NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF LONG TERM CARE

Traumatic Brain Injury Waiver

The Home and Community Based Services 1915c Medicaid Waiver for Individuals with Traumatic Brain Injury (HCBS/TBI) is one component of a comprehensive strategy developed by the New York State Department of Health to assure that New Yorkers with a traumatic brain injury receive services within New York in the least restrictive setting.

What is a Home and Community Based Services (HCBS) 1915c Medicaid Waiver?

In 1981, Congress authorized the waiver of certain federal requirements to enable a state to provide home and community services (other than room and board) to individuals who would otherwise require institutional/nursing facility services reimbursed by Medicaid. The waiver programs are called 1915c waivers, named after the section of the Social Security Act that authorized them. Under 1915c waiver authority, states can provide services not usually covered by the Medicaid program, as long as these services are required to keep the person from being institutionalized.

A 1915c waiver:

- Allows states to assemble a package of carefully tailored services to meet the needs of a targeted group in a community-based setting.
- Maintains the waiver participant's health and welfare through an individualized service plan.
- Assures that the overall cost of serving the waiver participants in the community is less than the cost of serving this same target group in an institution.

Why did New York State Develop the HCBS/TBI Medicaid Waiver?

- Chapter 196 of the Laws of 1994, Article 28-cc established the Traumatic Brain Injury Program (TBI) within the NYS Department of Health (NYSDOH). This legislation charged the Department "to develop a comprehensive statewide program…with primary emphasis on community-based services and to develop outreach services and to utilize existing organizations with demonstrated interest and expertise in serving persons with traumatic brain injury."
- The HCBS/TBI waiver provides a cost-effective community-based alternative to nursing facility care.

Anticipated Outcomes of receiving TBI Waiver Services:

- The applicant makes an informed choice to receive community based care instead of institutional care.

- The waiver participant is the primary decision maker in the development of goals and selection of services and providers.
- Participation in waiver services will improve the quality of care and health care outcomes for individuals with TBI.
- Services are person-centered and driven by participant need and choice.

To be Eligible for the HCBS/TBI Waiver an Individual Must:

- Have a diagnosis of TBI or a related diagnosis as established by Chapter 196 of the Laws of 1994, Article 27-cc;
- Be between the ages of 18-64 at the time of application to the waiver; once eligible, there is no age limit to continue to receive services;
- Be a Medicaid beneficiary with Medicaid coverage that supports community based long term care;
- Be assessed to need nursing facility level of care (NFLOC) as established by the currently approved assessment instrument, the Uniform Assessment System for New York (UAS-NY), as a direct result of the traumatic brain injury (TBI);
- Choose to participate in the waiver and be able to identify a residence in which he/she will be residing when receiving waiver services;
- Be able to be safely served with the services available under the HCBS/TBI waiver and New York State Medicaid State Plan.

Regional Resource Development Centers (RRDC)

The New York State Department of Health (NYSDOH) is responsible for the implementation and oversight of the HCBS/TBI waiver. NYSDOH contracts with qualified not-for-profit organizations or agencies, known as Regional Resource Development Centers (RRDC), in established regions across the state for the local administration of the waiver program. The contact person at the RRDC is the Regional Resource Development Specialist (RRDS).

The RRDC is responsible for:

- Receipt of program referrals, intake interviews and evaluating the applicant's functional status.
- Reviewing service plans and authorizes approval for waiver services.
- Facilitating person centered planning and waiver participant choice.
- Overseeing program compliance and participant eligibility.
- Development and oversight of sufficient providers to offer waiver services.

HCBS/TBI Waiver Services

TBI waiver services are used to complement already available sources of support and health care services. The following provides general service definitions available as waiver services. More specific information will be provided to applicants and participants as part of the service planning process. The 1915c Medicaid waiver application that authorizes the provision of these services is available at: https://www.health.ny.gov/health_care/medicaid/reference/tbi/docs/1915c_waiver_application_2017.pdf.

Service Coordination

Service Coordination is an individually designed service which provides primary assistance to the waiver applicant/participant in gaining access to needed waiver and Medicaid State Plan services, as well as other local, state, and federally funded educational, vocational, social, and medical services. The Service Coordinator assists the applicant in becoming a waiver participant and coordinates and monitors the provision of all services in the service plan once the individual is determined eligible. For individuals transferring from nursing facilities, the Service Coordinator assists the applicant in obtaining and coordinating services that are necessary to return to the community. For those individuals residing in the community, the Service Coordinator facilitates the necessary supports to maintain the individual's health and well-being sufficient to avoid unwanted nursing home placement.

There are 2 types of Service Coordination provided to the participant:

Service Coordination, Initial: Encompasses those activities involved in assisting individuals seeking application for waiver services and developing the documentation included in the Application Packet. Providers may only bill for this service upon the person's entry into the waiver. This service is one time per admission to the TBI waiver.

Service Coordination, Monthly: Ongoing Service Coordination begins as soon as the individual is determined eligible for waiver services. The Service Coordinator is responsible for the timely and effective implementation of the approved service plan. The Service Coordinator is responsible for assuring that there is adequate coordination, effective communication, and maximum cooperation between all sources of support and services for the participant. This type of service coordination is provided to waiver participants on an ongoing, monthly basis.

A Service Coordinator's caseload may not exceed twenty (25) TBI waiver participants. The Service Coordinator must complete a monthly face-to-face visit with each TBI waiver participant on their caseload. They must meet with the participant in their home at least quarterly.

Assistive Technology (AT)

Assistive Technology Services (AT) supplement State Plan Medicaid Services for Durable Medical Equipment and Supplies and offers medical devices and supplies not available under the State Plan. Medicaid State Plan and all other resources must be utilized before considering a request for Assistive Technology. All other sources must be explored utilized and/or exhausted before seeking Assistive Technology services.

Assistive Technology includes the costs associated with acquisition of the assistive technology, the evaluation of the assistive technology needs of a participant, implementation and oversight of the technology, including a functional evaluation of the impact of the provision of appropriate assistive technology to the participant in the customary environment of the participant and/or services consisting of selecting, designing, project management, fitting, customizing, adapting, maintaining, repairing, or

replacing Assistive Technology devices. In addition, the service may provide for training or technical assistance for the participant, family members, guardians, paid staff, advocates, or others who are utilizing or assisting with the implementation of the technology.

Service Limits: $35,000 per twenty-four (24) month period. This amount may be exceeded if there is enough justification and the request is approved by the New York State Department of Health.

Community Integration Counseling (CIC)

Community Integration Counseling (CIC) is an individualized counseling service designed to assist the waiver participant to effectively manage the emotional difficulties associated with adjusting to life after a traumatic brain injury. It is a counseling service provided to a participant coping with the need to revise long term expectations, his/her changing roles, and the impact of these changes on him/her, family members and informal supports. This service is provided in the provider's office or the participant's home. It is available to participants and/or anyone involved in an ongoing significant relationship with the consent of the participant when the issues discussed relate directly to the participant. The participant must be present (face-to-face) at the time of service delivery. "Collateral counseling" is not permitted without the participant present. Regarding client confidentiality, the sharing of information obtained during a CIC session can only be disclosed in accordance with accepted professional standards regarding client confidentiality.

Service Limits: Four (4) hours weekly, not to exceed two hundred twenty (220) hours annually. Goals must be reasonable and attainable and services do not extend beyond a two-year period. Services may be extended in extraordinary cases with sufficient justification and upon review and approval of the RRDC.

Community Transition Services (CTS)

Community Transitional Services (CTS) are defined as individually designed services and project management intended to assist a waiver participant in transitioning from a nursing home to living in the community. CTS is a one-time service per waiver enrollment. If the waiver participant is discontinued from the program and re-enters a nursing home, they can access this service again upon discharge. This service is only provided when transitioning from a nursing home. These funds are not available for moves from the participant's home in the community to another location in the community.

This service includes: the cost of moving furniture and other belongings; security deposits; broker's fees required to obtain a lease on an apartment or home; purchasing essential home furnishings; set-up fees or deposits for utility or service access (e.g. telephone, electricity, heating); and health and safety assurances such as pest removal, allergen control, or one-time cleaning prior to occupancy, costs and/or fees associated with securing the service. Assists individuals leaving nursing homes by providing

assistance with payment of a Security deposit, utility set up fees, moving expenses, purchase of essential furniture, and initial cleaning service.

Service Limits: $8,000 per waiver enrollment.

Environmental and Vehicle Modifications

Environmental Modifications (E-mods) are internal and external physical adaptations to the home that are necessary to assure the health, welfare, and safety of the waiver participant. These modifications enable the waiver participant to function with greater independence and prevent institutionalization. E-mods may include: the installation of ramps and grab bars; widening of doorways; modifications of bathroom facilities; installation of specialized electrical or plumbing systems to accommodate necessary medical equipment; or any other modification necessary to assure the waiver participant's health, welfare or safety. E-mods include the performance of necessary assessments and project management to determine the type of modifications needed and the assessment that the adaptation has been completed according to the required specifications.

Vehicle modifications provide the participant with the means to access services and supports in the community, increase independence and promote productivity. These modifications may include adaptive equipment and/or vehicle modifications.

Service Limits: Up to $45,000 per thirty-six (36) month period. This amount may be exceeded if there is enough justification and the request is approved by the New York State Department of Health.

Home and Community Support Services (HCSS)

Home and Community Support Services (HCSS) are the combination of personal care services (Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) with oversight/supervision services or oversight/supervision as a discrete service primarily at a participant's home.

HCSS is provided to a waiver participant who requires assistance with personal care service tasks and whose health and welfare in the community is at risk because oversight/supervision of the participant is required when no personal care task is being performed. Services are complementary but not duplicative of other services. HCSS are utilized when oversight and/or supervision as a discrete service is necessary to maintain the health and welfare of the participant living in the community. Oversight and/or supervision may be needed for safety monitoring to prevent an individual from harmful activities (for example wandering or leaving the stove on unattended). Oversight and/or supervision can be accomplished through cueing, prompting, direction and instruction. If the applicant/participant does not require oversight and/or supervision, HCSS would not be appropriate.

HCSS services are provided under the direction and supervision of a Registered Professional Nurse (RN). The RN supervising the HCSS staff is responsible for developing a plan of care and for the orientation of the HCSS staff about the participant.

HCSS services assist the individuals with the support of non-medical assistance, and includes safety monitoring assistance with activities of daily living and integration into the community. These services can be provided in the individual's residence or in the community. These non-medical services are a compliment to personal care services provided under Medicaid.

Service Limits: Not to exceed the approved total annual number of hours included in the service plan.

Independent Living Skills Training and Development (ILST)

Independent Living Skills and Training (ILST) services include assessment, training, and supervision of, or assistance to, an individual with issues related to self-care, medication management, task completion, communication skills, interpersonal skills, socialization, sensory/motor skills, mobility, community transportation skills, reduction/elimination of maladaptive behaviors, problem solving skills, money management, pre-vocational skills and skills to maintain a household.

ILST is provided in the environment and situation that results in the greatest positive outcome for the waiver participant and in an environment where the trained skills are most commonly used. ILST cannot be provided in the Structured Day Program.

Service Limits: Four (4) hours per day, not to exceed two hundred twenty (220) hours annually.

Positive Behavioral Interventions and Supports (PBIS)

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

These services include, but are not limited to: a comprehensive assessment of the individual's behavior (in the context of their medical diagnosis as determined by the appropriate health or mental health professional), skills and abilities, existing and potential natural and paid supports and the environment; the development and implementation of a holistic structured behavioral treatment plan including specific realistic goals which can also be utilized by other providers and natural supports; the training of family, natural supports, and other providers so that they can also effectively use the basic principles of the behavioral plan; and regular reassessment of the effectiveness of the behavioral treatment plan, making adjustments to the plan as needed. The participant must be present whenever services are provided.

A comprehensive assessment of the individual's behavior is completed in the context of his/her medical diagnosis, abilities/disabilities, and the environment which precipitates the behaviors. The number of hours utilized to complete this assessment must be included in the service plan and may not exceed 10 hours. This assessment must be consistent with information contained within the UAS-NY assessment.

Service Limits: Eight (8) hours per day, not to exceed two hundred forty (240) hours annually.

Respite Care

Respite service is an individually designed service intended to provide scheduled relief to non-paid supports who provide primary care and support to a waiver participant. The service is provided in a 24-hour block of time as required.

The primary location for the provision of this service is in the waiver participant's home. Receipt of respite services does not preclude a participant from receiving other services on the same day.

Payment may not be made for respite furnished at the same time when other services that include care and supervision are provided (such as HCSS).

Service Limits: Provided in 24-hour blocks of time; not to exceed thirty (30) days per year and must be provided in a community setting, preferably the participant's home.

Social/Waiver Transportation

Social Transportation is offered as a direct service to waiver participants in order to enable individuals to gain access to identified community resources, other community services, and activities as specified in their service plan. This service is offered in addition to medical transportation. It includes transportation for non-medical activities which support the participant's integration into the community. All other options for transportation, such as informal supports, and community services that provide this service without charge, are utilized prior to seeking this service. The least costly and most medically appropriate mode of transportation is utilized. Waiver transportation services/locations are subject to NYSDOH prior approval. A description of required social transportation services is included in each participant's service plan.

Structured Day Programs

Structured Day Program (SDP) services are individually designed services provided to facilitate acquisition, retention or improvement in self-help, socialization, and adaptive skills and takes place in a non-residential setting separate from the participant's private residence or other living arrangement.

Services may include assessment, training, supervision, or assistance to an individual with issues related to self-care, attention deficit, memory loss, task completion, communication skills, interpersonal skills, problem-solving skills, socialization, sensory/motor skills, mobility, community, and transportation skills. Structured Day Program services are provided in a socialized group setting outside of the home. This service may continue only when the waiver participant has reasonable and attainable goals. It is used for training purposes and not ongoing long term supports. Justification to provide or continue this service must be clearly stated in a service plan and approved by the RRDS.

Service Limits: Ten (10) hours per day.

Substance Abuse Program

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

The program must have a fully developed plan which details how it will work with existing community support programs, such as Alcoholics Anonymous (AA) and secular organizations for sobriety that provide ongoing support to individuals with substance abuse problems.

Substance Abuse Program services are provided in a non-institutional setting and include an assessment of the individual's substance abuse history; learning/behavioral assessment; development of a structured treatment plan which reflects an understanding of the participant's substance abuse history and cognitive abilities; implementation of the plan; on-going education and training of the participant, family members, informal supports and all other service providers; individualized relapse strategies; periodic reassessment of the plan; and ongoing support. The treatment plan addresses individual interventions and must reflect the use of curriculum and materials adopted from a traditional substance abuse program to meet the needs of individuals with TBI. The participant must be present at service delivery.

Service Limits: reimbursed on an hourly basis and for direct contact only, not to exceed three (3) hours per day. No more than three hours will be utilized to complete the initial service assessment Three (3) hours per day.

Additional Supports and Services Included/Identified in the Service Plan
The following are resources that will be considered when developing a waiver applicants individual service plan. They may be available through Medicaid or other funding sources.

Other State and Federally Funded Services

- Adult Career and Continuing Education Services-Vocational Rehabilitation (ACCES-VR)
- Home Energy Assistance Program (HEAP)
- Housing subsidies/subsidized housing
- Education benefits
- Mental health
- Substance abuse services
- Other

Medicaid State Plan Services and Supports

- Clinic
- Physician
- Dentist

- Hospital
- Therapies
- Home health – including personal care
- Pharmaceuticals
- Medical transportation
- Medical supplies and equipment
- Eyeglasses
- Hearing aids
- Consumer Directed Personal Assistance Program (CDPAP)
- Other

Additionally, waiver applicants/participants are encouraged to access available informal supports such as: family, friends, neighbors, community organizations, volunteers and/or their religious community to assist them while residing in the community.

Room and Board

The federal government does not allow funds provided under any Medicaid waiver to be used for housing or food. These necessities may be paid for through other private arrangements, including, but not limited to: family or personal funds or SSI/SSDI. Individuals admitted to a nursing home, psychiatric, rehabilitation, assistive living or other congregate care/institutional setting for more than short term are not eligible for waiver services.

This waiver initiative has been reviewed with applicant _____

on _____.

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Regional Resource Development Specialist (RRDS) signature