

## New York Clinical Criteria

Carelon Behavioral Health's Medical Necessity Criteria (MNC), also known as clinical criteria, are reviewed and updated at least annually to ensure that they reflect the latest developments in serving individuals with behavioral health diagnoses. Carelon's Corporate Medical Management Committee (CMMC) adopts reviews, revises and approves Medical Necessity Criteria per client and regulatory requirements.

- A. Members must meet medical necessity criteria for a particular LOC of care. Medically necessary services are those which are:
  - B. Intended to prevent, diagnose, correct, cure, alleviate or preclude deterioration of a diagnosable condition (most current version of ICD or DSM,) that threatens life, causes pain or suffering, or results in illness or infirmity.
  - C. Expected to improve an individual's condition or level of functioning.
  - D. Individualized, specific, and consistent with symptoms and diagnosis, and not in excess of patient's needs.
  - E. Essential and consistent with nationally accepted standard clinical evidence generally recognized by mental health or substance abuse care professionals or publications.
  - F. Reflective of a level of service that is safe, where no equally effective, more conservative, and less resource intensive treatment is available.
  - G. Not primarily intended for the convenience of the recipient, caretaker, or provider.
  - H. No more intensive or restrictive than necessary to balance safety, effectiveness, and efficiency.
  - I. Not a substitute for non-treatment services addressing environmental factors.

Carelon uses clinical criteria as guidelines, not absolute standards, and considers them in conjunction with other indications of a member's needs, strengths, and treatment history in determining the best placement for a member. Carelon applies clinical criteria to determine appropriate care for all members. In general, members will only be certified if they meet the specific medical necessity criteria for a particular level of care. However, the individual's needs and characteristics of the local service delivery system and social supports are taken into consideration.

Medical Necessity Criteria varies according to state and/or contractual requirements and member benefit coverage. New York uses the following criteria:

1. Centers for Medicare and Medicaid (CMS) National Coverage Determination (NCD) and Local Coverage Determination(LCD)Criteria for Medicare members
2. New York State Office of Mental Health(OMH) Clinical Criteria for certain Medicaid services
3. Office of Addiction Support and Services (OASAS) Level of Care for Alcohol and Drug Treatment Referral (LOCADTR) 3.0 for all lines of business (excluding Medicare) for providers located in New York
4. Change Healthcare's InterQual Behavioral Health Criteria for all mental health services in which CMS and OMH criteria is not applicable or available
5. American Society for Addiction Medicine (ASAM) Criteria for all Medicare members and for all other lines of business when the provider is located outside of New York State

## State Assurance

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
- Service to inmates in public institutions as defined in 42 CFR435.1010;
- Services to individuals residing in institutions for mental disease as described in 42CFR435.1 010
- Recreational and social activities
- Services that must be covered elsewhere in the state Medicaid plan

### Section 1: CMS Criteria

#### Overview

The Medicare Coverage Database (MCD) contains all NCD and LCD criteria. For all Medicare members, first the relevant NCD or LCD criteria is identified when applying clinical criteria.

The following is a listing of services in which CMS NCD and LCD is utilized in New York:

- A. NCD Guideline 130.1 Inpatient Hospital Stay for Alcohol Detoxification
- B. NCD Guideline 130.2 Outpatient Services for Treatment of Alcohol
- C. NCD Guideline 130.5 Treatment of Alcoholism and Drug Abuse in a Freestanding Clinic
- D. NCD Guideline 130.6 Treatment of Drug Abuse(Chemical Dependency)
- E. NCD Guideline 130.7 Withdrawal Treatment for Narcotic Addictions
- F. LCD Guideline L33398 Transcranial Magnetic Stimulation (TMS)
- G. LCD Guideline L336245 Psychiatric Hospitalization
- H. LCD Guideline L33636 Psychiatric Partial Hospitalization Programs
- I. LCD Guideline L33632 Psychiatric and Psychiatry Services

### Section 2: OMH Criteria

#### Overview

Carelon Health Options adopts the New York State Office of Mental Health (OMH) Clinical Criteria for use in rendering medical necessity determinations services available to members enrolled in Medicaid Managed Care.

The following services utilize OMH clinical criteria when accessed by Medicaid Managed Care members:

- A. Assertive Community Treatment (ACT)
- B. Personalized Recovery Oriented Services (PROS)
- C. Continuing Day Treatment (CDT)
- D. Intensive Psychiatric Rehabilitation Treatment Program (IPRT)
- E. Children and Family Treatment and Support Services(CFTSS)
  - 1. Other Licensed Practitioner(OLP)
  - 2. Community Psychiatric Support and Treatment(CPST)
  - 3. Psychosocial Rehabilitation (PSR)
  - 4. Family Peer Support Services (FPSS)
  - 5. Youth Peer Support and Training(Y PST)
  - 6. Crisis Intervention (CI)
- F. Home and Community Based Services –Adults
  - 1. Vocational Services
  - 2. Pre-vocational Services
  - 3. Transitional Employment(TE)
  - 4. Intensive Supported Employment (ISE)
  - 5. Ongoing Supported Employment
  - 6. Education Support Services
  - 7. Habilitation/Residential Support Services
- G. Home and Community Based Services Children
  - 1. Community Habilitation
  - 2. Day Habilitation
  - 3. Caregiver/Family Advocacy and Support Services
  - 4. Respite
  - 5. Pre-vocational Services
  - 6. Supported Employment

## Assertive Community Treatment (ACT)

The purpose of Assertive Community Treatment (ACT) is to deliver comprehensive and effective services to individuals who are diagnosed with severe mental illness and whose needs have not been well met by more traditional service delivery approaches. ACT provides an integrated set of other evidence based treatment, rehabilitation, case management, and support services delivered by a mobile, multi-disciplinary mental health treatment team. ACT supports recipient recovery through a highly individualized approach that provides recipients with the tools to obtain and maintain housing, employment, relationships and relief from symptoms and medication side effects. The nature and intensity of ACT services are developed through the person-centered service planning process and adjusted through the process of team meetings.

### Admission Criteria

All of the following criteria, 1-5, must be met; criteria 6 & 7 may also be met:

1. Severe and persistent mental illness (including, but not limited to diagnoses of schizophrenia, schizophrenia, other psychotic disorders (e.g., schizoaffective disorder), bipolar disorder and/or major or chronic depression), that seriously impairs their functioning in the community.
2. Recipients with serious functional impairments should demonstrate at least one of the following conditions:

- a. Inability to consistently perform practical daily living tasks required for basic adult functioning in the community without significant support or assistance from others such as friends, family or relatives.
  - b. Inability to be consistently employed at a self-sustaining level or inability to consistently carry out the homemaker role.
  - c. Inability to maintain a safe living situation (e.g., repeated evictions or loss of housing).
3. Recipients with continuous high service needs should demonstrate one or more of the following conditions:
- a. Inability to participate or succeed in traditional, office-based services or case management.
  - b. High use of acute psychiatric hospitals (two hospitalizations within one year, or one hospitalization of 60 days or more within one year).
  - c. High use of psychiatric emergency or crisis services.
  - d. Persistent severe major symptoms (e.g., affective, psychotic, suicidal or significant impulse control issues).
  - e. Co-existing substance abuse disorder (duration greater than 6 months).
  - f. Current high risk or recent history of criminal justice involvement.
  - g. Court ordered pursuant to participate in Assisted Outpatient Treatment.
  - h. Inability to meet basic survival needs or homeless or at imminent risk of becoming homeless.
  - i. Residing in an inpatient bed or in a supervised community residence, but clinically assessed to be able to live in a more independent setting if intensive community services are provided.
  - j. Currently living independently but clinically assessed to be at immediate risk of requiring a more restrictive living situation (e.g., community residence or psychiatric hospital) without intensive community services.
4. Member has been assessed and is not an immediate danger to self or others and does not require 24-hour medical supervision.
5. Member's condition is such that it can be expected to benefit and improve significantly through appropriate ACT interventions.
6. Member is stepping down from a higher level of care (LOC) and requires more intensive services than routine Outpatient behavioral health treatment or other community based supports; and/or has past history of a similar clinical presentation where less intensive treatment was not sufficient to prevent clinical deterioration and the need for a higher LOC.
7. For children or adolescents, the parent or guardian agrees to participate in the member's treatment plan, as appropriate. Priority is given to individuals with SMI, individuals with continuous high service needs that are not being met in more traditional service settings, and individuals with ACT in their AOT order.

## **Exclusions**

The following criteria is required for exclusion from this level of care:

1. Individuals with a primary diagnosis of a substance abuse disorder or mental retardation and members with a sole diagnosis of a personality disorder are not appropriate for ACT. The member is not enrolled in HCBS services other than crisis residential services.

## **Continued Stay Criteria**

All of the following criteria must be met:

1. Initial authorization criteria continue to be met.
2. A Comprehensive Assessment is completed within 30 days of admission, with specific objectives and planned services to achieve recovery goals.
3. Service plan is reviewed for progress and updated every 6 months, as necessary.

4. Continued coordination of care with other providers/stakeholders such as PCPs, specialty providers, inpatient treatment team, AOT, community supports, family, etc.
5. Active discharge planning is ongoing, with goal of transitioning the member to a less intensive LOC, when appropriate.

### **Discharge Criteria**

1. ACT recipients meeting any one of the following criteria 1, 2, 3, or 4 (criteria 5 & 6 are recommended, but optional) may be discharged:
2. Individuals who demonstrate, over a period of time, an ability to function in major life roles (i.e., work, social, self-care) and can continue to succeed with less intensive service.
3. Individuals who move outside the geographic area of the ACT team's responsibility, subsequent to the transfer of care to another ACT team or other appropriate provider and continued services until the member is engaged in care.
4. Individuals who need a medical nursing home placement, as determined by a physician.
5. Individuals who are hospitalized or locally incarcerated for three months or longer. However, an appropriate provision must be made for these individuals to return to the ACT program upon their release from the hospital or jail.
6. Individuals who request discharge, despite the team's best, repeated efforts to engage them in service planning. Special care must be taken in this situation to arrange alternative treatment when the recipient has a history of suicide, assault or forensic involvement.
7. Individuals who are lost to follow-up for a period of greater than 3 months after persistent efforts to locate them, including following all local policies and procedures related to reporting individuals as "missing persons", including, but, not limited to, conferring with Health Homes and MMCO/HARPs, to which Member may be assigned.

## **Personalized Recovery Oriented Services (PROS)**

PROS programs offer a customized array of recovery-oriented services, both in traditional program settings and in off-site locations where people live, learn, work or socialize. The purpose of PROS is to assist individuals in recovering from the disabling effects of mental illness through the coordinated delivery of rehabilitation, treatment and support services. Goals for members in the program may include, but are not limited 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. There are four service components, including Community Rehabilitation and Support (CRS), Intensive Rehabilitation (IR), Ongoing Rehabilitation and Support (ORS) and clinical treatment. Intensive Rehabilitation consists of four different services:

1. Intensive Rehabilitation Goal Acquisition
2. Intensive Relapse Prevention
3. Family Psychoeducation
4. Integrated Treatment for Dual Disorders. The minimum age for PROS is 18.

### **Admission Criteria**

All of the following criteria, 1-11, must be met:

1. The member has a designated mental illness diagnosis.
2. The member must be 18 years of age or older.
3. The member must be recommended for admission by a Licensed Practitioner of the Healing Arts.
4. The member exhibits functional deficits related to the severity and duration of a psychiatric illness in any of the following areas: self-care, activities of daily living, interpersonal relations, and/or adaptation to change or task performance in work or work-like settings.
5. Pre-Admission begins with initial visit and ends when Initial Service Plan (ISR) is submitted to MMCO/HARP.

6. Admission begins when ISR is approved by MMCO/HARP.
7. Individualized Recovery Plan (IRP) must be developed within 60 days of admission date.
8. Active Rehabilitation begins when the Individualized Recovery Plan (“IRP”) is approved by the MMCO/HARP and IRP indicates required services designed to engage and assist members in managing their illness and restoring those skills and supports necessary for living successful in the community.
9. The individual has developed or is interested in developing a recovery/life role goal.
10. There is not a lower level of care which is more appropriate to assist member with recovery goals.
11. A member is not receiving Home and Community Services other than peer support services, education support services and crisis residential services.

For Intensive Rehabilitation, any one of the following criteria, 1-5, must be met:

1. Member has a specific goal related to education, housing or employment in which short term; intensive rehabilitation services would assist in achieving goal within desired timeframe.
2. The member is experiencing psychosocial stressors and/or difficulty in symptom management that has increased risk for hospitalization, involvement in criminal justice system, loss of housing, or other identified issues in which community tenure is at risk.
3. Member would benefit from intensive rehabilitation and recovery services for relapse prevention.
4. Family psychoeducation would benefit member in achieving life role goals and maintaining community tenure.
5. Member has a co-occurring substance use disorder (including tobacco dependence) and would benefit from Integrated Treatment for Dual Disorders.
6. A member is not receiving Home and Community Services other than peer support services, education support services and crisis residential services.

For Ongoing Rehabilitation and Support (ORS), any one of the following criteria, 1-4, must be met:

1. Member has a specific goal related to competitive employment.
2. Member should be competitively employed and regularly scheduled for at least 10 hours of work per week, with exceptions made for illness and vacation.
3. Member would benefit from support in managing their symptoms in a competitive workplace.
4. A member is not receiving Home and Community Services other than peer support services, education support services and crisis residential services.

### **Continued Stay Criteria**

All of the following criteria, 1-3, must be met:

1. The member continues to work towards goals, identified in an IRP.
2. Concurrent review and authorizations should occur at 3-month intervals for IR, ORS, and 6-month intervals for CRS and Clinic Treatment services. Continuing stay criteria may include:
  - a. The member has an active recovery goal and shows progress toward achieving it; OR
  - b. The member has met and is sustaining a recovery goal, but would like to pursue a new goal; OR
  - c. 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.
3. A member is not receiving Home and Community Services other than peer support services, education support services and crisis residential services.

For Intensive Rehabilitation and Ongoing Rehabilitation and Support, admission criteria continue to be met.

### **Discharge Criteria**

Any one of the following criteria, 1-4, must be met:

1. The member has sustained recovery goals for 6-12 months and a lower level care is clinically indicated.
2. The member has achieved current recovery goals and can identify no other goals that would require additional PROS services.
3. The member is not participating in a recovery plan and is not making progress toward any goals. Extensive engagement efforts have been exhausted, and there is insignificant expected benefit from continued participation.
4. The member can live, learn, work and socialize in the community with supports from natural and/or community resources.

For Intensive Rehabilitation, any one of the criteria, 1-3, must be met:

1. The member is no longer at risk of hospitalization, involvement in criminal justice system and community tenure is assured in which intensive rehabilitation is no longer required.
2. The member has achieved current recovery goals and can identify no other goals that would require intensive rehabilitation.
3. The member can live, learn, work and socialize in the community with supports from natural and/or community

For Ongoing Rehabilitation and Support, any one of the following, 1 -3, must be met:

1. The member no longer requires supportive services for managing symptoms in the competitive workplace.
2. The member no longer is seeking competitive employment.
3. The member has achieved current recovery goals and can identify no other goals that would require ongoing rehabilitation and support.

## Continuing Day Treatment (CDT)

Continuing Day treatment services assist individuals in beginning the recovery and rehabilitative process, providing supportive, transitional services to members that are no longer acutely ill, but still require moderate supervision to avoid risk and/or continue to re-integrate into the community or workforce. This structured, activity-based setting is ideal for members that continue to have significant residual symptoms requiring extended therapeutic interventions. Continuing Day treatment is focused on the development of a member's independent living skills, social skills, self-care, management of illness, life, work, and community participation, thus maintaining or enhancing current levels of functioning and skills. Members participating in treatment have access to crisis management, individual group, family therapy, and coordination with collateral contacts as clinically indicated. Treatment declines in intensity as members develop skills and attain specific goals within a reasonable timeframe allowing the transition to an outpatient setting with other necessary supports and longer-term supportive programming (i.e. clubhouse, employment, school, etc.). The minimum age for CDT is 18.

### Admission Criteria

All of the following criteria, 1-7, must be met:

1. Symptoms consistent with a DSM or ICD diagnosis.
2. Member's exacerbation or long standing psychiatric disorder and level of functioning requires daily support and structure;
3. The member has the motivation and capacity to participate and benefit from day treatment.
4. Treatment at a less intensive level of care would contribute to an exacerbation of symptoms.
5. Member is assessed to be at risk of requiring a higher level of care if not engaged in day treatment services.
6. Member/guardian is willing to participate in treatment voluntarily
7. Member's psychiatric/substance use/biomedical condition is sufficiently stable to be managed in a day treatment setting.

## **Exclusions**

Any of the following criteria are sufficient for exclusion from this level of care:

1. The individual is a risk to self or others, or sufficient impairment exists that a more intensive level of service is required.
2. The individual can be safely maintained and effectively treated at a less intensive level of care.
3. The individual does not voluntarily consent to admission or treatment, and/or refuses or is unable to participate in all aspects of treatment.
4. The individual requires a level of structure and supervision beyond the scope of the program.
5. The individual has medical conditions or impairments that would prevent beneficial utilization of services.
6. The primary problem is social, economic (i.e. housing, family conflict, etc.), or one of physical health without a concurrent major psychiatric episode meeting criteria for this level of care, or admission is being used as an alternative to incarceration

## **Continued Stay Criteria**

All of the following criteria, 1-6, must be met:

1. Member continues to meet admission criteria.
2. Another less intensive level of care would not be adequate to administer care.
3. Treatment is still necessary to reduce symptoms and increase functioning for the member to be transitioned to a less restrictive setting.
4. Medication assessment has been completed when appropriate and medication trials have been initiated or ruled out.
5. Family/guardian is participating in treatment as clinically indicated.
6. Coordination of care and active discharge planning are ongoing.

## **Discharge Criteria**

1. Any one of the following criteria, 1 -4, must be met; criteria 5 -6 recommended, but optional:
2. Member no longer meets admission criteria and/or meets criteria for another level of care, either more or less intensive.
3. Member or guardian withdraws consent for treatment.
4. Member does not appear to be participating in the treatment plan.
5. Member is not making progress toward goals, nor is there expectation of any progress.
6. Member's individual treatment plan and goals have been met.
7. Member's support system is in agreement with the aftercare treatment plan.

# **Intensive Psychiatric Rehabilitation Treatment Program (IPRT)**

An Intensive Psychiatric Rehabilitation Treatment program is time-limited with active psychiatric rehabilitation designed to assist an individual in forming and achieving mutually agreed upon goals in living, learning, working and social environments; to intervene with psychiatric rehabilitation technologies, to overcome functional disabilities from mental illness and to improve environmental supports. IPRT programs shall provide the following services: psychiatric rehabilitation readiness determination, psychiatric rehabilitation goal setting, psychiatric rehabilitation functional and resource assessment,

psychiatric rehabilitation service planning, psychiatric rehabilitation skills and resource development, and discharge planning.

### **Admission Criteria**

All of the following criteria 1-4 must be met

1. DSM or corresponding ICD diagnosis
2. Member has adequate capacity to participate in and benefit from this treatment.
3. Member has significant impairment in daily functioning due to a psychiatric illness or substance use of such intensity that the member cannot be managed in a lower level of care
4. Member is assessed to be at risk of requiring higher levels of care if not engaged in IPRT treatment.

### **Continued Stay Criteria**

All of the following criteria 1 -2 must be met

1. The member continues to meet admission criteria
2. One of the following is present:
  - a) The member has an active goal and shows progress toward achieving it.
    1. The member has met and is sustaining a recovery goal, but would like to pursue a new goal related to a functional deficit in one of the above areas.
    2. The member requires a IPRT level of care in order to maintain psychiatric stability; there is not a less restrictive level of care that is appropriate or without IPRT services; and the individual would require a higher level of care.

### **Discharge Criteria**

Any one of the following: Criteria 1, 2, 3, 4, 5, or 6:

1. The member no longer meets PRS level-of care criteria.
2. The member has sustained recovery goals for 3-6 months and a lower level of care is clinically indicated.
3. The member has achieved current recovery goals and can identify no other goals that would require additional IPRT services in order to achieve those goals.
4. The member is not participating in a recovery plan and is not making progress toward any goals.
5. Extensive engagement efforts have been exhausted and there is insignificant expected benefit from continued participation.
6. The member can live, learn, work and socialize in the community with supports from natural and/or community resources

## **Children’s Family Treatment and Support Services (CFTSS)**

CFTSS are new mental health and substance use services, available with NYS Children’s Medicaid, that give children/ youth (under age 21) and their families the power to improve their health, well-being, and quality of life. These services strengthen families and help them make informed decisions about their care. Services are provided at home or in the community. There are six CFTSS:

1. Other Licensed Practitioner(OLP)
2. Psychosocial Rehabilitation (PSR)
3. Community Psychiatric Support & Treatment (CPST)
4. Family Peer Support Services (FPSS)
5. Youth Peer Support and Training(Y PST)

## 6. Crisis Intervention(CI)

Please refer to the “Children’s Health and Behavioral Health Service Transformation –Medicaid State Plan Provider Manual for Children’s BH Early and Periodic Screening and Diagnostic Testing(EPSDT) Services” for additional information regarding these services.

### **Other Licensed Practitioner (OLP)**

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 and Family Therapist: or
- Licensed Mental Health Counselor

An NP-LBHP also includes the following individual 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**

Either one of the following criteria, 1 or 2, must be met:

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:

1. Correct or ameliorates conditions that are found through an EPSDT screening; OR
2. 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.

### **Continued Stay Criteria**

Any one of the following criteria, 1 or 2, and all of the criteria 3-6 must be met:

1. 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
2. Continuation of the services is needed to prevent the loss of functional skills already achieved AND
3. The child/youth continues to meet admission criteria AND
4. The child/youth and/or family/caregiver(s) continue to engage in services AND
5. An alternative service(s) would not meet the child/youth needs AND
6. The treatment plan has been appropriately updated to establish or modify ongoing goals.

### **Discharge Criteria**

1. Any one of the following criteria, 1 -6, must be met:
2. The child/youth no longer meets continued stay criteria OR

3. The child/youth has successfully reached individual/family established service goals for discharge;  
OR
4. The child/youth or parent/caregiver(s) withdraws consent for services; OR
5. The child/youth is not making progress on established service goals, nor is there expectation of any progress with continued provision of services; OR
6. 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
7. 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.

### **OLP Limits and Exclusions**

1. Groups must not exceed more than 6-8 members. Consideration maybe given to a smaller limit of participants are younger than eight years of age
2. Evidence Based Practice (EBPs) requires prior approval, designation, and fidelity reviews on an ongoing basis as determined necessary by New York State.
3. Inpatient hospital facilities are allowed for licensed professionals other than social workers if a Preadmission screening and Resident Review (PASRR) indicates it is medically necessary treatment. Social worker visits are included in the Nursing Facility Visits and may not be billed separately.
4. Visits to Intermediate Care Facilities for individual with Mental Retardation (ICF-MR) are not covered.
5. All NP-LBHP services provided while the person is a resident of an institution for Mental Disease, such as a free standing psychiatric hospital or psychiatric residential treatment facility, are part of the institutional service and not otherwise reimbursable by Medicaid
6. If a child requires medical necessary service that are best delivered in the school setting by a community provider the service needs to be detailed on the treatment plan
7. 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).
8. Evidence based practice (EBP) requires approval, designations, and fidelity reviews on an ongoing basis as determined necessary by New York State. Treatment service must be a part of a treatment plan including goals and activities necessary to correct ameliorates conditions discovered during the initial assessment visits.

### **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 as necessary for 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.

### **Admission Criteria**

All of the following criteria, 1-4, must be met:

1. The child/youth has a behavioral health diagnosis that demonstrates symptoms consistent or corresponding with the DSM; AND
2. The child/youth is likely to benefit from and respond to the service to prevent the onset or the worsening of symptoms; AND

3. 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
4. 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

### **Continued Stay Criteria**

All the following criteria, 1-5, must be met:

1. The child/youth continues to meet admission criteria; AND
2. The child/youth shows evidence of engagement towards 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
3. The child/youth does not require an alternative and/or higher, more intensive level of care or treatment; AND
4. The child/youth is at risk of losing skills gained if the service is not continued; AND
5. Treatment planning includes family/caregiver(s) and/or other support systems, unless clinically indicated or relevant

### **Discharge Criteria**

Any one of the following criteria, 1 -6, must be met:

1. The child/youth no longer meets admission criteria and/or meets criteria for another level of care, either more or less intensive; OR
2. The child/youth has successfully met the specific goals outlined in the treatment plan for discharge; OR
3. The child/youth or parent/caregiver(s) withdraws consent for services; OR
4. The child/you this not making progress or established service goals, nor is there expectation of any progress with continued provision of service; OR
5. The child/youth is no longer engaged in the services, 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

### **PSR Limits/Exclusions**

1. 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
2. A child with a development disability diagnosis without a co-occurring behavioral health condition is ineligible to receive this rehabilitative service

3. Group should not exceed more than 6-8 members. Consideration maybe given to a smaller limit of members if participants are younger than eight years old
4. Treatment service must be a part of a treatment plan including goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visits

## **Community Psychiatric Supports and Treatment (CPST)**

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 evidence based psychotherapeutic interventions approved by New York State.

CPST includes the following components: Rehabilitation Psychoeducation, Intensive Interventions, Strength Based Treatment Planning, Rehabilitative Supports, Crisis Avoidance, and Intermediate Team 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 rehabilitation 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**

All of the following criteria, 1-4, must be met:

1. 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
2. The child/youth is expected to achieve skill restoration in one of the following areas:
3. Participation in community activates and/or positive peer support networks
4. Personal relationships
5. Personal safety and/or self- regulation
6. Independence/productivity
7. Daily living skills
8. Symptom management
9. Coping strategies and effective functioning in the home, school, social or work environment; AND
10. The child/youth is likely to benefit from and respond to the service to prevent the onset or the worsening of symptoms, AND
11. 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

### **Continued Stay Criteria**

All of the following criteria, 1-5, must be met:

1. The child/youth continues to meet admission criteria; AND
2. The child/youth shows evidence of engagement towards 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
3. The child/youth does not require an alternative and/or higher, more intensive level of care or treatment; AND
4. The child/youth is at risk of losing skills gained if the service is not continued; AND
5. Treatment planning includes family/caregiver(s) and/or other support systems, unless clinical indicated or relevant

### **Discharge Criteria**

Any one of the following criteria, 1 -6, must be met:

1. The child/youth no longer meets admission criteria and/or meets criteria for another level of care, either more or less intensive; OR
2. The child/youth has successfully met the specific goals outlines in the treatment plan for discharge; OR 3) The child/youth or parent/caregiver(s) withdraws consent for services; OR
3. The child/youth is not making progress on established services goals, nor is there expectation of any progress with continued provision of services; OR
4. The child/youth is no longer engaged in services, despite multiple attempts on the part of the provider to apply reasonable engagement strategies; OR
5. The child/youth and/or family/caregiver(s) no longer needs this service as he/she is obtaining a similar benefit through other service and resources.

### **CPST Limits/Exclusions**

1. The provider agency will assess the child prior to developing a treatment plan for the child
2. Treatment service must be part of the treatment plan including goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visit
3. A child with a developmental disability diagnosis without a co-occurring behavioral health condition is ineligible to receive this rehabilitative services
4. Group face-to-face may occur for Rehabilitative Supports
5. Group should not exceed more that 6-8 members. Consideration maybe given to a smaller limit of members if participants are younger than eight years of age
6. Evidence-Based practices (EBP) requires prior approval, designations, and fidelity reviews on an ongoing basis as determined necessary by New York State (Medicaid State Plan Provider Manual for Children's BH Early and Periodic Screening and Diagnostic Testing Services, Appendix D).
7. The institute of medicine (IOM) defines "evidence based practice" as a combination of the following three factors: (1)best research evidence,(2) best clinical experience, and (3)consistent with patient values(1 OM, 2 001). Implemented interventions using evidence-based techniques may ameliorate targeted symptoms and/or recover the person's capacity to cope with or prevent symptom manifestation.

### **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 abuse, 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.

This 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.

## **Admission Criteria**

Any of the following criteria, 1 or 2, and all criteria 3-5 must be met:

1. The child/youth has a behavioral health diagnosis that demonstrates symptoms consistent or corresponding with the DSM OR
2. The child/youth displays demonstrated evidence of skill(s) lost or underdeveloped as a result of the impact of their physical health diagnosis; AND
3. The child/youth is likely to benefit from and respond to the service to prevent the onset or the worsening of symptoms; AND
4. The child/youth's family is available, receptive to and demonstrates needs for improvement in the following areas such as but not limited to:
  5. Strengthening the family unit
  6. Building skills within the family for the benefit of the child
  7. Promoting empowerment within the family
  8. Strengthening overall supports in the child's environment; AND
9. 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

## **Continued Stay Criteria**

All of the following criteria, 1-7, must be met:

1. The child/youth continues to meet admission criteria; AND
2. The child/youth is making progress but has not fully reached established service goals and there is a reasonable expectation that continued service will increase the child/youth meeting service goals; AND
3. Family/caregiver(s) participation in treatment is adequate to meaningfully contribute to the child/youth's progress in achieving service goals; AND
4. 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
5. The child/youth does not require an alternative and/or higher, more intensive level of care or treatment; AND
6. The child/youth is at risk of losing skills gained if the service is not continue; AND
7. Treatment planning includes family/caregiver(s) and/or other support systems, unless not clinically indicated or relevant

## Discharge Criteria

Any one of the following criteria, 1 -6, must be met:

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

## FPSS Limits/Exclusions

1. The provider agency will assess the child prior to developing the treatment plan for the child.
2. Treatment service must be part of the treatment plan including goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visit
3. A child with a development disability diagnosis without a co-occurring behavioral health condition is ineligible to receive this rehabilitative service
4. A group cannot exceed more than 12 individuals in total
5. The treatment 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 a note of 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 intervention plan should be developed if there is no measurable reduction of disability or restoration of functional level. The new plan should identify different rehabilitation strategy with revised goals and services
6. Medicaid family support programs will not reimburse for the following:
  - 12 -step groups 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 service, 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, a 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 individual 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 authorized treatment plan
  - Service not in compliance with the service manual and not in compliance with State Medicaid standards

- Services provided to children, spouses, 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

## **Youth Peer Support and Training (YPST)**

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**

One of the following criteria, 1 or 2, and all criteria 3-6 must be met:

1. The youth has a behavioral health diagnosis that demonstrates symptoms consistent or corresponding with the DSM; OR
2. The youth displays demonstrated evidence of skill(s) lost or undeveloped as a result of the impact of their physical health diagnosis; AND
3. The youth requires involvement of a youth peer advocate to implement the intervention(s) outlines in the treatment plan, AND
4. The youth demonstrates a need for improvement in the following areas such as but not limited to
  5. Enhancing youth's abilities to effectively manage comprehensive health needs
  6. Maintaining recovery
  7. Strengthening resiliency, self-advocacy
  8. Self-efficacy and empowerment
  9. Developing competency to utilize resources and supports in the community
10. Transition into adulthood or participates in treatment ; AND
11. The youth is involved in the admission process and help determine service goals; AND
12. The Youth is available and receptive to receiving this service; AND
13. 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

### **Continued Stay Criteria**

All of the following criteria, 1-5, must be met:

1. The youth continues to meet admission criteria; AND
2. The youth shows evidence of engagement towards 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
3. The youth does not require an alternative and/or higher, more intensive level of care or treatment; AND
4. The youth is at risk for losing skills gained if the service is not continued; AND
5. Treatment planning includes family/caregiver(s) and/or other support systems, unless not clinically indicated

### **Discharge Criteria**

Any one of the following criteria, 1 -6, must be met:

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

### **YPST Limits/Exclusions**

1. The provider agency will assess the child prior to developing the treatment plan for the child.
2. Treatment service must be part of the treatment plan including goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visit
3. A youth with a development disability diagnosis without a co-occurring behavioral health condition is ineligible to receive this rehabilitative service
4. A group is composed of 2 or more youths and cannot exceed more than 12 individuals in total
5. 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 a note occurrence 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 service 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 strategy with revised goals and services
6. Medicaid family support programs will not reimburse for the following
  - 12-step groups 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 service, 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 personal such as, but not limited to, a teacher, a 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 individual 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 authorized treatment plan
- Service not in compliance with the service manual and not in compliance with State Medicaid standards
- Services provided to children, spouses, 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

## **Crisis Intervention (CI)**

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 maybe 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.

## **Admission Criteria**

All of the following criteria, 1-4, must be met:

1. The child/youth experiencing acute psychological/emotional changes 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
2. The child/youth demonstrates at least one of the following:
3. Suicidal/assaultive/destructive ideas, threats, plans or actions that represent a risk to self or others; or
4. Impairment in mood/thought/behavior disruptive to home, school, or the community or
5. Behavior escalating to the extent that a higher intensity or service will likely be required; AND
6. The intervention is necessary to further evaluate, resolve, and/or stabilize the; AND
7. 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

### **Continued Stay Criteria**

N/A

### **Discharge Criteria**

Any one of the following criteria, 1 or 2, must be met:

1. 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
2. The child/youth or parent/caregiver(s) withdraws consent for services

### **Crisis Intervention Limits/Exclusions**

1. 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 medication occurs, as appropriate, and a crisis plan is developed with the child/family. Warm handoff to providers of needed services should be occurring following this expectation.
2. The following activities are excluded, financial management, supportive housing, supportive employment services, and basic skill acquisition services that are habilitative in nature
3. Services may not be primarily educational, vocational, recreational, and 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 recipients 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.
4. The child/youth's chart must reflect resolution of the crisis, which marks the end of the episode. Warm hand off to follow up service with a developed plan should follow.

## **Adult's Home and Community Based Services (HCBS)**

Home and Community Based Services (HCBS) provide opportunities for Medicaid beneficiaries with mental illness and/or substance use disorders who are enrolled in a Health and Recovery Plan (HARP) to receive services in their own home or community. Implementation of HCBS will help to create an environment where managed care plans (Plans), Health Home care managers, service providers, plan members and their chosen supporters/caregivers, and government partners help members prevent, manage, and ameliorate chronic health conditions and recover from serious mental illness and substance use disorders.

These review guidelines provide a framework for discussion between HCBS providers and Plans. The review process is collaboration between all pertinent participants including but not limited to the Health Home care manager, HCBS provider, Plan and member to review progress and identify barriers or challenges that may be interfering with a reasonable expectation of progress towards the member's chosen goals. These conversations will focus on the member's needs, strengths, and history in determining the best and most appropriate fit of the services. These review guidelines are applied to determine appropriate care for all members. In general, services will be authorized if they meet the specific criteria for a particular service. The individual's needs, choice, and characteristics of the local service delivery system and social supports are also taken into consideration.

HCBS eligibility will be determined using a standard assessment tool, typically administered by the individual's Health Home(HH) care manager. Provision of Home and Community Based Services requires a person-centered approach to care planning, service authorizations, and service delivery.

MCO utilization management for HCBS must conform to guidelines listed in the NYS HCBS Provider Manual (latest version available at: <https://www.omh.ny.gov/omhweb/guidance/hcbs/html/services-application/>).

This manual outlines how HCBS care planning and utilization management emphasizes attention to member strengths, goals and preferences, and also ensures member choice of service options and providers. The following is a description of the various HCBS services:

## **Vocational Services**

Many of the HCBS services are designed to be provided in clusters that promote recovery along a spectrum and as such, Employment Support Services are grouped as a cluster and include Pre-Vocational Services, Transitional Employment, Intensive Supported Employment, and Ongoing Supported Employment.

### **Pre-vocational Services**

Pre-vocational services are time-limited services that prepare a participant 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 participant's stated career objective and a career plan used to guide individual employment support.

### **Transitional Employment (TE)**

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.

### **Intensive Supported Employment (ISE)**

ISE services that assist individuals with MH/SUD 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 will follow the 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 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 providing supports to participants who need ongoing support to learn a new job and maintain a job in a competitive employment or self-employment arrangement. Participants 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 participant's stated career objective and a career plan used to guide individual employment support. Services that consist of intensive supports that enable participants for whom competitive employment at or above the minimum wage is unlikely, absent the provision of supports, and who, because of their disabilities, need supports to perform in a regular work setting.

### **Ongoing Supported Employment**

This service is provided after a participant successfully obtains and becomes oriented to competitive and integrated employment. Ongoing follow-along is support available for an indefinite period as needed by the participant to maintain their paid employment position. Individual employment support services are individualized, person-centered services providing supports to participants who need ongoing support to learn a new job and maintain a job in a competitive employment or self-employment arrangement.

Participants 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 participant's stated career objective and a career plan used to guide individual employment support.

### **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. Education Support Services may consist of general adult educational services such as applying for and attending community college, university or other college-level courses. 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. Participants authorized for Education Support Services must relate to an employment goal or skill development documented in the service plan.

Education Support Services must be specified in the service plan as necessary to enable the participant to integrate more fully into the community and to ensure the health, welfare and safety of the participant. Examples of these goals would include, but not be limited to: tutoring or formal classes to obtain a Test Assessing Secondary Completion (TASC) diploma, vocational training, apprenticeship program or formal

classes to improve skills or knowledge in a chosen career, community college, university or any college-level courses or classes.

## **Habilitation/Residential Support Services**

Habilitation services are typically provided on a 1:1 basis and are designed to assist participants 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 participants 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**

All of the following criteria, 1-7, must be met:

1. The member must be deemed eligible to receive HCBS using the HCBS Eligibility Assessment tool.
2. Where the member has been deemed eligible to receive services, a Level of Service Determination is made to ensure recommended HCBS are appropriate for meeting the member's identified goals, and appropriate HCBS provider(s) are identified in a conflict-free manner.
3. Upon receipt of notification from the HCBS provider(s), up to 3 visits over 14 days is authorized for intake and evaluation.
4. The BH Prior and/or Continuing Authorization Request Form is submitted by the HCBS provider(s) for Prior Authorization and includes service scope, duration and frequency.
5. The service request must support the member's efforts to manage their condition(s) while establishing a purposeful life and sense of membership in a broader community.
6. The member must be willing to receive home and community based services.
7. There is no alternative level of care or co-occurring service that would better address the member's clinical needs.

### **Continued Stay Criteria**

All of the following criteria, 1-5, must be met:

1. Member continues to meet admission criteria and an alternative service would not better serve the member.
2. Interventions are timely, need based as per the CMHA (Full Assessment), consistent with evidence based/best practice, and provided by a designated HCBS provider.
3. One of the following is present:
4. Member is making measureable progress towards a set of clearly defined goals; Or
5. There is evidence that the service plan is modified to address the barriers in treatment progression; Or
6. Continuation of services is necessary to maintain progress already achieved and/or prevent deterioration.
7. There is care coordination with physical and behavioral health providers, State, and other community agencies.
8. Family/guardian/caregiver is participating in treatment where appropriate.

In addition, determination of progress and modifications to goals/objectives are made by reviewing the BH HCBS Prior and/or Continuing Authorization Request Form and/ or with a telephonic review with the provider.

## Discharge Criteria

Any one of the following criteria,1 -5,must be met; criteria 6 is recommended, but optional:

1. Member no longer meets admission criteria and/or meets criteria for another more appropriate service, either more or less intensive.
2. Member or parent/guardian withdraws consent for treatment.
3. Member does not appear to be participating.
4. Member's needs have changed and current services are not meeting these needs. Member's self-identified recovery goals would be better served with an alternate service and/or service level. As a component of the expected discharge, alternative services are being explored in collaboration with the member, the member's family members (if applicable), Health Home, HCBS provider, and MCO.
5. Member's goals have been met.
6. Member's support system is in agreement with the aftercare service plan.

## Children's Home and Community Based Services (HCBS)

### Requirements Applicable to All Services

The requirements contained in this section are applicable to all Children's Waiver HCBS. Additional details regarding the required components of each service, the modalities and settings appropriate for the service, provider agency and staff qualifications, service necessity requirements, continued stay and discharge criteria, and utilization expectations can be found in the service-specific sections below.

#### A. Definition

HCBS are community-based services to prevent the need for institutional care such as psychiatric hospitalization, residential treatment, or nursing home admission, or to assist the participant to return to their home and community after discharge from an institutional level of care. To be eligible for Children's Waiver HCBS, participants must have a medical condition, developmental disability, and/or serious mental health disorder that impacts their daily functioning and that places them at imminent risk of hospitalization or institutionalization, or results in the need for supports to return safely home and to their community after discharge from an institutional level of care. All services must be provided based on the participant's assessed needs and goals, and must be necessary to assist a waiver participant to avoid institutionalization and function in the community.

This policy provides definitions for each HCBS in each of the service-specific sections below.

#### B. Service Components

This policy contains the service components of each HCBS in each of the service-specific sections below.

#### C. Modality

HCBS cannot be provided via telehealth. Additional details on staffing ratios and group services are provided in each of the service-specific sections below.

#### D. Setting

Services are required to be offered in the least restrictive setting for the desired outcomes, including the most integrated home or other community-based settings where the participant lives, works, engages in services, and/or socializes. It also includes settings 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.

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

HCBS cannot be provided in residential or institutional settings providing comprehensive care, including, but not limited to hospitals, residential treatment facilities, skilled nursing facilities, and other institutional settings where a participant resides. Furthermore, individuals residing in certain residential or institutional settings are not eligible to receive HCBS when HCBS would be considered duplicative of services provided in the residential or institutional setting in which the member resides, regardless of where the HCBS is delivered. However, some individuals residing in restricted settings may be eligible for HCBS, if the HCBS is not duplicative of services provided in the residential setting and if they are provided at another allowable location. Refer to Appendix A of this document, the HCBS Settings Final Rule Compliance Policy, and the HCBS Manual for additional information on HCBS setting restrictions.

Unless the service definition allows for services to be provided to groups of participants, HCBS must be provided to individual participants, based upon their individualized assessed needs and goals.

Additional information on disenrollment of participants residing in ineligible settings can be found in the Children's HCBS Eligibility and Enrollment Policy.

Additional details on settings requirements are provided in each of the service-specific sections below.

#### E. Limitations/Exclusions and Utilization

Waiver services complement and/or supplement the services that are available through the Medicaid State plan and other federal, state and local public programs, as well as the supports that families and communities provide to individuals,<sup>1</sup> and when applicable, third-party insurance coverage. HCBS cannot duplicate or replace services otherwise available to the participant, including services available through the Medicaid State Plan, Section 110 of the Rehabilitation Act of 1973 (Rehabilitation Act), the Individuals with Disabilities Education Act (IDEA), private insurance, or Medicare<sup>2</sup> HCBS are not an appropriate substitute for medically necessary care covered under the state plan such as Early Intervention (EI), Applied Behavior Analysis (ABA) therapy, mental health assessment and treatment, physical therapy, occupational therapy, speech therapy, personal care assistance, and private duty nursing.

Rehabilitation services, which are services intended to restore and improve skills and function that have been lost or impaired, are available as State Plan services. For example, Psychosocial Rehabilitation is covered for participants whose skill performance has been impacted due to behavioral health conditions. Habilitation Services available under the Children's Waiver, which are intended to help individuals with intellectual/developmental disabilities acquire, retain, and improve skills are not appropriate substitutes for rehabilitation services authorized under the State Plan.

Children's HCBS is not billable when provided while another billable Medicaid service is provided, except in limited circumstances. Services that are substantively equivalent but cover care gaps because the procedures or form of that service is different in parameters such as time, quantity or acuity of service may be an exception. This is only permissible when HCBS is not duplicative in any way of the other services being provided. For example, it is not appropriate for Respite to be provided while the participant is receiving another service that includes general supervision of the child in the caregiver's absence, such as applied behavior analysis, or personal care assistance. It is not appropriate for habilitation services to be provided/billed at the same time that a child is receiving some form of medically necessary therapy. However, it may be appropriate for a child to receive palliative care while also receiving private duty nursing services. HCBS providers must coordinate with the care manager and family to ensure services are coordinated to avoid duplication and ensure appropriate scheduling of services. When it is necessary for the participant to receive more than one service simultaneously, the rationale must be documented in the

member's record or plan of care, explaining the need for a combination of services and how the services complement each other.

When appropriate and necessary during HCBS delivery, direct care workers may attend to the participant's medical and non-medical needs and other ADLs which would ordinarily be performed by a caregiver or family member. However, unlicensed direct care workers are not permitted to utilize medical equipment, administer medications, or utilize medical devices without appropriate training by a licensed professional. If requested by the family, determined appropriate by a clinician, and approved by the designated HCBS agency, an appropriately licensed professional such as a registered nurse, physical therapist, or occupational therapist may provide training to the direct care staff member to provide limited medical supports that do not require licensure.

Documentation of staff training must be maintained in the participant/staff record. All services must be provided in alignment with the service definition.

Some HCBS allow for both an Individual and Group modality. Group and Individual billing for the same service cannot overlap.

Services cannot be provided during school hours to participants attending school.

Additionally, Children's HCBS is not a substitute for parenting, babysitting, childcare, or generalized supervision. HCBS must be provided in a professional capacity with a clearly defined need that exceeds general childcare needs. HCBS does not replace the role of the parent/caregiver in fostering skill development essential to typical child development.

Children's HCBS cannot duplicate or replace the role of the participant's care manager.

Additional details on limitations/exclusions and utilization are provided in each of the service-specific sections below.

The anticipated utilization ranges in each of the service-specific sections below are provided as a guideline to assist in developing the HCBS Service Plan and is not a guaranteed or appropriate for all HCBS participants. Frequency of services may be different for participants in school versus participants who have graduated/aged out of school settings and must take into consideration the participant's age, development, and condition, along with the participant's other appointments and activities.

#### F. Certification/Provider Qualifications

In addition to staff meeting the service-specific provider qualifications, staff must be able to safely and effectively serve the participant. It is the responsibility of the HHCM/C-YES to share adequate information about the participant's needs as part of the HCBS referral to allow the provider to determine if they can meet the participant's need(s) in alignment with the service definition and requirements. It's the responsibility of the designated agency to ensure that HCBS staff have adequate knowledge and skills to address the individual participant's needs (including but not limited to physical and/or medical needs such as positioning or technology) OR have made arrangements for an appropriately trained and knowledgeable individual to address the individual participant'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 participant while in a Respite setting.

#### Provider Agency Qualifications

- Practitioners must operate in agencies that have been designated through the NYS Children's Provider Designation Review Team. This requires that agencies have appropriate license, certification, and/or approval in accordance with State designation requirements.
- Provider agencies and practitioners must adhere to all Medicaid requirements in this policy and in other applicable provider policies, manuals, regulations, and statutes.
- Provider agencies must adhere to cultural competency guidelines.
- Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.

- The provider agency must ensure that staff receive Mandated Reporting training prior to service delivery.
- The provider agency must ensure that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable.
- The provider agency must ensure that any insurance required by the designating state agency is obtained and maintained.
- The provider agency must ensure that any safety precautions needed to protect the participant population served are taken as necessary and required by the designating State agency.
- Additional information and application for Children's HCBS can be found on the Department of Health (DOH) website.
- Each service has specific qualification requirements for staff delivering services. In addition, certain provider agency and supervisory requirements may apply for some services.

Individual Staff Qualifications:

- Staff who provide direct care to participants under the age of 21 are required to have a Criminal History Record Check (CHRC) through DOH.
- The provider agency is required to conduct a Staff Exclusion List (SEL) check through the NYS Justice Center for the Protection of People with Special Needs (Justice Center) for all staff that will have regular and substantial contact with individuals under the age of 21.
- The provider agency is required to conduct a Statewide Central Register (SCR) Database check through OCFS for those employees that will have regular and substantial contact with participants, which includes but is not limited to HCBS providers. Additional information about background check requirements can be found in the HCBS Background Check Policy.
- To ensure a Children's Waiver enrollee's autonomy, preserve Freedom of Choice and reduce the potential for conflicts of interest, staff providing Children's HCBS cannot be immediate family members, individuals that are legally or financially responsible for the HCBS-enrolled youth/child, or an individual residing in the same residence as the HCBS-enrolled child/youth.

HCBS provided by any of the following individuals to a Children's Waiver enrollee is not eligible for reimbursement:

An immediate family member, which is defined as:

- Parent (biological, adoptive, or in-law)/stepparent/foster parent
- Grandparent or any variation (e.g., great grandparent, step-grandparent)
- Child or sibling (biological, adoptive, or in-law)/stepsibling
- Current or former spouse
- Any individual residing in/living in the home of the HCBS enrollee.
- An individual who is legally or financially responsible for the HCBS-enrolled child/youth which includes:
  - A Parent or Legal Guardian
  - Legally Responsible Individual (LRI)/ Legally Authorized Representative (An LRI is any person who has a duty under state law to care for another person and includes: (a) the parent (biological, adoptive, foster, or step) or guardian of a minor child or (b) a spouse of a waiver enrollee)
  - Individual who is financially responsible for the HCBS enrollee

Conflicts of interest are not limited to the list of individuals above and may exist in relationships beyond those included in this list. If a relationship with an individual, such as a distant relative or friend could affect the enrollee/family's freedom of choice or present a conflict of interest, then that individual should not provide HCBS to the enrollee. It is the responsibility of the Designated HCBS Provider to determine if a potential conflict of interest is present in a potential staffing relationship (due to family, social, personal, or other reasons) and make staffing decisions accordingly.

Additional details on provider requirements are found in each of the service-specific sections below.

## G. Service Admission Requirements

HCBS may only be provided when the following criteria are met:

1. The participant was found HCBS eligible by a Health Home Care Manager (HHCM), Children and Youth Evaluation Service (C-YES) assessor, or an allowed Office of Mental Health Single Point of Access through conducting the HCBS Eligibility Determination.
2. The HCBS Eligibility Determination is active within 365 days from being completed.
3. The Participant has active K-codes.
4. The participant is enrolled in care management either through HHCM or C-YES.
5. The need for the service has been assessed, determined, and authorized in alignment with the service definition as part of the person-centered planning process.
6. The service is identified in the participant's Service Plan and Plan of Care and is associated with specific attainable goal(s) and outcome(s) to enhance the participant's ability to remain in the home/community.
7. A referral for HCBS that outlines the assessed needs and goals of the participant and the requested service, has been made to a designated HCBS provider from a HHCM/C-YES.
8. When making a referral for HCBS, the care manager must explain the types of services recommended and provide the participant/family with the applicable HCBS Service Information Sheet. The care manager must document in the participant's record that this information was provided.

Additional details on service necessity requirements are provided in each of the service- specific sections below.

## H. Service Necessity Documentation

Prior to any HCBS delivery, the HCBS provider must receive a referral from the participant's HH/C-YES care manager. It is the responsibility of the HCBS provider to evaluate the referral for appropriateness and confirm the participant's eligibility prior to delivery of any HCBS. After determining appropriateness, the HCBS provider can provide HCBS for the Initial Service Period. The Initial Service Period is the period of time after accepting an HCBS referral but prior to submitting an HCBS Authorization Request lasting up to 96 units/24 hours or 60 days (whichever comes first). The Initial Service Period begins on the first date of billable service for the participant and is service specific. The Initial Service Period is used to complete an intake assessment, to finalize service goals, and objectives, and determine Frequency/Scope/Duration (F/S/D) for the service. If the service is needed beyond the Initial Service Period, an HCBS Authorization is needed.

The HCBS provider must maintain documentation that clearly substantiates the need for services to support the participant remaining in the home/community and must support the proposed frequency, scope, and duration of the service. The HCBS provider should work with the participant's other involved care professionals and the care manager to obtain documentation to support the proposed level of service provision and appropriateness for the type and amount of service being offered to meet the participant's identified need and goals. This may include assessments completed by the HCBS provider or a licensed professional, applicable evaluations conducted by a licensed practitioner, test results, diagnoses from licensed practitioners, school information, documentation of presenting problem(s), and/or demonstration of functional limitations. Documentation may vary by service and by participant but may include any intake evaluation/assessments completed by the provider, documentation from a licensed professional working with the participant indicating the need for services, and/or other evaluations outlining the participant's needs. Ongoing service progress notes should illustrate service necessity by outlining interventions utilized to meet the goals/objectives, responses from the participant/family, progress made towards goals, and ongoing communication with the care manager and other service providers.

Service utilization that exceeds the service limits (i.e., annual, monthly, daily, dollar amount) is expected to be rare, temporary, and must be necessary to prevent institutionalization and support the participant remaining in the home/community. As outlined in the Documentation Policy, service authorization requests in excess of the service limits must be justified by documentation from a third-party involved in the member's care demonstrating this need. Third-party entities are entities external to the HCBS provider, the

care management agency, and the Health Home, or if this documentation is provided by a clinician within the same organization as the HCBS provider or care manager, there are firewalls between the HCBS/care management functions and the clinician, consistent with the principles of Conflict-Free Case Management (CFCM). Additionally, there must be documentation in the case record that the multidisciplinary care team has determined a need for HCBS in excess of the service limits to prevent institutionalization, determined whether other services are appropriate, and has established a plan to monitor the participant's progress.

HCBS providers must develop and maintain a Service Plan for all HCBS provided. If a participant receives multiple HCBS, the goals for each service must be distinctly different from goals associated with other HCBS provided. Additional details about Service Plan and documentation requirements can be found in the Provider Service Delivery Documentation Policy for Children's HCBS.

HCBS providers should maintain documentation in the record to justify ongoing delivery of HCBS. This includes documentation of goals that have been accomplished through services so far, what is still needed to be accomplished, and what barriers are impacting participant outcomes, if applicable, as well as how these barriers are/will be resolved. The Service Plan must be updated to modify ongoing goals, and timeframe and the care manager/HCBS provider is responsible for maintaining documentation that ongoing services are necessary.

Additional details on service necessity documentation requirements are provided in each of the service-specific sections below.

#### I. Continued Stay Criteria

Ongoing delivery of HCBS is appropriate when the participant remains Waiver eligible and either of the following criteria are met:

1. the participant/family is making progress but has not fully reached established service goals, and there is a reasonable expectation that continued services will increase the likelihood of the participant meeting the service goals, or
2. the participant is at risk of losing skills gained if the service is not continued.
3. Additional details on continued stay criteria are provided in each of the service-specific sections below.

#### J. Service Discharge Criteria

Discharge from an HCBS is appropriate when any of the following apply:

1. Participant/family has successfully met their specific goal outlined in their Service Plan and no longer needs the service, OR
2. Participant no longer meets Children's Waiver eligibility criteria, transitions to OPWDD waiver services, or is admitted to an excluded residential or institutional setting, OR
3. Participant/family no longer wishes to receive the service or withdraws consent for the service, or transitions to other more appropriate services, OR
4. Participant is no longer engaged in the service despite multiple attempts on the part of the provider to apply reasonable engagement strategies.

Additional details on service discharge criteria are provided in each of the service-specific sections below.

## Community Habilitation

### A. Definition

Habilitation Services are designed to assist participants to acquire, retain, and improve skills necessary to reside successfully in home and community-based settings. Activities are designed to foster the acquisition of skills, building positive social behavior and interpersonal competence, greater independence, and personal choice.

Community Habilitation is an in-person service intended to support the participant's acquisition, maintenance, and enhancement of skills necessary to perform Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), or Health-Related Tasks. The service is delivered in the community (non-certified) settings.

Acquisition refers to the development of a new skill intended to foster greater independence by allowing a participant 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 means preventing or slowing regression in the participant's skill level and to prevent loss of skills necessary to accomplish identified tasks.

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

Habilitation services, defined above, are distinguished from Rehabilitation services, which are services intended to restore and improve skills and function that have been lost or impaired. Participants whose skill performance has been impacted due to behavioral health conditions must be served using Psychosocial Rehabilitation, a State Plan service, rather than Habilitation Services in the waiver.

## **B. Service Components**

Individuals appropriate for this service will have an assessed need for support with age-appropriate ADLs, IADLs, or Health-Related Tasks, beyond supports necessary to support typical child development. This service is intended 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 participants who have the capacity to learn to live in the community, with or without support. It is not permissible for this service to be used solely for the HCBS provider to complete the ADLs/IADLs listed below on behalf of the participant. Instead, the service must be geared towards teaching and/or enhancing the skills of the participant to increase their capacity to complete the ADLs/IADLs on their own. Goals associated with this service should outline specific objectives to be achieved through acquisition, maintenance, and enhancement of skills associated with age-appropriate ADLs, IADLs and Health-Related Tasks. Service delivery should be based on a prepared curriculum with a predictive goal achievement timeframe that can be altered towards the individual's needs, development, and experience and monitoring of progress.

ADLs, are basic self-care tasks that include:

- Walking and/or otherwise getting around the home or outside.
- Feeding, as in being able to get food from a plate into one's mouth.
- Dressing and grooming including selecting clothes, putting them on, and adequately managing one's personal appearance.
- Toileting, including getting to and from the toilet, using it appropriately, and cleaning oneself.
- Bathing/hygiene including washing face and body in the shower or bath.
- Transferring, defined as being able to move from one body position to another. This includes being able to move from a bed to a chair, or into a wheelchair. This can also include the ability to stand up from a bed or chair in order to grasp a walker or other assistive device.

IADLs are self-care tasks that include:

- Managing finances, such as paying bills, budgeting, banking, and managing financial assets.
- Managing transportation, either via driving or by taking other means of transport in the community.

- Shopping and meal preparation, this covers everything required to get a meal on the table. It also covers shopping for clothing and other items required for daily life.
- Housecleaning and room/home maintenance, this means cleaning kitchens after eating, keeping one's living space reasonably clean and tidy, and keeping up with home maintenance.
- Managing communication, such as the telephone, mail and electronic forms of communication.
- Managing medication, including obtaining medications and taking them as directed, including pouring, administering, and recording medications.
- Learning the skills needed to maintain personal safety in the home and community such as safety procedures, emergency contacts and responses.
- Health management skills, including performing simple measurements and tests; assisting with the preparation of complex modified diets; assisting with a prescribed exercise program; assisting with the use of medical equipment, supplies, and devices; assisting with special skin care; assisting with a dressing change; assisting with appointments, and how to prepare for a medical appointment (sharing information of effects of condition/medication, etc. and asking questions).
- Interacting with members of the community and maintaining religious practices, hobbies, or other interests.

Health Related Tasks include:

- Performing simple measurements and tests;
- Assisting with the preparation of complex modified diets;
- Assisting with a prescribed exercise program;
- Pouring, administering and recording medications;
- Assisting with the use of medical equipment, supplies and devices;
- Assisting with special skin care;
- Assisting with a dressing change; and
- Assisting with ostomy care.

Examples of appropriate Community Habilitation activities include:

- Providing opportunities for participants to acquire, retain, or strengthen age-appropriate socialization skills, communication skills, and/or adaptive skills that support their independence and involvement in the community.
- Teaching age-appropriate activities of daily living including hygiene tasks, establishing routines, dressing appropriately, etc.
- Teaching participants how to complete age-appropriate daily tasks such as laundry, cooking, personal hygiene, etc.
- Teaching participants how to manage age-appropriate health-related tasks, such as taking medications, preparing healthy meals, or using adaptive/assistive technology.
- Teaching and practicing age-appropriate time management, planning skills, and developing systems for managing tasks/scheduling (i.e. activity charts, etc.).
- When Community Habilitation is provided to help a participant acquire the skills to navigate travel from one location in the community to another, this service may include the assistance provided by a direct care worker to accompany the participant while learning the skill. The in-person service time when a direct care worker is assisting or providing transportation to an individual may also be billed as part of the Community Habilitation service.

### **C. Modality**

Individual Community Habilitation is provided in-person by 1 staff member to 1 participant.

Group Community Habilitation is provided in-person by 1 staff member to up to 3 participants. Participant to staff ratio cannot exceed 3:1. The group modality is only appropriate if participants in the group have

similar goals, and the group activities are appropriately geared toward the goals of all members of the group.

#### **D. Setting**

Refer to Requirements Applicable to All Services.

These services can be delivered in community settings. Such settings include, but are not limited to the participant's home, which may be owned or rented, or a work setting. This service cannot be provided in a OPWDD certified setting, regardless of where the participant resides.

#### **E. Limitations/Exclusions and Utilization**

Refer to Requirements Applicable to All Services.

Community Habilitation is limited to 6 hours (24 Units) per day (all Community Habilitation combined), 12 hours (48 Units) per month (all Community Habilitation combined), and 144 hours (576 Units) per calendar year (all Community Habilitation combined). However, not all participants will require this level of support. Frequency, scope, and duration of the service must be necessary to support the participant remaining in the home or community.

**Ages 0 through 6:** Anticipated Utilization: (0 units) per month (all Community Habilitation combined),

At this age, skill building is typically met through parental support/natural caregivers and use of services such as Early Intervention (EI) and daycare/preschool services. If Habilitative services are necessary at this age, they are typically provided by licensed practitioners including Occupational Therapy, Physical Therapy, and Speech Therapy, not Community Habilitation.

**Ages 7 through 13:** Anticipated Utilization: 0-6 hours (24 units) per month (all Community Habilitation combined),

At this age, Community Habilitation typically involves reinforcing skills, behaviors, or lessons taught in other settings, supporting skill development and retention when not available through BOCES, or other school/community programming. It may include reinforcing or practicing skills and abilities associated with physical, occupational, or speech therapies, if the direct support provider is appropriately trained, or supports with time management, hygiene, and organization for school and home life, supporting a developmentally appropriate level of independence,

**Ages 14 through 20:** Anticipated Utilization: 0-12 hours (48 units) per month (all Community Habilitation combined)

At this age, Community Habilitation typically involves supports with time management, hygiene, and organization for school and home life and/or supports for developmentally appropriate independence, including transition into adulthood/independent living, when not available through BOCES, or other school/community programming.

#### **F. Certification/Provider Qualifications**

Provider Agency Qualifications

- Refer to Requirements Applicable to All Services.
- Agencies must also be certified by the New York State Office for People with Developmental Disabilities (OPWDD).

Individual Staff Qualifications

- Refer to Requirements Applicable to All Services.
- Community Habilitation services will be performed by direct care workers who meet the licensure and certification requirements for providers approved by OPWDD to provide Community Habilitation.
- Direct support professionals must be employed by the designated agency and have completed the training stipulated in 14 NYCRR 633.8 and the Direct Support Professionals Core Competencies curriculum.

Additional information can be found in the DSP Core Competencies section of the OPWDD website.

### **G. Service Admission Requirements**

Refer to Requirements Applicable to All Services.

The HCBS Provider must conduct an assessment of the participant's functional level of ADLs/IADLs to determine the support that is needed and to establish goals, and objectives and determine when they are met.

Community Habilitation may be provided when the following criteria are met:

- There is evidence of an assessed need for support to build skills to independently complete age-appropriate ADLs or IADLs which may include a diagnosis of a developmental disability by a licensed practitioner, an assessment from a licensed professional noting delays in completing ADLs, or IADLs which are not associated with age; or other evidence justifying the need for support with ADLs or IADLs beyond supports necessary to support typical child development.
- The identified need can be met by a habilitation service focused on gaining, keeping, and improving ADL, IADL, or health-related skills of the individual.
- Community Habilitation is identified in the participant's Service Plan and Plan of Care and is associated with specific attainable goal(s)/outcome(s) to enhance the participant's ability to carry out ADLs, IADLs, or Health-Related Tasks independently.
- The activities are for the sole benefit of the participant and are only provided to the participant receiving HCBS.
- The activities are designed to preserve or enhance independence or slow/reduce the loss of independence.
- The activities provided are in support of skill acquisition, maintenance or enhancement of skills and 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 not use punitive methods.

### **H. Service Necessity Documentation**

Refer to Requirements Applicable to All Services.

For services provided within the initial service period, the participant must have an adequate and complete referral from an HHCM/C-YES which clearly indicates a need for supports with ADLs, IADLs, or Health-Related Tasks.

Services provided beyond the initial service period must be supported by clear documentation of a thorough assessment completed by the HCBS provider and maintained in the participant's record that indicates an assessed need for support to build skills to independently complete age-appropriate ADLs, IADLs, or health-related tasks at the frequency, scope, and duration requested.

If a comprehensive evaluation/assessment lacks relevant details or adequate justification, additional documentation may be required, as outlined below:

- Documentation from a licensed professional involved in the child's care noting delays in completing age-appropriate ADLs or IADLs and the need for support, which is not associated with age.
- Documentation outlining consideration of other school programming or documentation that additional support out of school to assist to re- enforce/maintain skills being taught.
- Consideration to transition to the OPWDD services (documentation from OPWDD indicating start of transfer process).
- Documentation of youth's graduation or discontinuance in K-12 educational services, if applicable.
- Exceeding the service limits (i.e., annual, daily, monthly) for this service would not be expected.

### **I. Continued Stay Criteria**

Refer to Requirements Applicable to All Services.

Documentation outlining consideration of other school programming or documentation that additional support out of school to assist to re- enforce/maintain skills being taught.

Consideration to transition to the OPWDD services; OR

Documentation of youth's graduation or discontinuance in K-12 educational services, if applicable.

### **J. Service Discharge Criteria**

Refer to Requirements Applicable to All Services.

## **Day Habilitation**

### **A. Definition**

Assistance with acquisition, retention or improvement in self-help, socialization and adaptive skills necessary to support age-appropriate Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs) 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 necessary to reside successfully in home- and community-based settings including appropriate behavior, greater independence, community inclusion, relationship building, self-advocacy, and informed choice.

Day Habilitation (DH) services must be provided to a participant at an OPWDD-certified setting typically between the hours of 9 a.m. and 3 p.m.

### **B. Service Components**

Day Habilitation services (Group and Individual) focus on enabling the participant to attain or maintain his or her maximum functional level. In addition, Day Habilitation may reinforce skills, behaviors, or lessons taught in other settings. Day Habilitation fosters the acquisition of ADL and IADL skills necessary to reside successfully in home- and community-based settings including appropriate behavior, greater independence, community inclusion, relationship building, self-advocacy, and informed choice.

Individuals appropriate for this service will have an assessed need for support to build skills to independently complete age-appropriate ADLs or IADLs beyond supports necessary to support typical child development. This service is intended 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 participants who have the capacity to learn to live in the community, with or without support. It is not permissible for this service to be used solely for the HCBS provider to complete the ADLs/IADLs listed below on behalf of the participant.

Instead, the service must be geared towards teaching and/or enhancing the skills of the participant to increase their capacity to complete the ADLs/IADLs on their own.

ADLs, are basic self-care tasks that include:

- Walking and/or otherwise getting around the home or outside.
- Feeding, as in being able to get food from a plate into one's mouth.
- Dressing and grooming including selecting clothes, putting them on, and adequately managing one's personal appearance.
- Toileting, including getting to and from the toilet, using it appropriately, and cleaning oneself.
- Bathing/hygiene including washing face and body in the shower or bath.
- Transferring, defined as being able to move from one body position to another. This includes being able to move from a bed to a chair, or into a wheelchair. This can also include the ability to stand up from a bed or chair in order to grasp a walker or other assistive device.

IADLs are self-care and health-related tasks that include:

- Managing finances, such as paying bills, budgeting, banking, and managing financial assets.
- Managing transportation, either via driving or by taking other means of transport in the community.
- Shopping and meal preparation, this covers everything required to get a meal on the table. It also covers shopping for clothing and other items required for daily life.
- Housecleaning and room/home maintenance, this means cleaning kitchens after eating, keeping one's living space reasonably clean and tidy, and keeping up with home maintenance.
- Managing communication, such as the telephone, mail and electronic forms of communication.
- Managing medication, including obtaining medications and taking them as directed, including pouring, administering, and recording medications.
- Learning the skills needed to maintain personal safety in the home and community such as safety procedures, emergency contacts and responses.
- Interacting with members of the community and maintaining religious practices, hobbies, or other interests.

Examples

- Providing opportunities for participants to acquire, retain, or strengthen socialization skills, communication skills, and/or adaptive skills that foster independence and community living.
- Teaching activities of daily living including hygiene tasks, establishing routines, dressing appropriately, etc.
- Teaching participants how to complete daily tasks such as laundry, cooking, personal hygiene, etc.

Specific objectives/activities with timeframes must be outlined to demonstrate how the goal/outcome for the service will be obtained. Due to the nature of the service, more short-term goals/outcomes may need to be identified to address the overall need. Providers must outline how various short-term goals/outcomes will meet the overall need and support longer-term goals. Service delivery should be based on a prepared curriculum with a predictive goal achievement timeframe that can be altered towards the individual's needs, development, and experience and monitoring of progress.

### **C. Modality**

Individual Day Habilitation is provided in-person by 1 staff member to 1 participant.

Group Day Habilitation is provided in-person by 1 staff member to up to 3 participants. Participant to staff ratio cannot exceed 3:1. The group modality is only appropriate if participants in the group have similar goals, and the group activities are appropriately geared toward the goals of all members of the group.

## **D. Setting**

Refer to Requirements Applicable to All Services.

Day Habilitation (DH) services are provided only at locations certified by OPWDD to provide site-based Day Habilitation. Day Habilitation Without Walls (i.e. Day Habilitation that takes place outside of a site-based setting) is not a component of Children's Waiver Day Habilitation.

## **E. Limitations/Exclusions and Utilization**

Refer to Requirements Applicable to All Services.

Regular Day Habilitation (DH) takes place during the hours of 9 A.M. and 3 P.M. Monday through Friday. 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. The same billing codes are used for Regular DH and Supplemental DH.

Day Habilitation Services are limited to 6 hours (24 units) per day (all Day Habilitation combined), 12 hours (48 Units) per month (all Day Habilitation Combined), and 144 hours (576 Units) per calendar year (all Day Habilitation Combined). However, not all participants will require this level of support. Frequency, scope, and duration of the service must be necessary to support the participant remaining in the home or community.

**Ages 0 through 6:** Anticipated Utilization: 0 hours (0 units) per month (all Day Habilitation combined),

At this age skill building needs are typically met through parental support/natural caregivers and use of services such as Early Intervention (EI), Preschool Supportive Health services, School Supportive Health services, or other educational/ school programs. Services necessary at this age typically are provided by licensed practitioners including Licensed Behavior Analyst, Occupational Therapists, Physical Therapist, and Speech Therapists.

**Ages 7 through 13:** Anticipated Utilization: 0-6 hours (24 units) per month (all Day Habilitation Combined)

At this age, Day Habilitation typically involves reinforcing skills, behaviors, or lessons taught in other settings, supporting skill development and retention. It may include reinforcing or practicing skills and abilities associated with physical, occupational, or speech therapies, if the direct support provider is appropriately trained. It may also include supports with time management, hygiene, and organization for school and home life or supports for developmentally appropriate independence, when not available through BOCES, or other school/community programming.

**Ages 14 through 20:** Anticipated Utilization: 0-12 hours (48 units) per month (all Day Habilitation Combined)

At this age, Day Habilitation typically involves skill development, with a focus on independence/life skills (not to replace prevocational service), when not available through BOCES, or other school/community programming. It may also include supports with time management, hygiene, and organization for school and home life.

## **F. Certification/Provider Qualifications**

Provider Agency Qualifications

- Refer to Requirements Applicable to All Services.
- Agencies providing this service must also be certified by OPWDD.

## Individual Staff Qualifications

- Refer to Requirements Applicable to All Services.
- Direct support professionals must have completed the training stipulated in 14 NYCRR 633.8 and the Direct Support Professionals Core Competencies curriculum. Additional information about this curriculum can be found in the DSP Core Competencies section of the OPWDD website.

## **G. Service Admission Requirements**

Refer to Requirements Applicable to All Services.

The HCBS Provider must conduct an assessment of the participant's ability to manage age-appropriate ADLs/IADLs to determine the support that is needed and to establish age-appropriate goals, and objectives and determine when they are met.

Day Habilitation may be provided when the following criteria are met:

- There is evidence of an assessed need for support to build skills to independently complete age-appropriate ADLs or IADLs, which may include an assessment from a licensed professional noting delays in completing ADLs or IADLs, which are not associated with age; or other evidence justifying the need for support with ADLs or IADLs beyond supports necessary to support typical child development.
- The need to build, maintain, or improve skills necessary to reside successfully in home- and community-based settings including appropriate behavior, greater independence, community inclusion, relationship building, self-advocacy, and informed choice skills has been assessed, determined, and authorized as part of the person-centered planning process.
- Day Habilitation is identified in the participant's Service Plan and Plan of Care and is associated with specific attainable goal(s)/outcome(s) to enhance the participant's ability to reside independently in home-based settings or to successfully participate in community activities.
- The activities are for the sole benefit of the participant and are only provided to the participant receiving HCBS.
- The activities are designed to preserve or enhance independence or slow/reduce the loss of independence when the participant has a progressive medical condition.
- Training for skill acquisition, maintenance, and enhancement activities that involve the management of behaviors must use positive reinforcement techniques.
- When Day Habilitation is provided to help a participant acquire the skills to navigate travel from one location in the community to another, this service may include the assistance provided by a direct care worker to accompany the participant while learning the skill. The in-person service time when a direct care worker is assisting or providing transportation to an individual may also be billed as part of the Day Habilitation service.
- Consideration of other school programming or documentation that additional support out of school to assist to re-enforce/maintain skills being taught is maintained.

## **H. Service Necessity Documentation**

- Refer to Requirements Applicable to All Services.
- For services provided within the initial service period, the participant must have an adequate and complete referral from an HHCM/C-YES which clearly indicates a need for support to build skills to independently complete age-appropriate ADLs or IADLs.
- Services provided beyond the initial service period must be supported by clear documentation of a thorough assessment completed by the HCBS provider and maintained in the participant's record, that indicates an assessed need for support to build skills to independently complete age-appropriate ADLs or IADLs, at the frequency, scope, and duration requested.

- If a comprehensive evaluation/assessment lacks relevant details or adequate justification, additional documentation may be required, as outlined below:
- Documentation from a licensed professional involved in the child's care noting delays in completing age-appropriate ADLs or IADLs and the need for support, which is not associated with age.
- Documentation outlining consideration of other school programming or documentation that additional support out of school to assist to re- enforce/maintain skills being taught.
- Consideration to transition to the OPWDD services (documentation from OPWDD indicating start of transfer process).
- Documentation of youth's graduation or discontinuance in K-12 educational services, if applicable.
- Exceeding the service limits (i.e., annual, daily, monthly) for this service would not be expected.

### **I. Continued Stay Criteria**

Refer to Requirements Applicable to All Services.

Documentation substantiating continued need for ongoing support to build skills to independently complete age-appropriate ADLs and/or IADLs

### **J. Service Discharge Criteria**

Refer to Requirements Applicable to All Services.

## **Caregiver/Family Advocacy and Support Services**

### **A. Definition**

Caregiver/Family Advocacy and Support Services (CFASS) are short-term interventions to train, coach, and educate the enrolled participant's caregivers and family related to the medical, physical, developmental, or behavioral health condition that puts them at risk of institutionalization. These temporary services develop and implement strategies and interventions that will result in the reduction of stress associated with caring for the child/youth's complex needs while building resilience to better care for the child/youth.

These services will also assist the participant, family/caregiver, and collateral contacts in understanding and addressing the participant's needs related to their condition(s) or disability(ies) that put them at risk of institutionalization.

Caregiver/Family Advocacy and Support Services enhance the participant's ability to function as part of a caregiver/family unit and community at-large; and enhance the caregiver/family's ability to care for the participant in the home and/or community and provides the participant, family, caregivers, and collateral contacts (family members, caregivers, and other stakeholders identified on the participant's POC) with techniques and information so that they can better respond to the needs of the participant and reduce the risk of institutionalization.

Participating in community events and integrated interests/occupations are important activities for all participants, including those with disabilities (developmental, physical, and/or behavioral health in origin). Success in these activities is dependent not only on the participant, but on the people who interact with and support the participant in these endeavors. Caregiver/Family Advocacy and Support Services improve the participant's ability to gain from experiences in the community and enables the participant's environment to respond appropriately to the participant's disability and/or healthcare issues.

The POC and Service Plan objectives must clearly state how the service can address the need for specific training, coaching, or education related to the participant's condition and/or diagnoses and the overall goal of the participant/family.

## **B. Service Components**

Based upon the Caregiver/Family Advocacy and Support Services plan developed by the participant and caregiver/family team, this service provides opportunities to:

- Interact and engage with family/caregivers and participants 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 participant in the home and community.
- Coach and support follow-up regarding another provider's treatment, counseling, guidance, etc. for the participant, caregivers and other family identified individuals.
- Educate and train the caregiver/family unit on available tools/strategies so that they might better support the needs of the participant.
- Educate and train family members or other individuals identified by the family of the participant's chronic condition, medical, developmental, and behavioral needs, so they may assist the family unit and provide support and respite (e.g., training for Consumer Directed Personal Assistance Services (CDPAS)).
- Provide guidance in the principles of living with participant's chronic condition or illness.
- Train (one-on-one or group) the participant or the family/caregiver regarding methods and behaviors to enable success in the community; each group must not exceed three eligible children/youth or 12 individuals (children and collaterals).
- Provide direct training in the community with collateral contacts regarding the participant's disability(ies) and needs related to his or her health care issues.
- Provide self-advocacy training for the participant and/or family/caregiver, including during community transitions.
- Attend and support participants and caregivers in meetings with professionals regarding the child's complex needs, such as IEP meetings or medical appointments.
- The service can be delivered to multiple family members or other collateral contacts identified for the participant to address the family's needs.

When the member's Plan of Care includes both Level 1 and Level 2 services, the HCBS provider must document how the services support the participant's goals, why the services are delivered in this way, why the services from more than one practitioner are needed, and how the services are inter-related. The need for two practitioners should reflect the child/youth's and/or family/caregiver's needs and align with the Plan of Care (POC) and HCBS Service Plan goals. Whether the service will be provided by a Level 1 or Level 2 practitioner must reflect the needs of the participant/caregiver. Level 2 is only appropriate if the services and supports provided to a caregiver or participant requires the training and experience of a Level 2 practitioner, which must be documented in the member's record.

When two practitioners deliver CFASS simultaneously:

- Each practitioner must address different goals or aspects of the service.
- The service and goals for each practitioner must be clearly documented in the child/youth's progress notes.
- The practitioner/child and practitioner/collateral must be located in physically separate spaces (i.e. all 4 individuals could not be engaged in the same activity).
- In instances where two practitioners are required to meet the needs of the participant/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 participant and/or multiple family members/ resources at the same date and time, the claim should reflect the exact time spent as a single encounter.

- o Examples
- o Educate other involved individuals (e.g., the participant's after school club instructor, soccer coach, etc.) on effective strategies to support the participant related to their chronic condition, medical, developmental, and behavioral needs.
- o Provide coaching and support within the home environment as follow-up and reinforcement of strategies, guidance, directions, etc. taught, shared, developed, or directed by another professional involved in the member's care, such as a teacher or physical therapist.
- o Attend school IEP Meetings to provide additional support to caregivers who are advocating for the participant's needs.
- o Training of family members and other involved adults on participant's condition/how to care for participant's needs to enhance their ability to support the family.
- o Host or participate in workgroups/classes along with the participant/caregiver that develop/strengthen understanding of a participant's medical, developmental or behavioral health needs that put them at risk of institutionalization.

### **C. Modality**

Individual Caregiver Family Advocacy and Support Services is delivered in-person to 1 participant/collateral.

Group Caregiver Family Advocacy and Support Service is delivered in-person to up to 3 participants/collaterals. Participant to staff ratio cannot exceed 3:1 (each group must not exceed three eligible children/youth or 12 individuals (children and collaterals)). The group modality is only appropriate if participants in the group have similar goals, and the group activities are appropriately geared toward the goals of all members of the group.

Note: Services can be delivered with or without the participant present.

### **D. Setting**

Refer to Requirements Applicable to All Services.

### **E. Limitations/Exclusions and Utilization**

Refer to Requirements Applicable to All Services.

While Caregiver/Family Advocacy and Support Services (CFASS) can be used to help prepare the participant/family for Individualized Education Program (IEP) meetings, or attend IEP meetings with the caregiver, this service cannot be used to develop an 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 participant.

Caregiver/Family Advocacy and Support Services cannot duplicate or replace the role of the participant's care manager. The Care Manager remains responsible for system navigation, linkages to community resources, and collaboration with care team members/involved service providers.

Caregiver/Family Advocacy and Support Services (CFASS) is limited to 6 hours (24 units) per day (all CFASS combined), 12 hours (48 Units) per month (all CFASS combined), and 144 hours (576 Units) per calendar year (all CFASS combined).

However, not all participants will require this level of support. Frequency, scope, and duration of the service must be necessary to support the participant remaining in the home or community.

**Ages 0 through 8:** Anticipated Utilization: 0-12 hours (48 units) per month (all CFASS combined)

At this age, CFASS typically involves training, education, and coaching to the caregivers, family members, collaterals regarding the specific needs of the participant. CFASS goals/objectives should be specific to the caregivers', family members', and collaterals' education and training regarding the identified needs. This type of training and support provided to a participant is not generally appropriate for children under the age of 9.

**Ages 9 through 20:** Anticipated Utilization: 0-12 hours (48 units) per month (all CFASS combined)

At this age, CFASS may involve training, education, and coaching of the caregivers, family members, collaterals, or the participant regarding the specific needs of the participant.

## **F. Certification/Provider Qualifications**

Provider Agency Qualifications

- Refer to Requirements Applicable to All Services.

Individual Staff Qualifications

Level 1

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

Level 2

- Minimum Qualifications: Requires a bachelor's degree plus two years of related experience.
- Preferred Qualifications: Requires a master's degree in education, or a master's degree in a human services field plus one year of applicable experience.

Supervisor Qualifications

Level 1

- Minimum Qualifications: Requires a bachelor's degree with one year of experience in human services working with children/youth.
- Preferred Qualifications: Two years' experience in human services working with children/youth.

Level 2

- Minimum Qualifications: Requires a master's degree with one year of experience or a bachelor's degree with four years of experience in human services working with children/youth.
- Preferred Qualifications: Master's degree with two years of experience in human services working with children/youth.

## **G. Service Admission Requirements**

Refer to Requirements Applicable to All Services.

CFASS may be provided when the following criteria are met:

- The need for coaching or training has been assessed, determined, and authorized as part of the person-centered planning process.
- CFASS is identified in the participant's Service Plan and Plan of Care and is associated with specific attainable goal(s)/outcome(s) to enhance the participant's ability, regardless of condition/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 participant in the home and/or community.
- The activities support the caregivers'/families' self-sufficiency in caring for the participant in the home and community.
- The Service Plan outlines specific training, coaching and educational objectives and planned activities that support the goal and the expected timeframe for achieving the goal.

## **H. Service Necessity Documentation**

- Refer to Requirements Applicable to All Services.
- For services provided within the initial service period, the participant must have an adequate and complete referral from an HHCM/C-YES which clearly indicates a need for training, coaching, or education support aligned with the service definition.
- Services provided beyond the initial service period must be supported by clear documentation of a thorough assessment completed by the HCBS provider and maintained in the participant's record, that indicates an assessed need. The assessment must include the specific training, coaching, or education needs related to the participant's medical, physical, developmental or behavioral health condition that puts them at risk of institutionalization and must support the frequency, scope and duration requested.
- If a comprehensive evaluation/assessment lacks relevant details or adequate justification, additional documentation may be required, as outlined below:
- Documentation from a licensed professional involved in the child's care (i.e. pediatrician or other licensed practitioner, school professional, etc.) noting the need for training, coaching or education support related to the participant's medical, physical, developmental, or behavioral health condition that puts them at risk of institutionalization.
- Documentation from a care manager of the specific identified assessed needs and the desired outcome.
- Supporting documentation of the timeframe and curriculum or training/education techniques that are utilized must be documented in the participant record. If training/ education to family members or collaterals is needed, then specific documentation regarding the goal and the connection to participant's need must also be documented. For example, if CFASS is being provided to assist with training a Consumer Directed Personal Assistance Services (CDPAS) provider, this must be clearly outlined in the record.
- CFASS utilization that exceeds the service limits (i.e., annual, daily, monthly), must be necessary to prevent institutionalization and support the child remaining in the home/community, and must be justified by documentation provided by a third-party entity involved in the participant's care. Such documentation may include but is not limited to the documentation types listed above.
- Additionally, there must be documentation in the case record that the multidisciplinary care team has determined a need for HCBS in excess of the service limits to prevent institutionalization, determined whether other services are appropriate, and has established a plan to monitor the participant's progress.

## **I. Continued Stay Criteria**

Refer to Requirements Applicable to All Services.

## **J. Service Discharge Criteria**

Refer to Requirements Applicable to All Services.

## Respite

### A. Definition

This service provides short-term assistance to families of participants because of the absence of or need for relief of the participant or the participant's family caregiver. HCBS respite provides short-term relief for primary caregivers who are responsible for parenting participants with significant medical, physical, developmental, or behavioral health needs that put the participant at risk of institutionalization. Respite enhances the family or primary caregiver's ability to support the participant's functional, developmental, behavioral health, and/or health care needs. Additionally, respite helps build stability in the family unit by avoiding disruptions in a participant's home environment and supporting the family in being able to care for the participant at home.

Respite workers provide appropriate temporary care and supervision to protect the participant's safety in the absence of family members or caregivers and engage the participant in participant-centered care directly related to the participant's unique abilities and circumstances. It is important that the respite worker has a knowledge of and understanding of the participant's particular needs and abilities to provide activities that support his/her and/or primary caregiver/family's constructive interests and abilities.

Respite providers regularly communicate with other providers to maintain familiarity with the participant's goals.

### B. Service Components

- Refer to Requirements Applicable to All Services.
- Respite can be provided in a planned mode or delivered in a crisis situation.
- Respite is not a substitute for routine childcare.

#### Planned

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

#### Crisis Respite

Crisis Respite is a short-term care and intervention strategy for participants 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 participant and/or family/caregiver is unable to manage without intensive assistance and support. Crisis Respite should be included on the POC to the extent that it is an element of the crisis/safety plan or risk mitigation strategy. Crisis Respite should only be used in response to an immediate crisis.

Ongoing communication between participant or the family/primary caregiver receiving Crisis Respite for their child, the Crisis Respite staff, and the participant's established behavioral health and healthcare providers are required to assure collaboration and continuity in managing the crisis situations and identifying subsequent support and service needs, as well as the anticipated end date for the crisis respite.

At the conclusion of a Crisis Respite period, Crisis Respite staff, together with the participant 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 participant's POC. Crisis Respite should be provided in the most integrated and cost-effective settings appropriate to meet the respite needs of the participant/family. Out-of-home Crisis Respite is not intended as a substitute for permanent housing arrangements.

Since Respite Services are short term services to provide relief to the caregiver or participant, it is incumbent for the HHCM/C-YES' plan of care to have goals to build supports and/or obtain other resources for the family/participant to support them long- term.

### Overnight Respite

Overnight Respite is defined as Respite services provided to a person on two consecutive days when Respite staff are providing supervision of a participant during nighttime hours.

Overnight Respite may be used to enhance the family/primary caregiver's ability to support the participant's functional, developmental, behavioral health, and/or health care needs or to help alleviate the risk for an escalation of symptoms, a loss of functioning, and/or a disruption in a stable living environment by giving the caregiver a break for caring for a child with complex needs.

HCBS providers must have clear documentation for the need of overnight respite and the risk being alleviated by overnight respite.

Note: Utilization of overnight respite for supervision "in case" there is a situation or if the participant has elopement concerns is not an appropriate use of overnight respite.

### Examples

- Engaging the participant in recreational activities (i.e. games, arts and crafts, sports) while parent/caregiver receives a break.
- Engaging the participant in community events and visiting community attractions (i.e. visiting the local park, participation in an event at the local library, spending time at the YMCA, etc.) while parent receives a break
- Engaging the participant in activities that will strengthen adaptive skills (that are Identified on the Plan of Care) while parent receives a break
- Overnight Respite: Providing a safe space for participant to sleep overnight when their caregiver undergoes surgery that renders them unavailable to care for the child for 24 hours.
- Crisis Respite: As a part of the participant's safety plan, the Crisis Respite provider offers the participant an opportunity for a safe space from their home environment. The Respite provider engages the participant in safe activities to assist the participant in de-escalation.

### **C. Modality**

- Refer to Requirements Applicable to All Services.
- Individual Respite is provided by 1 staff member to 1 participant.
- Group Respite is provided by 1 staff member to up to 3 HCBS participants. Participant to staff ratio cannot exceed 3:1.

### **D. Setting**

Refer to Requirements Applicable to All Services.

Planned or Crisis Day Respite services can be provided in the home of an eligible participant or a community setting. Community settings may include areas where a participant lives, attends school, works, engages in services and/or socializes.

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

Crisis Respite services may be delivered in the participant's 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.

Note: a provider can be designated for Crisis or Planned Respite without an overnight setting; however, they will only be authorized to provide Respite that does not include an overnight stay or overnight service provision. If the Respite service is provided overnight, it can only be done so in an authorized overnight setting, and that setting must be a licensed/certified facility as outlined below.

Planned or Crisis Overnight Respite 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 Children's Community Residence (community-based or state- operated), which has an OMH Operating Certificate demonstrating compliance with 14 NYCRR 594

OMH licensed Children's Crisis Residence (community-based or state- operated), which has an OMH Operating Certificate demonstrating compliance with 14 NYCRR 589\*

OCFS-Licensed agency boarding home, group home, group residence, or institution, or 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).

Billing for overnight Respite is allowable in the settings listed above only for participants who are not residents of these settings. Agencies designated to provide Respite and any of the residential services listed above cannot bill for both services provided to the same participant simultaneously.

## **E. Limitations/Exclusions and Utilization**

Refer to Requirements Applicable to All Services.

Services to participants in foster care must comply with Part 435 of 18 NYCRR. When HCBS respite is provided for the relief of a foster care provider, foster care respite services may not also be billed for the same time period. However, should additional respite in excess of foster care respite be necessary to meet needs of the participant or caregiver, due to the child's complex condition, HCBS respite may be utilized.

Respite is not an allowable substitute for permanent housing arrangements.

Participants living independently are not eligible to receive Respite.

Respite is not a substitute for routine childcare. In scenarios where the parent/caregiver otherwise routinely needs childcare (e.g., during their workday if they work apart from their child), respite is not permitted. If provided before and/or after school, the need for Respite must be documented: why the service will be provided in the morning (before school) and in the afternoon (after school). Respite cannot be connected to the caregiver's work schedule.

Respite is not an allowable substitute for medically necessary care or treatment in a residential or institutional setting. For instance, although an OMH licensed Children's Crisis Residence can be used for HCBS Respite services, HCBS respite should only be billed if a child does not otherwise meet admission criteria for the Crisis Residence service. If the child meets the admission criteria for the Crisis Residence, they must be admitted to the Crisis Residence and the service must be billed under the Crisis Residence benefit.

Respite workers may attend to the participant's medical and non-medical needs and other ADLs which would ordinarily be performed by a caregiver or family member. However, unlicensed Respite workers are not permitted to utilize medical equipment, administer medications, or utilize medical devices without appropriate training by a licensed professional. If requested by the family, determined appropriate by a clinician, and approved by the designated Respite agency, an appropriately licensed professional such as a registered nurse, physical therapist, or occupational therapist may provide training to the Respite staff member to provide limited medical supports that do not require licensure. Documentation of staff training must be maintained in the participant/staff record. Some examples of care that Respite workers for medically fragile participants can provide include turning and repositioning youth with limited mobility, and assistance with home exercise plan as guided by a therapist (OT, PT, ST, etc.). These activities are only permissible if provided for the sole purpose of supporting the participant's needs while providing a break to the primary caregiver.

Payment may not be made for Respite provided at the same time when other services that include care and supervision are provided. For example, a provider may not bill for community habilitation and respite provided to the same participant at the same time. Both services can be billed on the same date, but only if they are provided at different times that do not overlap during the day.

Respite Services are limited to 28 hours per month (all Respite combined), and 336 hours per calendar year (all Respite combined). However, not all participants will require this level of support. Frequency, scope, and duration of the service must be necessary to support the participant remaining in the home or community.

When Respite is provided simultaneously to another Medicaid service, documentation must be present in the record to indicate the rationale/justification for service delivery in this manner.

**Ages 0 through 6:** Anticipated Utilization: 0-6 hours per month (all Respite combined).

At this age, Respite services typically involve provision of a planned break to assist in managing an identified need for relief from stressors of caring for a child with complex needs.

**Ages 7 through 17:** Anticipated Utilization: 0-28 hours per month (all Respite combined).

At this age, Respite services typically involve provision of a planned break to assist in managing an identified need for relief from stressors of caring for a child with complex needs who requires supervision.

**Ages 18 through 21:** Anticipated Utilization: 0-15 hours per month (all Respite combined).

At this age, Respite services typically involve provision of a planned break to assist in managing an identified need for relief from stressors of caring for a youth with complex needs who requires supervision.

## **F. Certification/Provider Qualifications**

- Refer to Requirements Applicable to All Services.
- For Overnight Planned or Crisis Respite, must also be one of the following:
- OMH-certified Community Residence: (community-based or State-operated) including Crisis Residence

- OCFS licensed/certified setting including agency boarding home, a group home, a group residence, or an institution.
- OPWDD certified residential setting.

#### Individual Staff Qualifications

- Refer to Requirements Applicable to All Services.
- Minimum qualifications for providers of services in participant residence or other community-based setting (e.g., park, shopping center, etc.)
- Respite providers are paraprofessionals with a high school diploma or equivalent and with appropriate skills and training. It is the responsibility of the HHCM/C-YES to ensure that 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).
- Experience working with children/youth (preference given to those with experience working with children/youth with special needs)
- A high school diploma, high school equivalency preferred or a State Education Commencement Credential (e.g. SACC or CDOS)
- Minimum qualifications for providers of services outside child/youth's residence and in an allowable licensed/certified setting
- In foster boarding homes, respite providers must be Licensed Foster Parents pursuant to Part 435 of 18 NYCRR
- In OCFS licensed/certified settings, respite providers are paraprofessionals with a high school diploma or equivalent and with appropriate skills and training.
- In OMH licensed Children's Community Residences (community-based or State- operated), with an OMH Operating Certificate demonstrating compliance with 14 NYCRR 594, respite workers must be staff of the licensed program.
- In OMH licensed Children's Crisis Residence (community-based or State-operated) with an OMH Operating Certificate demonstrating compliance with 14 NYCRR 589, respite workers must be staff of the licensed program.
- In OPWDD-certified settings (community-based or State-operated), Family Care Home, Intermediate Care Facility for Individuals with Intellectual and Developmental Disabilities (ICF/IDD); Individualized Residential Alternative (IRA) or Community Residence (CR); or Free-Standing Respite facility under the auspices of OPWDD, respite workers must be staff of the certified program.

#### Supervisor Qualifications

- An individual with a bachelor's degree and one or more years of experience in human services working with children/youth.

### **G. Service Admission Requirements**

Refer to Requirements Applicable to All Services.

The following criteria must be considered in assessing whether respite services are appropriate. As with other HCB Services, the need for respite must be determined in the context of POC development, based on the individual needs of the child and family.

Specific criteria to be considered include:

- Severity of the child's disability and needs, including the need for supervision in the absence of the caregiver.
- Potential risk of out-of-home placement for the child if respite services are not provided.
- Lack of access to informal support systems such as extended family, supportive friends, community supports, etc.

- Lack of access to other sources of respite due to barriers such as waiting lists, and remote/inaccessible location of services.
- Presence of factors known to increase family stress, such as having only one caregiver, or having other family members with complex conditions.
- The perceived and expressed level of need for respite services by the primary caregiver.
- The perceived need for respite services by the parent, in the absence of any other factors, is not a sufficient indicator of the need for respite.
- Planned Respite may be provided when the following criteria are met:
  - The need for provider relief from caregiving stressors beyond routine childcare has been assessed, determined, and authorized as part of the person-centered planning process.
  - Respite is identified in the participant's Service Plan and Plan of Care and is associated with specific attainable goal(s)/outcome(s).
  - The activities are for the sole benefit of the participant and caregiver and are only provided to the waiver-enrolled participant receiving respite.
  - The activities are designed to preserve or enhance the caregiver's ability to care for the participant in the home.
- Crisis Respite may be provided when the following criteria are met:
  - Crisis Respite should only be used in response to an immediate crisis such as a challenging behavioral or situational crisis that the family/caregiver is unable to manage without intensive assistance and support.
  - The activities are designed to alleviate the risk for an escalation of symptoms, a loss of functioning, and/or a disruption in a stable living environment to preserve or enhance the caregiver's ability to care for the participant in the home.
  - Crisis Respite should be included on the POC to the extent that it is an element of the crisis/safety plan or risk mitigation strategy.
  - The participant's care team must collaborate to manage the crisis situation and identify subsequent support and service needs.

## **H. Service Necessity Documentation**

- Refer to Requirements Applicable to All Services.
- For services provided within the initial service period, the participant must have an adequate and complete referral from an HHCM/C-YES which clearly indicates a need for planned and/or crisis relief for the participant or family/primary caregivers to enhance the family/primary caregiver's ability to support the participant's functional, developmental, behavioral health, and/or health care needs and maintain the participant in the home and community.
- Services provided beyond the initial service period must be supported by clear documentation of a thorough assessment completed by the HCBS provider and maintained in the participant's record, that indicates an assessed need to relieve the stressors, assist with reducing disruptions, and maintaining stability within the home to avoid institutionalization through respite at the frequency and duration requested.
- If a comprehensive evaluation/assessment lacks relevant details or adequate justification, additional documentation may be required, as outlined below:
  - Documentation from another involved professional, (i.e., MH professional, pediatrician, school professional etc.) outlining the specific need for respite (break for the caregiver/youth) and the impact on the family tied to a specific outcome, OR
  - Documentation from a care manager based upon specific identified assessed needs and or stressors to be relieved that outlines the desired outcome and what efforts will be made to implement other supports or systems to be utilized in the future for the caregivers.
- The care manager must maintain documentation regarding other available sources of respite and must maintain documentation barriers accessing other supports, as appropriate, when participant's meet eligibility criteria for other supports (e.g., respite services under the Early Intervention program) and those services are not utilized.

- Respite utilization that exceeds the service limits (i.e., annual, daily, monthly), must be necessary to prevent institutionalization and support the child remaining in the home/community, and must be justified by documentation provided by a third-party entity involved in the participant's care. Such documentation may include but is not limited to the documentation types listed above.
- Additionally, there must be documentation in the case record that the multidisciplinary care team has determined a need for HCBS in excess of the service limits to prevent institutionalization, determined whether other services are appropriate, and has established a plan to monitor the participant's progress.

### **I. Continued Stay Criteria**

- Refer to Requirements Applicable to All Services. Ongoing delivery of Respite is appropriate when:
- The caregiver/ family members continue to need relief/break from caregiving stressors beyond routine childcare, which have been identified in the participant's record.
- Identification of new stressors/goals for continued respite, which have been identified in the participant's record.
- Other sources of respite, such as foster care respite or Early Intervention respite are not available or accessible to the participant.

### **J. Service Discharge Criteria**

Refer to Requirements Applicable to All Services.

## **Prevocational Services**

### **A. Definition**

Prevocational Services are individually designed to prepare a youth (age 14 or older) to engage in paid work, volunteer work, or career exploration. Prevocational Services are not job-specific but rather are geared toward facilitating success in any work environment for youth whose disabilities do not permit them access to other prevocational services. The service will be reflected in youth's POC/Service Plan and must be directed to teaching skills rather than explicit employment objectives. In addition, Prevocational Services assist with facilitating appropriate work habits, acceptable job behaviors, and learning job productivity requirements.

### **B. Service Components**

Prevocational Services may include volunteer work, such as learning and training activities that prepare a person for entry into the paid workforce. Prevocational Services should enable each participant to attain the highest level of work in the most integrated setting and with the job matched to the participant's interests, strengths, priorities, abilities, and/or capabilities, while following applicable federal wage guidelines from the U.S. Department of Labor. Prevocational services are intended to develop and teach general employability skills relevant to successful participation in individual employment.

HCBS providers should have a developed curriculum to provide services, with specific outcomes to be achieved, and approximate timeframes, taking into account the youth's development, particular needs, and condition, to achieve the outcome.

Examples include, but are not limited to:

- Ability to communicate effectively with supervisors, co-workers, and customers.
- Generally accepted community workplace conducts 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
- Financial literacy skills
- Proper use of job-related equipment and general workplace safety
- The ability to navigate local transportation options.
- Prevocational Services include activities that are not primarily directed at teaching skills to perform a particular job, but at underlying habilitative goals (e.g., attention span, motor skills, interpersonal relations with co-workers and supervisors) that are associated with building skills necessary to perform work and optimally to perform competitive, integrated employment, such as the examples listed below:
  - Resume writing, interview techniques, role play, and job application completion.
  - Exploring career options, facilitating appropriate work habits, acceptable job behaviors, and learning job productivity requirements.
  - Assisting in identifying community service opportunities that could lead to paid employment.
  - Helping youth to connect their educational plans to future career/vocational goals.
  - Helping youth to complete college, technical school, or other applications to continue formal education/training.
  - Helping youth to research and apply for financial aid or scholarship opportunities.
  - Assisting a participant to understand appropriate work behavior in preparation for obtaining employment including navigating relationships with co-workers, taking directions from a supervisor, professional interactions with customers, etc.
  - Activities geared towards teaching how to dress and act professionally.
  - Activities geared towards teaching time management skills related to employment.
  - Documentation is maintained by the care manager 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.). Note: most participants with disabilities with an IEP are eligible for the Pre-ETS program, which should be utilized prior to accessing Prevocational Services through the Children's Waiver. See the following for additional information: <https://www.acces.nysed.gov/vr/pre-ets>.

### **C. Modality**

- Individual Prevocational Service is provided in-person by 1 staff member to 1 participant
- Group Prevocational Service is provided in-person by 1 staff member to up to 3 participants. Participant to staff ratio cannot exceed 3:1.

### **D. Setting**

Refer to Requirements Applicable to All Services.

### **E. Limitations/Exclusions and Utilization**

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

Prevocational services will not be authorized for an HCBS participant if any of the following apply:

- Special education and related services are otherwise available to the individual through a local educational agency, under the provisions of the Individuals with Disabilities Education Act (IDEA), and the provision of HCBS Prevocational services would be duplicative of such services.
- Vocational rehabilitation services are otherwise available to the individual through a program funded under section 110 of the Rehabilitation Act of 1973 (Access VR), and the provision of HCBS Prevocational services would be duplicative of such services.
- Vocational services are provided in facility-based work settings that are not integrated in the general community workforce.
- Prevocational Services are limited to 2 hours (8 units) per day, 10 hours (40 units) per month, and 120 hours (480 units) per calendar year (all Prevocational combined).
- However, not all participants will require this level of support. Frequency, scope and duration of the service must be necessary to support the participant remaining in the home or community.

**Ages 0 through 13:** Anticipated Utilization: 0 hours (0 units) (all Prevocational combined).

This service is not billable for individuals in this age group.

**Ages 14 through 20:** Anticipated Utilization: 0-10 hours (40 units) per month (all Prevocational combined).

At this age, Prevocational services typically involve provision of curriculum-based services geared toward assisting the participant in obtaining employment.

#### F. Certification/Provider Qualifications

##### Provider Agency Qualifications

- Refer to Requirements Applicable to All Services.

##### Individual Qualifications

- Refer to Requirements Applicable to All Services.
- Minimum Qualifications: An individual with an associate degree and one year of human service experience
- Preferred Qualifications: Bachelor's degree with one year of experience in human services working with children/youth.

##### Supervisor Qualifications

- Minimum Qualifications: An individual with a bachelor's degree and three years of experience in human services
- Preferred Qualifications: Master's degree with one year of experience in human services working with children/youth.

#### G. Service Admission Requirements

Refer to Requirements Applicable to All Services.

#### H. Service Necessity Documentation

- Refer to Requirements Applicable to All Services.
- For Prevocational Services provided within the initial service period, the participant must have an adequate and complete referral from an HHCM/C-YES which clearly indicates the participant's interest and needed support in obtaining skills to assist with volunteer work or paid employment.

- Services provided beyond the initial service period must be supported by clear documentation of a thorough assessment completed by the HCBS provider and maintained in the participant's record, that indicates an assessed need for support in teaching employment related skills at the frequency, scope, and duration requested.
- If a comprehensive evaluation/assessment lacks relevant details or adequate justification, additional documentation may be required, as outlined below:
- Documentation from another involved professional, (i.e., MH professional, pediatrician, school professional etc.) outlining the specific need, purpose, and desired outcome of the service
- Documentation from a care manager based upon specific identified assessed needs that are outlined and the desired outcome
- The service must be outlined in the participant's transition age youth transition plan to support their transition to adult services.
- Exceeding the service limits (i.e., annual, daily, monthly) for this service would not be expected.

### **I. Continued Stay Criteria;**

Refer to Requirements Applicable to All Services.

### **J. Service Discharge Criteria**

Refer to Requirements Applicable to All Services.

## **Supported Employment**

### **A. Definition**

Supported Employment services are individually designed to prepare youth (age 14 or older) to engage in paid work. Supported Employment services assist participants in a work setting. Supported Employment provides ongoing supports to participants who, because of their condition which puts them at risk of institutionalization, 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, and negotiation with prospective employers,
- job analysis,
- job carving,
- training and systematic instruction,
- job coaching,
- benefits support,
- training and planning,
- transportation,
- career advancement services, and

- other workplace support services including services not specifically related to job skill training that enable the participant to successfully integrate into the job setting.

Supported Employment services may also include services and supports that assist the participant in achieving self-employment through the operation of a business including home-based self-employment. However, Medicaid funds are not used to defray the expenses associated with starting up or operating a business.

In addition to the need for an appropriate job match that meets the individual's skills and interests, individuals may also need long term employment support to successfully maintain a job due to the ongoing nature of the HCBS participant's support needs, changes in life situations, or evolving and changing job responsibilities.

## **B. Service Components**

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

- Supervision and training that are not job-related
- Benefits Education
- Career Exploration (e.g., tours, informational interviews, job shadows)
- Assistance with the development of visual or traditional resumes
- Trial work experiences
- Outreach to prospective employers on behalf of the participant (e.g., job development; negotiation with prospective employers to customize, create or carve out a position for the participant; employer needs analysis)
- Reemployment services (if necessary due to job loss)
- Intensive ongoing support
- Transportation to and from the job site
- Interface with employers regarding the individual's disability/disabilities and needs related to healthcare issue(s)
- Other activities needed to sustain paid work (e.g., employment assessment, job placement, and/or adaptive/assistive equipment and/or technology necessary for employment)
- Job finding and development training in work behaviors
- Assessing the interest and fit of an individual for particular job opportunities, staff work with employers and job sites preparing them to be able to make necessary and reasonable accommodations
- On-site support for the individual as they learn specific job tasks
- Monitoring through on-site observation and through communication with job supervisors and employers
- Assistance in locating/obtaining needed employment paperwork
- Assisting the participant in advocating for their needs at a job placement

## **C. Modality**

Individual Supported Employment is provided in-person by 1 staff member to the participant and/or the participant's employer.

## **D. Setting**

Refer to Requirements Applicable to All Services.

## **E. Limitations/Exclusions and Utilization**

- Refer to Requirements Applicable to All Services.
- Medicaid funds may not be used to defray the expenses associated with starting up or operating a business.
- Supported Employment service is not allowed for an HCBS participant if any of the following apply:
  - Special education and related services are otherwise available to the individual through a local educational agency, under the provisions of the Individuals with Disabilities Education Act (IDEA), and the provision of Supported Employment would be duplicative of such services.
  - Vocational rehabilitation services are otherwise available to the individual through a program funded under section 110 of the Rehabilitation Act of 1973, and the provision of Supported Employment would be duplicative of such services.
  - Supported employment does not include facility based, or other similar types of vocational services furnished in specialized facilities that are not a part of the general workplace.
  - Supported employment does not include payment for supervision, training, support, and/or adaptations typically available to other workers without disabilities filling similar positions in the business.
  - Supported employment does not include volunteer work. Such volunteer learning and un-paid training activities that prepare a person for entry into the paid workforce are addressed through Prevocational services.
  - Medicaid funding cannot be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
    - Incentive payments made to an employer to encourage or subsidize the employer's participation in Supported Employment
    - Payments that are passed through to users of Supported Employment services Supported Employment is limited to 3 hours (12 units) per day (all Supported Employment combined), 10 hours (40 units) per month (all Supported Employment combined), and 120 hours (480 units) per calendar year (all Supported Employment combined). However, not all participants will require this level of support. Frequency, scope, and duration of the service must be necessary to support the participant remaining in the home or community.

**Ages 0 through 13:** Anticipated Utilization: 0 hours (0 units).

This service is not billable for individuals in this age group.

**Ages 14 through 20:** Anticipated Utilization: 0-10 hours (40 units) per month.

At this age, Supported Employment services typically involve provision of curriculum- based services geared towards assisting the participant in obtaining or retaining employment.

## **F. Certification/Provider Qualifications**

### Provider Agency Qualifications

- Refer to Requirements Applicable to All Services.

### Individual Qualifications

- Refer to Requirements Applicable to All Services.
- Minimum Qualifications : An individual with an associate degree and one year of human service experience
- Preferred Qualifications : Bachelor's degree with one year of experience in human services working with children/youth.

### Supervisor Qualifications

- Minimum Qualifications: An individual with a bachelor's degree and three years of experience in human services
- Preferred Qualifications: Master's degree with one year of experience in human services working with children/youth.

### **G. Service Admission Requirements**

Refer to Requirements Applicable to All Services

### **H. Service Necessity Documentation**

- Refer to Requirements Applicable to All Services.
- For services provided within the initial service period, the participant must have an adequate and complete referral from an HHCM/C-YES which clearly indicates a need for intensive on-going supports, as a result of their condition which puts them at risk of institutionalization, to obtain and maintain employment.
- Services provided beyond the initial service period must be supported by clear documentation of a thorough assessment completed by the HCBS provider and maintained in the participant's record, that indicates an assessed need for intensive on-going support, at the frequency, scope, and duration requested, to obtain and maintain employment.
- If a comprehensive evaluation/assessment lacks relevant details or adequate justification, additional documentation may be required, as outlined below:
- Documentation from another involved professional, (i.e., MH professional, pediatrician, school professional etc.) outlining the specific need, purpose, and desired outcome of the service
- Documentation from the care manager regarding the specific need for support, desired career goals, and goal to be achieved.
- Exceeding the service limits (i.e., annual, daily, monthly) for this service would not be expected.

### **I. Continued Stay Criteria;**

Refer to Requirements Applicable to All Services.

### **J. Service Discharge Criteria**

Refer to Requirements Applicable to All Services.

## **Section 3: OASAS LOCADTR 3.0 Criteria**

### **Overview**

Carelon Health Options adopts the Office of Addiction Support and Services(OA SAS) Level of Care for Alcohol and Drug Treatment Referral(LOCADTR) 3.0 for use in rendering medical necessity determinations for all substance use services for all lines of business (excluding Medicare) for providers located in New York State.

NYS OASAS, in partnership with National Center on Addiction and Substance Abuse at Columbia University (CASA Columbia), developed the LOCADTR 3.0, a web-based tool, to assist substance abuse treatment providers, Medicaid Managed Care plans, and other referral sources in determining the most appropriate

level of care (LOC) for a client with a substance use disorder. This tool enables the referral source to identify the most appropriate treatment setting closest to the client's community.

The LOCADTR 3.0 Manual can be found here:  
<https://oasas.ny.gov/system/files/documents/2019/10/LOCADTRManual3.0.pdf>

The LOCADTR 3.0 Concurrent Review Manual can be found here:  
[https://oasas.ny.gov/system/files/documents/2019/10/CRMANUAL19June2019\\_Final%20%281%29.pdf](https://oasas.ny.gov/system/files/documents/2019/10/CRMANUAL19June2019_Final%20%281%29.pdf)

The following is a list of services for which LOCADTR Criteria is used:

- Inpatient Detoxification (Medically Managed and Medically Supervised)
- Inpatient Rehabilitation/ Residential Rehabilitation for Youth
- Residential (Stabilization and Rehabilitation)
- Outpatient Detoxification/ Withdrawal
- Outpatient Day Rehabilitation / Partial Hospital
- Intensive Outpatient
- Opioid Treatment Programs
- Outpatient Clinic Services

## Section 4: InterQual Criteria

### Overview

Carelon Health Options adopts Change Healthcare's InterQual Behavioral Health Criteria for use in rendering medical necessity determinations for all mental health services in which CMS and OMH criteria is not applicable or available.

The Carelon bookview can be found by registering and logging into the InterQual portal here:  
<https://mncex.carelonhealthoptions.com/mncportal/criteria/>

The following is a list of services for which InterQual Criteria is used:

| Adults   | Child and Adolescent   | BH procedures Q&A  |
|--|--|--|
| <ul style="list-style-type: none"><li>• Inpatient</li><li>• Observation</li><li>• Residential Crisis Program</li><li>• Residential Treatment Center</li><li>• Supervised Living</li><li>• Partial Hospital Program</li><li>• Day Treatment Program</li><li>• Home Care</li><li>• Intensive Community Based Treatment</li><li>• Intensive Outpatient Program</li><li>• Outpatient</li></ul> | <ul style="list-style-type: none"><li>• Inpatient</li><li>• Observation</li><li>• Residential Crisis Program</li><li>• Subacute Care</li><li>• Residential Treatment Center</li><li>• Supervised Living</li><li>• Partial Hospital Program</li><li>• Day Treatment Program</li><li>• Home Care</li><li>• Intensive Community Based Treatment</li><li>• Intensive Outpatient Program</li><li>• Outpatient</li></ul> | <ul style="list-style-type: none"><li>• Applied Behavior Analysis (ABA)</li><li>• Biofeedback</li><li>• Electroconvulsive Therapy (ECT)</li><li>• Multi-Gene Panels for Autism (ASD)</li><li>• Neuropsychological and Developmental Testing for Psychotropic Medication Drug Response</li><li>• Psychological Testing</li><li>• Stereotactic Introduction, Subcortical Electrodes</li><li>• Transcranial Magnetic Stimulation (TMS)</li><li>• Urine Drug Testing</li><li>• Vagus Nerve Stimulation</li></ul> |

## Section 5: ASAM Criteria

### Overview

Carelon Health Options adopts the American Society for Addiction Medicine (ASAM) Criteria for use in medical necessity determinations for all substance use services for all Medicare members (for which CMS Criteria is not available) and for all other lines of business when the provider is located outside of New York State.

An introduction to ASAM can be found here: <https://www.carelonhealthoptions.com/pdf/members/Introduction-to-The-ASM-Criteria-for-Patients-and-Families.pdf>

The following is a list of services in which ASAM Criteria is used:

- Early Intervention
- Opioid Treatment Program
- Outpatient Services
- Intensive Outpatient Services
- Partial Hospitalization Services
- Residential Services
- Inpatient Services
- Withdrawal Management(Ambulatory, Residential, Inpatient)