New York State
HCBS Settings

I. INTRODUCTION

New York State presents its response to CMS November 2022 request pertaining to its Statewide Transition Plan (STP) activities to come into compliance with the Home and Community-Based Services (HCBS) Final Rule. New York State operates one 1115 and four 1915(c) waivers across four agencies/offices that oversee programs and services to individuals with disabilities; either physical, behavioral, mental, developmental, or intellectual. Within the four agencies or offices that oversee New York's HCBS there are fourteen state entities (in some cases referred to as program areas) that oversee the programs and services described in their respective sections of this STP.

The agencies/offices which oversee New York State's home and community-based service (HCBS) provision are the: Department of Health (DOH); Office for People with Developmental Disabilities (OPWDD); Office of Mental Health (OMH); and Office of Addiction Services and Supports (OASAS). The below listed 1915(c) waivers are those waivers currently operating in New York State. The agency/office indicated to the right of each waiver operates the waiver under the oversight of the Department of Health, the State's Medicaid Agency.

- Nursing Home Transition and Diversion Waiver (DOH)
- Traumatic Brain Injury Waiver (DOH)
- Children's Waiver (DOH)[1]
- Home and Community Based Services (HCBS) Waiver (OPWDD)

The above noted agencies/offices offer HCBS through our Medicaid program, and DOH, OMH, and OASAS provide HCBS under the NY Medicaid Redesign Team 1115 Demonstration Waiver. While State Plan HCBS are not impacted by this regulation, per notification by the Centers for Medicare and Medicaid Services (CMS), New York has addressed the application of the HCBS Final Rule to all HCBS provided through its 1115 Demonstration, including Medicaid Managed Care – referred to as Mainstream (MMC) and Managed Long Term Care (MLTC), both

[1] The New York State Children's Waiver combined and replaced the Care at Home (CAH), Serious Emotional Disturbance (SED), and Bridges to Health (B2H) waivers in April 2019. References to these expired waivers have been removed from the STP where applicable, as well as the related Office of Children and Family Services (OCFS) section and were replaced by DOH's Children's Waiver section.

described in their respective sections of this transition plan.

The State's assessment of our HCBS delivery system indicates that the majority of individuals in receipt of Medicaid-funded HCBS are living in private homes including their own homes or sharing the homes of family members, friends, or neighbors. In addition, many Medicaid recipients may live in group homes or other settings where they enjoy the benefits of receiving services in the community, as opposed to in an institution. However, there are individuals who live in congregate housing, adult care facilities, and supportive housing where their autonomy, independence, and community integration may be less apparent, including children and youth whose rights are delegated to their parents or guardians. Also, respite care is generally provided throughout the State for thirty days or less, with a few exceptions that are noted in each agency/office/unit's Systemic Compliance Chart, linked within each agency/office/unit's Systemic Compliance section within this transition plan.

While the overall policy governing New York's Statewide Transition Plan provides a uniform framework across the agencies, and CMS guidance helped to provide a foundation for New York's systemic/overarching approaches to Rule implementation, the specific way agencies have developed their assessment methodologies, tools, and compliance approaches reflects their unique systems for quality improvement and budgetary resources.[2] Even though some differences in assessment methods exist, every New York State entity that sponsors a Medicaid HCBS waiver program or oversees HCBS followed or is following the required approach delineated by CMS for bringing the HCBS systems into compliance by March 17, 2023, including: (1) a comprehensive systemic review of rules, regulations, policies, etc., and the results of this activity, as well as the remedial actions required to come into full alignment with the HCBS rules; (2) a site-specific validation process for the respective service systems, and, where this was completed, the results of the assessments; (3) the remedial actions that are being implemented to achieve compliance; (4) methodology for ongoing monitoring and quality assurance; (5) training and other quality improvement activities and methods planned ongoing; and (6) Heightened Scrutiny processes where applicable. Note: for state entities responsible for the site level compliance of HCBS settings, their STP sections contained all of the above areas of focus, whereas MMC, MLTC, and Community First Choice Option (CFCO) are not directly involved in oversight of HCBS settings, therefore their STP sections focused on systemic assessment, ongoing monitoring and quality assurance, and beneficiary recourse.

The revised New York State HCBS Statewide Transition Plan activities that follow are the result of the work of our Interagency Workgroup. This group was convened in 2014 by the Governor's Office to address achieving compliance with the requirements of the HCBS Final Rule. DOH, as the Single State Medicaid Agency, will continue to lead and oversee the State's Interagency Workgroup. The Interagency Workgroup, comprised of agency representatives from the Executive Chamber, DOH, OPWDD, OMH, and OASAS, meet regularly to review how the respective state agencies are progressing in their efforts to achieve compliance with the HCBS Final Rule, and to establish time frames and processes for implementation activities based on internal and external stakeholder feedback and CMS guidance. Through the Interagency Workgroup and management of stakeholder outreach, DOH will continue to carry out its responsibilities related to the HCBS Final Rule.

[2] For example, OPWDD uses its existing quality surveyors to review each program and setting on-site for compliance with the HCBS Final Rule annually because the resources already exist within OPWDD to integrate the HCBS Final Rule into existing quality processes and protocols. The NYS Mental Hygiene Law (MHL) requires review of all facilities overseen by OPWDD at least annually; this same level of infrastructure does not exist as such in other state agency HCBS systems. For many other NYS entities, it was necessary to rely on provider self-assessment processes with required validation methodologies, as specified by CMS guidance.

Single State Medicaid Agency Background

DOH has a long history of community-based care, beginning with the Long Term Home Health Care Waiver in the 1980s. Through our ongoing commitment to providing individuals the opportunity to receive HCBS, we have moved to a system where more than 62 percent[3] of Medicaid spending on these services and supports is on community-based care (elsewhere referred to as community-based long term services and supports) rather than institutional care. We share CMS' goal that individuals in receipt of Medicaid-funded HCBS have their needs, preferences, and goals met in a way that maximizes their independence and community integration.

The majority of individuals participating in Medicaid-funded HCBS live in their own homes or homes of family members, close friends, or neighbors, and this includes individuals living in apartments and affordable housing units through supportive housing or "at market" rent in communities across the State.

There are 285,361 individuals enrolled statewide in New York's Managed Long Term Care Demonstration, (Partial Capitation and Medicaid Advantage Plus) as of September 30, 2022, each of whom requires more than 120 continuous days of long term services and supports. Currently, approximately 99% of these individuals live in the community. A portion of the individuals enrolled in one of New York's Medicaid Managed Care Demonstration plans also receive Medicaid-funded HCBS. In addition, DOH oversees the NHTD and TBI waivers serving 6,692 individuals.

NEW YORK STATE DEPARTMENT OF HEALTH (DOH) OFFICE OF AGING AND LONG TERM CARE (OALTC) ASSISTED LIVING PROGRAMS (ALP) AND ADULT CARE FACILITY (ACF) HCBS SETTINGS TRANSTION

I. SYSTEMIC COMPLIANCE

For the DOH ACF team to come into compliance systemically with the HCBS Final Rule the following was completed:

- A systemic compliance assessment pursuant to ACFs was conducted by DOH in 2018. Clicking this sentence brings you to the 2018 Systemic Compliance Chart on the ACF webpage that represents the results of that assessment.
- Assisted Living Program Home and Community Based Settings Rule Self-Assessment issued 07/05/2016. Clicking on this sentence brings you to Dear Administrator Letter (DAL) 16-15 on the ACF webpage.
- Guidance for Assisted Living Programs to Comply with the Home and Community Based Setting (HCBS) Final Rule issued 11/13/2017. Clicking on this sentence brings you to DAL 17-09 on the ACF webpage.
- Adult Care Facility, Assisted Living Program Onsite Evaluation of HCBS Compliance with attachment issued 11/13/2017. Clicking on this sentence brings you to DAL 17-16 on the ACF webpage.
- Guidance for Adult Care Facilities to Comply with the Home and Community Based Settings (HCBS) Final Rule issued 11/9/2018. Clicking on this sentence brings you to DAL 18-15 on the ACF webpage.
- Educational Webinar for providers on the impact of the HCBS Rule on Assisted Living Programs- “Division of ACF/ Assisted Living Surveillance Home and Community Based Services (HCBS) Settings Rule.” Clicking on this sentence brings you to DAL 21-12 on the ACF webpage. Home and Community Based Settings (HCBS) Final Rule Guidance issued 06/30/2021.
- Amendment of Adult Care Facility Regulation which will further bring the ACF and ALP into compliance systemically with all applicable HCBS Rule standards; anticipated release date is 3/1/2023, post public comment.

[3] According to 2022 Balancing Incentives Program data.

II. SITE VALIDATION

The DOH ACF team's transition planning team has worked thoughtfully to develop a series of comprehensive training and oversight activities that will help further promote the DOH ACF team's ability to fully comply with the federal HCBS site level requirements.

The first step the DOH ACF team took was to measure compliance of its existing licensed ALPs with the HCBS Final Rule requirements through provider self-assessment, using a standard tool developed by DOH based on CMS guidance "Exploratory Questions to Assist States with Assessment of Residential Settings" and with input from provider and patient advocate partners. In addition to "self-assessing" their compliance with the federal requirements, providers submitted pertinent information needed by the DOH ACF team to make a determination of their level of compliance. DOH mirrored this process for ACF's housing or potentially housing a resident who may be receiving Medicaid-funded HCBS within or outside the facility.

In addition, the DOH ACF team conducts site-specific evaluations for a statistically significant sample of ACFs using the federal requirements as a basis for the evaluation utilizing our HCBS Survey Checklist. Such evaluations were conducted by DOH ACF team personnel. To compliment this effort, a survey protocol for annual unannounced on-site licensure inspections was developed. Upon completion, the survey protocol was utilized by survey teams across the DOH ACF team to access each applicable program's efforts towards compliance.

Table 1 (below) details the activities and timelines followed to ensure timely compliance by applicable ACF and all ALP providers.

ADULT CARE FACILITY & ASSISTED LIVING PROGRAM TRANSITION ACTIVITIES

TABLE 1

Activity	Completion Date	Comments
Meet with Provider Associations to Discuss HCBS Requirements and Future Transition Activities	June 8, 2016	None
Solicit Provider Association Comments on Self-Assessment Tool	June 16, 2016	Comments received June 15, 2016, analyzed and incorporated as appropriate
Resident Advocacy Agencies to provide comments on ALP HCBS Self-Assessment Tool	June 17, 2016	Comments received June 17, 2016, analyzed and incorporated as appropriate
Dear Administrator Letter with 2016 ALP HCBS Self-Assessment Sent to Adult Care Facilities	July 5, 2016	None

Division of Adult Care Facilities Webinar for ALPs on Quality Assurance and HCBS Requirements	July 19, 2016	None
2016 ALP HCBS Self-Assessment Due to DOH	July 29, 2016	None
Regional Division of Adult Care Facilities Webinar for ALPs on Quality Assurance and HCBS Requirements	July 27, 2016	Open to all adult care and assisted living providers
State's Analysis of Self-Assessment Completed	September 23, 2016	Analysis will determine statistical sample to conduct on-site assessment
Outreach and Education Activities to Individual ALPs Begins	October 3, 2016	Site visits to a sample of ALPs
Regional Division of Adult Care Facilities Webinar for ALPs on Quality Assurance and HCBS Requirements	October, 2016	Open to all adult care and assisted living providers
Regional Division of Adult Care Facilities Webinar for ALPs and applicable ACF providers on HCBS Requirements	January 2019	Open to all adult care and assisted living providers
Issue compliance guidance to adult homes, enriched housing programs, and assisted living residences	June 2018	None
Issue self-assessment to adult homes, enriched housing programs, and assisted living residences	August 2018	None
Activity	Completion Date	Comments
Conduct a statistically significant sample of onsite assessments	December 2018	Setting standards were found to be in compliance
Developing a process to train surveyors	February 2023	None
Implement HCBS survey protocol	March 1, 2023	Conduct statewide surveyor training

III. REMEDIATION

42 of 44 ACFs have completed their remediation and are identified as compliant with the HCBS Final Rule, with the specific details of that remediation listed in the Heightened Scrutiny section below. Two facilities require additional remediation, as outlined in the Heightened Scrutiny section below. To track the progress of the pending remediation plans and to ensure all settings achieve compliance by the March 2023 deadline, the facilities are followed up with via phone and email every 2-3 weeks. The coordinator receives a status update and helps the facilities remain on track, providing technical assistance and additional guidance as needed.

IV. ONGOING MONITORING AND QUALITY ASSURANCE

To ensure that all settings remain fully compliant, the regional office surveillance teams will make part of their full and/or follow-up inspections to monitor and assess for compliance. This will be made part of the survey tool and will be implemented no later than March 17, 2023. This portion of the survey tool will include a checklist that corresponds with the HCBS Final Rule to ensure all areas continue to be met. All ACFs are monitored at least once every twelve- to- eighteen months on an unannounced basis by the State's regional office surveillance inspector(s). Residents of ACFs have free rein of the community and may come and go as they choose. However, at the height of the public health emergency (PHE), residents' community access was restricted by implemented DOH ACF team and federal guidance to ensure the health and safety of all. Though the COVID-19 PHE is still present, restrictions have lessened allowing residents to resume activities and community involvement as they were pre-PHE. Residents continue to access the community as they desire. All ACFs are "facility-based" and are not private homes or apartments, therefore, it is not applicable to have a process for monitoring private homes or apartments. Upon approval and implementation of the revised regulations, HCBS Rule compliant person-centered planning will be monitored for compliance across all settings, through the surveillance process. All ACFs are surveyed every 12-18 months. At each surveillance the DOH ACF team tours the facility to obtain an overall picture of the environment, residents and staff, and the interaction between them. The inspectors complete a record review with the sample size as the lesser of 15 records or 15% of a facility's total census, with a minimum of 5 records, and may be expanded at the discretion of the inspector. The inspector will also observe resident rooms with a sample size based on number of facility beds (0-20 beds= 100% of bedrooms, 21-40 beds= 50% of bedrooms, 41+ beds= 25% up to a maximum of 50 bedrooms). Resident interviews are also conducted with a sample size of 5 residents. Recipients and providers may refer to New York's Person-Centered Planning and Practice Resource Library (clicking this sentence brings you to the PCP Online Resources Library on the DOH webpage) for additional information about training opportunities made available.

New Adult Care Facility beds, including ALP program beds, added to New York's provider base must apply through the Public Health and Health Planning Council and would have to be compliant to receive certification of the planned beds/facility. In addition, State staff would have to ensure ongoing compliance with the regulations and applicable state and federal requirements including those contained in the HCBS Final Rule, including that meaningful person centered service planning was in full force, that modifications to the plan of care were appropriately individualized and documented, and that staff were trained in all applicable requirements of provider owned or controlled settings.

V. BENEFICIARY RECOURSE

Should a resident wish to file a grievance or complaint with the DOH ACF team they are able to call our

ACF Centralized Complaint Intake Program (ACF CCIP) by calling 1-866-893-6772. The ACF CCIP business hours are from 8:30am to 4:45pm Monday through Friday, excluding holidays. Complaints made after hours may be left on the hotline's voicemail system and will be addressed within 1-2 business days. The ACF CCIP staff will triage complaints as appropriate and will open complaint investigations for the Regional Office staff to investigate. Depending on priority (triage) code Regional Office staff have between 72 hours and 90 days to complete an investigation. Complainants receive an acknowledgment letter of their complaint.

NEW YORK STATE DEPARTMENT OF HEALTH (DOH) OFFICE OF AGING AND LONG TERM (OALTC) ADULT DAY HEALTH CARE PROGRAM (ADHCP)

I. SYSTEMIC COMPLIANCE

Systemic Compliance for ADHCP was achieved through issuance of sub-regulatory guidance, revised regulations, and other tools by the ADHCP team at DOH that will strengthen the alignment of ADHCP state requirements with the HCBS Final Rule. State technical assistance for ADHCP providers and ongoing monitoring activities will address the systemic compliance needs going forward, further addressed in the section Ongoing Monitoring below. The items below represent the major tasks completed to achieve systemic compliance.

The following Systemic Compliance Chart represents the results of the systemic compliance assessment conducted for ADHCP in 2018, on pages 13-18:

- Clicking this sentence brings you to the 2018 Systemic Compliance Chart on the DOH webpage.

Amendment of regulation 10 NYCRR 425 to be fully aligned with 42 CFR 441.301 (c) (1 - 4) to be finalized and released by 1/2023 - removing the requirement for a program to operate at a residential health care facility's primary site and inserting applicable HCBS standards.
Updated Dear Administrator Letter (DAL), sub regulatory guidance issued on March 20, 2022:

- Clicking this sentence brings you to the March 2022 DAL on the DOH webpage.

The Person-Centered Service Planning (PCSP) Guidance and PCSP Template that will now provide further support for compliant PCSP for ADHCPs were issued to providers on November 16, 2022 and added to the ADHCP webpage on November 17, 2022: (clicking this sentence brings you to the DOH webpage where the PCSP Guidance and Template are located within the ADHCP section of the page):

- Clicking this sentence brings you to the PCSP Guidance released to ADHCP providers on 11/16/2022
- Clicking this sentence brings you to the PCSP Template released to ADHCP providers on 11/16/2022

II. SITE VALIDATION

DOH's ADHCP team conducted a series of program self-assessments (PSAs developed based on CMS guidance "Exploratory Questions to Assist States in the Assessment of Non-Residential Settings"), against the standards of the HCBS Final Rule. The ADHCP team assessed all reopened programs (post pandemic) for HCBS compliance through PSA's, record reviews, virtual onsite reviews including interviews with registrants and staff done in private using questions from the guidance listed above, observations made during virtual tours, reviewing documentation such as person-centered plans and pictures of the buildings and signage to the program, checking program addresses for accuracy and google maps images of locations. Areas assessed were indicated as either "compliant," "partially-compliant," or "non-compliant," with the standards of the Final Rule. All 49 program sites were deemed "partially-compliant," or "non-compliant," see Remediation section below for details, and were remediated through phone calls with ADHCP staff and leadership, emails, letters and providing additional guidance on regulations for compliance. Each standard of the HCBS Final Rule was analyzed in the assessment results and discussed with the facility management and staff.

III. REMEDIATION

Through the site visit validation process described above programs that needed remediation were identified. General guidance and training on the HCBS Final Rule standards were provided to program staff (providers) to meet compliance. Policies and procedures and any remediation completed by the program to meet compliance were filed within the program's file for reference. Staff are being trained in person-centered care planning, resourced by the NYS DOH Person-Centered Planning Statewide Training Initiative and the Person-Centered Planning and Practice Resource Library, (clicking this sentence brings you to the PCP Resource Library on the DOH webpage), as well as other HCBS and ADHCP policies.

All reopened programs are fully compliant with privacy, dignity, respect, and freedom from coercion and restraint, and control of personal resources; policy and procedure development/revision to address rights of privacy, dignity, respect and freedom from coercion and restraint is being done by ADHCP providers and validated by a review from the ADHCP team at DOH. All 49 reopened ADHCPs required remediation in the following areas:

- Community integration plans, including opportunities to seek employment in the community, and regular scheduling of outdoor community activities.
- Transportation plans and resources for alternative transportation methods for individuals to pursue community activities that reflect individual preferences.

If the Corrective Action Plan for which New York State is applying is approved, our target date for remediating the areas of noncompliance for ADHCP listed above is July 1, 2024. Progress will be tracked quarterly through regular communications with ADHCPs requiring remediation and providing technical assistance as needed and updating their program files.

IV. ONGOING MONITORING AND QUALITY ASSURANCE

Ongoing monitoring of ADHCPs and quality assurance processes will be completed through onsite and offsite approaches. The ADHCP team will ensure all settings maintain ongoing compliance by:

- Commencing in March 2023, triennial onsite re-licensure surveys will be conducted and will include observations of the physical space, staff and registrants, program and registrant record reviews and interviews to determine ongoing compliance.
- The annual Program Survey Report has been edited to include a section asking questions that pertain to the HCBS Rule standards.
- Community integration will be reviewed yearly and during surveys.
- During the re-licensure survey, staff and registrants will be interviewed to monitor quality of care provided and that services/supports are planned and effectively implemented in accordance with each registrant's unique needs, expressed preferences and decisions concerning his/her life in the community.
- Person-centered plans will be reviewed for sampled registrants during the triennial re-licensure surveys to ensure the plans reflect individual preferences.
- ADHCP staff will be offered regular training opportunities in person-centered care planning, resourced by the NYS DOH Person-Centered Planning and Practice Resource Library (clicking this sentence brings you to the Person-Centered Planning Resource Library on the DOH webpage), as well as other HCBS and ADHCP policies.
- ADHCPs identified as in need of remediation will be followed every six months through ongoing data collection done by, and communication with, the ADHCP team to assess progress with compliance.

New programs' policies and procedures will have to comply with the HCBS Final Rule before becoming operational, including staff training in the requirements of the HCBS Final Rule. State staff will monitor new providers for ongoing compliance through the activities described above.

V. BENEFICIARY RECOURSE

Recipients may report allegations of provider non-compliance to the complaints hotline (1-888-201-4563) or by completing an online complaint form 24hours a day, seven days per week (clicking this sentence brings you to the online complaint form on the DOH webpage).

All complaints and or incidents received will be reviewed, triaged and appropriate action taken by the ADHCP team and/or the ADHCP provider. Intake and/or surveillance staff may contact the facility and obtain facility records and other information to determine the setting's compliance. The ADHCP team conducts interviews, reviews medical records and other facility documentation, and performs survey activities offsite and/or onsite. Facilities determined to be out of compliance with state and/or federal regulations are cited and required to submit a plan of correction. After receiving an approved plan of correction, the ADCHP team will conduct a desk audit/post survey revisit. The revisit consists of the ADHCP submitting evidence to demonstrate that the plan of correction has been implemented. Evidence review includes, but is not limited to, review of registrant records and ensuring the person-centered plan is appropriately developed relative to the cited deficient practice. Only when the ADHCP provides sufficient evidence that the plan of correction has been fully implemented will the ADHCP be put into substantial compliance.

NEW YORK STATE DEPARTMENT OF HEALTH (DOH) – OFFICE OF HEALTH EQUITY AND HUMAN RIGHTS (OHEHR) AIDS INSTITUTE HCBS SETTINGS TRANSITION

I. SYSTEMIC COMPLIANCE

AIDS ADULT DAY HEALTH CARE PROGRAMS

To ensure systemic compliance with the HCBS Rule, a comprehensive review of AIDS Institute AADHCP contracts and guidance were reviewed in 2018, with the results of that assessment being included in the following Systemic Compliance Chart: Clicking on this sentence will bring you to the 2018 Systemic Compliance Chart (pages 1-2) on the AI website.
AIDS Institute staff likewise provided HCBS guidance and worked with the AADHCPs to revise related policies and procedures to meet compliance with the HCBS standards. Comprehensive guidance that included all applicable standards was issued in 2019: Clicking on this sentence will bring you to the 2019 AADHCP guidance document on the AI website.

Standards that were not included due to program being non-residential:

- A lease or other legally enforceable agreement providing similar protections (residential provider-owned and controlled, not applicable)
- Privacy in their unit, including lockable doors, and freedom to furnish or decorate the unit (residential provider-owned and controlled, not applicable)

SUPPORTIVE HOUSING

HIV/AIDS supportive housing programs managed by AIDS Institute Supportive Housing Initiative staff are unlicensed and uncertified supportive housing programs providing services through contractual arrangements. Following the systemic assessment, it was determined that in all but two settings, tenants hold leases directly with a landlord in the community (not provider owned or controlled) in settings considered private homes where individuals have the same rights and protections as someone not receiving HCBS. Two programs are located within provider-owned and controlled congregate living settings, with one being for adult people living with HIV (PLWH) and the other for lesbian, gay, bisexual, and transsexual (LGBT) young adult PLWH. The assessment confirmed that both of those settings are deemed similar to private homes in that they are located in the community, clients are free to come and go as they please and can choose their own medical and social service providers, and the leases do not contain house rules not seen in a standard lease for someone not receiving HCBS. To further ensure compliance, AIDS Institute Supportive Housing Initiative staff revised its contract related documents and program guidance documents for all HIV supportive housing contracts managed by the AIDS Institute so that the language of such documents specifically references compliance with the HCBS standards listed in the Systemic Compliance Chart, a chart which represents the results of the 2018 systemic assessment conducted for AIDS Institute funded supportive housing: Clicking on this sentence brings you to the 2018 Systemic Compliance Chart (pages 3-4) on the AI webpage.

To come into compliance systemically with the HCBS Final Rule HCBS guidance was incorporated into the service standards and distributed to providers in September 2021 and made available online in July 2022: Clicking on this link brings you to the AIDS Institute Supportive Housing Services Standards on the AIDS Institute webpage.

II. SITE VALIDATION

AIDS ADULT DAY HEALTH CARE PROGRAMS

The AADHCP site validation process began with the AADHCP self-assessments conducted in June of 2021. The five (5) AADHCPs (inclusive of seven (7), non-residential sites) self-assessed their compliance with the applicable HCBS Final Rule areas using a provider self-assessment tool developed based on CMS guidance “Exploratory Questions to Assist States Assessment of Non-Residential Settings.”

Following the self-assessments, AIDS Institute AADHCP staff conducted in-person site visits from January to March of 2022 to assess compliance with the HCBS Final Rule through an onsite assessment tool developed using the abovementioned guidance, photos of the site, AADHCP policy/procedure review, supplemental document review (i.e., care plans, recreational calendar, group schedule, staff training materials, etc.), client and staff interviews.

AIDS Institute staff determined that all seven (7) AADHCP program sites required some form of remediation, but could come into full compliance, including the two (2) Heightened Scrutiny sites that had previously been identified. The issues identified through the review were relayed to each AADHCP via a formal site visit findings letter and AIDS Institute Corrective Action Plans (CAPs) were required to be submitted in order to remediate issues by March 17, 2023. Further details on remediation can be found in that section below.

SUPPORTIVE HOUSING

Through contractual arrangements, AIDS Institute currently funds twelve (12) agencies to provide supportive housing within eighteen (18) different contracts that annually serve approximately 593 persons living with HIV. The vast majority utilize scattered site models within the community. In all cases, AIDS Institute supportive housing settings are considered community based private homes where individuals have the same rights and protections as someone not receiving HCBS.

The AIDS Institute supportive housing site validation process began with provider self-assessments based on CMS guidance “Exploratory Questions to Assist States Assessment of Residential Settings” conducted in August 2020. AIDS Institute Supportive Housing program staff distributed a SurveyMonkey survey to all programs. The twelve (12) agencies responded on behalf of the eighteen (18) contracts and self-assessed their compliance with the applicable HCBS Final Rule areas. All providers completed the assessment within the timeframe requested, and the results were reviewed. AIDS Institute staff determined that all eighteen (18) supportive housing programs required remediation, but that all could come into full compliance with remediation.

In the vast majority of cases, discrepancies in anticipated responses only appeared when providers misunderstood or misinterpreted a question. Remediation involves conducting virtual site visit discussions for all settings to verify accuracy of provider self-assessment results, seek clarification when necessary, and give providers an opportunity to revise their responses. For example, some providers responded with “Not Applicable” for questions that they perceived to be outside of their scattered site scope and that of a private landlord. However, it is a programmatic requirement of the AIDS Institute Supportive Housing Services Standards that such considerations be taken into account when determining the most suitable placement for each client. Examples included:

- Are bus and other public transportation schedules and telephone numbers posted in a convenient location?
- Do residents shop, attend religious services, schedule appointments, have lunch with

family and friends, etc., in the community, as they so choose?

- Do residents take medications privately, unless stated differently in their service/support plan and is agreed upon by the individual?
- Are residents able to have visitors of their choosing at any time?
- Do residents have a checking or savings account or other means to control his/her funds and decide how to control their own funds?

One agency was unaware that it was a programmatic requirement to conduct biannual housing reassessments and service plans to determine ongoing need for housing retention and financial assistance services, and it subsequently responded “Not Applicable” to questions involving person-centered planning. The misunderstanding was immediately addressed by the contract manager and initiative director to ensure the agency remained compliant with both HCBS expectations and the AIDS Institute Supportive Housing Services Standards.

III. REMEDIATION

AIDS ADULT DAY HEALTH CARE PROGRAMS

Based on the onsite visit findings and document review, the AIDS Institute Office of Medicaid Policy and Programs, Acute and Chronic Care Unit (ACC) implemented a six (6) month collaborative Technical Assistance (TA) program with each AADHCP site. The TA program addressed unmet HCBS Final Rule components, using the submitted CAPs as a guide. During the TA period, each AADHCP participated in either monthly or bi-monthly meetings and submitted relevant supporting documentation to demonstrate progress towards meeting the unmet HCBS Final Rule requirements identified through the provider self-assessment and onsite visit. Supporting documentation submitted during these meetings included, but was not limited to, care plans, policies, procedures, etc. The AIDS Institute ACC reviewed documentation and provided feedback.

AADHCPs – seven (7) non-residential sites, inclusive of two (2) Heightened Scrutiny sites:

- Harlem United
- Housing Works Brooklyn
- Housing Works Manhattan
- Sun River Bronx
- Sun River Queens
- Richmond (Heightened Scrutiny Site)
- St. Mary’s (Heightened Scrutiny Site)

High-Level Remediation Needs Across All Sites:

- Settings are integrated and support full access of individuals receiving Medicaid HCBS to the greater community, specifically, receiving services in the community.
- Settings are selected by the individual from among setting options including non-disability specific settings and are identified and documented in the person-centered service plan.
- Any modifications for provider-owned and controlled settings must be supported by a specific assessed need and justified in the person-centered service plan.

Remediation Plans Across All Sites:

- Programs have resumed community activities in advance of the public health emergency (PHE) period ending. This will be reflected in the site's operations policy and evaluated through the TA program by March 17, 2023.
- Clients have the option to pick this setting, with many being referred by friends or other community agencies. This is not clearly reflected in the current care plans. This will be addressed through the TA program by March 17, 2023.
- Sites will incorporate program policies that outline the process to request modifications to additional provider-owned and controlled standards based on a specific assessed need and modifications to be implemented with member consent and clearly reflected in the goals and objectives to achieve the agreed upon outcome of the registrant and comply with program. This will be fully compliant by March 17, 2023.
- All ADHCPs are in the process of revising care planning documentation to be fully compliant by March 2023. The AIDS Institute ACC Unit TA program is tracking and monitoring remediation to ensure AADHCPs compliance on or before by March 17, 2023. Continuous quality monitoring of HCBS compliance has been integrated into the Comprehensive AADHCP biennial or every other year site visits, further described in the Ongoing Monitoring section below.

SUPPORTIVE HOUSING

All 18 supportive housing programs require some form of remediation to align programmatic policies and procedures with the HCBS Final Rule. Given that the units have the qualities of private homes, the Supportive Housing program has determined that all units can come into compliance with the HCBS Final Rule by March 17, 2023.

Ongoing training is being provided to all supportive housing providers to support remediation efforts. For example, a virtual provider meeting was held on May 5, 2022, to review the revised standards and HCBS Final Rule guidance and this presented an opportunity for providers to discuss best practices to ensure they are meeting the standards.

IV. ONGOING MONITORING AND QUALITY ASSURANCE

AIDS ADULT DAY HEALTH CARE PROGRAMS

AIDS Institute AADHCP staff will continue to monitor AADHCP processes through the Medicaid Policy and Programs Chronic Care Unit TA program and Comprehensive AADHCP biennial site visits.

The TA program will continue to operate on an individual basis with each AADHCP via monthly and/or bi-monthly meetings to ensure areas deemed compliant remain as such.

Comprehensive AADHCP site assessments are conducted every two (2) years by the AIDS Institute, Office of Medicaid Policy and Programs Chronic Care Unit for each AADHCP. Site visit are being scheduled in Fall/Winter of 2023 and then every two years going forward. Quality assurance and Monitoring site visit tools are being updated to include:

a. *Community Integration:* AADHCPs have already re-integrated into the community (i.e., movies, art galleries, bowling, food pantries, etc.) and have updated their operations policies to reflect the return of community events post

PHE. AIDS Institute AADHCP program staff verify policies have been amended and will ensure each AADHCP updates monthly recreational schedules accordingly.

b. *Process for Monitoring Private Homes /Apartments owned or Rented:* The A ADHCPs assess housing needs in the initial eligibility assessment and in the Psycho-Social assessment, which each agency conducts minimally bi-annually. Clients may also discuss housing needs with their assigned care coordinator at any time. AADHCP's do not provide direct housing services, but care coordinators can assist clients with housing related issues, such as recertifying for benefits, completing applications, budgeting/bill paying, and linkage to community housing supports. These referrals are reflected in the person-centered care plans.

c. *Person Centered Planning:* AADHCPs are encouraged to use the Person-Centered Planning and Practice Resource Library to ensure staff is fully trained in these areas. Clicking on this sentence will bring you to the Person-Centered Planning Online Resource Library on the DOH webpage. A Person-Centered Planning Checklist will be incorporated and monitored by the AIDS Institute AADHCP staff and will be sampled by Managed Care Organizations (MCOs) or ACC staff during routine quality monitoring activities as determined by the MCO and/or based-on results of the Comprehensive AADHCP site visit or TA Program.

New programs' policies and procedures will have to comply with the HCBS Final Rule before becoming operational, including staff training in the requirements of the HCBS Final Rule. State staff will monitor new providers for ongoing compliance through the activities described above.

SUPPORTIVE HOUSING

It is AIDS Institute Supportive Housing program policy that grant funded contracts be monitored every two years for comprehensive programmatic and fiscal compliance. Programmatic monitoring protocols relative to compliance with the HCBS Final Rule standards have been incorporated into routine contract monitoring for all supportive housing contracts managed by the AIDS Institute Supportive Housing program to ensure ongoing compliance with the federal rule. AIDS Institute staff have been conducting virtual programmatic monitoring protocols since the PHE began. Monitoring protocols include the review of: agency wide policies and procedures; program oversight and personnel; program safety and accessibility; data reporting; cultural and linguistic competence; quality management and improvement; consumer involvement, linkages and coordination; staff interviews; program specific policy and procedure review; and chart reviews to confirm client eligibility and service documentation requirements. On-site monitoring and validation began in July 2022 as staff started conducting hybrid monitoring site visits consisting of both onsite documentation review and virtual administrative and programmatic meetings. This practice will continue moving forward, and compliance will be ensured during the comprehensive monitoring every two years.

AIDS Institute Supportive Housing program does not fund or oversee the provision of any HCBS services and is therefore unable to determine which clients may be receiving HCBS. However, it is expected that MCO/partners providing HCBS to clients enrolled in AIDS Institute supportive housing programs will include the supportive housing programs in their person-centered planning processes specific to the provision of housing retention or financial assistance services and will conduct the monitoring of private homes or apartments as applicable and as described in the Managed Long Term Care (MLTC) and Medicaid Managed Care (MMC) sections of this Statewide Transition Plan (STP). Supportive housing providers who are interested in learning

more about person-centered planning are aware that New York's Person-Centered Planning and Practice Resource Library is available: Clicking on this sentence brings you to the Person Centered Planning and Practice Online Resource Library on the DOH webpage.

V. BENEFICIARY RECOURSE

AIDS ADULT DAY HEALTH CARE PROGRAMS (AADHCPs)

Registrants of AADHCPs may at any time access the NYS Medicaid Member Services Hotline to discuss issues that cannot be addressed within the program or to make a complaint regarding the AADHCP or program staff. AIDS Institute staff reviewed each AADHCP policy and procedure to confirm that a Bill of Rights and Grievance process has been shared with each registrant and their rights are clearly communicated. Through the TA Program, it has been determined that the AADHCP will update their policies and procedures to include opportunities for clients to appeal a site-specific determination, program rule, or requirement by March 17, 2023.

SUPPORTIVE HOUSING

Clients (i.e., individuals enrolled in contracted supportive housing programs) receive information about their programmatic rights and responsibilities at intake for the receipt of housing retention and financial assistance services. The AIDS Institute Supportive Housing program requires a written lease or occupancy agreement be present that provides eviction protections, due process appeals, specifies the circumstances when eviction would be required, and that they be reviewed by the grant funded supportive housing program staff. Each funded supportive housing program also maintains its own grievance policies and procedures that is accessible to clients. If a client feels that there are any issues around their living situation, funded supportive housing program staff can assist clients with the process of having those heard by the private landlord and/or by helping them search for a new apartment. Clients may also contact the AIDS Institute general information number at 1-800-541-AIDS or the DOH hotline at (877) 249-5115 to discuss issues that cannot be addressed within the grant funded supportive housing program or to make a complaint regarding the funded program if they feel their concerns have not been heard by pursuing resolution through the funded program's grievance policies and procedures.

NEW YORK STATE DEPARTMENT OF HEALTH (DOH) OFFICE OF HEALTH INSURANCE PROGRAMS (OHIP) COMMUNITY FIRST CHOICE OPTION (CFCO) HCBS SETTINGS TRANSITION

I. SYSTEMIC COMPLIANCE

To come into compliance with the HCBS Final Rule systemically the following tasks were completed:

A systemic review of the rules, policies and procedures related to CFCO was conducted in 2018, the results of which are in the Systemic Compliance Chart:

- By clicking this sentence, you will find the DOH Systemic Compliance Chart on DOH's website, with CFCO's chart located on p. 19-21.

Systemic and site level compliance with the HCBS Final Rule is assured through adherence to a Person-Centered Service Planning (PCSP) process described in revised PCSP Guidance and a

PCSP Template. All authorizers of CFCO services and supports (MCO and LDSS) will receive notice of revised PCSP Guidelines and Template by January 31, 2022 and be directed to use it beginning in March of 2023. The template or another tool that covers the same content is required in order to assure consistency across the State, ease monitoring for compliance and quality, and ensure that the standards are widely known and met.

- By clicking this sentence, you will open the PCSP Guidance on the CFCO webpage. • By clicking on this sentence, you will open the PCSP Template on the DOH website.

II. ONGOING MONITORING

The PCSP Template outlines all the standards required to be in place for individuals in receipt of HCB services and supports through the Medicaid program. Individuals receiving CFCO services must have a PCSP that details these services and who will provide them (scope, amount, frequency and duration). The primary Care Manager for such individuals (engaged by or as a Local Department of Social Services (LDSS), a Medicaid Managed Care Organization (MMCO), a Health Home or other care management entity designated by the MMCO or the State) will ensure that the standards are met during the meeting to develop the PCSP using the Template or a tool that covers all the same content it outlines.

Upon reassessment, which occurs annually unless there is a change in condition or upon individual's request, the entity that authorizes CFCO services must have the primary Care Manager revisit and revise, as appropriate, the PCSP with the individual, and/or their representative, and anyone the individual wishes to include. The template and all of its content will be reviewed and revised, as needed.

Authorizing entities (LDSS and MMCOs) are encouraged to ensure that their primary Care Managers take free person-centered planning trainings virtually or through the webpage where recorded courses are posted: clicking this sentence brings you to the PCP Online Resource Library on the DOH website.

New plans would be required to follow contractual and policy guidance to ensure compliance with the HCBS Final Rule and would be subject to the same surveillance requirements described here to ensure their continued compliance.

To ensure that individuals receiving services and supports under CFCO have access to high quality care that meets their identified needs, ongoing monitoring and quality assurance are undertaken through surveillance. All surveillance efforts include a review of sample cases, including the PCSP issued by LDSS, MMCO, HH and/or contracted case management entities. For instance, LDSS review case files, including the PCSP, of the greater of 5 cases or 10% of the cases in each county (capped at 100 cases). LDSS are reviewed by the State every other year. MLTC plans audit sample cases from plans on a revolving basis in which plans are surveilled every three years. MLTC surveyors collect a statistically significant sample of case files (with a cap of 500).

III. BENEFICIARY RECOURSE

As with recipients of other long term care services, individuals receiving services and supports under CFCO have recourse if they are not satisfied with their care, need additional or different assistance, experience problems with their caregiver or have other issues or concerns. Recipients who receive authorization from LDSS can either call the district office or the DOH Bureau of Long Term Care Policy in the Division of Policy and Program Management of the Office of Health Insurance Programs. A bulk mailbox is monitored daily. For enrollees of MMCO, there are technical assistance hotlines in both MLTC and MMC.

FFS contact information is: (518) 474-5888, services@health.ny.gov or consumerdirected@health.ny.gov
MLTC contact information is: 1-866-712-7197 or mltctac@health.ny.gov
MMC contact information is: 1-800-206-8125 or managedcarecomplaint@health.ny.gov

In addition, part of the PCSP includes contact information for the care/case manager to ensure that the individual knows who to reach out to, should problems arise. All service denials of any kind come with appeal and fair hearing rights:

- **DOH:** MMC Plan members or their designee can contact the DOH MMC Bureau of Consumer Services (BCS) at managedcarecomplaint@health.ny.gov or 1-800-206-8125 with concerns or complaints.

- **ICAN:** Independent Consumer Advocacy Network (ICAN) is the ombudsman program for MMC plan members. Go to www.icannys.org, or call 1-844-614-8800 for free independent advice about coverage, complaints, and appeals options.

NEW YORK STATE DEPARTMENT OF HEALTH (DOH) OFFICE OF HEALTH INSURANCE PROGRAMS (OHIP) COMBINED CHILDREN'S WAIVER SETTINGS TRANSITION

I. SYSTEMIC COMPLIANCE

To bring the Children's Waiver (CW) into compliance systemically, the program conducted the following tasks, which are described and linked below:

- **Systemic Compliance Charts:** Contains 2018 systemic review results from DOH OHIP Division of Long Term Care (DLTC), OCFS, and OMH within the following systemic compliance charts that were developed prior to the consolidation of the CWs:
    - Clicking on this sentence will bring you to the 2018 systemic compliance charts for CAH (pages 1-10) on the CW webpage
    - Clicking on this sentence will bring you to the 2018 systemic compliance charts for SED (pages 1-3) on the CW webpage
    - Clicking on this sentence will bring you to the 2018 systemic compliance charts for B2H (pages 1-30) on the CW webpage

The CW did not conduct the original systemic reviews; however, the CW team issued the remainder of the sub-regulatory guidance listed below that includes all HCBS Final Rule standards, guidance, and modifications:

- **CW HCBS Program Manual**: Clicking on this sentence will bring you to the HCBS Program Manual ("CMS Final Rule on HCBS Settings" and Appendix B) on the CW webpage issued in 2109 and last updated August 2022 that contains summary information regarding the settings requirements and standards of the HCBS Final Rule and an Appendix specific to the HCBS Final Rule that outlines person-centered planning requirements and guidance related to modifications of provider-owned and controlled standards.
- **CW HCBS Final Rule Policy**: Clicking on this sentence will bring you to the HCBS Final Rule Policy on the CW webpage issued in October 2022 that outlines providers' responsibilities in complying with the HCBS Final Rule, the Children's HCBS Waiver Team's process for conducting HCBS Final Rule compliance reviews for newly designated Children's HCBS providers, and the Children's HCBS Waiver Team's ongoing compliance monitoring process.
- **CW HCBS Final Rule Informational Letter**: Clicking on this sentence will bring you to the CW HCBS Final Rule Informational Letter on the CW webpage that was disseminated to all providers on December 3, 2020 prior to conducting the provider self-assessment (PSA) and onsite reviews.

II. SITE VALIDATION

To validate compliance for all categories of settings listed in the table on the next page, the CW team employed a standardized process to conduct reviews and determine compliance for all designated residential and non-residential settings overseen by the CW, as described in the introduction. First, the CW Team reviewed the address of each designated Children's HCBS provider site using Google Maps to visually search for proximity to location in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or location in a building on the grounds of, or immediately adjacent to, a public institution. An additional Google search was performed for each address to ensure that search results did not also yield results for those settings that do not meet the definition of being home and community-based, such as a nursing facility, institution for mental diseases, intermediate care facility for individuals with developmental disabilities, a hospital, and/or residential treatment facility. All designated providers and addresses were also compared against State Agency lists to further ensure that no providers were operating out of a restricted setting. These initial determinations were further validated during the virtual onsite review where reviewers requested to observe via video conferencing all aspects of the sites, both inside and outside, to verify that the sites were not restrictive/isolating settings. Photos and videos of the settings were taken to support the reviewers' observations.

Next, provider self-assessment surveys, developed based on CMS guidance "Exploratory Questions to Assist State's in the Assessment of Residential [and Non-Residential] Settings," were sent to all designated CW HCBS providers via the Survey Monkey tool. The CW Team hosted an informational webinar prior to disseminating the survey to walk through the entire compliance review process and answer provider's questions. The CW Team also discussed the provider self-assessment during monthly meetings with CW HCBS providers to provide information, collect stakeholder input and answer questions. Providers were instructed to complete one survey for each location (site) where they are designated to provide CW HCBS. Clicking on this sentence will bring you to the self-assessment survey on the Survey Monkey webpage. After receiving a 100% response rate to the surveys, the CW Team analyzed all responses and flagged initial instances where follow-up would be indicated, particularly those responses that indicated potential non-compliance.

To validate the survey responses, the CW Team instructed providers to submit documentation for each designated CW HCBS site. In much the same manner as educating providers about the provider self-assessment process, the CW Team hosted an informational webinar to walk through the provider documentation tool, the types of documentation required for submission, and fielded provider questions. Documentation was requested for each HCBS Final Rule standard; examples of applicable documentation were provided, including but not limited to, policies, procedures, and other forms of supporting documentation that demonstrates compliance with HCBS Final Rule standards. Clicking on this sentence will bring you to the documentation template and instructions. Clicking on this sentence will bring you to a recording of the informational webinar.

After reviewing each site's self-assessment and documentation submission, the CW conducted virtual onsite reviews to further validate the provider self-assessment responses and contents of provider documentation. All providers received an agenda that outlined the onsite review process and expectations prior to each site review. In many instances, a portion of the virtual onsite reviews was devoted to discussing elements of the submitted documentation that were unclear and instances of lack of alignment between the provider self-assessment survey responses and the submitted documentation. During these reviews, the CW Team also provided instructional guidance as to how providers can come into compliance. As part of the site review,the CW Team conducted interviews with provider representatives (administration and staff) to understand how the program/residence is structured. Whenever possible, children/youth and/or families/caregivers were either involved in an interview portion of the onsite review or were sent a participant survey to further ensure that all standards were being met. The CW Team conducted interviews with children/youth and/or families/caregivers without program staff present to ensure children/youth and/or families/caregivers could speak freely regarding the services received. Reviewers also conducted interviews with at least one program staff to establish if the setting has the effect of isolating individuals receiving CW HCBS from the broader community and determining compliance with all applicable standards.

The findings for all designated CW HCBS settings are depicted in the table below. The total number of sites also includes sites that have since de-designated since the review process concluded.

Setting Type	**# Sites that Could Come into Full Compliance**	**# Sites that Cannot Comply with Final Rule**	**# Sites that are Presumptively Institutional in Nature (i.e., Heightened Scrutiny)**
Residential Settings (Planned Overnight Respite and Crisis Overnight Respite)	6	0	*3
Home and Community-Based ONLY Settings (All HCBS)	66	0	0
Both Onsite setting AND Home and/or Community-Based Settings (All HCBS)	128	0	0

Total	**200**	**0**	**3**

**Further information regarding the three settings that were determined to be presumptively institutional in nature is located in the "Heightened Scrutiny" and "Strategy for Assisting Participants Living/Receiving Services in Non-Compliant Settings" sections.*

Many sites required some form of remediation before the CW Team could determine full compliance; a description of the remediation process is described in the "Remediation" section below.

III. REMEDIATION

The CW Team confirms that at the time of the issuance of this STP, all designated CW HCBS provider sites have fully remediated and are in full compliance with the HCBS Final Rule. After site reviews were completed, "Review Findings/Remediation Reports" were drafted for each provider/site that described a comprehensive account of the findings and overall compliance determination based on the provider self-assessment responses, submitted documentation, and the virtual onsite review. The Review Findings/Remediation Reports detailed the findings of HCBS Final Rule standards and determined whether the provider/site was in compliance for each standard by noting whether 1) no action was needed (fully compliant) 2) action was recommended, or 3) corrective action/remediation was required. The CW Team detailed next steps and guidance in Review Findings/Remediation Reports for instances where corrective action/remediation was required and/or recommended for the provider/site to be determined compliant with the HCBS Final Rule. Providers were required to return a signed copy of the Findings/Remediation Reports acknowledging receipt and understanding of the contents of the report and corrective actions, if applicable. Provider/sites were given one month to address any necessary corrective actions/remediations and provide additional/updated documentation.

Additional/updated documentation submitted by providers in response to corrective actions was reviewed and tracked. A Corrective Action Addendum to the Findings/Remediation Report was drafted to detail whether the provider/site was in compliance for each standard where a remediation was indicated in the Findings/Remediation Reports by noting whether 1) no action was needed (fully compliant) 2) action was recommended, or 3) corrective action/remediation was required. If the submitted documentation did not fully satisfy the corrective actions, the CW Team again provided next steps/guidance for those standards still not in compliance. This Corrective Action Addendum process was conducted until the provider/site came into full compliance with all standards. The CW Team offered additional support should the provider/site have any outstanding questions or need clarification.

IV. ONGOING MONITORING AND QUALITY ASSURANCE

Following this initial compliance review, the CW Team will continue to monitor providers' compliance with the HCBS Final Rule on an ongoing basis. Ongoing monitoring of compliance with the HCBS Final Rule will be included in the CW HCBS case record review process, which is conducted on a yearly basis. A HCBS Final Rule attestation component will also be added into the CW Team's current attestation survey where providers attest to compliance with background checks, education, and training. CW HCBS providers will be required to sign the attestation and attest to compliance with all HCBS Final Rule standards, including but not limited

to compliance with person-centered planning every year and every three years during CW's redesignation process. Additionally, participants will be periodically surveyed for satisfaction with CW HCBS service delivery and ensuring services are delivered in a person centered and community integrated manner. The processes described here apply to all CW HCBS setting types.

Since providers may elect to become designated CW HCBS providers on a rolling basis, post-March 2023, the CW Team will continue to conduct HCBS Final Rule compliance reviews for all newly designated CW HCBS providers following the process described in the Site Validation section.

For private homes or apartments owned or rented where children/youth live with family/caregivers, the CW Team will continue to ensure that HCBS Final Rule standards are followed through the monitoring processes described in this section to ensure that CW HCBS providers are following principles of person-centered planning and delivering services in a participant-driven manner, which is part of the yearly case review. If the CW team finds during monitoring that a CW participant is living with an unrelated paid caregiver, then the additional provider-owned and controlled settings standards and the full site assessment process, described in the Site Validation section above, apply. Should services be delivered to a CW HCBS participant in a manner inconsistent with person-centered planning, the State has several incident reporting processes and mechanisms to guard against coercion and abuse, which are outlined in the Beneficiary Recourse section. Further, children/youth and/or families/caregivers are provided CW HCBS Participants Rights at the onset of services by the Health Home Care Manager, which outlines the rights of a CW HCBS participants and provides information regarding courses of action to take if those rights are not being upheld. The Health Home Care Manager must communicate with children/youth and/or the family/caregiver at least once each month and will assess whether these rights are being upheld. Clicking on this sentence will bring you to the CW Participant: Rights & Responsibilities document on the CW webpage.

HCBS Final Rule compliant person-centered planning will be monitored for compliance across all settings described in the introduction, including through yearly case record reviews and the grievance and complaint reporting processes when person-centered planning principles are not followed. Further, a section specific to compliance with person-centered planning will be added to the attestation. CW HCBS providers are required to maintain documentation that describes how person-centered planning is executed, and staff are required to be trained in principles of person-centered planning. The State maintains a person-centered planning online resource library and encourages providers to leverage the training and resources contained on this site. Clicking on this sentence will bring you to the Person-Centered Planning Online Resource Library on the DOH webpage. Since the CW Team confirmed that all CW HCBS providers in all settings have reintegrated participants into the community, future verification will be managed through the standard ongoing monitoring process as described above.

V. BENEFICIARY RECOURSE

If a CW participant wishes to file a grievance, they can call NYSDOH at 1-800-206-8125 or submit via email to managedcarecomplaint@health.ny.gov. The 1915(c) Children's Waiver requires that participants are informed of their Freedom of Choice and Participant's Rights and Responsibilities (Clicking on this sentence will bring you to the Freedom of Choice Form on the CW webpage) (Clicking on this sentence will bring you the Participant's Rights and Responsibilities Document on the CW webpage) regarding their options to receive care, how to report a complaint and/or grievance, how to report abuse or suspected abuse, and when and how to request a Fair Hearing

should they not agree with the decision indicated on the Notice of Decision (NOD). Clicking on this sentence will bring you to the Notice of Decision on the CW webpage. Furthermore, the CW Team requires that Health Homes Serving Children (HHSC) and CW HCBS providers have policies in place to handle any reportable incidents in compliance with the standards outlined in the 1915(c) Children's Waiver. Clicking on this sentence will bring to you to these policies and procedures on the CW webpage, which are also outlined below.

- Identify, document, report, and review incidents within specified timelines
- Enter Reportable Incidents within the Incident Reporting and Management Systems (IRAMS)
- Evaluate individual incidents against HH policies and procedures to confirm quality care coordination activities are provided
- Review individual incidents to identify appropriate preventive or corrective action was taken to ensure health and safety of the member
- Identify incident patterns and trends through the compilation and analysis of incident data
- Review incident patterns and trends to identify appropriate preventive or corrective action, technical assistance, or training
- Implement preventative and corrective action plans
- Identify policy and/or procedure changes

As required of the 1915(c) Children's Waiver, CW HCBS participants are informed of the process for submitting a grievance or complaint related to their CW HCBS, care coordination, and/or participation in the CW. All complaints/grievances and critical incidents are timely documented within IRAMS, which is used to ensure the health, safety, and well-being of the children/youth served.

CW HCBS Providers and HHSCs report grievances/complaints and critical incident for CW HCBS participants as outlined in the CW and issued policies. HHSCs, which provide oversight in their network of Care Management Agencies (CMAs), ensure appropriate reporting and actions are taken according to policies and standards. For grievances/complaints, once a participant or the participant's representative files a grievance/complaint, the HHSC/CW HCBS provider enters the issue into IRAMS. The participant must be updated within 72 hours from the reported grievance/complaint as to the status. The HHSC/CW HCBS provider must then try to resolve the participant's complaint/grievance to the participant's satisfaction; otherwise, if the participant is not satisfied with the resolution, the participant can escalate the complaint/grievance with their lead Health Home, the State, the Medicaid Managed Care Plan Complaint line (if applicable), or to the Medicaid Help Line.

Please refer to Participants Rights and Protections section of the HCBS Manual and the or the HCBS Provider Grievances and Complaints Policy for further details regarding the guidance protocols and reporting requirements put in place to ensure the safety and well-being of Children's Waiver participants.

NYS DEPARTMENT OF HEALTH (DOH) OFFICE OF HEALTH INSURANCE PROGRAMS (OHIP) MANAGED LONG TERM CARE (MLTC) HCBS SETTINGS TRANSITION

I. SYSTEMIC COMPLIANCE

In order to come into systemic compliance with the federal requirements the following activities were completed:

- The MLTC Systemic Compliance Chart represents the results of the systemic assessment conducted in 2018 related to MLTC plans: clicking here brings you to the 2018 MLTC Systemic Compliance Chart on the DOH webpage. For MAP go to pages 46 and for MLTCPC, pages 7-9. Please note: ○ The NYS Fully Integrated Duals Advantage (FIDA) program, pages 1-3 of the chart, ended December 31, 2019.
    - MLTC Social Adult Day Care (SADC), pages 10-12, and Adult Day Health Care (ADHC), pages13-18, are described in their separate sections within this NYS Statewide Transition Plan (STP).

The list below includes all guidance released and updated to ensure MLTC plan compliance with the HCBS Final Rule.

- **MLTC Policy 21.05: SADC HCBS Final Rule Implementation**
    - Clicking here brings you to MLTC Policy 21.05 on the DOH website.
    - Release Date: 12/3/2021 and ongoing
    - Description: Policy 21.05 was issued to all MLTC plans and details all SADC requirements and provides resources for ensuring compliance with the HCBS Final Rule standards. Additionally, fact sheets, a timeline, assessment tools and Frequently Asked Questions (FAQ) documents were listed as detailed in the separate SADC section of this STP.

- **MAP and MLTCPC Model Contracts**
    - Clicking here brings you to the MAP Model Contract on the DOH website. ○ Clicking here brings you to the MLTCPC Model Contract on the DOH website.
    - Description: The current MLTC MAP Model Contract and the current MLTC Partial Capitation Model Contract were amended to correct the HCBS Final Rule citation. The 2022-2026 Model Contracts are in process now, which will incorporate all amendments to the 2017-2021 Model Contract versions.

- **Person Centered Service Plan (PCSP) Dear MLTC Health Plan Administrator Letter, Guidance, and Template**
    - Clicking here brings you to the Person Centered Service Planning Dear MLTC Health Plan Administrator Letter on the DOH website.
    - Clicking here brings you to the PCSP Template on the DOH website.
    - Clicking here brings you to the PCSP Guidance document on the DOH website.
    - Release Date: 1/22/2019
    - Description: The PCSP Template, which includes all required elements, and Guidance were released for use by the MLTC plans. The letter was sent to all MLTC plans detailing the requirement that the plans must be adherent to all person-centered planning specifications. Additionally, the letter provides guidance for ensuring person-centered planning requirements are met and the PCSP is complete and captures all necessary information.

- **Revised 2022 MLTC PCSP Template and Guidance**
    - Clicking here brings you to the 2022 PCSP Template on the DOH website.

- Clicking here brings you to the 2022 PCSP Guidance document on the DOH website.
- Release Date: 11/16/2022
- Description: This is an updated version of the PCSP Template created and the corresponding guidance. A webinar will also be conducted to share the revisions and new versions with the MLTC plans. The webinar will focus on proper use of the template and education of MLTC plans on the correct provision of person-centered planning.

II. ON-GOING MONITORING AND QUALITY ASSURANCE

The Bureau of Managed Long Term Care (BMLTC) provides oversight, maintains regulatory compliance, and ensures consistency with industry standards through review of MLTC plans' service delivery and education given by MLTC plans to their providers. These efforts are detailed below. The BMLTC is organized into four sub-units including plan management, systems support, the technical assistance consumer and provider call center and the compliance surveillance unit. These units work collaboratively on policy development and interpretation, contract implementation, plan, consumer and provider inquiries, enrollment and disenrollment transactions, and plan compliance and reporting. The BMLTC also works with other State agencies including the fair hearing office, the policy department, and the Office of Medicaid Inspector General (OMIG) to ensure that policies are developed in alignment to state and federal rules and regulations, and that members have rights to pursue complaints and appeals and that allegations of fraud, waste and abuse are reported and investigated. Additionally, the BMLTC publicly shares the official policies, guidance documents, tools, contracts, and webinars which are described in more detail below.

- **References and Resources:** Provide tools, resources, guidance, policies and procedures and timelines to MLTC plans, as needed based on changes or updates. The DOH website contains a section titled "MLTC Policies" with HCBS MLTC references and resources.
  - Clicking here brings you to the MRT Policies and Guidance on the DOH website.
  - Clicking here brings you to the MRT Policy Documents on the DOH website.

- **Communication Channels:** BMLTC supports an open two-way communication channel with all MLTC plans. The BMLTC has an active program specific mailbox that MLTC plans, and stakeholders may submit inquiries to. This email is MLTCInfo@health.ny.gov.

- **MLTC Surveillance Unit:** DOH has a dedicated surveillance unit charged with the continuous monitoring and oversight of the MLTC plans operating in NYS. This is achieved through on-going surveys of the service delivery and education of the MLTC Plan providers. The MLTC Surveillance Unit also maintains an active mailbox to which MLTC plans may submit inquiries: MLTCSurvey@health.ny.gov. See bottom of page for added detail on the MLTC Surveillance Unit efforts.

- **Plan Management Unit:** BMLTC has a dedicated Plan Management Unit that provides continuous support to MLTC plans with their provision of services through the MAP and MLTCPC programs. This is achieved through active engagement with plan contacts to resolve questions regarding updating or interpreting policies and procedures including, but not limited to, network questions, review of member materials, resolution of member

issues, and inquiries regarding service area expansions, mergers, and acquisitions.

- **Reporting and Systems Units:** BMLTC also has a unit that reviews reporting from health plans on an annual, monthly, and quarterly basis, and handles necessary member specific systems' inquiries/transactions which may occur daily. The Reporting and Systems Units also maintain active mailboxes to which MLTC plans may submit inquiries. The email address is mltc.compliance.reporting@health.ny.gov.

Whereas oversight and guidance of MLTC is provided through numerous avenues, as referenced above, monitoring of the MLTC program is primarily through the activities of the MLTC Surveillance Unit. The MLTC Surveillance Unit has developed multiple assessment methodologies, tools and compliance approaches that have been in place prior to the advent of the HCBS Final Rule. BMLTC will continue to initiate new efforts and expand upon existing practices, which have already begun or are being planned, to verify compliance for MLTC settings. For the MLTC, the MLTC Surveillance Unit assessment of HCBS settings is focused on of the person-centered planning process performed by MLTC plans, with an additional detailed review for SADC sites.

Note: All HCBS MLTC services are provided within members' private homes, or in the case of SADC and ADHC services, members access these services within their community. SADC and ADHC ongoing monitoring and quality assurance processes are described in their sections of this STP.

As previously stated, the monitoring being performed to ensure a member's access to the rights afforded by these federal requirements will focus on the MLTC plans' utilization and correct administration of the PCSP Guidelines, PCSP Template, and the person-centered planning process at enrollment, reassessment and through care management provision. The HCBS recipients' own home or the home of a family, friend, neighbor or relative, were not planned for site-level assessment, as these are presumed to be compliant. However, should the MLTC Surveillance Unit find that the residential setting resembles a congregate care residential situation that allegedly is provider owned or controlled, then a process of further investigation, assessment and remediation would be implemented. The appropriate entity would conduct this investigation and MLTC eligibility will be reviewed by the BMLTC.

Current and Ongoing Surveillance Activities for MLTC plans

Please note, any non-compliance may result in a Statement of Deficiency (SOD) to the applicable MLTC Plan. The types of surveys conducted are as follows:

- Comprehensive Operational Surveys are being conducted on a rolling schedule for all MAP and MLTCPC plans that focuses on plan administration activities in addition to quality and delivery of services to enrollees.
- Focused Surveys are conducted on targeted issues and may be across plans. Monitoring frequency can vary based on identified, emergent or trending issues. These focused surveys are not pre-planned and typically there are six or less surveys conducted per year.
- Focused Surveys are conducted on more specific issues identified as complaints by the Technical Assistance Center (TAC).

Person-centered planning compliance monitoring will be achieved through the surveys described below:

- Revised MLTC Operational Survey
    - Timing – Survey Expanded to Include HCBS: 10/2022
    - Frequency: Ongoing – All MLTCPC and MAP plans reviewed on a rolling schedule. MLTC Survey is currently working towards reviewing all plans within a 3-year cycle.
    - Description: Expansion of the review of PCSPs for enrolled members that is currently being performed during the Comprehensive Operational Survey on a rolling schedule for all MLTCPC and MAP plans that focused on quality and delivery of services to members. This expansion will focus on the documentation retained, services provided and the utilization of the just released revised PCSP Guidelines and PCSP Template. These surveys will conduct a review of 50 member case files for a multiple month timeframe and review care management notes, enrollment documents, PCSPs, assessments and reassessments, the provision of services, and notices sent during the survey timeframe.
- Focused Survey of the MLTC Plan PCSP Policies and Procedures, Performed on All MLTC plans:
    - Timing: 10/2022
    - Frequency: One-Time Plan Education
    - Description: This is a survey focused on obtaining and confirming the PCSP template and guidance currently in use by MLTC plans. At the conclusion of this review, interviews will be held with MLTC plans to discuss the survey findings, review the person-centered planning process being provided and advise of the requirements as well as the resources available to plans in the person-centered planning online resource library and recommend any identified process improvements.
    - Clicking here will bring you to the Person-Centered Planning and Practice Resource Library on the DOH website.
- Focused Survey of MLTC Plan Person-Centered Planning, Performed on All MLTC plans
    - Timing – Initial Survey: Estimated 10/2023
    - Frequency: As Needed – with PCSP Template and/or Guidance Updates
    - Description: This is a survey focused on person-centered planning process utilization by MLTC plans and compliance with HCBS requirements on services provided. A statistically valid sample size of members will be chosen for review. This survey will review the enrollees PCSP, documentation, and corresponding care management notes.
- Implementation of MLTC Monitoring and Oversight Practices for SADC Sites – as described in separate section of this STP： Initiated: 2015 and now ongoing

Monitoring and Oversight of MLTC Services

The following HCBS are provided by MLTC and monitored for HCBS Final Rule compliance:

- Home Care
- Personal Care, including Consumer Directed Personal Care
- Adult Day Health Care (ADHC)
- Social Adult Day Care (SADC)
- Personal Emergency Response System (PERS)

- Home-Delivered/Congregate Meals
- Social and Environmental Supports
- Assistive Technology

Community Reintegration Post COVID-19 Public Health Emergency (PHE)

Since MTLC members live in their own private home or that of a family member, neighbor or friend within the community, residential community integration is not an issue. If, through active case management, the case manager determines the member's residence is limiting their integration with the community, the case manager will coordinate with the member and appropriate other agencies, as necessary, to remediate the situation. Members may also travel outside their homes for SADC and ADHC services. During the COVID-19 PHE, many of these SADCs and ADHCs temporarily or permanently closed or delivered meals to member's private homes. In 2021, SADC and ADHC settings began to reopen under the guidance of their local health departments and members have already begun to reintegrate into the community toreceive these and other medical services. Continued monthly case management and the annual reassessment are opportunities to verify PCSP and enhanced community integration as the COVID-19 PHE officially ends.

New programs would be required to follow contractual and policy guidance to ensure compliance with the HCBS Final Rule and would be subject to the same surveillance requirements described here to ensure their continued compliance.

III. BENEFICIARY RECOURSE

If a member or their designee feels a MLTC plan is non-compliant or wishes to issue a grievance or voice a concern, they may do so in several ways. Additionally, MLTC service providers may report any issues or grievances regarding a MLTC Plan directly to DOH for investigation. The methods of reporting below are documented in the member handbook, which all members receive upon their enrollment in MLTC, are available publicly on websites, and/or included on member notices, as applicable to the reporting method. Complaints are tracked and reported in the member's case file, the technical assistance database for plan response and resolution and/or through an ombudsman process. All entities often work collaboratively to investigate and resolve the member's complaint, grievance, and/or appeal rights.

- **DOH:** MLTC Plan members or their designee can contact the DOH MLTC Technical Assistance Center (TAC) at mltctac@health.ny.gov or 1-866-712-7197 with concerns or complaints. This contact is also utilized by service providers who wish to report an issue with a MLTC Plan.
- **MLTC Plan PCSP Care Manager:** Members may notify their MLTC Plan Care Manager, who is responsible for their MLTC PCSP, of any concerns.
- **MLTC Plan:** Notify their MLTC Plan directly via members' services contact.
- **ICAN:** Independent Consumer Advocacy Network (ICAN) is the ombudsman program for MLTC plan members. Members may go to www.icannys.org, or call 1844-614-8800 for free independent advice about coverage, complaints, and appeals options.
- **Reporting Information – MLTC Website:** Members may also obtain information on reporting an issue on the MLTC website.
    - Clicking here will bring to you the MLTC complaint page on the DOH website.

NYS DEPARTMENT OF HEALTH (DOH) OFFICE OF HEALTH INSURANCE PROGRAMS (OHIP) - MEDICAID MANAGED CARE (MMC) HCBS SETTINGS TRANSITION

I. SYSTEMIC COMPLIANCE

For MMC come into systemic compliance with the federal requirements the following was completed:

- Amendment to the Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract with the addition of section 10.44, effective March 31, 2019:
  - Clicking this sentence will bring you to contract 10.44 on the DOH webpage: Settings for Home and Community Based Services

- Guidance regarding PCSP was revised to include all applicable HCBS Rule standards:
  - Clicking this sentence brings you to the Person-Centered Service Planning Guidelines on the DOH MMC webpage released November 17, 2022

- PCSP template was revised to include all applicable HCBS Rule standards:
  - Clicking this sentence brings you to the Person-Centered Service Planning Template on the DOH MMC webpage released November 17, 2022

- The results of the MMC 2018 systemic assessment can be found in the MMC Systemic Compliance Chart:
  - Clicking this sentence brings you to the MMC systemic compliance chart on the DOH webpage

II. ONGOING MONITORING & SURVIELLANCE

The Bureau of Managed Care Certification and Surveillance, (BMCCS), is within the Division of Health Plan Contracting and Oversight (DHPCO) and is responsible for ongoing oversight and compliance monitoring of MMC plans, inclusive of the application of Home and Community Based Services and Quality Assurance in accordance with regulations and guidance. The BMCCS Unit coordinates the surveillance of the MMC plans through the administration of various activities created to assess and monitor compliance. The survey unit collaborates and partners with subject matter experts from other units within BMCCS, the Certification Unit and the Utilization Review Unit, other Divisions within DOH including AIDS Institute, Office of Patient Quality and Safety (OPQS), in addition to other offices within the State, Office of Mental Health (OMH) and Office of Addiction Services and Supports (OASAS), to conduct standard surveillance activity through the Operational Survey and the Focus Survey, in addition to Ad Hoc Focus Surveys. BMCCS has developed multiple assessment methodologies, tools and compliance approaches that have been in place prior to the advent of the HCBS Final Rule. BMCCS has initiated new efforts and expanded upon existing practices, which have already begun or are being planned, to verify compliance with the HCBS Final Rule for MMC plan members by March 17, 2023.

The BMCCS Surveillance assessment of HCBS Final Rule is focused primarily on the person-centered care planning process completed by the MMC plans, either through Primary Care Management or Secondary Care Management, (also known as Care Coordination). Managed Care members may be eligible for a variety of HCBS dependent upon individual needs and assessment. BMCCS Operational surveillance includes standardized tools developed for each of the specific components included in HCBS Final Rule guidance. HCBS are authorized by the MMC plans and provided within the member's home or a community-based setting. The HCBS recipients' own home or the home of a family, friend, neighbor or relative, were not planned for site-level assessment, as these are presumed to be compliant by New York. Should BMCCS or its partners find through a rare review finding that the setting an individual lives in, which was anticipated to be a private home, resembles a congregate care residential situation requiring assessment, then a process of further investigation, assessment and remediation would be implemented for such a possible provider-owned and controlled setting, as applicable. The appropriate entity would conduct this investigation and MMC eligibility will be reviewed by the BMCCS and/or its partners. Covered non-residential services authorized by MMC plans, including, Adult Day Health Care Program (ADHCP) and Structured Day site validation and remediation are described within their respective sections of this Statewide Transition Plan (STP). As previously stated, the monitoring described here is being performed to ensure a member's access to the rights afforded by these federal requirements by focusing on the MMC plans' utilization and correct administration of the person-centered service planning (PCSP) Guidelines, PCSP Template, and the person-centered planning process at enrollment, reassessment and through care management.

CURRENT AND ONGOING SURVEILLANCE ACTIVITIES FOR MEDICAID MANAGED CARE PLANS

The surveillance and compliance process and protocols have been in place for several years. The surveillance and monitoring are completed during the Operational Survey of the MMC plans. There are two types of Operational Surveys, the first being the Comprehensive, which includes monitoring and completion of all the surveillance tools, the second is a Target review, or a follow-up to ensure the areas of noncompliance identified during the Comprehensive Survey have been corrected and the Plan of Correction has been implemented. The Operational Survey cycle is generally completed within two- to- three years. There have been reviews and revisions completed by the Division periodically, the most recent in 2019 through the Oversight Committee. The Oversight Committee was chaired by the Director of DHPCO and included representatives from all Bureaus, Divisions, and Departments involved in the surveillance requirements. BMCCS has identified the need to review and revise the survey tools and plans on resuming the Oversight Committee review and approval process in January 2023, to implement the new changes by the March 2023 federal deadline for HCBS Final Rule monitoring to commence. The current Operational Comprehensive Survey completed every other year, includes a request for the MMC plans to provide a list of all members receiving Care Management, in addition to all members in receipt of the various types of HCBS. These lists are reviewed to assess compliance with HCBS guidance, as well as to identify and choose case files for review. BMCCS reviews comprehensive case files for 35-50 members enrolled in Care Management, BH reviews 10-25 members indicated to need Care Management, and the AIDS Institute reviews comprehensive case files for 10-15 members enrolled in Care Management. When Care Management issues of noncompliance are identified during the Comprehensive Operational Survey, a follow-up review of Care Management is included as part of the Target Operational Survey, (completed the year following the Comprehensive Operational Survey) to ensure the Plan of Correction was implemented and the program is compliant with regulations and guidance.

The Care Management case files reviewed by BMCCS for the mainstream members include a random sample across the categories of Disease Management and services received, for example, Personal Care Assistance or Skilled Nursing. The BMCCS review includes primary Care Management, the MMC Plan staff develop the PCSP and are the primary and secondary Care Management or Care Coordination. The review for Care Coordination is based on the principles of the MMC plan Care Manager maintaining communication with both the member and the Primary Care Manager, for example for a member enrolled in a Health Home, the Health Home is considered the Primary Care Manager. The MMC Plan responsibilities include a review of the PCSP developed by the Primary Care Manager and assisting as needed for the member and/or the Primary. The current Operational Survey includes the following survey component tools that are specific to or include assessment of the requirements of the HCBS Final Rule. The current plan for revision is to further expand the review of Person-Centered Planning and to explore the integration of the survey tools into one comprehensive tool.

- Current Operational Survey Tools related to or inclusive of HCBS Final Rule
  - Long Term Support Services/Hospice/Nursing Home: created in 2019
  - Health Home: created in 2019
  - Behavioral Health: created in 2019, with concentration on members in HARP
  - AIDS Institute: revised in 2019, with focus on HIV and SNP programs
  - Case Management Review Tool: revised in 2019, revised 2022
  - Utilization Review: revised in 2019, authorization and denial process and rights
  - Complaints and Grievances: revised in 2019, reviews process and rights
  - Quality Assurance: revised in 2019, includes Care Management review
- PCSP Template
  - Release Date: January 2023
  - Description: DOH revised a template that includes all items and details to be incorporated into a complete person-centered plan. BMCCS is reviewing the template and guidance, revising the mainstream process to align with these documents as indicated above. The start date is March 2023.

BMCCS surveillance activity specific to the HCBS Final Rule requirement is to assess the members access to the HCBS identified as needed in accordance with the PCSP. BMCCS completes this oversight responsibility by ensuring the MMC plan providers include those that can deliver or provide HCBS, that services requested are reviewed and authorized in accordance with regulations and guidance, that members have access to Primary Care Management or Care Coordination, to ensure that the member or member representative is actively involved in the development of the PCSP. BMCCS surveillance activity and compliance review does not include direct provider oversight or visits.

Community Reintegration Post COVID-19 Public Health Emergency (PHE)

As previously stated, the monitoring being performed to ensure a member's access to the rights afforded by these federal requirements will focus on the MMC plans' utilization and correct administration of the PCSP Guidelines, PCSP Template, and the person-centered planning process at enrollment, reassessment and through care management provision The HCBS recipients' own home or the home of a family, friend, neighbor or relative, was not planned for

site-level assessment, as this are presumed to be compliant. However, should the BMSCC Unit or through active case management it is discovered that the residential setting resembles a congregate care residential situation that allegedly is provider owned or controlled, then a process of further investigation, assessment and remediation would be implemented. The appropriate entity would conduct this investigation and MMC eligibility will be reviewed by the BMCCS.

Continued case management and the annual reassessment are opportunities to verify the PCSP and enhanced community integration as the COVID-19 PHE officially ends. At this time, DOH has removed all restrictions on services settings and has instructed MMC plans and providers to follow any local health department guidance. Members identified by MMC plans to meet criteria for HCBS are referred to Health Homes enrollment to provide the opportunity for in person, face to face interactions with the assigned Care Manager. Members enrolled in Health Homes receive Primary Care Management from the Health Home, with Care Coordination provided by the MMC Plans.

New plans would be required to follow contractual and policy guidance to ensure compliance with the HCBS Final Rule and would be subject to the same surveillance requirements described here to ensure their continued compliance.

III. BENEFICIARY RECOURSE

If a member or their designee feels a MMC plan is non-compliant or wishes to issue a grievance or voice a concern regarding their HCBS, they may do so in several ways listed below. The methods of reporting below are documented in the member handbook, which all members receive upon their enrollment, and is available publicly on websites, and/or included on member notices: DHPCO will contact the plan directly with any complainant allegations of noncompliance that are received by the Bureau of Consumer Services. Complaints can be sent to BCS via phone or email sent to the bureau's 800 number or email address.

- **MMC Plan Care Manager:** Notify their MMC plan Care Manager who is responsible for their PSCP.

- **MMC Plan:** Notify their MMC plan directly via members' services contact.

- **DOH:** MMC plan members or their designee can contact the DOH MMC Bureau of Consumer Services (BCS) at managedcarecomplaint@health.ny.gov or 1-800-206-8125 with concerns or complaints.

- **ICAN:** Independent Consumer Advocacy Network (ICAN) is the ombudsman program for MMC plan members. Go to www.icannys.org, or call 1-844-614-8800 for free independent advice about coverage, complaints, and appeals options.

- **MMC website:** Complaints and Appeals - Managed Care - New York State Department of Health (ny.gov)

NEW YORK STATE DEPARTMENT OF HEALTH (DOH) OFFICE OF AGING AND LONG TERM CARE (OALTC) NURSING HOME TRANSITION AND DIVERSION (NHTD) & TRAUMATIC BRAIN INJURY (TBI) 1915(c) WAIVERS HCBS SETTINGS TRANSITION

I. SYSTEMIC COMPLIANCE

To come into systemic compliance with the HCBS Final Rule the following tasks were completed:

- The notice found at the link below was distributed to providers advising of the HCBS Final Rule requirements for Structured Day Programs (SDP) and Provider Owned Residential Settings. This notice was circulated about a year ago and all standards were included, and modifications were used as applicable. Clicking on this sentence brings you to the 2021 NHTD TBI HCBS guidance on the DOH webpage
- This link contains the original HCBS Final Rule guidance notice disseminated to providers: Clicking on this sentence brings you to the NHTD TBI guidance document on the DOH webpage.
- The link below is provided as a reference for the 2018 systemic compliance assessment process that was conducted for NHTD and TBI waivers. Please note, the Care at Home (CAH) I/II waiver referenced on this notice has been consolidated into the Children's Waiver (CW), which is further described in the Children's Waiver section of this Statewide Transition Plan (STP): Clicking on this sentence brings you to the 2018 Systemic Compliance Chart on the DOH webpage.
- Additionally, the waiver unit anticipated publishing a revised NHTD manual by March of the following year, unfortunately, this was delayed and the revised NHTD manual was published last year. Clicking on this sentence brings you to the 2021 Program Manual on the DOH webpage.

II. SITE VALIDATION

Settings that required site validation within the NHTD and TBI waivers were non-residential Structured Day Programs (SDP) and Provider Owned Residential Settings (i.e., there is no program name, simply providers that own an apartment or complex). A NHTD and TBI Waiver Unit site assessment and remediation tool, developed based on CMS guidance "Exploratory Questions to Assist States Assessment of Residential [and Non-Residential] HCBS Settings," was used in order to assess and validate sites. There was a total of two (2) Provider Owned Residential Settings and 54 Structured Day Program Sites to be assessed. The provider serves as a landlord but may also provide waiver services to those individuals residing in the home and others.

The onsite assessments at each setting and remediation tools were completed by the Regional Resource Development Center (RRDC) staff overseeing the region in which the sites were located. RRDCs are grant-funded contractors of DOH that manage the application, participation, and renewal processes of the NHTD and TBI programs. Any interested provider must contact the appropriate RRDC region(s) to start the application process for the NHTD and/or the TBI Waiver. The RRDC will complete a Waiver Service Provider Interview and the program

application packet and then submit to DOH's NHTD and TBI Waiver Unit for review and approval. RRDCs are funded through a grant for a 5-year period and are the local representatives of DOH for the purposes of the NHTD and TBI waivers.

Professionals/organizations interested in becoming an NHTD or TBI Waiver Service Provider must submit documentation to the RRDC for review and approval in order to complete the application process: RRDC staff are authorized to act on behalf of the state and the NHTD and TBI Waiver Unit has a process to validate their activities, which is described further below.

As a result of the site validation process, Provider Owned Residential Settings were determined to have all of the characteristics of private homes located in the community. They required no remediation to meet the HCBS Final Rule beyond issuing guidance to align official policies and procedures with the federal requirements.

As a result of the site assessment and validation, it was determined that 54 SDP Sites could come into full compliance with remediation.

Through the site assessment and validation process, four (4) SDP were found to be presumptively institutional in nature and triggered Heightened Scrutiny. All non-residential and residential settings utilized by NHTD/TBI waiver participants are monitored by the NHTD and TBI Waiver Unit. To ensure completeness of site validations conducted by the RRDCs, NHTD and TBI waiver unit staff reviewed each Heightened Scrutiny evidence package.

III. REMEDIATION

As mentioned, the two (2) Provider Owned Residential Settings were found to be similar to privately owned homes. As such, remediation was not required.

The main issues requiring remediation in SDP sites were: The setting is free from locked gates, fences or other barriers that inhibit entry to or egress from the location; there are sufficient staffing and/or resources (e.g., volunteers and natural supports) to address each person's needs and individualized plan priorities for community inclusion and integration activities outside of the setting; and the setting staff will adapt activities to accommodate each individual's needs and preferences as requested by the individual.

Remediation tasks that are being undertaken include: educating individuals, families, and/or advocates on the rights of the individuals served, including how to make informed choices, any risks involved in making those choices, and safeguards that may be put in place to support individuals to make such choices, and implementing key code entry to be provided to participants seeking to exit safely.

The RRDCs, in coordination with NHTD and TBI Waiver Unit, is tracking progress with all remediation plans to ensure all SDP settings achieve compliance with all of the HCBS Final Rule standards, including the two non-negotiable criteria listed below, by the March 2023 deadline:

- Privacy, dignity, respect, and freedom from coercion and restraint; and
- Control of personal resources

NHTD and TBI Waiver Unit will continue to provide technical assistance to the RRDCs as necessary to ensure that all SDP settings become fully compliant.

IV. ONGOING MONITORING AND QUALITY ASSURANCE

Ongoing monitoring and quality assurance of participant's (i.e., individuals who receive NHTD or TBI waiver services) residential settings, whether they be Provider Owned Residential Settings or private homes, will be completed on an annual basis through the service plan document, which includes a section regarding HCBS settings compliance of the participant's residence. The participant and their Service Coordinator are responsible for completing the service plan. The RRDC's review and approve all service plans, ensuring that residential settings continue to be compliant.

For SDP settings, ongoing compliance and quality assurance will be monitored by the RRDCs and systemic controls including, but not limited to: the established incident reporting and complaint process which is overseen by NHTD and TBI Waiver Unit, the provider agreement which contains controls within it, audits by the RRDC and audits by the OMIG. These activities are overseen by the NHTD and TBI Waiver Unit by a review of 100% of serious reportable incidents, regular review of quarterly reports submitted by the RRDC, quarterly review of complaint reports submitted by the RRDC and regular communication with the RRDC on provider trends or specific concerns. The provider agreement requires providers upon application to attest that they will abide by all applicable federal and State laws, and regulations of DOH and the Department of Health and Human Services (HHS). As such, failure to meet required HCBS Final Rule requirements will result in corrective action. This process will be initiated by the RRDC in conjunction with NHTD and TBI Waiver Unit. NHTD and TBI Waiver Unit will provide technical assistance and oversight as needed to ensure compliance.

The nature of the NHTD and TBI waivers ensures that individuals are integrated into their communities. This is reinforced by the format of the person-centered service plan, the design of the services themselves, and the robust reporting systems available to participants.

The NHTD and TBI waiver programs use person-centered service planning philosophies in the development and monitoring of participant services. At a minimum, every participant's service plan is reviewed and updated on an annual basis. The RRDC is the approver of the service plan and is tasked with ensuring that every service recipient has led, to the extent possible, and participated in the process of service planning per the participant's choice. Should an RRDC find that a service plan was not developed in concert with person-centered methods, the RRDC would contact the participant and implement a plan of correction in conjunction with that participant and their Service Coordinator. The RRDC may choose not to approve the service plan if it does not meet person centered planning criteria and/or it is confirmed that the participant did not actively participate in the development of the plan. On a regular basis, NYSDOH distributes and encourages participation in person-centered planning, thinking and practice resources and training opportunities and maintains a PCP Online Resource Library (clicking this sentence brings you to the PCP Online Resource Library on the DOH webpage), which can be accessed by providers, participants and other stakeholders at any time.

Community Re-integration Achieved and Verified Post PHE

In order to ensure ongoing compliance and to assess community integration for Structured Day Program settings, the annual participant satisfaction survey will include questions regarding satisfaction with services, specifically related to the Structured Day Program setting, and its compliance with HCBS settings regulations. In addition, the program manual states that providers must keep the RRDC and NHTD/TBI Waiver Unit apprised of all service locations and

any changes made to their service locations. Participant files and the SDPs sign-in/sign-out log must be available for inspection/audit upon request. Community reintegration for SDPs is verified on an ongoing basis by RRDCs.

As previously described, Provider Owned Residential Settings are home like and provide full access to the community as with private homes, therefore reintegration is not a relevant concern.

V. BENEFICIARY RECOURSE

Should a participant wish to file a grievance or complaint with NHTD/TBI Waiver Unit they can call the main waiver line at (518) 474-5271. The RRDCs each maintain a main number to receive complaints that has 24-hour availability. All interested parties file a complaint using these lines, including participants. Individuals can also submit complaints via email, physical mail, or in person at any RRDC location. Complaints can be made at any time. All complaints are investigated by the RRDC or NHTD and TBI Waiver Unit as appropriate. Waiver protocols require that staff responsible for the complaint follow-up will contact the complainant within two (2) business days to acknowledge receipt of the complaint and to advise that the matter is under review. Once a resolution is reached, the RRDC/ NHTD and TBI Waiver Unit will contact the complainant to discuss the outcome of the investigation consistent with HIPAA confidentiality regulations and will provide confirmation of the discussion.

Once the complaint investigation/review is completed, the complainant will be notified of the investigation findings as “substantiated,” “unsubstantiated,” or “inconclusive.” This notification will also notify the complainant of any actions required to remedy the problem. Due to confidentiality requirements, copies of investigations are not distributed, but the complainant may request a summary of the investigation process and findings.

The Service Coordinator must ensure, on an annual basis, that:

a. the participant has a copy of the NHTD Participant Instructions for the Complaint Process (DOH-5729) in an easily accessible location; and
b. the participant understands the complaint process well enough that they are able to make a complaint if necessary.

Further details of the complaint processes can be found here: Clicking on this sentence brings you to an NHTD TBI application with complaint information on the DOH webpage and here: Clicking on this sentence brings you to a compliant process document on the DOH webpage

Each waiver participant has a Service Coordinator. The participant selects their Service Coordination provider. All Service Coordinators are required to maintain monthly contact with each individual on their caseload. Any issues related to community integration and related activities, access to the community, participant rights and home living circumstances may be reviewed and discussed during that contact. All incidents and potential violations will be reported by the Service Coordinator and addressed.

NYS DEPARTMENT OF HEALTH (DOH) OFFICE OF HEALTH INSURANCE PROGRAMS (OHIP) SOCIAL ADULT DAY CARE (SADC) HCBS SETTINGS TRANSITION

I. SYSTEMIC COMPLIANCE

To come into compliance systemically with the federal requirements the following actions were taken:

A systemic assessment was conducted in 2018 for SADC, the results of which are included in this chart on pages 10-12: Clicking this sentence brings you to the SADC systemic compliance chart on the DOH webpage.

Listed below is the guidance released to ensure SADC site compliance with the HCBS Final Rule:

- **MLTC Policy 21.05: Social Adult Day Care HCBS Final Rule Implementation**
  - Clicking this sentence brings you to MLTC Policy 21.05 on the DOH webpage.
  - Release Date: 12/3/2021
  - Description: This policy was issued to all MLTC Plans and details all applicable requirements and provides resources for ensuring SADC site compliance with the HCBS Final Rule standards.

- **Fact Sheet and Timeline for SADC HCBS Final Rule Compliance**
  - Clicking this sentence brings you to the Fact Sheet and Timeline for SADC HCBS Settings Final Rule Compliance on the DOH webpage.
  - Release Date: 12/3/2021
  - Description: This fact sheet and timeline were issued with MLTC Policy 21.05 which details the requirements, steps, and timeline for SADC site compliance with the HCBS Final Rule.

- **HCBS Rule Compliance Assessment SADC Guiding Questions for MLTC Plans**
  - Clicking this sentence brings you to the HCBS Rule Compliance Assessment Guiding Questions.
  - Release Date: 12/28/2021
  - Description: Detailed guidance for MLTC Plan on-site assessors to utilize in ensuring HCBS Final Rule compliance at SADC sites. Provides guidance and information on ensuring compliance with all HCBS Final Rule requirements.

II. SITE VALIDATION

Efforts Undertaken to Validate HCBS Compliance

The SADC Team is currently undertaking efforts to validate SADC site compliance with the HCBS Final Rule. The SADC site network is continuously changing as MLTC Plans contract with new SADC sites or cancel contracts with existing SADC sites. However, at the time of this

update, there are approximately 425 SADC sites which are in the process of being validated for compliance. Therefore, validation of a statistically significant sample of SADC sites will be completed before March 17, 2023.

The SADC Team is utilizing the following assessments, tools, and methods to validate compliance:

- **Self-Assessment Survey:** This self-assessment survey tool was developed based on the Centers for Medicare and Medicaid's (CMS') "Exploratory Questions to Assist States in Assessment of Non-Residential HCBS Settings." It was completed and submitted to the SADC Team between January and July 2022 for each SADC site and MLTC Plan contract. Since SADC sites can be contracted with more than one MLTC Plan and for more than one line of business, it was common to see a multitude of submissions for one SADC site.

- **Quality Assurance (QA) Validation Review:** Once the SADC self-assessment surveys were received back, the SADC Team began validation of the submissions. This began in May 2022 and validation activities continue as corrected resubmissions are received. Utilizing all self-assessments, supporting documentation submitted with the surveys, and a geographical address search, the SADC Team is reviewing the information to identify if the SADC site appears to be compliant. The geographical address search is used to determine if the SADC site is inside of, on the grounds of, or adjacent to an institutional setting.

- **Virtual On-Site Review:** For all SADC sites where non-compliance was noted during the QA Validation Review process, the SADC Team is conducting a virtual on-site review to confirm compliance or to note issues that will need remediation. These virtual on-site reviews began October 2022 and will continue. Additionally, if a SADC site appears to be inside of, on the grounds of or adjacent to an institutional setting, the SADC Team also conducts the virtual on-site review, to determine if the SADC site can demonstrate compliance.

- **Member Experience Survey:** Prior to each Virtual On-Site Review, the SADC Team is requiring a Member Experience Survey to be conducted with up to three of the MLTC Plan members that attend the SADC site being reviewed. This is utilized to verify the setting being community integrated and identify potential non-compliance issues and areas of focus for the Virtual On-Site Review.

- **SADC PCSP Review:** Prior to each Virtual On-Site Review, the SADC Team is obtaining copies of the most recent SADC person-centered service plan (PCSP) for up to three of the MLTC Plan members that attend the SADC site being reviewed. These are being scrutinized to identify any potential non-compliance issues and areas of focus for the Virtual On-Site Review and to ensure person-centered planning is compliant.

Calendar of the SADC Team Site Validation Activities

The SADC Team has made extensive headway towards validating all SADC site compliance and will continue the process to ensure compliance before March 17, 2023. The SADC Team is currently conducting compliance activities based on the following risk pools:

- **Risk Pool 1:** SADC site and/or MLTC Plan reported the SADC site is prong 1, 2, or 3.

- Approximate Number of SADC Sites: 160

- **Risk Pool 2:** SADC site and/or MLTC Plan reported the SADC site is not fully compliant with all HCBS Final Rule standards.
  - Approximately Number of SADC Sites: 265
  - Risk pool 2 will be broken into two groups.
    - The first group (a) will contain approximately 45 SADC sites, which represents the remainder of sites needing to be reviewed to ensure a statistically significant sample.
    - The second group (b) will be the remainder of the SADC sites in the risk pool.

The below activities have been completed or are in-progress and are planned to be completed to ensure SADC sites meet compliance standards. The below efforts include reviews of a statistically significant sample of SADC sites.

- **December 2021 – Self-Assessment Survey Release:** Self-Assessment Survey released to MLTC Plans to complete for all contracted SADC sites.

- **January 2022 – December 2022 – Self-Assessment Intake Reviews:** Intake and verification of completeness of the Self-Assessment Surveys. Most acceptable surveys were fully received by July 2022 but, the process remains ongoing for new SADC sites and new contracts between MLTC Plans and SADC sites (i.e., over 6,500 reviewed and repeated submissions to date).

- **May 2022 – November 2022 – QA Validation Reviews (Risk Pool 1):** QA Validation Reviews of self-assessment surveys and supporting documentation submitted for SADC sites.

- **October 2022 – December 2022 – Virtual On-Site Reviews (Risk Pool 1 – Possibly Non-Compliant):** If a SADC site is deemed still possibly non-compliant or prongs 1, 2, or 3 after the QA Validation Review, a Virtual On-Site Review, which includes review of members' SADC PSPs, is conducted to make a final determination on compliance.

- **December 2022 – January 2023 – Heightened Scrutiny List Public Comment Period:** Once the QA Virtual On-Site Reviews are conducted for risk pool 1, the complete list of SADC sites that are Heightened Scrutiny, along with the evidence packages, will be posted for public comment.

- **December 2022 – January 2023 – QA Validation Reviews (Risk Pool 2a):** QA Validation Reviews will be conducted for self-assessment surveys and supporting documentation submitted for SADC Sites in group (a) of risk pool 2a. This risk pool will be the remaining SADC sites that need to be reviewed to ensure a statistically significant sample of all sites have been verified.

- **January 2023 – February 2023 – Virtual On-Site Reviews (Risk Pool 2a – Possibly Non-Compliant):** If a SADC site is deemed still possibly non-compliant or prongs 1, 2, or 3 after the QA Validation Review, a Virtual On-Site Review, which includes review of members' SADC PCSPs, is conducted to make a final determination on compliance.

III. REMEDIATION

The SADC Team is currently in the process of validating SADC site compliance with the HCBS Final Rule standards. Therefore, remediation efforts for any non-compliance found or noted, are still being performed and NYS understands that all SADC sites will require some form of remediation, at this time. The SADC Team is requiring that all remediation efforts are completed prior to March 17, 2023, unless a CMS approved NYS Corrective Action Plan (CAP) allows flexibility for the deficiency in question. Please see the section on the SADC Team's portion of the NYS CAP request below for additional details. For SADC sites that are unable to meet compliance, the MLTC Plan will terminate the contract(s) with the SADC site and if the SADC site would like to provide services in the future, they will need to provide evidence that they are fully compliant before contracting with a MLTC Plan.

There are two levels of SADC remediation efforts being undertaken, those by the SADC Team and those by the MLTC Plans.

Remediation Oversight of MLTC Plans

MLTC Plans are required to ensure all contracted SADC sites are compliant with state and federal regulations, and the MLTC Surveillance Unit monitors the MLTC Plan oversight of the SADC sites. Details on oversight of the MLTC Plans can be found in that portion of this STP. The SADC Team is in the process of verifying SADC site compliance with the HCBS Final Rule. As the SADC Team implements efforts to ensure compliance, any SADC site found to not be fully compliant is reported to all MLTC Plans contracted with the site. Every MLTC Plan contracted with that SADC site is expected to complete a strategic remediation plan with the SADC site and return the plan to the SADC Team. Once received, the SADC Team will review the remediation plans to ensure they will bring the SADC site into full compliance.

If a MLTC Plan is not cooperating and performing the required oversight of the SADC sites they are contracted with, the MLTC Surveillance Unit may issue a statement of deficiency to the MLTC Plan. SADC sites may report issues and grievances with a MLTC Plan to DOH directly at the DOH MLTC Technical Assistance Center (TAC). See the Beneficiary Recourse section below for additional details on reporting to the MLTC TAC.

MLTC Plan Remediation Oversight of SADC Sites

As part of their contract with DOH, the MLTC Plans are responsible for ensuring all their contracted SADC sites are fully compliant. Additionally, any non-compliance findings must be remediated with MLTC Plans supporting the SADC sites with that process via technical assistance and guidance. The SADC Team and MLTC Surveillance Unit have provided continuous support, training webinars, and guidance to the MLTC Plans in ensuring they have the tools (see Site Validation section for details), resources, timelines, and knowledge to ensure their SADC sites are complying. If a SADC site is not compliant, all MLTC Plans contracted with that site must ensure the SADC site is in compliance.

Additionally, in September 2022 the SADC Team issued reminders to all MLTC Plans of their responsibility to ensure compliance and provided detailed information for SADC sites that had self-reported as possibly being institutional or institutional-like in nature (prongs 1, 2, or 3), or not being fully compliant. The MLTC Plans are currently working with their contracted SADC

sites to remediate these non-compliance issues before March 17, 2023, unless a CAP is approved and allows flexibility for specific deficiencies (see the CAP section below for additional details). For SADC sites that are unable to meet compliance, the MLTC Plan will terminate the contract(s) with the SADC site and if the SADC site would like to provide services in the future, they will need to provide evidence that they are fully compliant before contracting with an MLTC Plan.

Identified Non-Compliance Trends

Based on the SADC self-assessment surveys received, the SADC Team has identified the below trends related to SADC site non-compliance. The trends are being closely verified for compliance using the methods described above.

Additionally, the SADC Team has identified that approximately one-third of the originally contracted SADC sites were closed during the COVID-19 public health emergency (PHE). The SADC Team has directed that upon reopening the SADC sites must be in full compliance with the HCBS Final Rule and all state and federal standards before members may receive services. At this time, the SADC Team has determined that some SADC sites are considered noncompliant due to non-response to the SADC Team and MLTC Plan compliance verification efforts and were removed from the MLTC Plans' networks. Where applicable, any members that had received services at these closed SADC sites are being outreached to and assisted to choose another compliant SADC site.
Based on self-reporting, the SADC Team noted that almost all SADC sites are compliant with the following three standards, and will ensure that all SADC sites are fully compliant with them prior to March 17, 2023:

- The setting ensures an individual's rights of privacy, dignity, and respect, and freedom from coercion and restraint.
- The setting facilitates individual choice regarding services and supports, and who provides them.
- The setting optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices including but not limited to daily activities, physical environment, and with whom to interact.

The SADC Team also noted that the compliance standard most SADC sites self-reported a deficiency for was that the setting is integrated in and supports full access to the greater community. For this standard, the SADC Team saw that most SADC sites are already compliant with the portion of the standard that relates to an individual's ability to control personal resources and will ensure all SADC sites are fully compliant with this portion of the standard prior to March 17, 2023.

However, the SADC Team noted self-reported deficiencies mainly in the following three areas:

- Does the site restrict individuals from receiving services or engaging in activities outside of the setting?
- Is information regarding transportation available to individuals in a convenient manner such as participant handbooks, handouts, or public postings?
- Are resources other than public transportation, including financial and staff resources, available for individuals during the time at the SADC to access the site and/or individualized activities that participants may wish to attend in the community?

These self-reported areas of non-compliance align with the SADC Team's expectations of where deficiencies are occurring for many HCBS settings and exemplify the impact the COVID19 PHE has had on the SADC sites. Further analysis of these areas will determine upcoming guidance from the SADC Team to the MLTC Plans and their SADC networks.

IV. ONGOING MONITORING AND QUALITY ASSURANCE

Ongoing monitoring and quality assurance entails two levels of efforts being undertaken to ensure SADC site compliance with all state and federal regulations and the HCBS Final Rule standards. These entail efforts by the SADC Team and/or MLTC Surveillance Unit, and those by the MLTC Plans. The MLTC Plans are required by contract to monitor their contracted SADC sites and in turn, the SADC Team and MLTC Surveillance Unit monitor the MLTC Plans to ensure their oversight and compliance efforts of the SADC sites are sufficient and meaningful.

Note: Since the MLTC Plans are responsible for creating and maintaining the PCSPs for members, PCSP oversight activities can be found in the separate MLTC section of this STP.

The SADC Team has begun preparing for and will begin implementing the plan for ongoing processing and monitoring. At the start of this process, the SADC Team also plans to conduct the following continued efforts, ensuring all SADC sites known to date have been reviewed, not just the required statistically significant sample.

- **February 2023 – May 2023 – QA Validation Reviews (Risk Pool 2b & 3):** Validation reviews of the remaining self-assessment surveys will be conducted and supporting documentation submitted for SADC Sites in group a of risk pool 2b.

- **June 2023 – September 2023 – Virtual On-Site Reviews (Risk Pool 2b & 3– Possibly Non-Compliant):** If a SADC site is deemed still possibly non-compliant or prongs 1, 2, or 3 after the QA Validation Review, a Virtual On-Site Review, which includes review of members' SADC PCSPs, will be conducted to make a final determination on compliance.

Monitoring and Oversight of MLTC Plans

To monitor and oversee the MLTC Plans, the SADC Team and DOH MLTC Surveillance Unit has and will be conducting the below activities. Failure to comply with all requirements and standards of any survey will result in the issuance of statements of deficiency.

- **Support and Education:** Continuously provide tools, resources, guidance, and timelines to MLTC Plans and SADC sites.
- **Communication Channels:** The SADC Team will continue to have an open two-way communication channel with all MLTC Plans. The SADC Team has an active mailbox that MLTC Plans, and stakeholders, submit inquiries to: hcbssadcsiteassessments@health.ny.gov
- **SADC Compliance Annual Survey:** The DOH MLTC Surveillance Unit will conduct a planned annual review of SADC sites' compliance, as reviewed by MLTC Plans, on a statistically valid sample of contracted SADC sites for all MLTC Plans. This review will include review of the MLTC Plan conducted SADC site annual site visits as well as MLTC Plan conducted Member Experience Surveys. This cycle has started as of October 2022 and will continue annually thereafter.

- **Operational Surveys:** The DOH MLTC Surveillance Unit already performs ongoing and monitoring operational surveys. However, the DOH MLTC Surveillance Unit is enhancing these surveys to include a more in-depth focused examination of SADC site compliance. See the MLTC Plan portion of this STP for additional details on this effort.

Efforts that have already begun or are planned to implement this process are as follows:

- **September 2022 – Suggested SADC Site Evaluation Tool:** In September 2022, the SADC Team released the Suggested SADC Site Evaluation Tool, along with the corresponding user guide, for all MLTC Plans to utilize during their annual SADC site reviews or when first contracting with a SADC site, to ensure compliance with the HCBS Final Rule and other state and federal standards. MLTC Plans are required to utilize the SADC Team's tool or confirm their tool covers at minimum all items in the SADC Team tool. This tool will ensure a comprehensive and consistent review is performed by all MLTC Plans across all contracted SADC sites.
- **September 2023 – Annual SADC Compliance Survey:** The MLTC Surveillance Unit's annual review of the SADC sites' compliance, as reviewed by MLTC Plans, will be conducted and continue annually thereafter. See the MLTC Plan portion of New York's STP for additional details on this effort.

MLTC Monitoring and Oversight of SADC Sites

By contract, all MLTC Plans are required to conduct an annual on-site evaluation of all contracted SADC sites. Additionally, an on-site evaluation must be conducted prior to contracting with a SADC site. MLTC Plans are also required to conduct annual Member Experience Surveys.

The SADC Team and MLTC Surveillance Unit have provided guidance on all standards that must be verified for compliance during these evaluations, which include HCBS Final Rule compliance and other state and federal requirements.

All deficiencies noted during the annual evaluations and Member Experience Surveys must be addressed and remediated. If a SADC site is unable to remediate the deficiency, the MLTC Plan is required to terminate their contract with the SADC site, support any members in selecting and transitioning to a HCBS-compliant SADC site through their person-centered planning process and remove the non-compliant SADC site from their network.
The SADC Team and MLTC Surveillance Unit continuously provide support to the MLTC Plans to establish continuous quality improvement and confirm compliance with all state and federal standards.

Community Reintegration Post Public Health Emergency

The SADC Team is working with MLTC Plans, providing education, tools, and technical assistance to support them in encouraging the SADC sites to become fully community-facing and integrated programs that offer offsite activities and the ability to access the community on an individual and group basis. Receiving the CAP will help afford enough time to ensure that transportation, staffing, and other PHE impacted barriers to integration are removed. The above-described SADC site ongoing monitoring and quality assurance process includes assessment of community integration and will be addressed going forward through that process as described above.

V. BENEFICIARY RECOURSE

If a member or their designee feels a MLTC SADC site is non-compliant or wishes to issue a grievance or voice a concern, they may do so via several ways. Additionally, SADC sites may report any issues or grievances regarding a MLTC Plan directly to DOH for investigation. The methods of reporting below are documented in the member handbook, which all members receive upon their enrollment in MLTC, available publicly on websites, and/or included on member notices, as applicable to the reporting method. Complaints are tracked and reported in the member's case file at the plan level, the technical assistance database for plan response and resolution and/or through an ombudsman process. All entities often work collaboratively to investigate and resolve the member's complaint, grievance, and/or appeal rights.

- **DOH:** MLTC Plan members or their designee can contact the DOH MLTC Technical Assistance Center (TAC) at mltctac@health.ny.gov or 1-866-712-7197 with concerns or complaints. This contact is also utilized by SADC sites who wish to report an issue with a MLTC Plan.

- **MLTC Plan PSCP Care Manager:** Members may notify their MLTC Plan Care Manager, who is responsible for their MLTC PSCP, of any concerns.

- **MLTC Plan:** Notify their MLTC Plan directly via members' services contact.

- **ICAN:** Independent Consumer Advocacy Network (ICAN) is the ombudsman program for MLTC plan members. Members may go to www.icannys.org, or call 1-844-614-8800 for free independent advice about coverage, complaints, and appeals options.

- **Reporting Information – MLTC Website:** Members may also obtain information on reporting an issue on the MLTC website.
    - Clicking this sentence will bring to you the MLTC complaint page on the DOH website.

OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES (OPWDD) HCBS SETTINGS TRANSITION PLAN

I. SYSTEMIC COMPLIANCE

Regulatory Compliance

The Division of Policy and Program Development (DPPD), in conjunction with OPWDD's Counsel's Office, engaged in a comprehensive assessment of OPWDD regulatory compliance with HCBS Final Rule. As a result, OPWDD promulgated or amended regulations, found in Title 14 of the New York Codes, Rules and Regulations (NYCRR) as summarized below. All regulations or amendments are currently in effect and are applicable to all OPWDD HCBS waiver services and applicable as required to Care Management services provided though Care Coordination Organizations (CCOs). Links to all OPWDD regulatory changes or updates can be viewed in greater detail on the OPWDD Systemic Compliance Chart. The complete OPWDD Systemic Compliance Chart, which represents our 2018 systemic assessment results, can be viewed on the OPWDD webpage. A summary of the regulations are as follows:

- OPWDD promulgated 14 NYCRR- 636-1, Person-Centered Planning. These regulations govern person-centered planning requirements and were effective as of November 1, 2015. The 14 NYCRR- 636-1, Person-Centered Planning regulations can be viewed on

the OPWDD webpage.

- OPWDD promulgated 14 NYCRR 636-2, Home and Community Based Services and Settings requirements. These regulations govern HCBS general requirements for all settings providing HCBS and were effective as of October 1, 2021. The 14 NYCRR 6362, Home and Community Based Services and Settings requirements can be viewed on the OPWDD webpage.

- OPWDD made two changes to 14 NYCRR 633, to include language on documentation of rights modifications and all are in effect as of October 1, 2021. These regulations govern protections for people receiving services. The changes to 14 NYCRR 633 regulations on Protection of Individuals Receiving Services in facilities and Services Operated and/or Certified by OPWDD can be viewed on the OPWDD webpage.

- OPWDD made changes effective November 1, 2015, to 14 NYCRR 635, to include HCBS Final Rule rights and language governing the individualized service environment defining the Individualized Service Plan. The changes to 14 NYCRR 635 can be viewed on the OPWDD webpage.

- OPWDD made changes to 14 NYCRR 686, to include HCBS Final Rule rights and language governing the individualized service environment defining the Individualized Service Plan and were in effect as of November 1, 2015. These regulations govern the operations of community residences, such as IRAs. The 14 NYCRR 686 regulations on the Operation of Community Residences can be viewed on the OPWDD webpage.

II. SITE VALIDATION

Initial Assessment of Settings

Starting in 2014, OPWDD began a multi-year initial assessment process of certified settings to determine site level compliance and the need for remediation that included technical assistance and training to providers of HCBS. Based on this assessment, OPWDD found that all certified residential service categories, IRAs, and Family Care Homes, required remediation of some form due to the nature of new requirements. OPWDD found that while certified day services, Day Habilitation, Site Based Prevocational Services were at a high level of compliance they would benefit from HCBS training and remediation activities similar to other settings.

As noted by CMS, private homes are presumed compliant but are included in on-going monitoring activities by OPWDD Division of Quality Improvement (DQI). In addition, all OPWDD employment services are community-based, integrated, individualized, and presumed compliant but are also included in on-going monitoring activities by OPWDD DQI.

Initial Assessment Data is summarized below on Table 1, OPWDD Initial Site Level assessment Data. It must be noted that at the time of the completion of initial assessments for IRAs and Day Habilitation settings, OPWDD was using criteria based on our initial interpretation of HCBS standards that all settings adjacent to former public institutions and all settings that converted from an Intermediate Care Facility (ICF) to an IRA after March 2014, were to be subject to Heightened Scrutiny. OPWDD no longer uses this second criterion to determine Heightened Scrutiny status, therefore the projections noted below in this initial assessment data are overestimated. Despite these factors, OPWDD used the site assessment data to develop robust remediation activities.

Table 1: OPWDD Initial Site Assessment Data

Setting Type	Type of Assessment and Validation Method	Total Number of Settings Assessed	Number of Settings that Were Compliant	Number of Settings that are Not Compliant but will be by March 17, 2023	Number of Settings that Cannot Comply	Number of Settings that may be Subject to Heightened Scrutiny that Have or Will Comply by March 17, 2023
IRAs	2017 (update of 2014-2016 data)-OPWDD DQI conducted random site-based reviews and utilized assessment tools based on CMS Exploratory Questions, in 2014-2016, 2017 OPWDD DQI updated data and utilized the Site Review Protocol, Validated by DQI Survey staff	6,166	5,672	251 (Does not include Heightened Scrutiny projection)	0	243 (Included former ICFs and settings adjacent to Former public institutions)
Day Habilitation	2016-17- OPWDD DQI utilized the Site Review Protocol, Validated by DQI Survey staff	727	712	15	0	0 (Note that future site assessment determined some settings subject to Heightened Scrutiny)
Site-Based Prevocational Settings	2018 through 2022- DQI utilized the Site Review Protocol, Validated by DQI Survey staff	21	21	0	0	0

Family Care	2018- OPWDD assessed Family Care Homes utilizing a survey based on the CMS Exploratory Questions that were validated completed by Family Care Staff.	1001	1001	0	0	0

Building on the OPWDD assessment results, OPWDD continues the HCBS transition through the DQI survey validation process. Site validation data is summarized below on Table 2, Site Based Assessment Data, and reflects OPWDD site review data and validation for required settings. OPWDD survey and monitoring activities were impacted by the PHE, however, the comprehensive OPWDD DQI survey process using DQI survey protocols that include all HCBS standards, has continued. Of note, DQI is conducting interviews with individuals receiving services, as well as their family members/advocates as part of OPWDD's site validation activities for HCBS Final Rule compliance and ongoing monitoring. Interviews with individuals are conducted as part of OPWDD's Site Review Protocol and Person-Centered Review Protocols. All interviews conducted with individuals routinely focus on satisfaction, rights, choices, preferences, autonomy, and outcomes in a person-centered way.

For certified IRAs, Day Habilitation settings, and Site-Based Prevocational services, the data in the table below is based on the results of the most recent full site survey using the DQI Site Protocol. OPWDD is continuing to validate IRAs and Site-Based Prevocational services with completion no later than March 17, 2023. Validation of Site-Based Prevocational settings are complete. Validation of Family Care Homes is complete and was conducted by OPWDD Developmental Disabilities State Operations Offices staff.

OPWDD's request for Corrective Action Plans (CAP) due to the impact of the PHE and in accordance with guidance form CMS, is noted later in this Transition Plan. All OPWDD HCBS settings will be fully compliant with the following standards by March 17, 2023:

- Privacy, dignity, respect, and freedom from coercion and restraint; and
- Control of personal resources.

In addition, all OPWDD HCBS provider-owned and controlled residential settings, such as IRAs, will be fully compliant with the following standards by March 17, 2023:

- A lease or other legally enforceable agreement providing similar protections;
- Privacy in their unit, including lockable doors, and freedom to furnish or decorate the unit;
- Access to food at any time;
- Access to visitors at any time;
- Physical accessibility; and
- Person-centered service plan documentation of modifications to relevant regulatory criteria.

Table 2: Site Based Assessment Data

Setting Type	Type of Assessment and Validation Method	Total Number of Settings Assessed	Number of Settings that Were Compliant	Number of Non-Isolating Settings that are Not Compliant but will be by March 17, 2023	Number of Settings that Cannot Comply	Number of Settings that are Subject to Heightened Scrutiny that Have or Will Comply by March 17, 2023

IRAs	DQI Site Review Protocol Validated by DQI Survey staff 10/1/2018-9/22/22 DQI survey data	6,243	5,631	612	0	64
Day Habilitation	DQI Site Review Protocol Validated by DQI Survey staff 10/1/2018-9/22/22 DQI survey data	781	734	47	0	13
Site-Based Prevoca-tional Services	DQI Site Review Protocol Validated by DQI Survey staff 10/1/2018-9/22/22 DQI survey data	19	19	0	0	0
Family Care Homes	Assessment based on DQI Site Review Protocol Validated by DDSO Staff	1001	1001	0	0	0

III. REMEDIATION

Using the results of the systemic assessment process, OPWDD embarked on a comprehensive program of remediation. Because OPWDD began training providers in 2014 OPWDD HCBS Settings developed a high level of HCBS Final Rule compliance early in the transition to full compliance. The remediation efforts are summarized below but here are a few of the initiatives:

- OPWDD partnered with The Council on Quality and Leadership (CQL) to offer Personal Outcome Measure (POMs) Work Shops to OPWDD state operations staff, OPWDD DQI surveyors, and to staff with OPWDD voluntary providers. As of October 2017, 726 OPWDD staff from all areas of the state, engaging in all aspects of service provision and/or administration, were trained in CQL POMs. In addition, over 2600 staff from voluntary providers also benefited from this training.
- OPWDD developed, in conjunction with a stakeholder work group that included people receiving services, a Rights Card to make people receiving services, their families, and

providers, aware of rights and to assist with starting conversations and person-centered planning. The Rights Card can be viewed on the OPWDD webpage.

- OPWDD's DQI Survey Protocols were re-designed to include all HCBS Settings standards, with the first updated protocol implemented in 2016. OPWDD providers received training on these Protocols as well as on HCBS Settings compliance during regularly scheduled Bi-Annual DQI provider training.
- OPWDD developed a video series titled "Transitions" depicting stories of community transition and the profound positive changes that community living makes in the lives of people with developmental disabilities and the lives of the people around them. The video segments portray, through personal stories, the successful transition of individuals receiving OPWDD services from segregated, institutional settings to integrated, community-based opportunities. The stories focus on their living situations, workplace, daily activities, relationships, and how OPWDD supports, and services are assisting them with their move to the community. The Transitions Video Series can be viewed on the OPWDD webpage.
- OPWDD providers and all HCBS providers in New York state continue to benefit from the DOH Person-Centered Planning On-Line Resource Library which provides a diverse and user-friendly collection of person-centered planning resources and tools. The PCP Online Resource Library can be viewed on the DOH webpage.

Site Specific Remediation Process

Remediation is an integral component of OPWDD's systemic and comprehensive survey process. The survey process includes the remediation of any standards found not met during site surveys and during the completion of the Person-Centered and Agency Review Protocols.

The data for IRAs, Day Habilitation and Site-Based Prevocational services is based on the results of the most recent full site surveys completed by DQI utilizing the Site Review Protocol from 10/2018 to the 9/2022.

Beginning in 2016, OPWDD has conducted on-site reviews using protocols that include HCBS Final Rule standards. OPWDD survey activities were suspended in 3/2020 during the PHE and routine survey activities resumed in 4/2021.

The identification of site level compliance is achieved through evaluation of the DQI protocol data collected each survey year. The focus of the analysis of survey data is to identify any patterns or trends found non-compliant in the core areas included in HCBS standards.

The most prevalent concern for remediation identified in the analysis of both the IRA and Day Habilitation Site Protocol data is in the requirement to provide sufficient staffing to support the individual's participation in individualized and personally meaningful community activities. The overall concern in not having sufficient staffing is a contributing factor in secondary areas identified as prevalent in the standards below.

In both the IRAs and Day Habilitation sites, another prevalent issue of non-compliance requiring further remediation was in having a mechanism to access individual's satisfaction with their service environment.

The next standards most prevalent and identified in the review of IRA and Day Habilitation data varied by setting. In the IRAs, the standard for having a mechanism to assess living arrangement choice was identified as area for further remediation. In the Day Habilitation

settings, individual's being encouraged and supported to have access to the broader community was identified and is a concern directly related to not having adequate staffing to support participation in individualized and meaningful community activities.

The data for the Prevocational service sites was also reviewed and there are no trends or patterns of non-compliance identified. Systems implemented by OPWDD to track the progress and completion of remedial actions to achieve compliance is described in the following processes:

During the completion of Site surveys and Person-centered and agency reviews, a written summary of unmet standard findings is provided to the agency providing HCBS. Any areas of non-compliance identified during the review is documented on the finding reports that are given to the agency. The agency must correct any areas of non-compliance identified on the reports, within the established timeframes required and identified by OPWDD.

When warranted, Statements of Deficiencies (SODs) are issued to the agency. Agencies must submit a written Plan of Corrective Action (POCA) that is acceptable to OPWDD. For a POCA to be found acceptable to OPWDD, it must include how the agency will correct the specific concern identified and include the agency's systemic actions to correct the deficiency across the programs to prevent recurrence of the deficiency in the future. The POCA must also include the actions the agency has implemented to verify that corrective actions were implemented and how the agency will monitor and maintain compliance.

The implementation and effectiveness of plans' of corrective actions are reviewed by OPWDD during the subsequent protocol reviews and surveys conducted annually. OPWDD also completes additional validation and monitoring visits when warranted to ensure that corrective actions have been implemented. OPWDD has policies and procedures to deal with egregious situations or situations that raise the risk of imminent harm requiring more immediate or ongoing visits to the setting.

Protocol documentation and data is reviewed, assessed, and monitored by OPWDD. On-going data analysis is completed to ensure remediation occurred at a specific site/program. Systemic reports are pulled from this data and is utilized to re-evaluate OPWDD's site level compliance in its programs.

OPWDD conducts statewide provider training to update the provider community on changes in policy, clarify expectations, and to provide technical assistance and resources in remediation strategies and share best practices.

Site specific remediation activities included the following:

IRAs

-OPWDD Person-Centered Regulations Issued
-OPWDD Survey Protocols updated to include HCBS Settings standards
-Provider Training
-Train state and voluntary staff on person-centered practices
-Develop Occupancy Agreement Template
-Incorporate HCBS Final Rule in OPWDD DSP Training
-Rights "Card" developed for individuals receiving services

Day Habilitation

-OPWDD Person-Centered Regulations Issued
-OPWDD Survey Protocols updated to include HCBS Settings standards
-Interim Guidance Document developed for Day Habilitation Providers
-Train state and voluntary staff on person-centered practices -Incorporate HCBS Final Rule in OPWDD DSP Training
-Rights "Card" developed for individuals receiving services

Site-Based Prevocational Settings

-OPWDD Person-Centered Regulations Issued
-OPWDD Survey Protocols updated to include HCBS Settings standards
-Train state and voluntary staff on person-centered practices -Incorporate HCBS Final Rule in OPWDD DSP Training
-Rights "Card" developed for individuals receiving services

Family Care

-OPWDD Person-Centered Regulations Issued
-Family Care On-Going monitoring was updated
-Rights "Card" developed for individuals receiving services
-Train providers on rights including access to keys to front and bedroom doors
-Develop Occupancy Agreement Template

IV. ONGOING MONITORING

Site Reviews are conducted at individuals' certified residential and day settings that are certified for operation by OPWDD. Reviews are typically unannounced. Site reviews occur using a risk-based strategy based on a variety of factors, including the compliance history of the site. All HCBS settings receive on site visits during their certification period. These site-based reviews are part of a suite of review tools including Person Centered reviews and Agency reviews. Thus, DQI's reviews approach services from several perspectives to better understand the service environment.

Through the OPWDD on-going monitoring process, individual settings that did not achieve 100% compliance received Exit Conference documentation and technical assistance from the DQI in order to achieve 100% compliance.

Person-Centered Review~~s~~ (PCR) is a comprehensive assessment of all services an individual receives including HCBS. The review encompasses services that are site-based, community-based and Care Management services. The review evaluates that person-centered planning processes were implemented and resulted in an array of services that address the person's desired and needed outcomes. The randomly selected annual PCR sample includes individuals who live in private homes and Family Care Homes. The sampling process ensures that all service providers, OPWDD-sponsored services, and service setting types are evaluated. The Person-Centered Review tool is intended to assess compliance with federal PCP requirements as well as HCBS standards, such as choice of living arrangement including non-disability specific settings.

Agency Reviews assess the provider's organizational mechanisms to ensure the delivery of

quality services in compliance with quality practices and state and federal regulatory requirements. Through survey/review activity using information from all survey protocols, a determination is made whether each HCBS standard is met or not met. Standards not met are discussed with the agency at the end of the survey. Findings are entered into a protocol database and a summary document of findings is provided to the agencies. Agencies are required to address/correct any findings detailed in the report. Findings and data are reviewed and monitored as part of OPWDD's oversight. Analysis of this data is used to determined site level corrections as needed.

OPWDD's HCBS Setting Regulations were promulgated effective October 1, 2021, requiring agencies to comply with these regulatory requirements. Using established standardized practices, findings are provided to the agency and corrective actions are required within specified timelines. Additional monitoring/remedial action may be implemented by OPWDD as deemed necessary.

Failure of an agency to achieve compliance within timeframes determined by OPWDD, and consistent with CMS guidance, may result in the suspension of waiver funding. Other remedial actions may include fines, change of auspice, and revocation of operating certificates.

Ongoing monitoring activities for Family Care Homes follows a different process and is the responsibility of the OPWDD State Operations Regional Offices. OPWDD State Operations Regional Offices monitor Family Care Holmes. All Family Care Homes undergo an annual review using the *Form 238 Family Care Home Evaluation and Survey* review tool. The Family Care Form 238 on the OPWDD webpage can be viewed by clicking here. This review tool includes a section specific to the OPWDD Home and Community Based (HCBS) Waiver Settings regulations. At least annually, each Family Care Home operated by a Sponsoring Agency will also be reviewed by the associated Sponsoring Agency against the established standards to confirm compliance with all HCBS regulations. Each Sponsoring Agency is responsible to assign a staff member familiar with the Family Care program to complete this task. Prior to recertifying Family Care Homes, OPWDD's Developmental Disabilities State Operations Offices' (DDSOO) designated Quality Assurance staff review each *Form 238 Family Care Home Evaluation and Survey* and other recertification records, to verify that the certification standards have been met. A *Family Care Home Evaluation and Survey Deficiency Report and Verification of Correction Form* is completed if a standard is not met, which must include a plan of corrective action (POCA). The POCA must identify responsible parties from the State Operated or Sponsoring Agency and timelines for correcting the deficient practice or the home may not be recertified. Upon verification that the certification standards have been met or an acceptable POCA has been established, the DDSOO Director signs and submits a "*DDSOO Family Care Attestation: Readiness for Recertification Attestation* to OPWDD's Division of Quality Improvement for the issuance of an operating certificate."

Community Integration Verification Post Public Health Emergency

As of this date the PHE is still in effect. OPWDD will continue to support individuals receiving HCBS though our vast system of supports, to participate in community-based activities of their choice as noted in their person-centered plans. The OPWDD 2023-2027 Strategic Plan addresses community integration and participation within each of its three strategic goals. For example, Goal 2, Objective 2.1, focuses on the development of more integrated day services, expanding access to assistive technology, and environmental modifications, and promoting the use of Supported Decision Making.

Likewise, OPWDD's strategic plan outlines efforts to increase access to the community by

prioritizing and strengthening the Direct Care workforce (Goal 1, Objective 1.1). Direct Care Professionals are essential to achieving the goal of community integration. Therefore, OPWDD has made significant investments in the workforce using ARPA resources (described in Section V of this document). The 2023-2027 OPWDD Strategic Plan, also known as the 5.07 Plan pursuant to section 5.07 of state mental hygiene law, can be viewed on the OPWDD webpage by clicking this sentence.

To assess the impact of these efforts and ensure activities are yielding results, OPWDD's DQI will engage in ongoing- survey and monitoring processes. Additionally, OPWDD routinely offers technical assistance and guidance to service providers on a site-specific basis. The OPWDD DQI Person-Centered Review addresses this topic. This data will be used to assist OPWDD with oversight of a CAP, should New York have its request for a CAP approved.

New providers of OPWDD Waiver Services and Supports must be in full compliance with HCBS Final Rule requirements before being added to the provider base. Ongoing monitoring and quality assurance will ensure that all activities follow these requirements on an ongoing basis. Providers are required to submit a proposal to the Regional Field Office when requesting an expansion, development or relocation of any site-based service(s). Prior to initiating a new operating certificate for site-based programs, the OPWDD DQI and Regional Field Office staff review the facilities policies, fiscal position and operating protocols to ensure compliance with HCBS settings. Any new development or relocation that would fall under Prong 1 or Prong 2 is subject to Heightened Scrutiny review, public comment, and submission to CMS prior to approval and the initiation of HCBS service delivery. On-going compliance with all HCBS settings criteria is assured through the OPWDD DQI survey process using DQI review protocols that include all HCBS settings standards. Of note, DQI conducts interviews with individuals receiving services, as well as their family members/advocates as part of OPWDD's site validation activities and ongoing monitoring for HCBS Final Rule compliance. Interviews with individuals are conducted as part of OPWDD's Site Review Protocol and Person-Centered Review Protocols. All interviews conducted with individuals routinely focus on satisfaction, rights, choices, preferences, autonomy, and outcomes in a person-centered way.

V. BENEFICIARY RECOURSE

A person or their representative may call the OPWDD Infoline at 866-946-9733 to register a complaint and request assistance regarding an OPWDD HCBS setting and/or service that is not compliant with HCBS Final Rule Standards. The info line business hours are from 9:00 am to 5:00 pm Monday through Friday, excluding holidays. Complaints made after hours may be left on the hotline's voicemail system. In addition to the Infoline, there are informal and formal means to resolve concerns related to any person-centered plan or services or proposed changes to the services using the Objection to Services Process as described in 14 NYCRR 633.12. The Objection to Services Process can be viewed on the Westlaw webpage. If, through informal mechanisms, a resolution cannot be reached, individuals or their representatives may submit a formal written objection to the DDRO at which point a hearing will be scheduled. If the individual or their representative is not satisfied with the result of the hearing, an appeal may be submitted to the Commissioner of OPWDD.

NEW YORK STATE OFFICE OF MENTAL HEALTH (OMH) HCBS SETTINGS TRANSITION

I. SYSTEMIC COMPLIANCE

To come into compliance with the HCBS Final Rule systemically, the following tasks were completed:

- Systemic assessment of the rules and regulations governing OMH residential sites was conducted in 2018. The 2018 Systemic Compliance Chart developed as part of that review can be found on the OMH webpage by clicking this sentence. Note: OMH's SED waiver, found on pages 1-3 of the Systemic Compliance Chart, was moved into the Children's Waiver in April of 2019, and is now overseen by New York State Department of Health (DOH) and described in full in the Children's Waiver section of this Statewide Transition Plan (STP).
- OMH issued updated Supportive Housing Guidelines to unlicensed residential providers on September 30, 2022. The Supportive Housing Guidelines govern all supportive housing providers funded by OMH. The Supportive Housing guidelines can be found on the OMH webpage by clicking this sentence.
- OMH issued to sub-regulatory guidance to licensed residential providers on October 7, 2022. This sub-regulatory guidance pertains to OMH 14 NYCRR Part 595, and the operation of all licensed Apartment Treatment programs and all Community Residence Single Room Occupancy (CR-SRO) programs. This sub-regulatory guidance includes all aspects of the HCBS Final Rule and can be found on OMH's webpage by clicking this sentence.
- BH HCBS Provider Manual was reissued on 09/26/22 to include CMS language related to HCBS Final Rule standards. This Provider Manual is specific to non-residential services and therefore did not include standards that are required for provider owned and controlled residential settings. For example, given the short duration of the services, community-based settings they are delivered, and the focus on skill development and supporting work or school goals in relevant settings, BH HCBS providers are not required to provide access to food or visitors during service delivery, however would not restrict either. The BH HCBS Provider Manual can be found on OMH's webpage by clicking this sentence.
- OMH further undertook a review of regulations and policies governing adult residential settings to ensure systemic HCBS Final Rule compliance.

II. SITE VALIDATION

SITE REVIEW OF OMH NON RESIDENTIAL SETTINGS

OMH has implemented steps to comply with the Center for Medicaid and Medicare Services (CMS) HCBS Final Rule. (42 CFR 441.301, et. seq). Under the rule, States were required to develop a transition plan for existing HCBS demonstrating how they will ensure that HCBS existing at the time of the promulgation of the regulation would be brought into compliance with the new requirements. Because the implementation of HARP and the inclusion of HCBS in its benefit plan for adults were subsequent to the date of the issuance of the rule, compliance with the new requirements was mandatory from the date of the inception of the program. It is further noted that BH HCBS came into existence after March 1, 2014 and have been compliant with the HCBS Final Rule since implementation. There is no site level assessment, validation, or remediation needed for these sites and services.

SITE REVIEW OF OMH RESIDENTIAL SETTINGS

Accordingly, OMH undertook an assessment of the various adult residential programs and options available to individuals with serious mental illness who would otherwise be eligible for HCBS in order to determine which settings were already compliant, and whether and how settings that were non-compliant could be brought into compliance, in order to enable residents of such settings to participate in HCBS.

To accomplish this, OMH began by having adult residential providers complete a HCBS Settings Residential Program Assessment, a provider self-assessment developed based on CMS guidance "Exploratory Questions to Assist States Assessment of Residential Settings." This assessment allowed OMH to compile baseline data that was used to assist OMH in determining which sites were compliant, and which sites required remediation to achieve full compliance. The provider self-assessment assisted OMH to:

- Inventory OMH's current residential settings
- Identify specific sites for heightened scrutiny (now non eligible settings)
- Develop and implement compliance plans for non-compliant sites
- Collect and verify evidence of settings compliance

The final submission from Apartment Treatment, CR-SROs, and SP-SROs programs to OMH included:

- HCBS Residential Settings provider self-assessment for each site
- Attestation signed by the provider's Executive Director
- Additional supporting evidence such as maps, pictures of setting and/or other information
- List of non-compliant sites owned/operated by the provider
- An OMH Corrective Action Work Plan, if required, via the electronic assessment or OMH

When completing the assessment:

- Providers established a team of appropriate staff to complete the assessment.
- Providers had their Executive Director sign and submit the attestation form with their site-specific assessment to OMH.
- Providers included additional supporting evidence where needed such as maps, pictures of the setting and/or other information that provides strong evidence the setting is a community-based setting.

OMH pre-determined the following as settings automatically non-compliant with the HCBS Final Rule. These sites were NOT required to complete an assessment and were therefore not submitted for heightened scrutiny:

- OMH Licensed Congregate Treatment Sites (Community Residences)
- Family Care Programs
- Owned and/or operated sites located on the grounds of or adjacent to a psychiatric institution

Based upon the standards set forth by the federal regulation, OMH determined that the following OMH funded settings were in need of further review for compliance and must complete a HCBS Settings Residential Program Assessment for each housing site:

- Apartment Treatment Programs
- Community Residence Single Room Occupancy Programs (CR-SRO)
- Supportive Single Residence Occupancy Programs (SP-SRO)
- Supportive Scattered-Site Housing

Please note: Supportive Scattered-Site Housing programs were initially required to complete an assessment for each program. However, upon further review it was determined that these sites should not be included in the review of OMH's residential system. Supportive Scattered-Site Housing programs provide a rental stipend for individuals to rent market-rate apartments, with limited services to help maintain housing stability. Individuals in these programs hold a lease or sub-lease and receive the protections of landlord tenant laws. These sites have all the characteristics of private homes and will be reviewed as such if an individual is referred for HCBS.

To validate the provider self-assessments OMH staff conducted onsite validation visits. OMH determined 324 site visits would represent a statistically significant sample of the 2,076 sites to be assessed (see assessment results in Remediation section below for more info). To account for any margin of error, we conducted visits to 408 sites, completed in October 2022. Staff used a validation tool developed based on CMS guidance "Exploratory Questions to Assist States Assessment of Residential Settings," as with the provider-self assessment. All sites visited were found to be in compliance.

TRAININGS & OMH STATE OFFICE CONTACT INFORMATION

A series of trainings were available through the Managed Care Technical Assistance Center: (clicking this sentence brings you to the MCTAC website) and the OMH Website: (clicking this sentence brings you to the OMH website) regarding the HCBS Final Rule to assist providers in completing the assessment. Trainings targeting agency executives and residential program directors were provided in 2016 and are archived and made readily available to applicable providers. In addition, OMH has set up an email mailbox which is specifically designated to questions and concerns regarding HCBS Final Rule compliance and integration. The email address is hcbs-residential@omh.ny.gov.

In 2021 and 2022, OMH offered technical assistance to providers via phone, email, and video conference to help them develop and implement remediation plans to come into compliance with the HCBS Final Rule.

III. REMEDIATION

Residential settings that did not meet HCBS settings standards at the time of the provider self-assessment were required to develop a Corrective Action Work Plan outlining how the setting would achieve HCBS Final Rule compliance. Once submitting the initial assessment, providers were automatically given a list of flagged areas of non-compliance via the electronic review tool. Using this list, providers composed a Corrective Action Work Plan to demonstrate steps to resolve all flagged issues. The plan was initially submitted to OMH with the final submission of the provider self-assessment.

In February through October of 2022, OMH met with every program that was initially determined to be non-compliant as a result of the provider self-assessment. OMH reviewed Corrective Action Work Plans to ensure they were successful in achieving compliance. The biggest area that required remediation was access to visitors of their choosing at any time. The other areas that generated flags on the assessment tool largely required clarification, not remediation. For example, we asked about residents having a checking/savings account or other means to control their own funds. Many sites responded in the negative because residents did not have bank accounts, but further clarification that funds were controlled by the client and not the program irrespective of a bank account allowed us to confirm compliance. We also asked about

sites being accessible to the residents, which generated negative responses because it was interpreted to mean every site needed to meet Accessibility requirements. When we clarified that the program must ensure sites met the accessibility needs of the specific individuals residing in them, we were able to resolve those flags without remediation.

OMH provided technical assistance to programs that had not yet developed appropriate plans for issues that required remediation. Finally, via review of residency agreements, policies and procedures, and any other relevant documentation, OMH ensured remediation had occurred via the effective implementation of Corrective Action Work Plans. Both OMH Central Office and designated field offices will have copies of the site's completed assessment and Corrective Action Work Plan for monitoring purposes and to make certain goals identified in the plan continue to be met.

ASSESSMENT RESULTS

As of February 2022, the following number of sites that had completed self-assessments remained operational, and thus the self-assessments were validated:

- Apartment Treatment: 1,888 sites
- CR-SROs: 56 sites
- SP-SROs: 132 sites

As noted above, OMH met with all of the programs that contained sites that were not immediately compliant based on the self-assessment, to ensure the development of an appropriate Corrective Action Work Plan. OMH then reviewed implementation of the Corrective Action Work Plan to ensure providers came into compliance with the rule. Once review of Corrective Action Work Plans was complete, OMH conducted site visits to a statistically significant sample of sites to verify compliance (see next section for more information).

Based on the review of the provider self-assessments and implemented Corrective Action Work Plans, OMH determined that 2,068 of the 2,076 sites are in compliance with the HCBS Final Rule at this time. It was determined that eight sites (4 CR-SROs and 4 Apartment Treatment sites) could not come into compliance. These eight sites are all located on the grounds of a psychiatric institution and as such, should not have received a self-assessment.

Review of the provider self-assessments and implementation of Corrective Action Work Plans was completed in August 2022. OMH field offices will incorporate HCBS standards into annual program and site performance reviews, further details of which can be found in the Ongoing Monitoring section below.

IV. ONGOING MONITORING AND QUALITY ASSURANCE

OMH HOUSING & RESIDENTIAL

OMH has a robust monitoring and quality assurance process conducted by our field offices located across the state. OMH has five field offices in the following regions: Long Island, New York City, Hudson River, Central New York, and Western New York. Licensed programs (Apartment Treatment and CR-SROs) receive a site visit at least once every three years, and unlicensed residential programs (SP-SROs) receive a site visit at least once every five years. In between site visits, ongoing monitoring and technical assistance occurs.

OMH field offices will be provided with the HCBS review tool, developed based on CMS guidance "Exploratory Questions to Assist States in Their Assessment of Residential Settings" and will be incorporating it into monitoring visits effective January 1,2023. Any areas that OMH staff find to be non-compliant will require a Corrective Action Work Plan and follow a

remediation process that is similar to what was described above.

Please see below for information on how private homes and person-centered plans of care are monitored.

NON-RESIDENTIAL: ADULT BH HCBS

BH HCBS designated providers are designated by both OMH and Office of Addiction Services and Supports (OASAS); once designated, providers are assigned a State Host Agency which is responsible for ongoing monitoring and quality assurance. OMH and OASAS use the BH HCBS Service Standards, conducting reviews at least every 36 months for all providers. This process involves an administrative review, chart reviews, and staff and client interviews to ensure compliance with state and federal standards. At OMH, this process is conducted by the Field Office Managed Care staff; at OASAS, this process is conducted by Central Office in coordination with their regional offices. BH HCBS Service Standards were reissued on October 18, 2022. This tool is used in the routine oversight and monitoring of BH HCBS providers and has been updated to explicitly include HCBS standards (see Service Standard 5.1).

The chart review and interviews place specific emphasis on reviewing person-centered planning by the BH HCBS provider in the development of their Individual Service Plan (ISP).

As part of the person-centered planning process, the Health Home Care Manager is responsible for ensuring that the individual has chosen to live in their current residence (as documented on the Plan of Care, elsewhere referred to as the Person-Centered Service Plan (PCSP)). If an individual has not chosen their residential setting, the Care Manager must support the individual with identifying a plan to move to the setting of their choice.
It is noted that the Department of Health (DOH) designates Health Homes; ongoing monitoring for the BH HCBS Plan of Care and person-centered planning falls under their oversight process.

HEALTH HOME CARE MANAGEMENT AND ADULT BH HCBS

Within the BH HCBS the Health Home is the care management service model whereby all of an individual's caregivers communicate with one another so that all of an individual’s needs are addressed in a comprehensive manner. This is done primarily through a Care Manager who oversees and provides access to all of the services an individual needs. Health records are shared among providers so that services are not duplicated or neglected. Health Home services are provided through a network of organizations – providers, health plans and community-based organizations. When all the services are considered collectively, they become a virtual "Health Home."

The "Health Home Standards and Requirements for Health Homes, Care Management Providers and Managed Care Organizations" requires Health Homes to prepare Plans of Care for members receiving BH HCBS that meet the requirements in this checklist, offer choice of providers, and document choice in the Plan of Care. See D. 6 and also B.13 at: clicking this sentence brings you to the Health Home Standards and Requirements for Health Homes, Care Management Providers and Managed Care Organizations on the OMH webpage.

Health Home care managers are responsible for creating the person-centered Plans of Care for BH HCBS. MCOs are responsible for the review and approval of the Plans of Care, including ensuring that Plans of Care contain the elements in the checklist and meet all of requirements per the "Health Home Standards and Requirements..." document.

In addition, the Medicaid Managed Care Model Contract revisions for the behavioral health transition to managed care, currently under CMS review, contain provisions requiring the MCO

to ensure that a person-centered Plan of Care is developed. The Plan of Care must be consistent with the requirements set forth in the "Health Home Standards and Requirements..." document and must reflect the individuals' preferences for services and providers. Contract language must also reflect MCO policies and procedures to monitor the implementation of the Plan of Care.

To ensure HARP members and HARP-Eligible HIV SNP members who are not currently enrolled in a Health Home are given the opportunity to access Adult BH HCBS, the State has established Recovery Coordination Agencies (RCAs), who are Health Home affiliated and charged with complying with the same federal rules as the individuals who are health home enrolled: (clicking this sentence brings you to the RCA guidance document on the OMH webpage). All individuals enrolled in Adult BH HCBS have either a care manager or recovery coordinator. These entities are responsible for maintaining the person-centered Plan of Care and monitoring of private homes.

V. BENEFICIARY RECOURSE

OMH residential providers across all setting types are required to have a grievance process. They are required to notify all residents of their rights and the program's grievance process upon admission and at least once annually. OMH ensures these practices are in place and that grievances have been resolved appropriately during ongoing monitoring.

OMH also operates a customer relations line to receive and address complaints at 1-800-597-8481. OMH requires that providers must inform residents of the opportunity to contact OMH with complaints or concerns. Contact information for the OMH field offices and the customer relations line can be found at: Clicking on this sentence brings you the complaints information page on the OMH webpage, Contact OMH (ny.gov).

NEW YORK STATE OFFICE OF ADDICTION SERVICES AND SUPPORTS (OASAS) HCBS SETTINGS TRANSITION

I. SYSTEMIC COMPLIANCE

In order to come into compliance systemically, all applicable standards and guidance regarding HCBS Final Rule compliance has been put into our Permanent Supportive Housing Program Guidelines, which was last updated in 2020. As part of that process, updated language regarding person centered planning processes was included.

- Clicking this sentence brings you to the PSH OASAS webpage.
- Clicking this sentence brings you to the PSH guidance manual on the PSH OASAS webpage.

As part of OASAS' process to come into compliance systemically an assessment of our rules, policies and procedures related to HCBS was conducted in 2018. The results of that assessment can be found in this Systemic Compliance Chart:

- Clicking this sentence brings you to the 2018 Systemic Compliance Chart on the OASAS webpage.

II. SITE VALIDATION

As mentioned, all PSH sites have been validated and found to be independent apartments. OASAS used an online provider self-survey using questions provided by CMS guidance "Exploratory Questions to Assist States Assessment of Residential Settings." Surveys were completed January 2017. There was a 100% completion rate for the self-survey. Additionally, staff from the OASAS Counsel's Office at visited two sites in person. State staff from the OASAS Housing Bureau have inspected all 2800 residential units, with the exception of the units that are part of the Continuum, of Care Program which are overseen and inspected by the Department of Housing and Urban Development.

One site was found to be presumptively institutional in nature and is discussed in more detail in the Heightened Scrutiny section below.

OASAS conducted an assessment of units available through each of its PSH brands. Assessments were conducted using the process noted above (self-survey with onsite inspections by staff), as well as surveys of tenants to determine client satisfaction and HCBS Final Rule compliance using questions from CMS guidance, as well as interviews with tenants in private. This process was completed by June 2021.

The number of units, broken out by PSH brand, is included below:

- Continuum of Care (CoC) Program – 897 units (Inspected by the federal Department of Housing and Urban Development (HUD), not New York State)
- NY/NY III Singles – 375 units
- NY/NY III Families – 285 units
- NY/NY III Population E – 822 units
- Re-Entry – 12 units
- Upstate PSH – 119 units
- MRT – 300 units

III. REMEDIATION

No site level remediation was found to be necessary for our PSH sites. All sites comply with the requirements of the HCBS Final Rule, including the eight non-negotiable criteria described in CMS 2022 guidance:

- Privacy, dignity, respect, and freedom from coercion and restraint; and
- Control of personal resources.
- A lease or other legally enforceable agreement providing similar protections;
- Privacy in their unit, including lockable doors, and freedom to furnish or decorate the unit;
- Access to food at any time;
- Access to visitors at any time;
- Physical accessibility; and
- Person-centered service plan documentation of modifications to relevant regulatory criteria (*i.e*., the additional standards are afforded to PSH recipients at all times and may not be modified)

IV. Ongoing Monitoring and Quality Assurance

OASAS conducts annual monitoring reviews of its PSH brands to evaluate program compliance with the HCBS Final Rule and other State and federal requirements. OASAS conducts interviews with staff and tenants, as well as a review of tenant files, to ensure effective management of the program. Monitoring focuses on overall program management, admission procedures, service plans, documentation of service and housing quality standards. In addition, housing providers are required to submit a monthly report to OASAS, regarding current census, admissions, discharges and educational/vocational information. Moving forward, this annual review will also be utilized to ensure that all of our PSH units maintain compliance with the HCBS Final Rule. Guidance for providers regarding HCBS requirements was incorporated into the Permanent Supportive Housing Program Guidelines in 2019. This document serves as the basis for inspections.

All units are inspected regularly by OASAS Housing Bureau staff. In a normal year, 60% of all units are inspected. However, between late 2019 and the onset of the pandemic in early 2020, approximately 85% of units were inspected. When onsite inspections are allowed again, staff will be able to inspect the remaining units in 4-6 months. Staff will inspect each unit in-person. When warranted, emergency inspections are conducted in-person as well. In between inspections, staff monitors monthly reports submitted by providers. Staff also performs periodic check-ins with providers either through telephone or email.

V. BENEFICIARY RECOURSE

Beneficiaries have multiple means of reporting non-compliance to OASAS. They can call 1-800-553-5790 for program complaints or 1-800-482-9564 for counselor complaints. OASAS has also posted our Patient Advocacy Unit on our agency website. This information also is provided to tenants when they move into an OASAS PSH unit. Complaints are timely sorted and addressed by phone calls to providers, as well as by referral to the Housing Bureau for further investigation or inspection is necessary. Patient Advocacy also conducts follow up review, by contacting tenants to ensure that their complaints were resolved.

Additionally, all OASAS PSH tenants also can report provider non-compliance to their case managers, who will follow up appropriately with OASAS and the provider.
Tenants who reside in OASAS PSH units which are provided in collaboration with local government programs, also can file complaints with their local government programs.

Finally, during inspections, OASAS staff meet with tenants individually, without provider staff being present, to discuss issues and concerns about non-compliance.