537	2,723	1,446	0	81,101
Number on waiting lists (2008)						
US	253,306	119,196	18,967	1,613	14	393,096
NY	0	0	unknown	0	NA	0

Data from Kaiser HCBS Update, *supra*.

FINANCIAL ELIGIBILITY ISSUES FOR WAIVERS

- *Hybrid Budgeting:* Waivers are complicated because they use a hybrid of Medicaid institutional and community budgeting rules. The Lombardi program is sometimes known as the "Nursing Home Without Walls" because it uses, in part, institutional budgeting rules. This causes inconsistencies and some gray areas in the rules described below.

- *Transfer of Assets.* As of September 2007, home and community-based waiver services applicants or recipients are exempt from the transfer of assets rules in New York State. For these services applicants/recipients are only required to document resources for the month for application. .*NYS DOH* GIS 07 MA/018.

- *Home Equity Limit.* An individual applying for HCBS services on or after January 1, 2006, will not be eligible for such services, if the individual's equity interest in his or her home exceeds $750,000, unless a spouse, disabled or minor child live in the home. This would not apply for children's waiver services, as a parent's financial criteria are not used when determining eligibility for the child.

- *Spousal Budgeting.* NYS has historically used spousal impoverishment protections in the Lombardi and other waivers, under an interpretation of federal regulations that had long been approved by the federal agency, CMS, and its predecessor HCFA. The continued use of spousal impoverishment protections has been in doubt since 2006, when, under the previous Administration, CMS held up renewal of this waiver when it decided to reverse its policy after 20 years and insist that New York drop the spousal protections. CMS had re-interpreted federal regulations to prohibit the spousal protections in waiver programs, restricting them to nursing home care.

  The dispute has finally reached at least a temporary resolution through 2019. The national health reform law, the Patient Protection and Affordable Care Act (PPACA) mandates that all waiver programs nationally must include spousal impoverishment protections. This change will be effective in 2014, but will sunset in five years in 2019.[9] Until that law takes effect in 2014, CMS reached an agreement with DOH to

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[9] Section 2404 of the Patient Protection and Affordable Care Act (PPACA) amends 42 USC 1396r-5(h)(1)(A) to define "institutionalized spouse" -- whose spouse is eligible for the impoverishment protections -- to include individuals who are eligible for HCBS waiver services. Exact language of the legislation follows, posted at http://www.ncsl.org/documents/health/ppaca-consolidated.pdf p. 205.

SEC. 2404. PROTECTION FOR RECIPIENTS OF HOME AND COMMUNITYBASED SERVICES AGAINST SPOUSAL IMPOVERISHMENT.
"During the 5-year period that begins on January 1, 2014, section 1924(h)(1)(A) of the Social Security Act (42 U.S.C. 1396r–5(h)(1)(A)) shall be applied as though ''is eligible for medical assistance for home and community-based services provided under subsection (c), (d), or (i) of section 1915, under a waiver approved under section 1115, or who is eligible for such medical assistance by reason of being determined

permit the spousal impoverishment protections to continue in the Lombardi program. See GIS 10 OLTC/003 *Long Term Home Health Care Program (LTHHCP) Waiver Extension* (May 3, 2010). http://www.health.state.ny.us/health_care/medicaid/publications/docs/gis/10oltc-003.pdf. Unfortunately, these protections had already been removed from the TBI and Nursing Home Transition & Diversion Waiver programs, under pressure from CMS which had held up approval of the waivers on this basis (see citations below). When federal law changes in 2014 to mandate these protections, the protections should be restored to these waivers.

- *Spouses' Income Not Counted In TBI and NHTDW Waivers* – Even though the TBI and NHTDW waivers do not currently permit spousal impoverishment protections, there is a positive side of this policy. The non-applying "community" spouse's income and resources are not counted toward eligibility of the waiver spouse. No spousal refusal is necessary. This contrasts with the Lombardi program, which continues to have spousal impoverishment protections, and where a spousal refusal would be necessary in order not to count the spouse's income or resources toward eligibility.

- *Use of Supplemental Needs Trusts to Reduce the Spend-down*.

  It is still a gray area whether excess income may be sheltered in a pooled trust or individual SNT to eliminate the spend-down in the HCBS waiver programs. In *Wong v. Doar*, 571 F.3d 247 (2d Cir. N.Y. 2009), the court held that the plaintiff, a disabled 54-year-old nursing home resident, could not place his "excess income" from Social Security disability benefits into a trust to reduce his Net Available Monthly Income (NAMI). The case involves complex federal regulations on post-eligibility budgeting, used for chronic care institutional budgeting in nursing homes, which do not allow the same deductions from income that are allowed in the community. 18 NYCRR § 360.9; 42 CFR § 435.832(c). The budgeting in HCBS waivers borrows some aspects of institutional budgeting (spousal protections in LTHHCP) but also uses community budgeting (no penalties for transfers of assets). Since *Wong* was decided, local districts have varied regarding whether they permit use of SNTs to eliminate the spend-down.

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eligible under section 1902(a)(10)(C) or by reason of section 1902(f) or otherwise on the basis of a reduction of income based on costs incurred for medical or other remedial care, or who is eligible for medical assistance for home and community-based attendant services and supports under section 1915(k)'' were substituted in such section for ''(at the option of the State) is described in section 1902(a)(10)(A)(ii)(VI)''.

LONG TERM HOME HEALTH CARE PROGRAM (LTHHCP) LOMBARDI PROGRAM

The Long Term Home Health Care Program (LTHHCP) waiver is a coordinated plan of care and services for individuals who are medically eligible for placement in a hospital or residential health care facility for an extended period of time, but who instead receive services in a community based setting. Also known as the Lombardi Program or the Nursing Home Without Walls program, the LTHHCP can be provided in the person's home, an adult care facility (other than a shelter for adults), or in the home of a responsible adult.

CITATIONS: NY Social Services Law §366(6), 367-c, 461-1.1(d); NY Pub Health Law §§3602.8, 3616.1; 18 NYCRR §505.21; 78 ADM-70, 80 ADM-77, 83 ADM-74, 85-ADM-27, 89 INF-20, 02 OMM/ADM-4 (May 28, 2002)(Notice and Fair Hearing Procedures for the LTHHCP); GIS 07 MA/018 (elimination of transfer penalty); GIS 2010 OLTC/003 (continuation of spousal impoverishment protections)

Related Web Links: *LTHHCP Reference Manual (June 2006, 219 pp.), available at:*
http://www.health.state.ny.us/health_care/medicaid/reference/lthhcp

Available Waiver Services

If eligible for LTHHCP the program, an individual will have access to all medically necessary services covered by Medicaid. In addition, the following waiver services are available:

- Case management services
- Skilled nursing care
- Physical and occupational therapies
- Speech therapy
- Audiology
- Respiratory therapy
- Home health aide/personal care aide
- Personal care (35 to 42 hours per week maximum because of budget neutrality)
- Medical Social Services
- Nutritional counseling/education
- Medical transportation
- Housekeeper and homemaker services
- Medical supplies and equipment

In addition, the LTHHCP provider may also provides these other waiver services, some of which require pre-authorization:

- Home maintenance
- Home improvement
- Social adult day care and social transport - NOTE that social adult day care is not normally paid for by Medicaid as a stand-alone service, unlike MEDICAL model adult day care. Social adult day is only available through the Lombardi program, some managed long term care programs, or on a private pay basis.
- Respite care
- Home-delivered and congregate meals
- Moving assistance
- Personal Emergency Response System (PERS)

Qualifying for Long Term Home Health Care Program

- Individuals must be Medicaid eligible. If an applicant for LTHHCP is not currently a Medicaid recipient, s/he must apply for Medicaid at a local Medicaid office. However, individuals cannot participate in the LTHHCP and be in a Medicaid Managed Care Program simultaneously. An individual currently enrolled in a Medicaid Managed Care plan must be disenrolled before LTHHCP services can be received.

- Medicaid Financial Criteria: the financial budgeting is a hybrid of the method used for Community Medicaid with Community-Based Long-Term Care and Institutional Medicaid.

    - The personal needs allowance (PNA) for the individual receiving waiver services is as follows:

        - Single: the same as the income level for community-based Medicaid recipients ($767 per month in 2010).

        - Married: if only one spouse of a married couple requires Lombardi services, then the income limit is the difference between the allowance for one-person and two-person households under the regular community Medicaid levels ($350 per month in 2010).[10] If both spouses are applying, then the usual couples' income limit applies to their combined income ($1117/mo. in 2010).

[10] The formula for setting the PNA at this amount, the difference between one- and two-family households, was established by *Evans v. Wing*, 277 A.D.2d 903, 716 N.Y.S.2d 269 (4th Dept. 2000), reargument denied, 724 N.Y.S.2d 143 (4th Dept. 2001). The action challenged the former state policy of setting the PNA at only $50 per month for a married LTHHCP recipient -- the same amount as used for the PNA for a married person in a nursing home. The $50 was found to be an "irrational" amount because $50 does not cover the cost of maintaining the LTHHCP participant in the community. The court remanded the action to the lower court to determine a rational PNA amount. The new formula was announced in GIS 01-MA-021 (June 28, 2001).

If the applicant has income in excess of the limit, they can participate in the spend-down program as with regular Community Medicaid programs. The Lombardi program will bill them each month for their surplus. See explanation of Medicaid budgeting in this program in NYS DOH Long Term Home Health Care Program Reference Manual (2006), Chapter 6, at http://www.nyhealth.gov/health_care/medicaid/reference/lthhcp/lthhcpmanual.pdf.

- Spousal Impoverishment Protections. See discussion above. The continued use of spousal impoverishment protections is assured by the national health reform law, that includes a mandate that all waiver programs nationally must include spousal impoverishment protections. This change will be effective in 2014.[11] In the meantime, CMS reached an agreement with DOH to permit the spousal impoverishment protections to continue, See GIS 10 OLTC/003 *Long Term Home Health Care Program (LTHHCP) Waiver Extension* (May 3, 2010). http://www.health.state.ny.us/health_care/medicaid/publications/docs/gis/10oltc-003.pdf.

- Transfers of Assets. As of September 2007, home and community-based waiver services applicants or recipients are exempt from the transfer of assets rules. For these services applicants/recipients are only required to document resources for the month for application. GIS 07 MA/018. *Note* that DOH has not updated the LTHHCP Reference Manual (2006), which incorrectly continues to state that a transfer penalty applies.[12]

- FINDING a LTHHCP: New York State has a new website listing Long Term Home Health Care Programs, as well as CHHAs and hospices by county at http://homecare.nyhealth.gov/ . The LTHHCP program assesses the client for eligibility and devises the plan of care.

- Individuals must have a chronic condition and be medically eligible for placement in a hospital or residential health care facility for an extended period of time.

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[11] Section 2404 of the Patient Protection and Affordable Care Act (PPACA) amends 42 USC 1396r-5(h)(1)(A) to define "institutionalized spouse" -- whose spouse is eligible for the impoverishment protections -- to include individuals who are eligible for HCBS waiver services.

[12] *http://www.health.state.ny.us/health_care/medicaid/reference/lthhcp* P. 6-3.

- Have a safe home environment – a physician must determine whether or not the individual's health and safety needs can be met in the home and the individual is able to remain at home;

- COST NEUTRALITY -- The service plan cost must fall within the budget cap for the level of care for which the individual is approved. With certain exceptions, total Medicaid expenditures for the individual's health and medical services cannot exceed (on an annual basis) 75% of the cost of care in either a Skilled Nursing Facility or a Health Related Facility. The costs of services for an individual can be averaged over 12 months to ensure that the annual cost of care remains under the 75% cap. The monthly budget cap is computed by the NYS DOH. In New York City and most parts of the state, the effect of the budget cap is to limit services to no more than 35 to 42 hours of personal care per week

    - The three exceptions to the 75% budget cap include special needs individuals, participants in the AIDS Home Care Program, and residents of adult care facilities.

    - For dual eligibles, to the extent services may be billed to Medicare, these costs are not counted toward the Lombardi cost cap. Hence dual eligibles may receive more services than Medicaid-only individuals. NYS DOH Long Term Home Health Care Program Reference Manual, at http://www.nyhealth.gov/health_care/medicaid/reference/lthhcp/lthhcpmanual.pdf (2006) pp. 4-14 - 4-15.

TRAUMATIC BRAIN INJURY (TBI) WAIVER PROGRAM

Description of TBI Waiver Program

The Traumatic Brain Injury (TBI) waiver program provides supports and services to assist individuals with a traumatic brain injury (TBI) toward successful inclusion in the community. Waiver participants may choose to move into the community from a nursing facility. Others may choose to participate in the waiver to prevent unnecessary institutionalization. It is administered centrally by the New York State Department of Health (DOH) and implemented through Regional Resource Development Centers (RRDC) and Specialists (RRDS).

CITATIONS: N.Y. Pub Health § 2740 et seq, 95 LCM-70, 96 INF-21; NYS DOH Directive 08-MA–024, 8/26/08 (eliminates spousal impoverishment protections for new applicants eff. 9/1/08) 09 OLTC-GIS 009 (requiring the HCSS service to be provided by

licensed home care services agencies, and allowing time to transition to these providers), Medicaid Reference Guide pp. 517-18.

Related Web Links: (HCBS/TBI) Program Manual (June 2006, 123 pp.): http://www.health.state.ny.us/health_care/medicaid/reference/tbi/docs/tbiprovidermanual.pdf

NYS DOH 96 INF-21 http://www.health.state.ny.us/health_care/medicaid/publications/pub1996inf.htm.

CONTACT: TBI Waiver services may be accessed through the DOH Regional Resource Centers, 2010 list attached. In 2010, DOH changed the RRDCs so that the same organizations now are contracted to administer both the TBI and Nursing Home Transition and Diversion Waivers. LIST ATTACHED.

Available Waiver Services

If eligible for the TBI Waiver program, an individual will have access to all medically necessary services covered by Medicaid. In addition, the following waiver services are available:

- Structured Day Program services include assessment, training and supervision of or assistance to an individual with issues related to self-care, medication management, task completion, communication skills, interpersonal skills, problem-solving skills, socialization, sensory/motor skills, mobility, community transportation skills, reduction/elimination of maladaptive behaviors, money management skills, and skills to maintain a household.

- Substance Abuse Program services provide individually designed interventions to reduce/eliminate the use of alcohol and/or other substances by the participant, which, if not effectively dealt with, will interfere with the individual's ability to remain in the community.

- Positive Behavioral Interventions and Support Services (PBIS) are provided to participants who have significant behavioral difficulties that jeopardize their ability to remain in the community of choice due to inappropriate responses to events in their environment. The primary goal of PBIS services is to decrease the intensity or frequency of targeted behaviors, and to teach more socially appropriate behaviors.

- Community Integration Counseling Service (CIC) is a counseling services that assists the waiver participant to more effectively manage the emotional difficulties associated with adjusting to and living in the community.

- Home and Community Support Services (HCSS) include personal care assistance with Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL). The service must be provided under the direction and supervision of a Registered Professional Nurse (RN) based on an assessment of the individual's needs and supported by physicians orders.

    - On Oct. 1, 2009, State DOH issued 09 OLTC-GIS 009, *Timeframes for Transition to Licensed Home Care Services Agency (LHCSA) Licensure Requirements for the Traumatic Brain Injury Medicaid Waiver Providers of Home and Community Support Services. P*rior to 2009, these services did not have to be provided by a LHCSA. Under an agreement with CMS, all providers of HCSS services had to become licensed as a LHCSA by NYS. The 2009 GIS gave a transition period for providers with license applications pending, but this was insufficient and threatened disruption of services. In January 2010, *Branham v. Daines* (No. 8-10 CV-111 N.D.N.Y.) was filed, seeking injunctive relief against the forced transition to new providers. The case was settled allowing a transition period.

    - Apparently HCSS was originally only supposed to be supervision -- not actual assistance with activities of daily living (ADLs). The less formal supervision could be provided by a friend or employee of a social service organization, as opposed to a certified home health aide.. There were instances of people being assisted to bathe, feed, etc. by staff of social services agencies who were not trained/certified as home health aides. Hence DOH required the service to be provided by a licensed home care agency. Consumer advocates are concerned about the over-medicalization of the program, also being copied in the NHTDW waiver.

- Respite Care Services provide relief to informal, non-paid supports who provide primary care and support to a participant.

- Environmental Modifications are internal and external physical adaptations to the home, which are necessary to ensure the health, welfare and safety of the individual.

- Vehicle modifications provide the participant with the means to access services and supports in the community, increase independence and promote productivity.

- Assistive Technology Services supplements durable medical equipment and supplies, which provides a broad range of special medical equipment and supplies. The Medicaid State Plan and all other resources must be utilized before considering Assistive Technology Services. Requests for Assistive Technology

must be less than $15,000 per 12 month period, unless approved by DOH waiver management staff.

- Waiver transportation supplements transportation provided by the Medicaid program. It includes transportation for non-medical activities which support the participant's integration into the community. All other options for transportation, such as informal supports, community services and public transportation, must be explored and utilized prior to requesting waiver transportation. Use of this service must be indicated in the Service Plan.

- Community Transitional Services (CTS) provide funding for the reasonable costs of one-time set-up expenses for individuals transitioning from a nursing home to their own home or apartment in the community. Reasonable costs must be included in the Initial Service Plan and may not exceed $3,000. Eligible items include security deposits, essential furnishings, broker's fees, moving expenses, and one-time set up fee for services, such as electric, heat, phone.

- *HOUSING SUPPORT* - a unique feature of the TBI waiver is the availability of a housing subsidy. In 2010, for the 1700 participants enrolled in the waiver, over $700,000 per month is spent on housing and utility subsidies.[13] THIS SUBSIDY MAKES IT POSSIBLE FOR PARTICIPANTS TO BE DISCHARGED FROM NURSING HOMES AND OBTAIN SERVICES IN THE COMMUNITY.

  > "…Individuals who are eligible for supplemental rental subsidies and housing supports must be participants in the HCBS/TBI Waiver who have been assessed as financially unable to obtain and maintain fair market value housing in the community without supplemental subsidies. These individuals are required to disclose all financial resources and must apply for all available public housing monies, including HUD Section 8 rental subsidies. They must contribute 1/3 of their income towards fair market value rent. The DOH pays the remainder of the rental cost as a rental subsidy. The monthly check for rental subsidies is issued directly to the landlord, not to the individual.."

  NYS DOH 96 INF-21 - Home And Community-Based Services Waiver For Persons With Traumatic Brain Injuries (HCBS/TBI WAIVER)(JUNE 6, 2006) http://www.health.state.ny.us/health_care/medicaid/publications/pub1996inf.htm.

Qualifying for TBI Waiver Program

An individual applying to participate in the waiver must meet all of the following criteria:

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[13] NYS DOH Request for Proposals, Housing Payment Services for Traumatic Brain Injury Waiver Participants, http://www.nyhealth.gov/funding/rfp/0912291016/ March 1, 2010

- Individuals must be approved for Community Medicaid with Community-Based Long-Term Care coverage. If an applicant for TBI is not current a Medicaid recipient, s/he must apply for Medicaid at a local Medicaid office.

- Medicaid Financial Criteria: the financial budgeting is the same as for skilled nursing homes.

  - The personal needs allowance for the individual receiving waiver services is as follows:

    - Single: the same as the income level for community-based Medicaid recipients ($767 per month in 2010).

    - Married: the difference between the allowance for one-person and two-person households under the regular community Medicaid levels ($350 per month in 2010).

  - *NO Spousal Impoverishment Protections.* Unlike the Lombardi waiver, spousal impoverishment budgeting is not used with the TBI waiver. Instead, the applicant spouse is treated as a household of one and only his or her income is counted in determining eligibility. This was a change made in 2008 from previous policy, which did afford spousal protections. NYS DOH Directive GIS 08-MA–024, 8/26/08, http://www.health.state.ny.us/health_care/medicaid/publications/docs/gis/08ma024.pdf.

    - In 2014, changes under federal health care reform will take effect that mandate spousal protections in waivers, which will likely restore these protections. See Lombardi discussion.

    - FLIP SIDE. While there are no spousal protections, there is a benefit for couples where the non-applying spouse is working or has other income and assets. The GIS directive above provides that the spouse's income and assets are not considered in the applicant's eligibility. No spousal refusal is required.

  - Transfer of Assets. As of September 2007, home and community-based waiver services applicants or recipients are exempt from the transfer of assets rules. For these services applicants/recipients are only required to document resources for the month for application. GIS 07 MA/018

- Be between the ages of 18 and 64 upon application to the waiver; injured on or after 18th birthday.

- Have a diagnosis of traumatic brain injury (TBI). Individuals who experience deficits similar to a traumatic brain injury as a result of anoxia, toxic poisoning,

stroke or other neurological conditions may also be eligible. Individuals with gestational or birth related difficulties such as cerebral palsy or autism or who have a progressive degenerative disease, are not eligible for the waiver.

- Be assessed to need a nursing home level of care as a direct result of the traumatic brain injury.

Applying for the TBI Waiver

The TBI waiver is administered centrally by the New York State Department of Health and implemented under contract to Regional Resource Development Centers (RRDC) and Specialists (RRDS). The RRDC's for the TBI and NHTD waivers have been combined. An updated list of the combined contacts is attached. applicant for TBI should contact the RRDS in the region where s/he chooses to reside. Go to http://www.dhcr.state.ny.us/Forms/NHTD/RRDCList.pdf to find a listing by area in NYS. (See Appendix - list updated from one online).

The following steps describe the application process for becoming a waiver participant:

- The RRDS makes a preliminary determination of probable eligibility for the waiver.

- The RRDS provides the potential participant with a list of approved Service Coordination providers, which the applicant can interview. The applicant will then select a Service Coordination Agency.

- The applicant, and anyone he/she may choose, work with the Service Coordinator agency to develop an *Initial Service Plan* and complete the application packet.

- Once the applicant selects a Service Coordinator agency, the agency has 60 calendar days to submit a completed application packet, including the *Initial Service Plan* to the RRDS. The selected Service Coordinator must also submit a status report to the RRDS 45 days after selection to allow the RRDS to track progress of the ISP.

    - If a delay is expected in submitting an application packet, the Service Coordinator must notify the RRDS to receive technical assistance. The RRDS may choose to grant a brief extension of the sixty day deadline.

- The RRDS reviews the application packet and either approves the packet or requests, in writing, revisions and/or additional information needed for approval. The RRDS will issue a Notice of Decision. If eligible, it will indicate the start date for the initial six months of waiver participation.

Cost Neutrality

As true for all waivers, costs in the waiver must be cost-neutral compared to statewide nursing home costs. Unlike the Lombardi waiver, an *aggregate* cost cap is used, so that the average aggregate cost of all waiver participants in the region is less than the average cost of serving such individuals in an institution. Also, unlike the Lombardi and other waivers, the average cost of serving individuals in an institution is higher in the TBI waiver because of the large number of such individuals who were historically institutionalized outside of New York State. Since the cost to NYS Medicaid program of institutionalizing them out of state is high, this higher cost is taken into account in the waiver, allowing higher costs to be paid for services in the community.

NURSING HOME TRANSITION AND DIVERSION WAIVER (NHTD)

Description of NHTD Waiver

The newest of the Home and Community-Based Services waiver programs in New York State, the NHTD waiver offers another option for elderly and disabled New Yorkers to avoid institutionalization and receive services in their communities. The waiver has a cap of 5000 people. Its third year of implementation ends August 2010. Unfortunately, only 426 active participants are enrolled as of April 2010.

April 2010 - Number of enrollees in NHTD in NYS[14]

NYC	27
Long Island	60
Lower Hudson Valley	46
Capital	38
Adirondack	59
Syracuse	17
Binghamton/ Southern Tier	65
Rochester	87
Buffalo	30
TOTAL	**429**

CITATIONS: SSL § 366(6-a), NYS DOH Directive 08-OLTC-ADM-1, 4/28/08

[14] Data given by the NYS Dept. of Health to the Advisory Group of the NHTDW waiver, May 2010

HOME AND COMMUNITY BASED WAIVER SERVICES IN NEW YORK STATE

State DOH NHTDW manual posted at
http://www.health.state.ny.us/facilities/long_term_care/waiver/nhtd_manual/index.htm

In addition to personal care and other Medicaid "state plan" services, which are accessed through normal local district procedures, the services included in the NHTD waiver include:

- Service Coordination
- Assistive Technology
- Community Integration Counseling
- Community Transitional Services
- Congregate and Home-Delivered Meals
- Housing Subsidy -- Information at NHTDW Housing Subsidy Program Guide
  http://www.dhcr.state.ny.us/Forms/NHTD/nhtd.pdf
  http://www.dhcr.state.ny.us/programs/nhtd/index.htm
    - Environmental Modifications Services -- " "
- Home and Community Support Services - see note below
- Home Visits by Medical Personnel
- Independent Living Skills Training Services
- Moving Assistance
- Nutritional Counseling / Educational Services
- Peer Mentoring
- Positive Behavioral Interventions and Supports
- Respiratory Therapy
- Respite Services
- Structured Day Program Services
- Wellness Counseling Service

Qualifying for NHTD Waiver

An individual applying to participate in the waiver must meet all of the following criteria:

- Individuals must be approved for Community Medicaid with Community-Based Long-Term Care coverage. If an applicant for NHTD is not currently a Medicaid recipient, s/he must apply for Medicaid at a local Medicaid office.
- Medicaid Financial Criteria:
  - The personal needs allowance for the individual receiving waiver services is as follows:
    - Single: the same as the income level for community-based Medicaid recipients ($767 per month in 2010).
    - Married: the difference between the allowance for one-person and two-person households under the regular community Medicaid levels ($350 per month in 2010).
  - Unlike the Lombardi waiver, spousal impoverishment budgeting is not used with the NHTD waiver. Instead, the applicant spouse is treated as a household of one and only their income is counted in determining eligibility. NYS DOH Directive 08-OLTC-ADM-1, 4/28/08 http://www.health.state.ny.us/health_care/medicaid/publications/docs/adm/08oltcadm-1.pdf pp. 5-6
- Be capable of living in the community with needed assistance from available informal supports, non-Medicaid supports, and/or Medicaid State Plan services and be in need of one or more waiver services
- Be eligible for nursing home level of care
- Be at least 18 years of age or older
- COST NEUTRALITY -- Be considered part of an aggregate group that can be cared for at less cost in the community than a similar group in a nursing home
- Choose to live in the community as a participant in this waiver rather than in a nursing home
- Not participate in another HCBS waiver

Applying for NHTD Waiver

The NHTD is administered through a network of Regional Resource Development Centers (RRDC). The contact person at the RRDC is the Regional Resource Development Specialist (RRDS). See list attached -- same RRDC's administer TBI waiver. The responsibilities of the RRDS include:

- Interviewing potential waiver participants
- Assisting participants to access approved providers

- Reviewing Service Plans for approval
- Determining whether applicant meets all non-financial eligibility requirements
- Maintaining regional budgets for waiver services (cost neutrality)
- Issuing Notice of Decision forms to applicants to approve or deny waiver participation

Additionally, the RRDC employs a Nurse Evaluator (NE), whose responsibilities include:

- Utilizing clinical expertise to review medically complex Service Plans
- Providing technical assistance to the RRDS and waiver service providers
- Resolving issues associated with level of care determinations

Issues in Implementation

Advocates have identified several problems with implementation causing delays and barriers to enrollment.:

1. Cumbersome service plans - requiring up to 100 hours for drafting,

2. Definition of HCSS - Home and Community Support Services -- and Lack of Personal Care Services. As in the TBI program, discussed above, this service has had barriers. Advocates report that it has only been authorized for those individuals who have Alzheimer's or other cognitive deficits, even though people with physical disabilities also need the services. Meanwhile, the same individuals cannot obtain personal care services from their local DSS because most counties do not authorize these services, even though mandated under state law. In addition to longstanding local DSS resistance to authorizing this service, there is a real aide shortage in many rural areas.

3. Barriers to Enrolling Providers. Each of the list of varied waivered services must be provided by a provider licensed to provide the particular service in that region. Extremely burdensome, resulting in lack of sufficient providers.

4. Administration Overload. -- Both the RRDC and the Service Coordinator are involved in development of a service plan, with the RRDC also employing a Nurse Evaluator.

5. Housing Shortage -- Since the goal is to discharge people from nursing homes, housing is vital, yet the housing subsidy available is less generous than that in the TBI program. http://www.dhcr.state.ny.us/programs/nhtd/index.htm,

http://www.dhcr.state.ny.us/Forms/NHTD/nhtd.pdf Rent and utilities must be within Payment Standards of 90-110% of HUD *Fair Market Rent* [FMR] http://www.huduser.org/portal/datasets/fmr/fmrs/FY2010_code/select_Geography.odb

OFFICE OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES (OMRDD)

Description of OMRDD Waiver Program

The OMRDD Waiver, operated by the NY State Office of Mental Retardation and Developmental Disabilities (OMRDD), is a program of supports and services that enables adults and children with developmental disabilities to live in the community as an alternative to Intermediate Care Facilities (ICFs). These services can include many things not normally covered by the Medicaid program.

Unlike the TBI and LTHHC waivers, the OMRDD waiver is not administered by the Department of Health, but instead by OMRDD. The services are provided through Developmental Disabilities Services Offices (DDSOs) throughout the state and through non-profit organizations that contract with OMRDD.

The services that may be provided to a participant in the OMRDD waiver include:

- **Medicaid Service Coordination** – Each recipient is assigned a service coordinator who works with the recipient and their family to develop a plan of care that assures they receive the assistance they need.

- **Consolidated Supports and Services** - A self-directed service option that empowers people with disabilities and their families to hire and manage their own staff supports and pursue employment, volunteerism, or other community service activities.

- **Residential Habilitation** - Individually tailored supports that assist with skills related to living in the community, including adaptive skill development; assistance with activities of daily living (hands-on); community inclusion and relationship building; training and support for independence in travel; transportation; adult educational supports; development of social skills, leisure skills, self-advocacy and informed choice skills; and appropriate behavior development to help the individual access their community. Residential Habilitation also may include program related personal care, health care and protective oversight and supervision.

- **Housing/Individual Support Services**

- **Individual Support Services (ISS)** - Assistance locating, leasing, or buying individualized living arrangements that are alternatives to traditional group living. Residential options include home sharing, independent living, HUD rental subsidy programs, low income home ownership programs, and other leasing and ownership initiatives.
- **Environmental Modifications (E-Mods)** - Adaptations to the home that are necessary to increase or maintain a person's ability to live at home with independence.
- **Adaptive Devices** - Aids, controls, appliances, or supplies which help enable an individual to increase or maintain his or her ability to live at home and in the community with independence and safety. They may assist the person in communication, self-care, work, play/leisure activities, or physical exercise.

- **Family Support Services**
- **Respite Services**
- **Crisis Intervention**
- **Supportive and Supervised Residences**
  - **Residential Habilitation -** provide individually tailored supports that assist with skills related to living in the community. These supports include adaptive skill development; assistance with activities of daily living (hands-on); community inclusion and relationship building; training and support for independence in travel; transportation; adult educational supports; development of social skills, leisure skills, self-advocacy and informed choice skills; and appropriate behavior development to help the individual access their community. Residential Habilitation also may include program related personal care, health care and protective oversight and supervision.
  - **Family Care** - a certified residential program that provides a structured and stable home environment within a family unit to a person with a developmental disability, offering support, guidance, and companionship. Family Care providers are home owners who receive a monthly stipend to care for individuals with developmental disabilities in their own homes.
  - **Individualized Residential Alternatives** - certified homes that provide room, board and individualized service options. There are two different kinds of IRAs. A **Supervised Individualized Residential Alternative** is a home that has staff nearby at all times that individuals are at the residence. A **Supportive Individualized Residential Alternative** is a home in which living is more independent and supervision is based on the person's needs for

supervision; staff typically are not onsite at all times when residents are home.

- **Intermediate Care Facilities** - residential treatment options in the community for individuals with specific medical and/or behavioral needs. ICFs provide 24-hour on-site assistance and training, intensive clinical and direct-care services, supervised activities and a variety of therapies. ICFs are designed for individuals whose disabilities severely limit their ability to live independently.

- **Community Residences** - provide housing, supplies for daily living like food and toiletries, and services on a daily basis for individuals who have developmental disabilities. Community Residences foster supportive interpersonal relationships, offer supervision to ensure health and safety, and assistance in learning activities that are a part of daily living. Community residences are designed to provide a home environment, and also to provide a setting where individuals with developmental disabilities can acquire the skills necessary to live as independently as possible. There are two types of community residences: **Supervised Community Residences**, in which staff are nearby at all times that individuals are at the residence, and **Supportive Community Residences** in which living is more independent. In supportive residences, staff are onsite and available less than the entire time individuals are home, based on the specific support needs of an individual.

- Supported Employment Services

Qualifying for the OMRDD Waiver

An individual applying to participate in the waiver must meet all of the following criteria:

- Individuals must be approved for Community Medicaid with Community-Based Long-Term Care coverage. If an applicant for OMRDD is not current a Medicaid recipient, s/he must apply for Medicaid at a local Medicaid office.

- Medicaid Financial Criteria:

  - The personal needs allowance for the individual receiving waiver services is as follows:

    - Single: the same as the income level for community-based Medicaid recipients ($767 per month in 2010).

    - Married: the difference between the allowance for one-person and two-person households under the regular community Medicaid levels ($350 per month in 2010).

  - Unlike the Lombardi waiver, spousal impoverishment budgeting is not used with the OMRDD waiver. DOH Medicaid Reference Guide p. 231.2. Instead, the applicant spouse is treated as a household of one and only their income is counted in determining eligibility.

- The applicant's disability must be deemed a "developmental disability" as defined by NY Mental Hygiene Law:
  - Is attributable to:
    - mental retardation, cerebral palsy, epilepsy, neurological impairment or autism;
    - any other condition of a person found to be closely related to mental retardation because such condition results in similar impairment of general intellectual functioning or adaptive behavior to that of mentally retarded persons or requires treatment and services similar to those required for such persons; or
    - dyslexia resulting from a disability described in (1) or (2);
  - Originates before such person attains age twenty-two;
  - Has continued or can be expected to continue indefinitely; and
  - Constitutes a substantial handicap to such person's ability to function normally in society.

Applying for the OMRDD Waiver

To qualify for the OMRDD waiver, one must first be found eligible to receive services from OMRDD (waiver or not). This requires an application to the local DDSO for a finding that the applicant has a developmental disability. To further qualify for Medicaid waiver services through OMRDD, the applicant must also be approved for Community Medicaid with coverage of Community-Based Long-Term Care. The DDSO will typically refer the applicant to a community Medicaid office for this part of the process.

The first step is to locate the DDSO that covers the applicant's residence. You can find all of the DDSO's in the state using this website:
http://www.omr.state.ny.us/ws/ws_linemap.jsp

CHILDREN'S WAIVERS:

Care at Home for Children with Physical Disabilities - Levels I & II

The Children's Care at Home (CAH) program is for families with children who have severe disabilities and who would normally be ineligible for Medicaid because of Medicaid's financial eligibility rules. Medicaid helps to pay for medically necessary in-home services to make it possible for physically disabled children to live in their own home with their families. There are two waiver programs:

- CAH I is for physically disabled children who require a level of care provided in a skilled nursing facility.
- CAH II is for physically disabled children who are technology dependent and require the level of care provided in a hospital.

Related Web Links: *Children's Home & Community Based Services go to* *www.health.state.ny.us/facilities/long_term_care/docs/manual.pdf*

State Directives:

Care at Home Case Management Waiver Program for Children, GIS 09 OLTC/004 (April 2009); GIS 10 OLTC/002 (palliative care now available)

90-ADM-20 (May 30, 1990); 92 LCM 170

DOH manual for parents posted at http://www.health.state.ny.us/nysdoh/medicaid/cah/crhmgts.pdf;

See also Arkontaky, Adrienne, *Special Needs Forum: Waivers In New York,* NYSBA Elder Law Attorney, Fall 2008, Vol. 18 No. 4, p. 25 (available on NYSBA website

GIS 09 OLTC/004 clarifies criteria – must

- Be under the age of 18 (and not married) - when turns 18, no longer eligible;
- Be physically disabled, according to the SSI program criteria;
    - Forms *DSS 486T, Medical Report for Determination of Disability* (pp. 1-2 and other pages to extent relevant must be completed by the child's attending physician) and the *DSS 1151, Disability Interview* (completed by the child's parent or a case worker) must accompany the Medicaid application.

- Require the level of care provided by a skilled nursing facility (CAH I) or hospital (CAH II),
    - A copy of the *Pediatric Patient Review Instrument* (PPRI), completed as part of the home assessment, should be used to show the level of care needed at home.

- Be capable of being cared for in the community safely.

- Note: *Applicants no longer require a 30 day inpatient stay*.

AVAILABLE WAIVER SERVICES

If eligible for the CAH program, a child will have access to all medically necessary services covered by Medicaid. CAH also has available, when medically necessary, three special waiver services that are not available through the regular Medicaid program:

- Respite Care - short term, periodic care for the child when a family or the primary caregiver cannot provide necessary care; respite care cannot exceed 30 days per calendar year.

- Case Management –services to assist and enable the child and family to access the full range of services and resources for which they are eligible.

- Home Adaptations/Vehicle Modifications – to improve movement and/or safety for the child within his/her home and to improve a child's access from the home to the community. Examples include, but are not limited to, installation of wheelchair ramps, widening of doorways, modifications to permit independent use of bathroom or modifications to facilitate bathroom use, modification to a parent-owned vehicle to accommodate the needs of the disabled child.

QUALIFYING FOR CHILDREN'S CARE AT HOME PROGRAM

- Medicaid Financial Criteria - The child must be ineligible for Medicaid when his/her parent's income and resources are counted and eligible for Medicaid when using only the income and resources belonging to the child. The disability income and resources will be used when determining financial eligibility.

    - If a child is found eligible for Medicaid when parental income and resources are counted, then the child (and possibly other family members) will be able to get regular Medicaid and will not be enrolled in the CAH program.

- Cost Neutrality -- The cost of care must not be greater than in the appropriate facility.

- The monthly budget cap for CAH I is based on the monthly Medicaid costs for care in a skilled nursing facility.
- The monthly budget cap for CAH II is based on the monthly Medicaid costs for care in a hospital.
- A copy of the estimated monthly budget for home care should be used to show all of the costs of caring for your child at home, including those services to be paid for by Medicaid.

Note: *Only the care paid for by Medicaid is looked at under the monthly cap. It is important to remember that all other insurance must be billed before Medicaid is billed. Using other insurance available to the child will ensure that Medicaid costs for care at home do not exceed the monthly program cap.*

May Have Other Insurance -- Families can apply for CAH even if they already have health coverage from another insurer. The CAH program is designed to work with other insurance plans so a child's coverage can be as complete as possible. Medicaid will be the secondary payer (all other insurance plans will be billed before Medicaid will pay for any service) and provide services that the family's primary insurer does not cover.

APPLYING FOR CHILDREN CARE AT HOME PROGRAM

- Apply for the Care at Home program at local Dept. of Social Services or CASA.

- NYC -- Contact 212-896-5750. HRA Leaflet on NYC program posted at http://www.nyc.gov/html/hra/html/directory/care_at_home_program.shtml

OMH Waiver for Children and Adolescents with Serious Emotional Disturbance

The OMH waiver for children with serious emotional disturbance is for children and adolescents with serious emotional disturbance and provides supports and services that enable children who would otherwise require an institutional level of care to live at home or in the community. The program is for persons between the ages of 5 and 17 who have complex health and mental health needs. The target population of children eligible for the waiver are children with a diagnosis of serious emotional disturbance who without access to the waiver would be in psychiatric institutional placement. Parent income and resources are not considered in determining a child's eligibility.

The waiver is administered by OMH and monitored by OMH's central office and regional offices.

Related Web Links:
http://www.omh.state.ny.us/omhweb/guidance/hcbs/ - comprehensive website

www.health.state.ny.us/health_care/medicaid/program/longterm/omh.htm

AVAILABLE WAIVER SERVICES

If eligible for the OMH waiver for children with serious emotional disturbance program, a child will have access to all medically necessary services covered by Medicaid. In addition, waiver services are available based on the specific needs of the child and his/her family and are made available for as long as necessary. Providers develop an individualized service plan for each child and family, and coordinate the mental health and health care services needed to enable individuals to remain in their homes.

Services include:

- Crisis Response Services are activities aimed at stabilizing occurrences of child/family crisis where it arises.
- Intensive In-home Services are ongoing activities aimed at providing intensive interventions in the home when a crisis response service is not enough.
- Respite Care are activities that provide a needed break for the family and the child to ease the stress at home and improve family harmony.
- Family Support Services are supportive services to the child's family, in such areas as behavior management, system access, and negotiation, parent education and support groups
- Skill Building Services are activities designed to assist the child in acquiring, developing and addressing functional skills and support, both social and environmental.

QUALIFYING FOR OMH WAIVER FOR CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE

- Medicaid Financial Criteria - The child must be ineligible for Medicaid when his/her parent's income and resources are counted and eligible for Medicaid when using only the income and resources belonging to the child.
    - If a child is found eligible for Medicaid when parental income and resources are counted, the child (and possibly other family members) will be able to get

regular Medicaid and will not be enrolled in the OMH waiver for children with serious emotional disturbance.

- The child must be under age 18 on the date they are approved for services. Once approved, they can remain in the program until their 21st birthday.

- The child must have been on the waiting list kept by the State Office of Mental Retardation and Development Disabilities (OMRDD) for residential placement.

  - The child does not need to be determined disabled, unless such a determination is needed to make the child financially eligible for Medicaid under the more generous income budgeting formula for children with disabilities.

- The child must have a safe home environment – a physician must determine whether or not the individual's health and safety needs can be met in the home.

- The child must have a designated emotional disturbance diagnosis, and either

  - Has extended impairment in functioning due to emotional disturbance or

  - Has current impairment in functioning with severe symptoms

May Have Other Insurance -- Families can apply for OMH waiver for children with serious emotional disturbance even if they already have health coverage from another insurer. The OMH waiver for children with serious emotional disturbance program is designed to work with other insurance plans so a child's coverage can be as complete as possible. Medicaid will be the secondary payer (all other insurance plans will be billed before Medicaid will pay for any service) and provide services that the family's primary insurer does not cover.

APPLYING FOR OMH WAIVER FOR CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE

A child applies through one of the community-based organization, called Individualized Care Coordination (ICC) Agencies. There is one ICC agency in each borough of NYC. An ICC representative will apply for community Medicaid on behalf of the child. The supervisor of the OMH waiver for children with serious emotional disturbance for each borough can be contacted at that borough's ICC as follows:

Bronx St. Dominic's Family First, 1 Fordham Plaza, Bronx, NY 10458
HCBS Supervisor: 718-295-9112

Brooklyn St. Christopher-Ottilie, 570 Fulton Street, Brooklyn, NY 11217
HCBS Supervisor: 718-935-9466

Manhattan St. Luke's-Roosevelt Hospital, 411 W. 114th Street, NY, NY 10025 HCBS Supervisor: 212-523-2876

Queens Steinway Child & Family Services, 41-36 27th Street, Long Island City, NY 11101 HCBS Supervisor: 718-786-0740

Staten Island Jewish Board of Family & Children's Services, 2795 Richmond Avenue, SI 10314 HCBS Supervisor: 718-982-6982

Bridges to Health (B2H) Waiver

http://www.ocfs.state.ny.us/main/b2h/about.asp

B2H Program Manual (July 2009) http://www.ocfs.state.ny.us/main/b2h/manual.asp

DESCRIPTION OF B2H WAIVER

The B2H waiver is intended to improve the health and well-being of children in foster care, including after leaving foster care up to age 21. It provides additional services not usually covered by Medicaid for three groups of children in foster care: those with Serious Emotional Disturbances, Developmental Disabilities, and Medically Fragile.

B2H includes the following services:

- Health Care Integration
- Family/Caregiver Supports and Services
- Skill Building
- Day Habilitation
- Special Needs Community Advocacy and Support
- Pre-vocational Services
- Supported Employment
- Planned Respite
- Crisis Avoidance, Management and Training
- Immediate Crisis Response Services
- Intensive In-home Supports
- Crisis Respite

- Adaptive and Assistive Equipment
- Accessibility Modifications

QUALIFYING FOR B2H WAIVER

To be eligible to participate in B2H, a child must:

- be in the custody of the commissioner of the local department of social services (LDSS) / New York City Administration for Children's Services (ACS), or New York State Office of Children and Family Services (OCFS);
- be Medicaid eligible;
- have a qualifying diagnosis; and
- be able to benefit from the service.

Since the number of "slots" statewide is limited, applications are accepted on a first-come, first-served basis, and the child may be placed on a waiting list.

APPLYING FOR B2H WAIVER

To be eligible for the B2H waiver, children must already be in the foster care system, and their eligibility is evaluated by the local DSS. One cannot separately apply for B2H unless they are already in foster care. See List of B2H Integration Agencies at http://www.ocfs.state.ny.us/main/b2h/

NEW OPTIONS UNDER FEDERAL LAW – PPACA[15]

Community First Choice Option, PPACA § 2401, Recon. Act § 1205

This provision creates a new optional HCBS state plan benefit for individuals who meet two criteria:

1. Income limit – the greater of 150 percent FPL or the state income limit for eligibility for nursing facility or equivalent services under the state plan, up to 300 percent of the SSI benefit rate ($2,022 in 2009).

2. Individuals must be "*nursing facility clinically eligible*" (NFCE), meaning they would otherwise be, without the services, in a nursing home, hospital, intermediate care facility or institution for mental diseases. State may not limit to any particular age or diagnosis.

As an incentive to states to offer the service, *a state's federal participation (FMAP) is increased six percentage points for these service.* .

The state must implement this service in collaboration with a Development and Implementation Council in the state, which must include elderly individuals and people with disabilities. Other requirements create further protections for consumers, ensure adequate state spending and quality, and require reporting. The Secretary is required to conduct an evaluation of services under this provision, collect data from state reports, and make interim and final public reports to Congress.

Since this provision is NOT a waiver, it will be an important option in states that have long waiting lists for waiver services (see Table 2, supra) or have limited or no personal care programs. As a state plan service, the state will receive federal matching funds for all the individuals to which it chooses to extend coverage.

This funding may be used to help transition an institutionalized individual to community based settings where the individual would then be eligible for personal care and other services under the State Plan, and could pay for a wide range of related expenditures that Medicaid normally would not cover as a "state plan" service, such as:

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[15] The PPACA was modified by later amendments in the Reconciliation Act known as HCERA. The complete combined legislation can be viewed at http://www.ncsl.org/documents/health/ppaca-consolidated.pdf. The materials in this section are largely based on analyses by the National Health Law Program posted at http://healthlaw.org/images/stories/PPACA_Part_II.pdf (June 2010) and the National Senior Citizens Law Center posted at Gene Coffey, http://www.nsclc.org/areas/long-term-care/At-Home-Care/the-medicaid-long-term-services-and-supports-provisions-in-the-senate2019s-patient-protection-and-affordable-care-act/at_download/attachment. (January 2010)

- rent and utility deposits, first month's rent and utilities;
- bedding, basic kitchen supplies; and
- other necessities required for an individual to make the transition.

In addition, this provision includes language that matches the ADA integration mandate and applies this as a requirement for State Plans offering services under this provision.

Adding new § (k) to 42 U.S.C 1396n, by § 2401, *see* new § (k)(3)(B) for the integration mandate provision. Effective Date: October 1, 2011.

Removal of Barriers to Providing Home and Community Based Services, PPACA § 2402

This section requires the HHS Secretary to promulgate regulations ensuring that all states develop service systems that are responsive to the needs and choices of beneficiaries receiving state and Medicaid-funded, community-based, long-term care services. These systems must also:

- enable beneficiaries to receive services in a way that maximizes their independence, including through the use of client-employed providers;[16]
- provide the support and coordination needed to design a self-directed, community supported life;
- improve coordination, consistency, and regulation of federally and state-funded services, including development of effective eligibility determination and assessments, complaint, management and monitoring systems; and
- assure an adequate number of qualified direct-care workers to provide self-directed personal assistance services. § 2402(a).

§ 2402(a). Effective date: March 23, 2010.

Expansion of State Plan Option, Created by the DRA, to Provide Home and Community-Based Services (1915(i))

The Deficit Reduction Act of 2005 added a new section to the Medicaid Act that authorized states to provide home and community-based services through a state plan option – that is, without a waiver – to certain individuals whose household incomes do not exceed 150 percent of FPL. 42 U.S.C. § 1396n(i). Even though this was not a waiver benefit, the DRA allowed states to cap the number of people enrolled, and to limit

[16] NYS is already a leader in its consumer-directed personal assistance program. See http://wnylc.com/health/entry/40/

eligibility to a particular geographic area of the state. Unlike a waiver, there is no "budget neutrality" requirement, so that the cost of services could exceed a nursing home. In order to offer this option, states had to establish criteria for determining an individual's need for supportive services covered under this state plan option. Only four states, not including New York, added this benefit, available in 2006, to their programs.[17]

The PPACA amends § 1396n(i) to expand this optional state plan benefit.

1. Financial eligibility – Expanded from 150% FPL to up to 300 percent of the federal Supplemental Security Income (SSI) benefit rate. § 2402(b).

2. "Comparability" requirement waived -- States may choose to offer home and community-based services through this state plan option to specific, targeted populations, and offer different amount, duration, and scope of services to different groups, as long as the services are within the scope of services described in 42 U.S.C. §1915(c)(4)(B). See #5 below.

3. Statewide -- States must offer the services statewide

4. No Caps – States may not place caps on enrollment; in other words, no waiting lists are permitted. § 2402(e), (f).

5. Clinical eligibility - States retain their ability to modify entrance criteria for the plan if enrollment exceeds projections, but the new legislation extends the period for which grandfathered individuals are eligible. § 2402(e), amending 42 U.S.C. § 1396n(i)(1)(D)(ii)(I).

6. Expanded services – Before, states could offer the services listed in the statute -- 42 U.S.C. § 1396n(c)(4)(B). These are the services normally offered in HCBS waivers -- case management, homemaker/home health aide and personal care, adult day health, habilitation, respite care, day treatment or other partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness. Now, states may, with permission from CMS, offer other services not specifically listed. § 2402(c).

7. New Medicaid categorical eligibility option -- The PPACA also adds an optional category of full Medicaid eligibility for individuals who would be eligible for home and community-based services through § 1396n(i), which will allow states to offer them full scope Medicaid benefits. § 2402(d).

States may authorize these programs for a renewable period of five years, with a gradual phase-in of individuals and services during the initial five years. § 2402(b).

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[17] Gene Coffey, *The-Medicaid-Long-Term-Services-And-Supports-Provisions-In-The-Senate's-Patient-Protection-And-Affordable-Care-Act*, National Senior Citizens Law Center, January 2010, posted at http://www.nsclc.org/areas/long-term-care/At-Home-Care/the-medicaid-long-term-services-and-supports-provisions-in-the-senate2019s-patient-protection-and-affordable-care-act

Effective date: The first full day of the first FY quarter after enactment (April 1, 2010) § 2402(g).

Money Follows the Person Rebalancing Demonstration, PPACA § 2403

The DRA of 2005 directed the HHS Secretary to award Money Follows the Person(MFP) Rebalancing Demonstration grants to states to increase the use of the home andcommunity-based services offered under a state's waiver or regular Medicaid program. Participating states could waive comparability, income and statewideness requirements. To be eligible, individuals were required to be living in an inpatient facility and have been living there for 6 months to two years. A determination must also have been made that the individual requires home and community-based services to remain safely in the community. The program provided grants of up to five years. Deficit Reduction Act of 2005, Pub. L. No. 109-171 § 6071, *codified at* § 1396a (note).

Thirty-one states, including New York, were awarded grants under this program, in the form of an enhanced federal match for services for the first 12 months after transition from an institution.[18]

The PPACA extends the demonstration for five additional years, until 2016. § 2403(a). It also reduces the amount of time an individual must reside in an institution from six months to only 90 days. Days of residency that are solely for the purpose of receiving short-term rehabilitative services during Medicare's waiting period will not be counted toward the 90 days. § 2403(b).

Effective date: April 22, 2010.

State Balancing Incentive Program (Sec 10202 PPACA)

The PPACA creates the State Balancing Incentive Program to provide enhanced federal matching payments (FMAP) to eligible states to increase the proportion of non-institutionally-based long-term care services. In 2007, 69 percent of Medicaid long term care spending nationally was spent on institutional care. Selected states will be eligible for FMAP increases for medical assistance expenditures for non-institutionally based long-term services and supports.

States spending less than 25% of their total Medicaid long-term care services dollars on HCBS services may have their FMAP increased for all HCBS services by five percentage

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[18] Gene Coffey, n 16, supra.

points through Sept. 2015. States spending between 25 – 50% of their total long term care dollars on HCBS services are eligible for a 2 percent increase in FMAP for HCBS services.

How CMS decides to quantify the percentage of Medicaid long term care dollars spent on HCBS services may be contentious. The percentage can vary depending on which services are included and other factors. For example, in an influential study by AARP, New York is cited as spending only 26 percent of long term care dollars on HCBS services, with the rest spent on nursing homes.[19] This statistic contrasts greatly with the figures in Table 1, supra, showing nearly a fifty-fifty split between HCBS and institutional care in New York State. The difference is partly explained by AARP's decision to omit state plan certified home health services (CHHA) from inclusion as HCBS services, because in most states CHHA services are solely for short-term sub-acute home care and rehabilitation, rather than long-term care. AARP Study, supra, at pp. 4-5. In New York, CHHA services are used for both purposes. Also, AARP excluded all long-term care services for the MR/DD population – both the HCBS waiver services and the ICF-DD services. As shown in Table 2, supra, a large part of HCBS dollars in NYS are spent on MR/DD population.

State must, within six months of application, make the following structural changes in its HCBS system:

(A) ''NO WRONG DOOR—SINGLE ENTRY POINT SYSTEM''.—Development of a statewide system to enable consumers to obtain information about availability and application procedures to access all long-term services and supports through a coordinated network or portal,

(B) CONFLICT-FREE CASE MANAGEMENT SERVICES.—Conflict-free case management services to develop a service plan, arrange for services and supports, support the beneficiary (and, if appropriate, the beneficiary's caregivers) in directing the provision of services and supports for the beneficiary, and conduct ongoing monitoring to assure that services and supports are delivered to meet the beneficiary's needs and achieve intended outcomes.

(C) CORE STANDARDIZED STATEWIDE ASSESSMENT INSTRUMENTS.— to determine a beneficiary's needs for training, support services, medical care, transportation, and other services, and develop an individual service plan to address such needs.

Section 10202 Effective October 1, 2011 through September 30, 2015. Actual language is at p. 804 at http://www.ncsl.org/documents/health/ppaca-consolidated.pdf.

[19] Enid Kessner et al., *A Balancing Act: State Long Term Care Reform,* AARP Public Policy Institute, July 2008 http://assets.aarp.org/rgcenter/il/2008_10_ltc.pdf