Public comments and Responses on the Children's 1915(c) waiver

Public Comment	State Response
1. The waiver describes consumer engagement- We don't believe that this is happening as much as it should and that webinars and trainings have been targeted to providers NOT families. The state needs to increase outreach efforts to families that include in person, letters etc. This refers to the following: NYSDOH staff and state agency partners work closely on a continuing basis with advocacy groups for families of children with disabilities and waiver service providers. A service provider summary of the MRT meetings since 2011 can be found at: https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/web - info_child_mst.htm,	The State has been working to keep providers and advocacy groups apprised of the implementation of new services and the transition of children enrolled in waivers to Health Homes, through open Webinars, monthly meetings with Plan Advocates and Plans, and meetings and service training with various providers groups, including Care at Home and Foster Care providers. Commencing immediately, approximately one quarter prior to waiver transition to Health Home on January 1, 2019, the State will conduct in-person trainings and forums across the State to provide information to the transitioning providers to facilitate improved communication with families. The training includes providing brochures and other information to help care managers explain to families the process for accessing Health Home, State Plan, and HCBS services ensuring continuity of care and as seamless a transition as possible for children and families. The goal is to ensure effective provider communication to these families prior to their receipt of written notification of transition to Health Homes and to the new array of services available under the consolidated waiver. The State is open to all suggestions to improve communications with families, and to feedback and adjustments as we move through the in-person trainings over the next few months. The State will work as closely as possible with CMS to ensure that the timing of notices and communication to families, in relation to the timing of CMS approvals, will not result in confusion and the potential need to "start" and the "stop" transition activities, which would be disruptive to families, providers and plans.
2. The waiver states there will be a 30 day notice to families. We advocate that should be increased to 60-90 day notice to assist families in preparing.	Under the current timeline, each family will receive a 30-day written notice on November 15, 2018. Care managers will be requested to verbally provide as much notice as possible (60 to 90 days) to each of the members/families on their caseload. The actual transition to Health Home will begin on January 1, 2019 for children now enrolled one of the six 1915(c) waivers and the transition of services and most waiver children to managed care will occur on 4/1/2019. Foster care children will transition to managed care on 7/1/19. The State will work as closely as possible with CMS to ensure that the timing of letters to families, in relation to the timing of CMS approvals, will not result in confusion and the potential need to "start" and the "stop" transition activities, which would be disruptive to families, providers and plans.

Public Comment	State Response
3. The waiver states that staff should begin discussing transition with families and will be supported by state guidance and training. When? Where? How will state support?-This should begin ASAP and should include multiple forums and mediums since staff are carrying heavier caseloads and schedules	Beginning now, about one quarter before the beginning of the waiver transition to Health Home on January 1, 2019, the State will conduct in-person trainings and forums across the State to provide information to transitioning providers to facilitate improved communication with families. The schedule will be released by Mid-October. The trainings will include providing brochures and other information to help care managers explain to families the process for accessing Health Home, State Plan, and HCBS services , with a focus on ensuring continuity of care and as seamless a transition as possible for children and families. The goal is to ensure effective provider communication prior to written notification to families explaining the transition to Health Home and to the new array of services available under the consolidated waiver. The State is open to all suggestions for methods to communicate with families and will be open to feedback and adjustments as we move through the in-person trainings over the next few months. The State will work as closely as possible with CMS to ensure that the timing of notices and communications, to families in relation to the timing of CMS approvals, will not result in confusion and the potential need to "start" and the "stop" transition activities, which would be disruptive to families, providers and plans. Training webinars conducted for Health Homes can be found at: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/webinars/index.htm and other information regarding the Children's Medicaid Redesign can be found at: https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/web-info_child_mst.htm.
4. The waiver states that "state has ensured no 1915 transitioning youth will lose access to services"- This cannot and should not be promised. Given the delay in the transition the challenges with rates, staffing qualifications etc providers are losing capacity to serve	The State's transition plan is designed to ensure that all children currently in receipt of 1915(c) services retain the access to services they need with no interruption due to the Children's Medicaid Transformation. If a specific child is found to have difficulty maintaining his/her services during this transition, the family may contact their care manager, call the State's toll-free managed care help line at: 1-800-206-8125 or email: managedcarecomplaint@health.ny.gov
5. The waiver states "HH will ensure adequate network of former waiver providers"- This is a challenge with the changes re staff qualifications and the transition delay that has created staff shortages in some programs	The State recognizes the difficulties that have arisen due to delays in the implementation. The State will be tracking the transition of each child individually and will make sure there is a care manager for that child. The State will continue to work closely with CMS towards timely approvals to implement the elements of the Children's Design effective January 1, 2019, April 1, 2019, and July 1, 2019. The State will closely monitor the CMS approval process and keep providers and families abreast of any emerging impediments

Public Comment	State Response
	that may impact the schedule, and make any necessary adjustments. The goal is to ensure continuity of care, and readiness of providers, children and families and avoid confusion and the potential need to "start" and the "stop" transition activities, which would be disruptive to families, providers and plans. Providers are encouraged to work with their staff to meet the new standardized staff qualifications.
6. The waiver says State will provide training and education to staff to help walk families through the transition-When?	Please see the responses to comments 1 and 3.
7. Importance of claims testing- We would ask that adequate time be provided to do this properly.	The State has begun working with MCOs on this transition and has provided the necessary information to allow claims testing with providers to begin as early as possible.
8. The draft states several times that there will be a seamless transition for families- This is not accurate and should not be stated	The goal of the transition is to ensure continuity of care and the transition for children and families be as seamless as possible. The State's transition plan is designed to ensure that all children currently in receipt of 1915(c) services retain the access to services they need with no interruption due to the Children's Medicaid Transformation. If a specific child is found to have difficulty maintaining his/her services during this transition, the family may contact their care manager, call the State's toll-free managed care help line at: 1-800-206-8125 or email: managedcarecomplaint@health.ny.gov
9. What is the "global cap" and "capitated rates"? Is there an individual "cap" for Medicaid billed services per youth?	There are no individual cost caps for Medicaid billed for each youth. The global cap is the State's budget for the entire Medicaid program. Capitated rates are the insurance premiums paid to the managed care plans

Public Comment	State Response
10. Can state provide a crosswalk case example of B2H and Waiver services today and what it will look like in new environment with similar services?	For any child on B2H, the current services on the child's care plan would crosswalk to the new authorities/new service names in the following manner: Existing OCFS B2H Waiver Services cross walks to the following services: -Immediate Crisis Response Services crosswalks to the new EPSDT Crisis Intervention SPA*. -Crisis Avoidance, Management & Training AND Intensive In-Home Services crosswalks to the new EPSDT Community Psychiatric Supports & Treatment SPA. -Skill Building crosswalks to EPSDT Psychosocial Rehabilitation Services SPA. -Health Care Integration crosswalks to the Health Home, Health Home-like HCBS care management, or the Independent Entity. -Crisis & Planned Respite crosswalks to Respite in the Children's waiver amendment -Prevocational Services crosswalks to Prevocational Services in the children's waiver amendment. -Family/Caregiver Support Services crosswalks to Caregiver/Family Support & Services in the Children's waiver amendment -Supported Employment crosswalks to the Supported Employment in the Children's waiver amendment -Special Needs Community Advocacy and Support (SNCAS) crosswalks to Community Self-Advocacy Training and Support in the Children's waiver amendment -Day Habilitation crosswalks to Community or Day Habilitation in the Children's waiver amendment -Adaptive and Assistive Equipment crosswalks to Adaptive and Assistive Equipment in the Children's waiver amendment -Accessibility Modifications crosswalks to Environmental or Vehicle Modifications in the Children's waiver amendment

Public Comment	State Response
	**Note: Providers will not be permitted to bill the former waiver services codes once the 5 Children's waivers (including the OMH SED waiver) is terminated on 4/1/2019. Providers will need to bill the new codes published on 8/7/2018. Three Children and Family Treatment and Support Services will be implemented statewide as State Plan services on January 1, 2019. These services are: Community Psychiatric Support and Treatment (CPST), Other Licensed Practitioner (OLP) and Psychosocial Rehabilitation (PSR). From January 1, 2019 to March 31, 2019, OMH SED waiver and OCFS B2H waiver providers who are designated to provide the Children and Family Treatment and Support Services listed above, should bill the Children and Family Treatment and Support Service for crisis activities that correspond to the Crisis Response or Immediate Crisis Response crisis activities from the waivers. This is outlined in the grid found on page 9 of the New York State Children's Health and Behavioral (BH) Services-Children's Medicaid System Transformation guidance for the Transitional Period January 1, 2019-January 1, 2020, available online at: https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/billing_supplement.pdf, and in compliance with the provider qualifications in the Medicaid State Plan Children and Family Treatment and Support Services Provider Manual, available at: https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/proposed_spa.htm* *The authorities direct the provider to bill the new crisis Intervention service under the 1115, not the former service rate codes for Crisis Response or Immediate Crisis Response under the terminated waivers.*
11. Explain capacity and removal of slots/removal of waitlist.	Under all of the existing waivers, except the CAH I/II, there isa maximum number of children the State has been budgeted to serve (i.e., slots). Presently, when the slots under the current waivers are at capacity, eligible children needing those services are placed on a waiting list until a budgeted position/slot becomes available. Under the new consolidated Children's waiver, the State will increase the capacity to serve children by gradually adding additional capacity to the waiver until all children meeting the criteria under the new waiver will have access to the waiver and there is no waiting list. It is expected that in 2022 all children needing services will immediately receive services and not be placed on a waiting list to await a budgeted slot (i.e., the waiting list will be eliminated).

Public Comment	State Response
12. Care Management must not be removed as a Waiver Service: The State asserts that "no programmatic changes are being proposed" and that "all of the HCBS services authorized under the six current 1915(c) children's waivers will continue to be authorized". The State has provided assurances that the waiver would not result in "eliminating a service" [Transition Plan-Attachment #1]. That said, upon reading the proposed Children's Waiver, Care Management has been completely removed as an independent waiver service, although many medically fragile children rely on and need case management as their only waiver service through current 1915(c) waiver. This must be remedied. How will Family-of-One Children who meet HCBS LOC institutional admission criteria and need care management as their only waiver service be able to access that service and HCBS enrollment moving forward, if Care Management is made exclusively a State Plan service, which those Family-of-One children would not be able to access absent waiver enrollment? If care management is removed as an HCBS waiver service, continuity of care and maintenance of benefits cannot be appropriately assured. Health Home Care Management "look-alike" should be added back as a specific waiver service for those children unable to access care management through State Plan.	The State will work with CMS to ensure that all Family of One children currently in a Children's HCBS waiver remain eligible for HCBS, under either the 1915(c) or 1115 Demonstration waiver. The State will ensure that any Family of One children receiving HCBS and/or comprehensive care management, who are determined medically needy as individuals without regard to parental income and resources, remain eligible in the same manner as under the former children's 1915(c) waivers now in #NY.4125 concurrent under the 1115 MRT waiver. This includes waiving deeming of income and resources (if applicable) for all medically needy children (both SSI-related and non-SSI related) who meet targeting criteria, risk factors, and institutional level of care and needs based criteria for HCBS. Because Family of One children meeting LOC are not eligible for CFCO services under the approved CFCO State Plan, the State will make them eligible for the CFCO services under the 1115.
13. Spousal Deeming: Just as medically fragile children not otherwise eligible for Medicaid because of parental income and resources are able to receive HCBS/Medicaid eligibility through parental deeming, we encourage the State to expand on the Medicaid Eligibility Groups identified in the proposed Children's Waiver, permitting spousal deeming as well as parental	New York does not utilize the Special Income Group authorized under 42 CFR 435.217 which would allow spousal deeming/impoverishment rules to be applied. The State's waiver of §1902(a)(10)(C)(i)(III) of the Act allows the State to use institutional income and resource rules for the medically needy and only applies to the Family of One group of children.

Public Comment	State Response
deeming, especially given children's waiver eligibility is being extended to age 21.	
14. Wait Lists: The State has expressed intention to limit number of participants served in the Children's Waiver at any point in time, at least for 3 years. Current Care at Home waivers do not have limits or waitlists imposed by the State. We appreciate the State's assurance that "there will be no wait list for Medically Fragile Children", though request specific documentation and guidance on the methodology the State intends to use to manage waiver capacity with further description on how waiver access will be assured for all medically fragile children. How specifically will the State manage waitlists for Family of One children unable to access Medicaid services until enrolled in the waiver, including specific timeframes when functional eligibility is determined up until enrollment can begin?	Children who would have been eligible under CAH I/II and OPWDD CAH Medically Fragile including Family of One will not have a wait list. There are slots reserved for children meeting the CAH criteria. In addition, there are emergency slots that will be held back to be utilized for all children including CAH Family of One children to ensure that no child remains in an institutional setting awaiting an open slot. The State's Independent Entity will determine HCBS eligibility for all Family of One children who are unable to access Medicaid services until enrolled in the waiver. This will ensure timely processing of Family of One eligibility.
15. Public Input: In the State's description of how it secured public input developing the waiver, there is no mention of the State seeking input from the children and families who need and receive waiver services who will be impacted. We have and continue to strongly encourage the State to actively engage families in children's service system redesign, seeking their direct input on proposed waiver and service system changes, as families are the heart and purpose behind these essential supports, and their voices must be valued and heard.	Over the past several years, the State has continued to provide public information in a variety of forums on the elements of the children's transition, and has been sensitive to the timing of discussions with children and families given changes the implementation schedule and the desire to avoid member confusion about the timing and implementation of new services. Based on guidance from CMS on the structure of approvals required to implement the design, we are moving forward with the key transition dates of January 1, 2019 for new State Plan services and the transition to Health Home, and the April 1, 2019 and July 1, 2019 implementation dates. The State will work as closely as possible with CMS to ensure that the timing of letters to families in relation to the timing of CMS approvals will not result in confusion and the potential need to "start" and the "stop" transition activities, which would be disruptive to families, providers and plans. Please see responses 1, 2, and 3.

Public Comment	State Response
16. Supporting current Waiver "Age Outs" during Children's Waiver Transition Period: Currently, Care at Home 1915(c) waiver enrolled children age out upon turning 18. We fully support the direction the State has taken in the new Children's Waiver extending eligibility and access to waiver services to age 21. Up until 04/01/2019 though, there will continue to be waiver age-outs of children turning 18, who may otherwise qualify for upcoming children's waiver services until 21. Discontinuing current waiver enrollment and access to services for just a few months, to then require those children go back through a potentially arduous enrollment process, tasked with securing service providers again, seems counterproductive and an unnecessary disruption in care. In order to help with ensuring a smooth transition to Health Homes and the Children's Waiver, we recommend the State put parameters in place now so those "age-out" youth can maintain waiver eligibility and access to services during the interim transition process until full transition to concurrent 1915(c)/1115 Children's waiver takes place.	At this time, children aging out of the CAH I/II waiver may access services through the MLTC waiver. Children aging out of the CAH OPWDD waiver may access services through the OPWDD comprehensive waiver. Beginning on 4/1/2019, the age limits do go to 21 and there will be a streamlined process.
17. HCBS Eligibility & Level of Care Determinations: The State's Transition Plan points to a new HCBS Eligibility Determination tool to be included in a modified version of the CANS-NY. We request the State make available that tool and the proposed HCBS LOC eligibility Screen, for public review and comment. To ensure full transparency and equitable access to waiver services, we continue to request the State share the specific criteria and algorithms to be applied to the CANS-NY, which will be used for LOC determinations and establishing eligibility for Home and Community	The State has made the LOC criteria for HCBS eligibility public at the following website: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_children/docs/hcbs_loc_functional_criteria_algorithm.pdf

Public Comment	State Response
Based Waiver Services for populations including medically fragile children.	
18. The description of Target Criteria for the medically fragile population mentions SSI certification. Given individuals may have SSI certifications based on a variety of conditions, how will SSI certifications be reviewed in comparison to children's waiver eligibility requirements to ensure an appropriate condition is present? Significant issues and delays have occurred enrolling children in CAH waiver when SSI Diary Date letters are provided, to then find later the SSI approved condition is not an approved condition to make the child eligible for waiver, then having to pursue a disability determination causing further impactful delays in the child receiving waiver approval and access to care. What steps will the State take to ensure SSI certification and disability determination review issues do not persist in the new Children's Waiver? We so appreciate the State creating a framework to establish physical disability through completion and approval of childhood disability review forms [i.e. OHIP 0005, 0006, 0007 etc] by Licensed Practitioners of the Healing Arts as an alternative to current SSI certification and Disability Determination processes. It would help if the State could share additional guidance on overall anticipated documentation and work flow required if using that pathway to substantiate LOC target criteria.	Children will not have to have an SSI determination to establish eligibility under the program. Additional guidance on the OHIP forms can be found at: https://www.health.ny.gov/health_care/medicaid/publications/gis/15ma016.htm. The child must meet one of the following: i. Current SSI Certification or ii. LDSS-639 disability certificate or iii. Forms: OHIP 0005, OHIP 0006 and OHIP 0007 completed by appropriate professionals and caregivers to be reviewed and approved by an LPHA Please note: NY has requested a waiver under the 1115 demonstration to allow Family of One under ADC rules. However, Family of One children are recommended to continue to obtain SSI eligibility for more favorable eligibility treatment under the waiver.

Public Comment	State Response
19. The Children's Waiver references OPWDD's intent to use the ICF/IID level of care instrument used in the OPWDD comprehensive 1915(c) waiver. We wish to point out that the referenced tool is not the same Care at Home Level of Care Medical Care Screen used to establish eligibility and level of care for CAH waiver today, so we are not sure why OPWDD would use a different LCED form instead. Processes to establish eligibility that include OPWDD involvement continue to seem cumbersome overall. We recommend the State create a "pass through" process for Developmental Disability determinations for children in Early Intervention as those children have already been determined to have a qualifying disability.	The current CAH Level of Care Medical Care Screen elements have been cross walked to the CANS and all required LOC elements have been included in the CANS. If a child is eligible for a hospital or NF level of care, then that child may continue to obtain eligibility under that level of care. However, historically the CAH IV waiver (CAH OPWDD waiver) has permitted children who are medically frail to meet ICF-IID level of care and become eligible for HCBS. The State does not intend to remove this level of care from the Children's HCBS waiver and intends to meet Maintenance of Effort requirements. *Maintenance of eligibility for Medicaid* *In order to qualify for federal reimbursement for their Medicaid programs, states may not use or have in effect any eligibility standard, methodology, or procedure for determination of Medicaid eligibility that is more restrictive than those in the state plan or any applicable waiver program in effect on the date of enactment of the PPACA. This maintenance of effort requirement is effective until 10/1/2019, with respect to individuals under age 19 (or the state's higher age limit, if applicable). States are free to use less restrictive eligibility requirements. A methodology, standard or procedure is less restrictive if an individual who was not eligible for Medicaid or a waiver on the date of enactment becomes eligibility when the standard is changed.* *Act Sec. 2001(b)(1) of the PPAC (P.L. 111-148) amending SSA 1902(a) by adding paragraph 74 Act Section 201(b)(2) of the PPAC, amending SSA 1092 by adding subsection (gg)*

Public Comment	State Response
20. Habilitation: We wish to express great concern with the use of "mentally capable" terminology as a pre-requisite for enrollment into Habilitation services. The Children's Waiver defines Acquisition as "the service available to a physically and mentally capable individual who is thought to be capable". That terminology is not consistent with Habilitation standards, is certainly not person-centered and will undoubtedly lead to messy and inconsistent interpretation of eligibility requirements and inappropriate service denials. Clear and appropriate standards must be put in place. Additionally, the descriptions and eligibility requirements pertaining to Habilitation Services are quite differently described in the State Plan Amendment (SPA) 13-0035 for CFCO as compared to Waiver Habilitation services described in the proposed Children's Waiver and NYS Children's Medicaid System Transformation Billing and Coding Manual. If the State intends to use CFCO as a substitute for Waiver Habilitation services, to ensure consistency in eligibility and access, this begs a closer review.	The State has modified the definition to remove "mentally capable" terminology and to make the Community Habilitation definition more consistent with the CFCO definition.
21. Respite: The proposed Children's waiver expresses that "It is the responsibility of the Care Coordinator…to ensure that respite providers have adequate training and knowledge to address the individual child/youth's needs". This language should be changed. It is the Respite provider who must ensure their staff are appropriately trained and equipped to provide the service. Care Coordinators cannot be held responsible for ensuring the requirements of other providers are met, especially in light of conflict free case management requirements	The following change has been made: It is the responsibility of the provider upon referral to ensure that respite providers have adequate training and knowledge to address the individual child/youth's needs (including but not limited to physical and/ or medical needs such as medications or technology), OR have made arrangements for an appropriately trained and knowledge individual to address the individual child/youth's needs (including but not limited to physical and/ or medical needs such as medications or technology. Examples include arrangement of approved Private Duty Nurse for a technology dependent child while in a respite setting.

Public Comment	State Response
22. Environmental Modifications/Assistive Technology: We encourage the State to reconsider language in the Children's Waiver that says EMOD/AT "costs cannot exceed $15,000 per year without prior approval from the LDSS in conjunction with NYSDOH". That language seems prohibitive and could lead to inappropriate LDSS/MCO denials. The reality is that costs for home and vehicle modifications are typically well above 15k, though we do appreciate the language in the waiver assuring exceptions will be considered when medically necessary. Perhaps the State should consider changing those cost limits to 45k every 3 years instead, along with the medical necessity exceptions. Additionally, much training and reinforcement of requirements is needed for LDSS staff to ensure they understand and can fulfill their role in Emod/Atech processes. The Children's Waiver expresses that the "LDSS or MCO secures a local vendor qualified to complete the required work." That is all well and good, but as it stands today LDSS CAH Coordinators do not often work with families to secure initial assessments or contractors to bid and complete these necessary projects. Much of those responsibilities are shifted instead to Care Managers time and time again. There has been a standstill with emods, so how will the State ensure current issues are rectified in the new Children's Waiver? Also, the proposed Waiver references 00 OMM/ADM-4 from year 2000 – 18 years ago. That ADM and associated guidance, expectations, documentation and work flow must be reviewed and updated. We request the State publish a list of available assessors/contractors approved and able to assist with emod/atech projects.	The limits are consistent with the limits for mods that will become State Plan services when Community First Choice Option services are implemented – which includes $15,000 authorization and DOH prior authorization in excess of that amount. Members are required to access State Plan services before waiver services – so this amount and threshold will be in play for members eligible for CFCO (which will include nearly all children under the 1915(c) waiver). The State will look at historical utilization of mods at various thresholds and evaluatewhether threshold adjustments are appropriate. The State is working to provide more detailed guidance on the implementation of CFCO and is working to ensure access to these services is maintained, regardless of the authorization (1915(c) or CFCO) applicable to accessing the service.

Public Comment	State Response
23. Waiver Services Furnished by Relatives/Legal Guardians: In the proposed Children's Waiver, the State has identified that payment will not be made to relatives/legal guardians. In the OPWDD comprehensive waiver, OPWDD has policies in place to allow relatives to be paid as service providers as long as they are at least 18 years of age, if the service is a function not ordinarily performed by them. Additionally the State may provide exceptions wherein family members, including parents and legal guardians, may be paid to provide waiver services when it can be clearly documented that the arrangement is in the best interest of the participant – this includes respite and community habilitation. This item is also applicable to the Non-Medical Transportation section of the Children's Waiver, as parents/legal guardians today receive approval and reimbursement through MAS to provide Medicaid transportation for their child when appropriate. We encourage the State to rethink stance on this issue, and consider options for allowing relatives/guardians to provide waiver services when in the best interest of the child.	The State will leverage the current State Plan transportation broker to provide services. The State will pay its Transportation broker and leverage policies in the State Plan and Adult HARP program. Those policies allow the broker to make reimbursement for relatives/legal guardians for mileage in certain circumstances. Additional guidance for children's Non-Medical Transportation is forthcoming. **Note: MAS is a contracted transportation provider**
24. Case Manager Qualifications: The Children's Waiver describes Care Managers as employees of a Health Home. This is not entirely accurate and should be changed to reflect that Care Managers are employed by a Health Home OR by a Care Management Agency (CMA) who is contracted to provide care management for the Health Home through a Business Associate Agreement.	This change has been made.

Public Comment	State Response
25. Health Home Notices of Determination: The Children's Waiver describes Health Homes issuing Notices of Determination Decisions when children are approved for Health Home care management, denied or have services subsequently terminated. Health Homes have shifted this responsibility to Care Management Agencies and Care Manager. We strongly urge the State to reconsider the expectation for Case Managers making service related eligibility determinations, as this seems a conflict of interest. Instead, DOH or the Health Home itself should maintain responsibility for noticing individuals, providing info on Rights and opportunity to request Fair Hearing.	The HHCM determines HH eligibility and will conduct the HCBS eligibility determinations – so the HHCM is the appropriate person/entity to send the letters. Additionally, HH CMA are not providing the direct HCBS. If the CMA agency provides services, the agency must have conflict free case management with separate staff, supervisory structure and have firewalls in place. .
26. The Enrollment Broker is responsible to notice children who are required to enroll in a Medicaid Managed Care Plan, due to discontinuation of the 1915(c) waiver exemption. Even now, there are multiple examples of children being improperly enrolled in managed care who meet other exemption/exclusion criteria beside 1915(c) waiver enrollment. Individuals with comprehensive third party health insurance are automatically enrolled in managed care, to then later be dis-enrolled with resulting service disruptions and conflicts from what the managed care plan would cover vs. what FFS will cover. What mechanisms will the State put in place with the Enrollment Broker to ensure no clients who are exempt/excluded from managed care are incorrectly enrolled? The Children's Waiver asserts that "the vast majority of children will be served by MCOs." That said, many children will continue to be exempt/excluded from managed care and will remain in FFS Medicaid, including children with access to comprehensive third party health insurance. Can the State provide an idea as	If the child's comprehensive third party health insurance is noted on the Child's eligibility record, then the child will not automatically be enrolled in managed care. It is the responsibility of the family to ensure that TPL is correctly reflected on the Child's eligibility file. It is estimated that 500-600 HCBS children will remain in FFS.

Public Comment	State Response
to the number of children anticipated to transition to Managed Care vs. children who will remain straight Medicaid?	
27. "Family of One" Children - Support Needed with Medicaid Application Processes: The Transition Plan states that "Medicaid application processes will remain the same". It is worth noting existing issues with Medicaid application processes, particularly impacting "Family of One" children/youth who apply for Medicaid in conjunction with waiver enrollment. Unfortunately, many Family of One applicants who require parental deeming are not recognized as Medicaid eligible by LDSS and are ultimately denied or experience unnecessary delays in approval, which then lead to delays in service access. LDSS/State staff who assist with Medicaid application determinations need training and support to better understand Medicaid eligibility criteria and the regulatory requirements surrounding determinations of eligibility for children enrolling in waiver, ensuring decisions are timely and in keeping with most advantageous Medicaid determination criteria. Additionally, many children who have been inpatient for months are not supported through the hospital to apply for inpatient SSI and Medicaid, with directives given to discharge and then apply through the Marketplace, causing further delays in enrollment. Recognizing these concerns, what steps will the State take to adjust current processes and provide training to LDSS/State staff to ensure "Family of One" children have their Waiver and Medicaid application determinations made appropriately and expeditiously moving forward?	All Family of One eligibility applications will be processed through the Independent Entity using the State's single standardized application processing procedures. The Independent Entity will be trained to streamline the process. The State will commit to monitoring this on an on-going basis.

Public Comment	State Response
28. Early Intervention/Role of Independent Entity: Individuals may not receive more than one form of targeted case management service at a time. When Care at Home case management is approved for Early Intervention eligible children, the CAH case manager must assume the roles and responsibilities of EI ongoing service coordination in addition to CAH. Very little is mentioned in the proposed Children's waiver about Early Intervention, so additional information concerning EI and how it intersects with the Children's Waiver should be added. It stands to reason that when the Independent Entity acts in a case management capacity, developing and monitoring implementation of the plan of care, the IE should assume the roles and responsibilities of ongoing EI service coordination as well. What responsibilities will the IE have in providing ongoing case management supports, face to face visits, linkages to services/supports, compliance activities and incident reporting? Why has it been made the responsibility of current CAH services coordinators to provide EI ongoing service coordination, but for individuals in the OPWDD CCO Health Homes and those to be supported by Independent Entity, those roles are being separated out?	Children who are eligible for HCBS and require care management will receive comprehensive care management through the Health Home program The Independent Entity will provide care management for children who opt out of Health Homes and do not want comprehensive care management. The role of the IE is defined in Appendix D in general and in Appendix G for incident reporting/compliance. It is anticipated that the Health Homes will serve the majority of children in the Children's waiver. For children enrolled in the Early Intervention Program (EIP) and the Health Home (HH) Program, HH care management and EIP on-going service coordination services are provided by a HH Care Management Agency (CMA) who is dually trained and designated to serve this population. The State is working to increase the number of providers who are cross-trained to provide EI and HHSC care management. .
29. Use of Technology and Tele-visiting: With continued advancement in health information technology, we encourage DOH to explore further opportunities to utilize technology, including the ability to use web-conferencing to conduct tele-visits for care management meetings with families and care teams when practical as an alternative to in-person meetings. This would help cut down on unnecessary care manager travel time, promoting more time for	The following change has been made: Note: the use of telehealth meeting HIPAA privacy requirements (Health Insurance Portability and Accountability Act of 1996) may be utilized for care management to monitor health and welfare as provided for in statute, State regulations and policy. The State is assessing the potential role of telehealth in care management under current statutory authorization and regulations.

Public Comment	State Response
substantive follow-up to meet the needs and advance the plans of each client.	
30. Transitional Payments-Billing-Rate Codes: The State has expressed that providers who historically provided care management services under one of the 1915(c) waivers that are eliminated and who will provide services that are being transitioned to Health Home may receive a transitional rate. CAH providers do not bill a monthly unit of service, but rather bill and receive reimbursement in unit increments for necessary services provided to each child based on their unique and individualized needs. Given that, how will DOH review current rates, with units that fluctuate monthly, to determine transitional rates for CAH providers moving to Health Home per member per month rate structure?	Transitional Payments-Billing-Rate Codes: The State has indicated that providers who historically provided case management services under one of the 1915(c) waivers and who will be transitioned to Health Home and Health Home rates, may receive a transitional rate to transition them from current 1915(c) waiver rates for care management to Health Home care management rates. CAH providers do not bill a monthly unit of service, but rather bill and receive reimbursement in ¼ hour increments for necessary services provided to each child based on their unique and individualized needs. A current analysis of CAH case management billings shows that providers, on average, bill lower than the current Health Home rates Therefore, the transition to Health Home will result in increased reimbursement, and a transitional rate is unnecessary.
31. We appreciate the time and effort put forth by DOH in development of the Children's Waiver. It is apparent the DOH Health Home Serving Children administrative team have given the children's transition due thought and attention. We also value ongoing communication, transparency, partnership with providers and families alike, and thank you for your review and consideration of our comments.	Thank you.
32. The transition being proposed is extremely complicated on the operational side for providers who are also implementing multiple other transitions and new services at the same time. We urge that implementation be adjusted in the following ways:	The State's goal is to streamline the structure of the program so that children and families are no longer siloed into 6 different waivers with 6 different benefit packages, multiple administering entities, and multiple changes.

Public Comment	State Response
32 a. No implementation of HCBS services begin until at least 90 days AFTER FINAL CMS approval of all aspects of the consolidated HCBS array (rates, standards and conditions and details beyond a conceptual framework). If plans need 90 days from final rate notification to operationalize billing, then providers need 120 days to allow for test claims.	The State has begun working with MCOs on this transition and is encouraging early claims testing with providers.
32. b. If transition of children from ICC and HCI continues to move forward in advance of the implementation of the new service array, for agencies with 200 or more children to transition, they be allowed 4 months to complete reassessments and caseload transfers, rather than the proposed 3 months. This is necessary because of staff turnover, which will be exacerbated once the new CFTS services are implemented on January 1 as many OLP staff will be former ICC and HCI staff due to the credentials required to provide that service and the limited workforce to draw from to meet the staffing needs of multiple programs.	Agencies are encouraged to begin discussions now with children and families consistent with released guidance for OLP, CPST, and PSR transitions effective 1/1/2019. The State encourages agencies to develop internal business plans which take into consideration changes in staffing during this transition. Agencies are responsible for supporting continuity of care for families currently being served and should have processes in place to ensure warm handoffs and ability to meet timing constraints of transition to Health Home.
32. c. All children currently on existing OMH SED and OCFS B2H Waiver wait lists must be eligible for transition to the new array.	There is no authority to transition a child on a wait list to the new HCBS who is not actually enrolled in a waiver as of April 1, 2019. Children who are on wait lists as of April 1, 2019 will be afforded access to the waivers according to the State's capacity management plan, if found eligible under the Children's waiver criteria. The State is now developing processes to help connect kids on current waiver lists with new services.

Public Comment	State Response
32. d. If any Medicaid Managed Care Plans do not have their operational systems ready for April 1, 2019 transitions, the entire region served by that plan will be delayed for 30 days or until all plans are operational.	The State is currently working with MMCPs to ensure they are qualified to provide the benefits through a readiness review process. The plan will notify its providers at least 30 days in advance if it will not be permitted to implement on 4/1/2019. The State anticipates all Plans can meet the readiness requirements. If a Medicaid Managed Care Plan's system is not operational, the plan's implementation will be delayed.
32. e. No implementation, even the proposed transition from HCI/ICC to HHSC should occur until at least after 90 days after all community forums have concluded and 120 days after consumer educational materials and all required Medicaid notification has been provided to existing recipients and their families.	Implementation to Health Homes will begin on 1/1/2019 and continue through 4/1/2019 with the transition to managed care. DOH will send families their health home, managed care selection and waiver termination notices more than 30 days in advance of the transition.
33. The implementation of the new HCBS array without the follo wing details is not possible and the information must be public at least 120 days prior to transition:	The 1915(c) waiver has been available in draft since August 7, 2018, and the required 30 day public notice and public comment have been fulfilled. Public comments were due on September 23, 2019.
34. It indicates transitional rates but the amount for these rates are unknown. They are not reflected in the billing manuals either. Providers need to know as they build out their billing systems.	The State is working to finalize draft transitional rates and anticipates posting them in October.
35. The transition rate will be reduced in three phases over a 2 year period. Providers need to know what this reduction amount looks like so they can plan fiscally throughout the remainder of FY19 and beyond. (ex: is it a 33% during each phase?)	The State is working to finalize draft transitional rates and anticipates posting them in October.

Public Comment	State Response
36. Concurrent 1115 MRT Waiver will authorize Crisis Intervention to HCBS eligible children between 4/1/19 and the date the service becomes a State plan which is proposed to be January 2020. During that time, can the provider identify the correct crisis service? OLP Crisis, referral to local Mobile Crisis response, or can they continue providing the current HCBS crisis response and Immediate Crisis response and bill the current waiver services code until next January?	Providers will not be permitted to bill the former waiver services codes as of the termination date of the 5 Children's waivers (including the OMH SED waiver) on 4/1/2019. Providers will need to bill the new codes published on 8/7/2018. Three Children and Family Treatment and Support Services will be implemented statewide as State Plan services on January 1, 2019. These services are: Community Psychiatric Support and Treatment (CPST), Other Licensed Practitioner (OLP) and Psychosocial Rehabilitation (PSR). From January 1, 2019 to March 31, 2019, OMH SED waiver and OCFS B2H waiver providers who are designated to provide the Children and Family Treatment and Support Services listed above, should bill the Children and Family Treatment and Support Service for crisis activities which correspond to the Crisis Response or Immediate Crisis Response crisis activities from the waivers. This is outlined in the grid found on page 9 of the New York State Children's Health and Behavioral (BH) Services-Children's Medicaid System Transformation guidance for the Transitional Period January 1, 2019- January 1, 2020, available online at: https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/billing_supplement.pdf and in compliance with the provider qualifications in the Medicaid State Plan Children and Family Treatment and Support Services Provider Manual, available at: https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/proposed_spa.htm These authorities direct the provider to bill the new crisis Intervention service under the 1115, not the former service rate codes for Crisis Response or Immediate Crisis Response under the terminated waivers.
37. When will consumers and providers get educational materials/fact sheets, etc. It seems the providers are absorbing the heavy lift of messaging and providing materials which is an added expense.	The State has developed a consumer education plan in collaboration with stakeholders. There are monthly meetings with stakeholders to discuss consumer education. Educational materials including brochures, posters, and videos will be released publicly from the fall of 2018 through spring 2019.
38. Will the enrollment broker (EB) only notify the individual of the MMCP assignment? Who will notify the Health Home care manager (HHCM)?	The EB only notifies the individual of the MMCP assignment. HHCM should verify Medicaid eligibility and specific plan enrollment. Additional notifications will not be generated to Health Homes and providers.
39. For LOC's, why can't the LPHA also determine functional criteria instead of just risk factors? Is there a	The federal standard for HCBS eligibility requires children to meet specific target, risk, and functional criteria. The HCBS Eligibility Determination, completed by the HH or IE, is the State's tool for to determining functional criteria. LPHAs will not determine HCBS

Public Comment	State Response
need to use the CANS tool to just determine that eligibility component? Does the LPHA need to provide their NPI# on the written clinical documentation? It only asks for their license number right now. Will the CANs algorithms be the same algorithms used now to determine acuity or when will providers see the revised algorithms?	eligibility. The Health Home or Independent Entity will utilize the CANS for the LOC functional eligibility determination. LPHAs will need a NPI# for recommending a service and attesting to the clinical need for the service. However they will not need a NPI# for referring the child to a service, as anyone can refer a child to services. See the definitions below for referral vs. recommendation. Referral: when an individual or service provider identifies a need in a child/youth and/or their family and makes a linkage/connection to a service provider for the provision of a service to meet that need. Recommendation: when a treating Licensed Practitioner of the Healing Arts (LPHA) identifies a need in a child/youth based on a completed assessment and documents the medical necessity for a specific service, including the service on the child/youth's treatment plan. Recommendation and Referral definitions can be found in the Children and Family and Support Services in-Depth Training w/ Review of New Implementation Timeline, In person Training May-June 2018, available at (under Transformation Webinars tab): https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/web-info_child_mst.htm The CANS algorithms have been modified. The State has made the LOC criteria for HCBS eligibility public at the following website: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_children/docs/hcbs_loc_functional_criteria_algorithm.pdf

Public Comment	State Response
40. Fiscal Criteria for family of one - not clear if the standard is the same for Foster Care Medicaid eligible kids and community Medicaid kids and OMH waiver eligible kids. Clarification required.	Family of One fiscal criteria under the 1915(c) waiver will apply only to children who have had SSI eligibility determined. The State has requested additional authority through the 1115 to apply Family of One criteria to children under ADC rules (i.e., waive deeming of income and resources (if applicable) for all medically needy children (both SSI-related and non-SSI-related) who meet targeting criteria, risk factors, and institutional level of care and needs based criteria for HCBS). As noted above, Family of One children are encouraged to obtain SSI eligibility for more favorable eligibility budgeting. Note: Foster care children are categorically eligible for Medicaid during the time they are in foster care and for 12 months following the point they leave foster care. Consequently, they are Medicaid-eligible due to their foster care status; and financial or medical need are not considered in determining Medicaid eligibility. Upon expiration of the 12 month period, the child's Medicaid eligibility may be determined using the Family of One budgeting methodology, and former foster care status would have no impact on the child's ability to receive that budget, if appropriate.
41. If any MMCP does not have their operational systems in place by 4/1/19, will all providers with contracts be notified? Who will provide notification? Will notification come 30, 60 or 90 days prior to 4/1/19?	The State is currently working with MMCPs to ensure they are qualified to provide the benefits through a readiness review process. The plan will notify its providers at least 30 days in advance if it will not be permitted to implement on 4/1/2019.
42. How will the Enrollment Broker will engage VFCAs? What is meant by VFCA will confirm enrollment? Doesn't the EB enroll the child into the MMCP?	The State is in the early phases of designing a plan selection process for children in the care of a voluntary foster care agency (VFCA). At this time the State envisions that the Enrollment Broker will process plan enrollments for this population and that VFCAs will have a role in the plan selection process. Providers should always confirm MMCP enrollment via eMedNY prior to delivery of service.
43. How and when the state will inform providers of the survey results and which MMCPs are on corrective action plans?	The State will not distribute the readiness review results to providers. The State will work with MMCPs directly on any corrective action plans which may be in place throughout the transition period.
44. We strongly support the State in upholding the Medicaid transformation design plans to include the Level of Need (LON) eligibility criteria under the 1115 Waiver as released in April 2018 to include children who have: a) experienced abuse, neglect or maltreatment, b) meet Health Home complex trauma eligibility criteria and c) Serious Emotional Disturbance (SED) with or without co-occurring	Thank you - the State is continuing its negotiations with CMS around this population in the 1115.

Public Comment	State Response
Substance Use Disorders (SUD). The LON eligibility criteria fill a critical gap by helping children to access HCBS when they are not so functionally impaired as to meet Level of Care (LOC) criteria, and yet are needing services beyond those available through the State Plan	
45. We also strongly support the expansion of LOC slots for HCBS services. The New York City region regularly experiences a shortage of OMH 1915(c) Waiver slots to accommodate the need for services and assigns children to interim levels of care while they are on a waitlist for HCBS. We recommend the slot expansion be allocated across the state proportionate to population size and identified need. In this way we hope to see a reduction in behavioral health related hospitalizations and other forms of institutional care in the coming years as more children benefit from the array of HCBS available through the children's system of care.	The State is anticipating apportioning the slots by region and region size as noted in the 1915(c) waiver.
46. DOHMH and ACS believe it is critical that comprehensive guidelines are created by the State to ensure that uniform transition plans are created for youth aging out of children's services, so they may continue to receive services appropriate for their needs as they age-into the adult service system. As the application notes, the Children's Waiver package of services does not align with adult services and resources. Therefore it is critical that the responsible entities, be it the MCO, HHCM, and IE are adequately equipped to make the appropriate referrals for services and support youth with their transition to adult services and ensure linkages have occurred. DOHMH and ACS believe that given the proper supports, knowledge and resources by these entities, youth will successfully transition into the adult system when they turn 21.	The State agrees that additional guidance to Health Homes and MCOs concerning transition-age youth is needed, and looks forward to developing this future guidance with stakeholders. Mainstream MCOs must manage BH care for special populations including children participating in BH programs and HCBS, also known as Transition Age Youth (TAY). Management of this population includes developing a transition plan to ensure continuity of care until age 23 or until the youth is stabilized in the adult system, whichever is later.

Public Comment	State Response
47. ACS appreciates that the services detailed in Appendix C very closely match services currently offered to youth in Bridges to Health (B2H) services. We are encouraged that this will ease the transition for both service providers and for the children and families currently in B2H programs.	Thank you.
48. NYC local government has the responsibility for ensuring the health and well-being of NYC's child and family population, and we have the shared goal with New York State of ensuring that children receive the care that they need through this HCBS workflow. With access to data, NYC can monitor local implementation of the State's Medicaid System Transformation and its impact on children's access to care. Examples of data that would be needed to fulfill this role include but are not limited to real time and historical data on child Medicaid enrollees, including CANS assessment data, acuity scores, HCBS eligibility determinations, plans of care, and utilization of services.	The State will work with local government to ensure that data necessary for monitoring quality of care is made available.
49. This section appears to describe the target populations for LOC along with capacity limits. Can the state provide clarification on the component of 'Level of Need' being included in this waiver amendment? Previous feedback indicated LON indicators would not be developed or shared prior to 2021, and there is confusion about LON being included in this amendment.	Level of Need is not included in this 1915(c) waiver, because that functional criteria is less than an institutional level of care. HCBS for children meeting LON will continue to be authorized under the 1115 Demonstration requested from CMS and will be implemented after the full implementation of LOC.

Public Comment	State Response
50. This section describes the service differences between Community Habilitation and Day Habilitation. The document also stated that only habilitation services not reimbursable under CFCO will be reimbursable under the HCBS Waiver. Can additional information relative to CFCO services (eligibility, UM guidelines, medical necessity criteria, etc.) be made available? What habilitation services (or unit thresholds) are not reimbursable under CFCO? Is a recipient authorized to use both benefits in the same calendar year?	The service definitions for Community Habilitation align with CFCO definition of community habilitation. When community habilitation becomes a State plan service upon implementation of CFCO, members will be required to access State Plan services first. The State will amend the 1115 waiver to ensure children who are eligible for the 1915(c) waiver are eligible for CFCO services (including Family of One Children). The State is working to provide more detailed guidance on the implementation of CFCO and to ensure access to these services is maintained, regardless of the authorization (1915(c) or CFCO) applicable to accessing the service.
51. The document references that the State Medicaid Agency is responsible for tracking the licensure and certification status of HCBS designated providers, and intends to collect that data from MCO credentialing files. MCOs have previously been provided information that plans must accept state designation as credentialing and are not authorized to conduct individual credentialing of staff conducting HCBS. Please provide clarification of the credentialing responsibilities of the plan.	The State will perform the licensure and certification of HCBS designated providers. MCOs must accept State designation. However, the MCO must continue to verify that the provider continues to receive designation from the State in its credentialing process.
52. Regarding the provider training verification, please clarify what training verification records MCOs are expected to maintain from their provider network	The MCO is expected to maintain attendee records of any HCBS trainings it conducts for its providers. This includes any HCBS trainings the MCO conducts in conjunction with the State or other managed care plans.
53. Additional clarification is requested regarding the MCO responsibilities to report critical incidents to NYSDOH. Currently, plans do not have access to state databases containing this information and are reliant on member or provider reporting this information to the plan.	The MCOs are expected to report critical incidents to NYSDOH according to the Model Contract section 10.38.

Public Comment	State Response
54. The claims auditing process described to occur in eMedNY references cross-review of Care plans. Please provide clarification on the MCO responsibilities to conduct audits of HCBS provider care plans during the first two years of the implementation during the non-risk period.	The MCOs are expected to perform utilization review and ensure that HCBS Plans of Care contain the federally-required components of the Plan of Care outlined in the MCO contract. This includes ensuring that the needs and goals of the beneficiary identified in the assessment are addressed in the HCBS plan of care and that the assurances outlined in the RFQ are met. The MCO reviews all enrollment and annual reevaluation documentation. This includes Application form, Freedom of Choice form, Choice of Case Management/Provider Selection form, proof of age, proof of physical disability, proof of Medicaid eligibility, Level of Care, care management selection, MD orders (if any), and Plan of Care. Finally, if the member has opted out of the Health Home, the MCO Care Manager must routinely contact families and providers regarding waiver applicants and services rendered to the waiver participant. MCOs monitor plans of care. If corrective actions are indicated, the MCOs or State staff will notify the provider in writing of necessary remedial actions. MCOs also will evaluate the documentation from the plans of care against claim data acquired through the MCO claims payment, to assure that services have been appropriately delivered in accordance with the approved plan of care. The MCO can request adjustments to the plan of care, either at time of application, at the six month review, or any time during the review period, when the MCO determines that the proposed or implemented POC will not meet or is not meeting the needs of the applicant/waiver participant. If the necessary parties (providers, MCO, HH/IE, and applicant/parent) cannot agree, the MCO Medical Director or NYS DOH OHIP Medical Director or his/her designee will review case documentation and take action to resolve the situation.
55. Additional information on claims/ auditing analysis criteria that MCOs are expected to use to monitor HCBS services being delivered as billed is requested to meet this requirement.	The MCOs are expected to ensure that the services billed and paid match the POC developed and approved for the member. MCOs will also evaluate the documentation from the plans of care against claim data acquired through the MCO claims payment or the FFS eMedNY to assure that services have been appropriately delivered in accordance with the approved plan of care. If the HCBS providers bill excess services above what is in the POC, the MCO is expected to determine if a change in the POC is needed. If the HCBS providers do not bill the authorized services on the POC, then the MCO is expected to determine if there is an access issue or other issue that needs to be addressed to ensure the health and welfare of the beneficiary. The MCO is expected to work with the HH in all instances.

Public Comment	State Response
56. Actuarially sound capitation rates are referenced as a data source to inform the requirement that the state pays the MCO sound rates after year two of managed care. Additional information on the actuarial assumptions and rate structures for capitation used in this transition is requested for plan finance teams to be able to participate in this data collection requirement.	This information will be forthcoming.
57. Appendix I-2 describes that Accessibility Modifications or Adaptive and Accessibility modifications are paid using a contract amount, and the MCO or LDSS is the provider of record for billing purposes. MCOs require information about the standard bidding process and verification of completion expectations that are referenced in the waiver.	The State is working to develop guidance on providing these services.
58. Medical necessity criteria that authorizes a contract amount for Home and Vehicle modifications in excess of the maximum expenditure limits must be defined and provided to the MCO to adhere to this requirement	As noted above, additional guidance will be provided.
59. The billing validation process describes that an individual's waiver eligibility determination will be entered by the HHCM/IEIE through the HCS system to NYSDOH or it's designee. Please provide more information if MCOs will be receiving this notification through HCS or through previously described RRE K codes on the roster files.	Consumers who have been determined Level of Care (LOC) eligible for children's HCBS will be identified with RRE K1. Even if a consumer has been determined HCBS eligible, the MMCP must authorize specific HCBS against the consumer's POC. Therefore, the State anticipates that MMCP will need to use a combination of RRE K1 and the consumer's POC to authorize payments.

Public Comment	State Response
60. Appendix J-2 appears to provide estimates of the anticipated number of unduplicated participants served during the course of the waiver- and the count of participants is significantly lower than previously reported estimates of waiver populations carving into MMC under each waiver, and are also lower than plan specific data that was shared for CY 2017. Please provide clarification on the estimated number of participants served by the waiver, or if the estimates reflected here are a subset of the whole population impacted by the 'concurrent' waiver approach.	
61. Home and vehicle modification data on appendix J indicates that the average cost per unit is $25,000, yet the current billing guidance indicates there is a maximum expenditure of $15,000. Please provide additional information on how the limit was calculated as being appropriate.	The maximum expenditure of $15,000 reflects the average expected cost for all 6 waiver populations combined, which is a lower weighted average than the $25,000 CAH I/II average cost per unit in the initial years of the waiver prior to adding the other populations.
62. The Children's Waiver Could Be Helpful if Dually Diagnosed Children Could Participate Permanently DRNY is supportive of DOH's proposal to consolidate several Home and Community Based Services ("HCBS") Waivers into a single Children's Waiver as this could increase the efficiency and effectiveness of the current Waiver delivery system. DRNY regularly encounters children with both serious mental illness and intellectual and developmental disabilities ("dually diagnosed children") who are routinely unable to obtain the necessary supports and services for safe and effective community living. Dually-diagnosed children are eligible for services from both the Office for Mental Health and the Office for People with Developmental Disabilities ("OPWDD"), but are forced to pick one agency and thus forego essential services only offered by the other.	Thank you

Public Comment	State Response
Children with both developmental and psychiatric needs require services tailored from both programs. The formation of a single Children's Waiver addresses this gap.	
63. However, we object to limiting access to the Children's Waiver to three years for dually-diagnosed children. DOH intends to implement the Children's Waiver for dually diagnosed children in July 2019, but in 2022, exclude dually diagnosed children who are eligible for OPWDD services. Delivery of OPWDD services for dually diagnosed children is currently ineffective; forcing these children to revert to OPWDD in 2022 makes no sense. While dually diagnosed children are approved for OPWDD services, they often do not receive them. The lack of services frequently results in emergency and permanent institutionalization. For example, in 2017, the Washington Post highlighted one such child, a16 year-old who resided in the emergency room at Erie County Medical Center's ER for nearly a year.1 Other children end up in residential school settings, juvenile detention centers, and other inappropriate settings. OPWDD services alone are insufficient because children and families are not able to secure the community-based services they are approved for and which are essential to the stability of the child in the community.	There is no limitation on Waiver participation for dually-diagnosed children. Dually diagnosed children will not be excluded from this waiver in 2022. In fact, in 2022, waiver access will be increased by the anticipated elimination of the waitlist, and children will be able to readily access the waiver immediately upon being determined eligible. .

Public Comment	State Response
64. In addition, one of the barriers in accessing OPWDD community based services is the inability to recruit providers due to the low Medicaid reimbursement rates. The Children's Waiver proposal addresses this issue. DOH's proposed reimbursement rates for services like respite and community habilitation are significantly higher than through OPWDD's HCBS Waiver. Accordingly, it is more likely children under the Children's Waiver will be able to secure community-based services. Therefore, the DOH should not automatically disqualify dually diagnosed children from participating in the Children's Waiver in 2022 if they are enrolled in OPWDD's HCBS Waiver. Rather, the proposal should be amended to allow the guardians of dually diagnosed children eligible for both OPWDD and Children's Waiver service a choice of participating in the Children's Waiver or staying with OPWDD's HCBS Waiver. Providing sufficient community supports and avoiding institutional placement is both fiscally sound and legally mandated.	There is no limitation on Waiver participation for dually-diagnosed children. Dually-diagnosed children will not be excluded from this waiver in 2022. In fact, in 2022, we anticipate that the waiting list will be eliminated and children will be able to readily access the waiver immediately upon being determined eligible. Children who are eligible under the Children's waiver, and whose needs are met by the array of services are encouraged to enroll under this authority.

Public Comment	State Response
65. We support the Children's Waiver proposal to consolidate the OPWDD and DOH HCBS Waivers for medically fragile children. Moreover, we agree with DOH's Plan to provide children with complex medical needs the services necessary to remain in the community with their families. However, there are presently 500 medically fragile children at pediatric nursing facilities in New York State. In addition, there are at least 50 medically fragile New York children placed by the DOH at an out-of-state nursing home in New Jersey. The Children's Waiver proposal is silent regarding these children. Services for medically fragile children in an institutional setting are expensive. In 2011, the State spent $209.6 million dollars on in-state and out-of-state pediatric nursing homes, specialty hospitals, and specialty hospitals for medically fragile children.2 Based on an ongoing investigation by DRNY, a substantial number of these children no longer require nursing home level of care. Nevertheless, they remain institutionalized due to the lack of active screening for community placement, active monitoring by DOH, and the lack of community-based services needed for community placement. Accordingly, we recommend DOH amend the proposal to state that medically fragile children already in skilled nursing facilities are screened for the Children's Waiver and provided appropriate community-based services.	Children residing in pediatric nursing facilities, as well as in out-of-state nursing homes, are eligible for this waiver. However, children may not actually receive waiver services while residing in an institution. Medically fragile children residing in skilled nursing facilities at the time of their eligibility determination will be screened for the Children's Waiver and provided with appropriate community-based waiver services upon transition from the institutional setting.