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STATE DISCUSSION WITH CHILDREN'S WAIVER HCBS PROVIDERS

October 22, 2025

PURPOSE

For the Department of Health (the Department) to **share updates, guidance, and policy changes, and obtain feedback** from Home and Community Based Service (HCBS) providers.

Provide an opportunity for HCBS providers to **discuss barriers** and be a part of the **problem-solving discussion**.

Have an **open dialogue** to communicate about the program and how it is working.

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AGENDA

- ✓ IRAMS Requirement Reminders
- ✓ IRAMS Updates & Survey
- ✓ Service Definition and Necessity Criteria Policy Feedback
- ✓ HCBS Provider Case Reviews
- ✓ Proposed 1915(c) Amendment
- ✓ Future Meetings

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IRAMS REQUIREMENT REMINDERS

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HCBS Referral and Authorization Portal Purpose

All Health Homes Serving Children (HHSC), Care Management Agencies (CMAs), Children and Youth Evaluation Services (C-YES), Children's Home and Community Based Service (HCBS) Providers, and Medicaid Managed Care Plans (MMCPs) are required to use the HCBS Referral and Authorization Portal within the Incident Reporting and Management System (IRAMS).

On June 17, 2024, the HCBS Referral portion of the Referral and Authorization Portal was launched (referenced as the Portal). All HCBS referrals sent by Health Home Care Manager (HHCM)/Children and Youth Evaluation Services (C-YES) are required to go through the Portal. HCBS providers receive all referrals through the Portal and are required to respond to the referral to serve participants.

The Portal was developed to streamline the service connection process and provide real time information about service status to care team members and the Department.

The Portal does not replace the need for communication between HHCMs/C-YES and HCBS providers.

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REFERRAL

Health Home Care Managers (HHCM) / Children's Youth Evaluation Services (C-YES) must make a referral in the Referral and Authorization Portal of IRAMS

HCBS providers need to respond if they can serve the participant based upon the information of the participant's needs and goals, their preferences, requirements, and schedule

Upon receipt of the referral, referred HCBS Providers **must respond to the referral within 7 calendar days**; responses are to "accept", "waitlist", or "decline" the referral

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HCBS PROVIDER REFERRAL OPTIONS

- **Accept** indicates that the HCBS Provider is available to provide the designated service(s) to the child/youth
- **Waitlist** indicates that the HCBS Provider is not currently able to provide the designated service(s) to the child/youth, but they anticipate being able to serve them in the next 90 days
  - If the Provider selects this option, child/youth will move to the Agency waitlist
  - **Agency waitlist** describes a list of children/youth for whom an HCBS Provider indicates they may be able to provide service within 90 days
- **Decline** indicates that the HCBS Provider cannot and will not be able to provide the requested service(s)
  - If all Providers decline the child/youth, the child/youth will move to the Statewide waitlist.
  - **Statewide waitlist** is a list of children/youth where HCBS Providers have indicated that they are currently unable to provide services

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ACCEPTING A REFERRAL

HCBS providers can **only** accept a referral when they know there is a staff person able to serve the participant.

Accepting the referral and having an intake person or someone else conduct the first appointment/intake with the participant/family without having a staff member identified is **not appropriate or fair** to participants/families as this often results in long wait times while the agency attempts to hire staff.

DOH will be auditing Referral process with HCBS providers

Any time there is a disruption to services (i.e. staff member leaves, etc.), this information **must be** communicated to the CM. CMs have a responsibility to connect with families and discuss their options including a potential referral to another agency

It is **not appropriate** to submit HCBS Authorization Requests if a staff person is not identified to provide services to the participant.

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REFERRAL PORTAL REQUIREMENT

For an HCBS Provider to be able to serve a participant:

- A referral (or previous connection) MUST be entered in the Referral Portal
- Once the HCBS provider(s) have responded with “accept”, “decline”, or “waitlist”, the care manager MUST **“select”** the HCBS provider to serve the participant
    - HCBS providers cannot serve participants just because a referral was sent to them, or the because the provider accepted the referral
- Regardless if the participant is enrolled with a Medicaid Managed Care Plan or Fee-for-Service Medicaid, a referral MUST go through the Portal for the HCBS provider to serve them

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Are all your children/youth that are being served in the Portal? If not, contact BH.Transition@health.ny.gov

IRAMS UPDATES & SURVEY

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Planned and Crisis Respite Updates

Historically, the Portal and DOH policy has not allowed for more than one agency to provide the same HCBS to the same participant.

When a second Respite provider was selected by the HHCM/C-YES, the participant was automatically discharged from the first Respite provider.

In response to Stakeholder feedback, **the Portal has been updated to allow for service connections to more than one Planned and/or Crisis Respite Provider.**

This allowance is only applicable to Planned Respite and Crisis Respite. This update is intended to assist in meeting the need for both daytime and overnight Respite and is live in the IRAMS Referral and Authorization portal effective October 3, 2025.

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Details of this update were announced on October 10, 2025.

Planned and Crisis Respite Updates

Children's HCBS participants cannot receive the same HCBS from multiple designated provider agencies (e.g., participant cannot receive Planned Respite from both Provider Agency (A) and Provider Agency (B)), except in extenuating circumstances.

If **extenuating circumstances** necessitate the provision of the same HCBS from different providers, the HHCM/C-YES must provide documented justification for this scenario and receive approval from the State.

Extenuating Circumstances may include a need for overnight Respite and daytime, hourly Respite. Due to overnight Respite provider requirements, many agencies do not offer this type of Respite. Therefore, the currently referred and selected planned Respite provider cannot meet the full needs of the participant.

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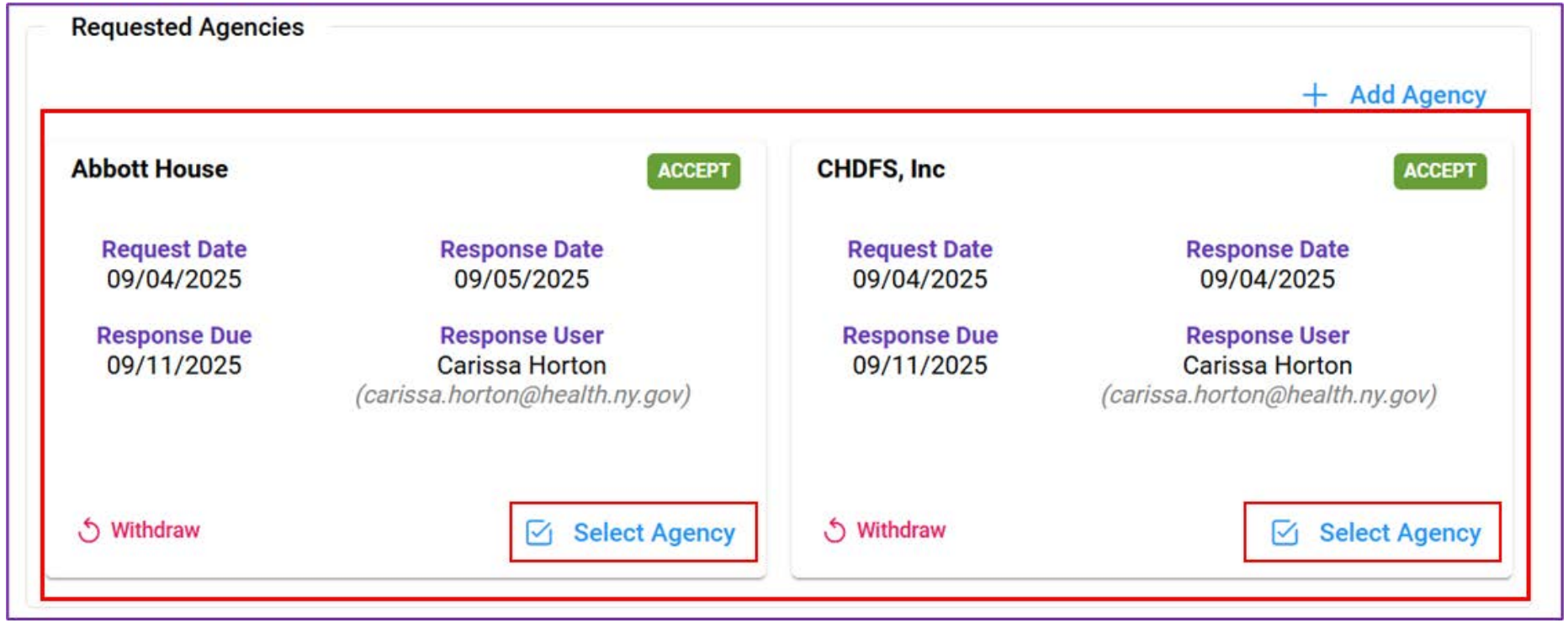
Planned and Crisis Respite Updates

If a participant is in need of two Planned Respite providers, the system will **no longer automatically discharge an existing Planned Respite provider when a new provider is selected via the 'Select Agency' button in a referral.**



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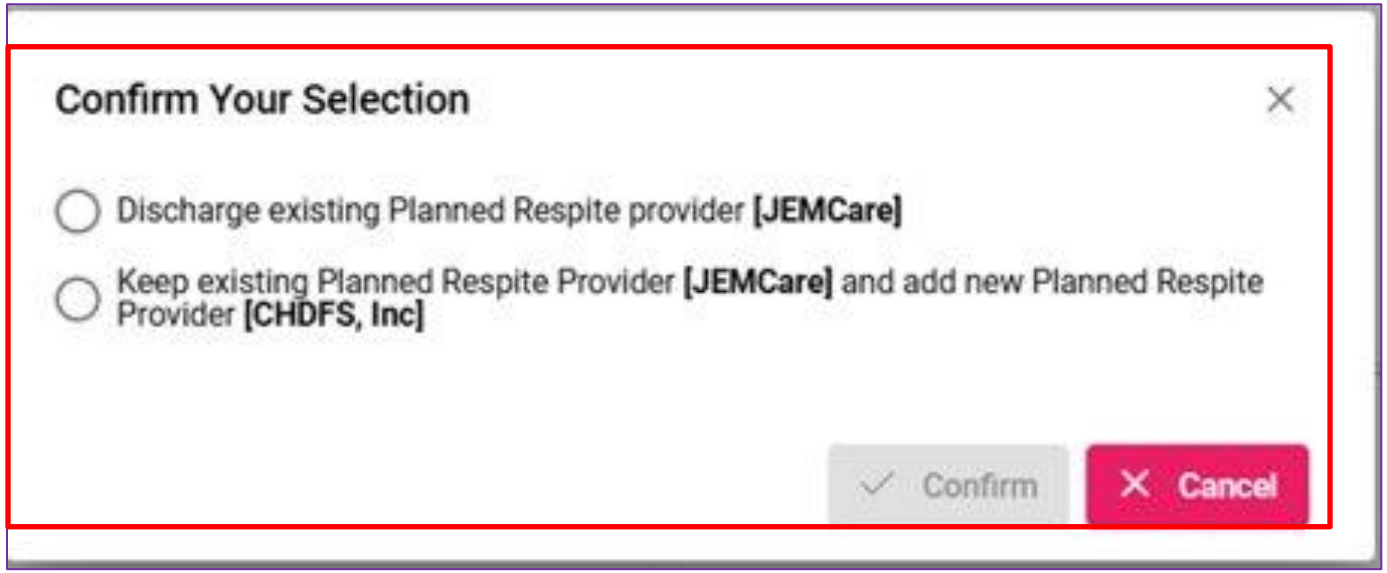
Planned & Crisis Respite Updates

After sending a second referral and receiving an “Accept” response from a second Respite Provider, the system will present a prompt to the Care Manager to confirm provider selection. When selecting a **second** provider for Respite, the following two options will appear:

- Discharge existing Planned/Crisis Respite provider [PROVIDER NAME]
- Keep Existing Planned/Crisis Respite provider [CURRENT PROVIDER] and add new Planned Respite provider [NEWLY SELECTED PROVIDER].



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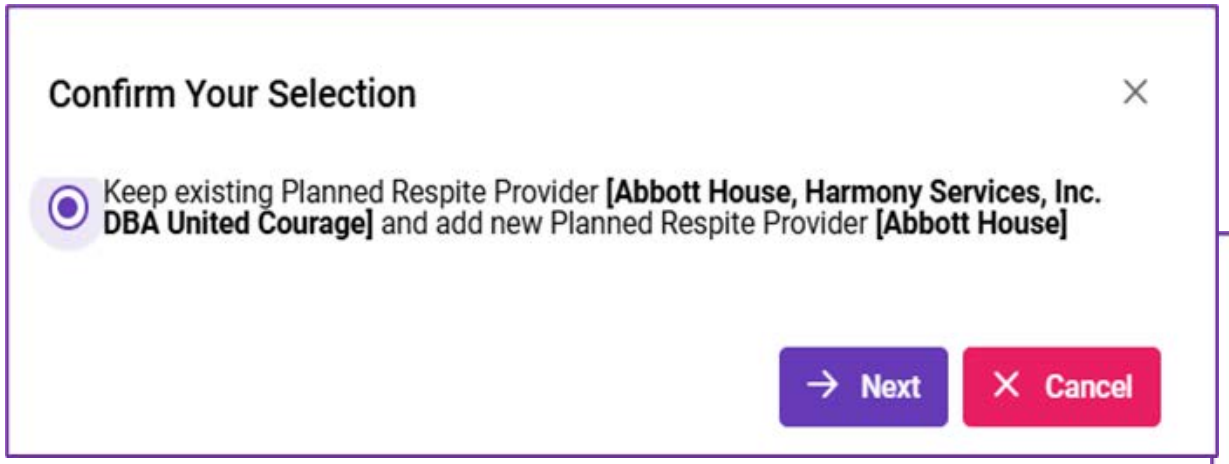
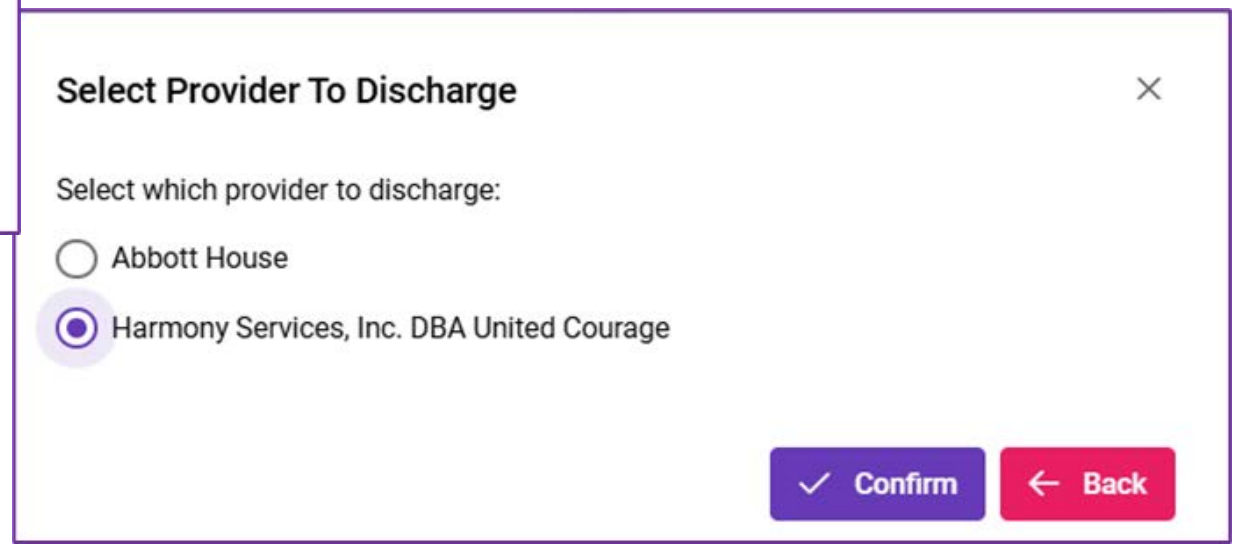
Planned & Crisis Respite Updates

Only 2 Planned Respite/Crisis Respite providers can be selected to provide the service. If an HHCM/C-YES sends a 3rd Respite referral, they'll be prompted to discharge at least one of the existing Respite providers:

Step 1: Confirm Selection



Step 2: Select Provider to Discharge



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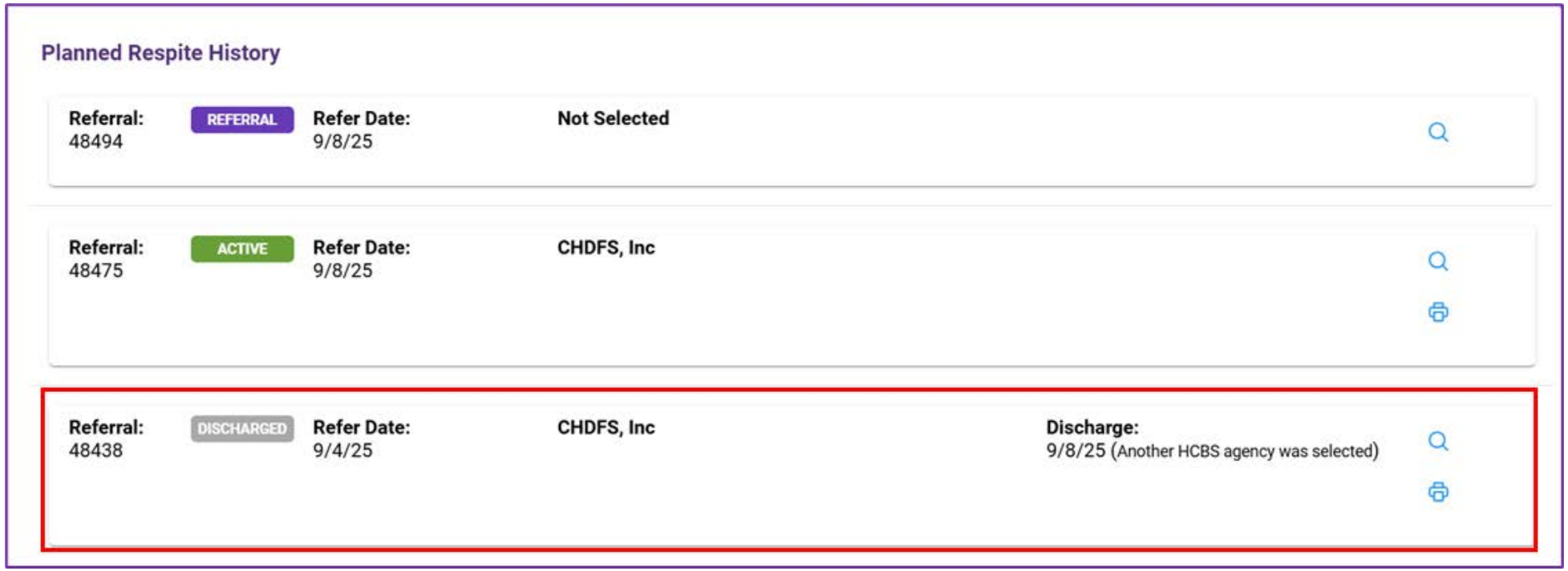
Planned & Crisis Respite Updates

After a discharge, if services are to be resumed with the **previously** discharged provider, the Care Manager **must** submit a **new referral** to that provider. After discharge, the Service History will indicate that the participant was discharged.



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Extracts

The system has the ability to generate downloadable reports on the following:

Waitlist Extract- CURRENTLY AVAILABLE

- Information about participants on Agency Waitlists
- Additional information found in the Waitlist Extract Definition Document

Member Level Information Extract- COMING SOON

- Information about participant Eligibility, Enrollment, and Services (i.e. LOC due dates, Medicaid enrollment errors, etc.)

Staff Compliance Extract- COMING SOON

- Information about staff training and background check compliance (i.e. training completion dates, etc.)

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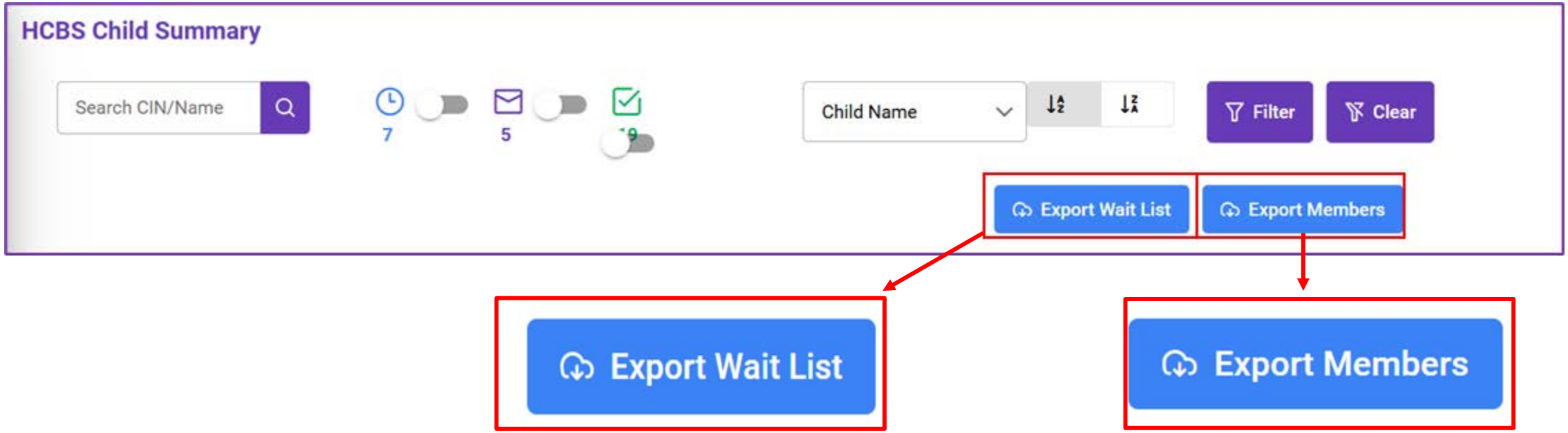
**Definitions of all report fields will be outlined in supplemental Definition Documents*

Extracts

On the Child Summary Page, at the top of the page, users will find two essential export features: “**Export Waitlist**” and “**Export Members**”. To Export Waitlist or Members Files:

1. Click on the either “Export Waitlist” or “Export Members” button.
2. The export process will commence automatically, and the file will begin downloading.



*The *Staff Compliance Extract* can be downloaded from the Staff Compliance component of IRAMS.

IRAMS SURVEY RESULTS

On September 16, 2025, the Department issued a survey to HCBS Providers about proposed updates Incident Reporting and Management System (IRAMS) Referral and Authorization Portal to further streamline processes.

49 HCBS Providers responded with feedback on additional features that would help improve functionality and workflow.

Key results from the survey were:

1. Most HCBS providers (44/49) indicated an interest in managing their MMCP contracting status in IRAMS.
2. Most HCBS providers (38/49) indicated an interest in reporting their ability to accept new referrals in IRAMS. Some providers reported needing more information.
3. Some agencies shared requests for additional “Discharge Reasons” and “Referral Decline Reasons”.

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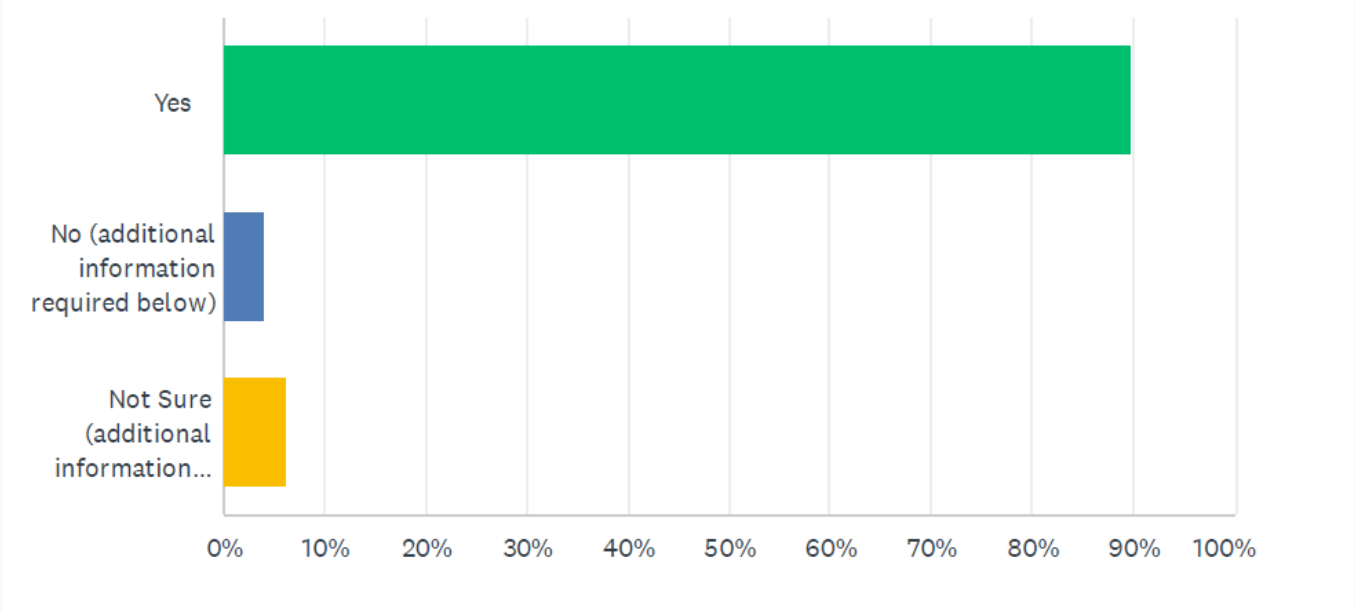
**This is a summary of some of the most requested items and is not inclusive of all requests.*

IRAMS SURVEY RESULTS

In response to stakeholder requests, the Department is considering an update to IRAMS that would allow HCBS providers the ability to indicate which MMCPs they have contracts with. The intent of this feature is to assist care managers in identifying appropriate referral sources and reduce the likelihood of HCBS providers receiving referrals for participants enrolled in MMCPs with whom they do not have a contract. Information about HCBS provider/MMCP contracting status would be the responsibility of the HCBS provider to update and manage in the system. Based on this information, would you be interested in this feature?



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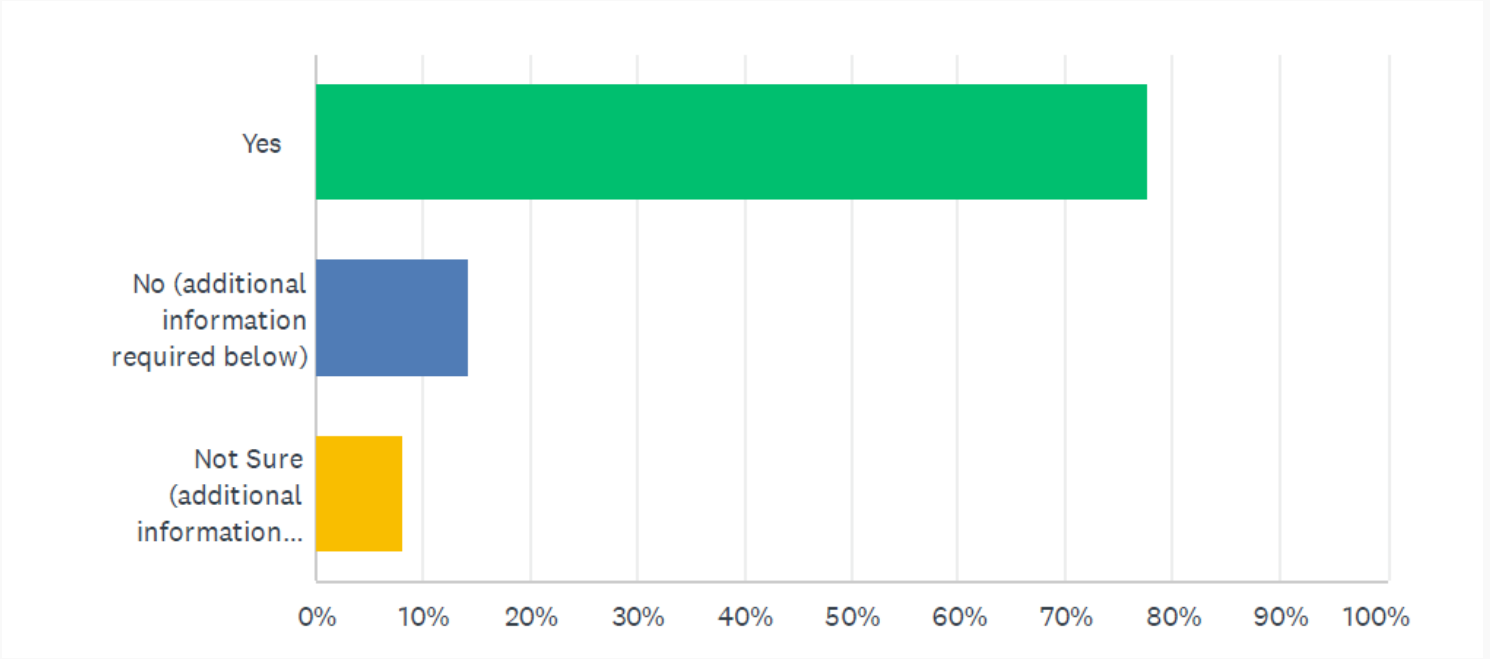
IRAMS SURVEY RESULTS

In response to stakeholder requests, the Department is considering an update to IRAMS that would allow HCBS providers to indicate their capacity to take cases. This feature would allow agencies to indicate the specific services and counties in which they have staff immediately available to render services for referrals. The intent of this feature is to assist in connecting participants to services quicker by highlighting immediately available providers to care managers. Information about capacity/availability would be the responsibility of the HCBS provider to update and manage in the system. Based on this information, would you be interested in this feature?



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IRAMS SURVEY RESULTS

Providers also suggested the following updates be implemented to enhance functionality/improve workflow:

- Add a notification for HCBS providers when an FFS authorization determination is issued
- Require MMCPs to issue authorization determinations directly through IRAMS
- Add a service “hold” status indicating when a participant’s services are temporarily halted due to staff leaving, etc.
- Allow HCBS providers to edit finalized authorizations when mistakes are identified (i.e. incorrect date entered, etc.)
- Offer HCBS providers information about Statewide Waitlists
- Send alerts about participant events (i.e. LOC expiring, MMCP enrollment change, etc.)

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**This is a summary of some of the most requested items and is not inclusive of all requests.*

IRAMS Technical Assistance

The Department is available for technical assistance calls with providers if needed.

Some examples of TA topics are:

- IRAMS Navigation/Features
- Authorization Process Questions
- Referral Process Questions

Reach out to BH.Transition@health.ny.gov if you'd like to schedule a time to meet for IRAMS TA

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HCBS SERVICE DEFINITION AND NECESSITY CRITERIA POLICY FEEDBACK

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SERVICE NECESSITY POLICY FEEDBACK

Appropriateness of the level of services being requested

Mindful of the other commitments and the participant's schedule

The frequency of services may be different for participants in school versus participants who have graduated/aged out of school settings and must take into consideration the participant's age, development, and condition, along with the participant's other appointments and activities.

Example:

- 3 yr old already receiving Private Duty Nursing 12 hours a day, Early Intervention Physical Therapy several times a week, and CDPAP every day for 2 hours. HCBS provider requesting Respite 3 times a week for 4 hours.

- ***Does this take into account the child's age, development, attention span, and other services?***
- ***How would you document the need and how the above was taken into account?***

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SERVICE NECESSITY POLICY FEEDBACK

Appropriateness of the level of services being requested

Children's HCBS is not billable when provided while another billable Medicaid service is provided, except in limited circumstances.

When it is necessary for the participant to receive more than one service simultaneously (i.e. required for the health and safety of the participant), the rationale must be documented in the member's record or plan of care, explaining the need for a combination of services and how the services complement each other.

- ***Is it realistic for the services to be provided at the same time and for the age and development of the child?***

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SERVICE NECESSITY POLICY FEEDBACK

Appropriateness of the level of services being requested

Does not duplicate or replace services otherwise available to the participant and MUST be used first.

Including services through the Medicaid State Plan, Rehabilitation Act, the Individuals with Disabilities Education Act (IDEA), private insurance, or Medicare.

HCBS are not an appropriate substitute for medically necessary care covered under the State Plan services such as Early Intervention (EI), Applied Behavior Analysis (ABA) therapy, mental health assessment and treatment, physical therapy, occupational therapy, speech therapy, personal care assistance, and private duty nursing.

- ***Reach out to the Care Manager and/or Health Home if these services or activities like these services are being requested.***
- ***No activities on the HCBS service plan should resemble these types of services. If they are being provided in this manner, they are not billable and OMIG reporting must occur.***

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SERVICE NECESSITY POLICY FEEDBACK

Children's HCBS are supplemental services to other needed clinical services.

- HCBS should not be the only service the child/youth is receiving to **prevent risk of institution** or **support returning home from an institution**.

Children's HCBS is not a substitute for parenting, babysitting, childcare, or generalized supervision.

- HCBS must be provided in a professional capacity with a clearly defined need that exceeds general childcare needs.
- HCBS **does not** replace the role of the parent/caregiver in fostering skill development essential to typical child development.

Requested Units of Services as outlined in the Documentation Policy

- Service authorization requests in excess of the service limits must be **justified by documentation from a third-party** involved in the member's care demonstrating this need.

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SERVICE NECESSITY POLICY FEEDBACK

Anticipated utilization ranges and limitations/exclusions Reminder:

The maximum units/hours noted in the service utilization ranges are meant for the highest needs children. Providers should be requesting units/hours that are appropriate for the needs of the specific participant rather then just requesting the max units/hours noted in the range. ***This is a requirement of the Waiver and reportable to CMS.***

Service utilization that exceeds the service limits

(i.e., annual, monthly, daily, dollar amount) is expected to be rare, temporary, and must be necessary to prevent institutionalization and support the participant remaining in the home/community.

There must be documentation in the case record that the multidisciplinary care team has determined a need for HCBS in excess of the service limits

to prevent institutionalization, determined whether other services are appropriate, and has established a plan to monitor the participant's progress.

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HCBS PROVIDER CASE REVIEWS

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HCBS PROVIDER CASE REVIEWS PROCESS

1. HCBS Providers will be notified of the Quarter their review will occur, the date period of the records that will be reviewed and the documentation to submit for their sample

2. HCBS providers receive their sample identifying the cases that will be reviewed

3. The Case Review Team will conduct the HCBS Provider review. During this time, outreach will occur if there is an immediate safety concern, a specific question to clarify for the review, or a case concern about provided services

4. After the case review is complete, the HCBS Provider will receive a Summary of Findings (SOF) and the Member Level Details (MLD) for cases reviewed

5. If a Corrective Action Plan (CAP) is necessary, a CAP Workbook will be provided. **HCBS Provider Review CAP Technical Assistance Guide**

HCBS providers should implement corrective action strategies and not wait for CAP response from DOH

6. The CAP Workbook must be completed and returned timely to address the outlined deficiencies that were identified during the review

7. During the next case review, the Department will verify if previous CAP items were addressed and the HCBS provider has met waiver compliance

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REFERRAL HOLD PROCESS

1. When the HCBS provider receives the Summary of Findings (SOF) and the Member Level Details (MLD) for cases reviewed, the SOF will notify the HCBS provider of the Referral Hold

2. HCBS Providers on Referral Hold cannot accept new HCBS referrals through the Referral and Authorization Portal

3. A Corrective Action Plan (CAP) must be completed - HCBS providers should implement corrective action strategies and not wait for CAP response from DOH

4. CAP will be submitted to DOH

5. HCBS providers will be asked when they have fully implemented their CAP.

6. Effectiveness of the HCBS Providers CAP is assessed by the DOH during the next appropriate quarterly HCBS Case Review, which allows for enough time to pass for the records to demonstrate the implemented changes.

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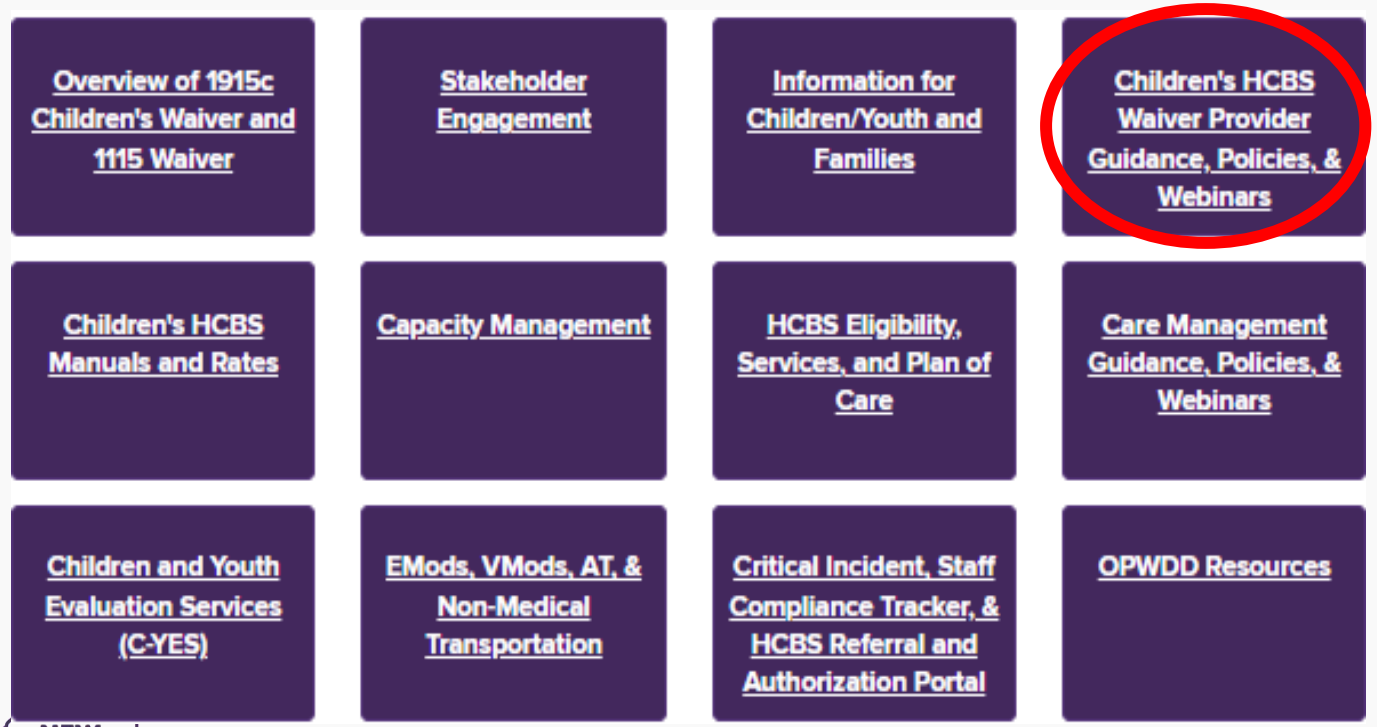
OMIG AND MMCP REPORTING

In addition to any requirements imposed by the Department under the Children's Waiver, HCBS Providers are independently required to report, return, and explain any overpayments according to OMIG's self-disclosure program or the Medicaid Managed Care Plan (MMCP) within 60 days of when the overpayment was either identified or should have been identified through the exercise of reasonable diligence. HCBS Providers should refer to OMIG's Self-Disclosure Program webpage for additional information. Penalties for violations of the Self-Disclosure process can also be found on OMIG Self-Disclosure Guidance webpage.



Additional information about the **OMIG Self-Disclosure Process webinar** is posted to the DOH website under HCBS Case Reviews

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PROPOSED AMENDMENT TO THE CHILDREN'S WAIVER

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PROPOSED 1915(C) AMENDMENT

Target Effective Date: January 1, 2026

Additional Service: Transitional Care Coordination

Transitional Care Coordinators will seek out children/youth who have long term institutionalization. This coordinator will work with institutional levels of care such as hospitals, nursing homes, etc. to determine the needs of the child/youth to be able to return to their home and community and assist with coordinating the following so that the child/youth can return home:

- Housing
- Vehicle/environmental modifications
- Arrangements for medical equipment
- Parent/caregiver education/training
- Development of supportive services and caregiver supports, etc.

- **Eligibility**: Available to children 1 year or older who have been institutionalized or hospitalized continuously for one year or longer, or, in the case of infants aged 12 months or younger, infants who have been institutionalized or hospitalized for at least 12 weeks continuously or longer.

- **Service Limits:** This service is available for the 180 calendar days prior to transition as well as the 60 calendar days following transition out of the institution/hospital. The service is billed upon the child's transition.

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DOH will be soliciting interest in designation for this service in the upcoming months. Providers will be required to submit information demonstrating their relevant experience.

PROPOSED 1915(C) AMENDMENT

Target Effective Date: January 1, 2026

Additional Services: Transitional Services

Transitional Service funds are usually one-time expenses that are related to the child/youth's complex healthcare needs such as:

- The cost of moving furniture and other belongings
- Broker's fees required to obtain a lease on an apartment or home that is conducive to the participant's healthcare needs
- Purchasing essential home furnishings
- Basic needs and supplies
- Health and safety assurances such as pest removal, allergen control, or one time cleaning prior to occupancy

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PROPOSED 1915(C) AMENDMENT

Target Effective Date: January 1, 2026

EMod/VMod/AAT and NMT Updates

- Modifying the FMS to*: 1) Include Administration of Transitional Services 2) Increase the FMS rate for Environmental Modifications, Vehicle Modifications, Adaptive and Assistive Technology
- Updating EMod, VMod, and AAT Limitations
- Language in the EMod, VMod, and AAT definitions has been clarified to refer to an established limit per service and that limit cannot be exceeded without special circumstances and medical necessity documentation meeting specific NYSDOH requirements, and prior approval from FMS/NYSDOH
- Allow Environmental Modifications, Vehicle Modifications, Assistive and Adaptive Technology, and Transitional Services to be purchased up to 180 days prior to discharge from an institutional setting
- Changed Vehicle Modification provider qualifications from ACCES-VR to National Mobility Equipment Dealers Association (NMEDA)
- Clarifying in Environmental Modifications that the practice of “balance billing” or requiring/allowing families to fund some of the cost of a service from their own funds is prohibited under Federal and New York law.
- Eliminating Service Dogs as allowable Adaptive and Assistive Technology
- Updating language regarding the ability to utilize Non-Medical Transportation (NMT)

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**A 1915b4 amendment will be submitted simultaneously to the 1915c amendment to account for FMS related updates*

PROPOSED 1915(C) AMENDMENT

Target Effective Date: January 1, 2026

Removal

- Removal of the C-YES/Independent Entity. Participants will have choice of Health Home care management. HCBS Eligibility Determinations for participants without Medicaid will be conducted by DOH/OMH. Once Medicaid and HCBS eligible, participants will receive care management from HHs.

- Removal of Day Habilitation as a service under the Children's Waiver and transition to Community Habilitation, which cover the same needs however does not have the added restriction to be delivered in an OPWDD certified sites

- Removed wording that OPWDD directs provider agencies to screen staff against the Medicaid Excluded Provider lists maintained by the Department of Health and the HHS Office of the Inspector General because this is already a Medicaid provider enrollment requirement for all providers and their employees

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FUTURE MEETINGS & CONTACT INFORMATION

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MEETING SCHEDULE

The Department has updated the **2025 HCBS Provider/State Discussion** schedule. The remaining dates/times for 2025 are below:

Date	Time	Registration Link
Wed, Dec 17, 2025	1:00 PM - 2:30 PM	Register

2026 HCBS Meeting Schedule **is now posted online**

- **Reminder:** In order to attend these meetings, participants are required to register for each meeting individually using the corresponding link above.

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CONTACT US

All **Children's Waiver HCBS** questions and concerns should be directed to the NYS Department of Health at BH.Transition@health.ny.gov mailbox or (518) 473-5569.

Questions related to specific **Fee-for-Service case issues** can be submitted through the Health Commerce System (HCS) Secure File Transfer to hcbsffsauthorization@health.ny.gov

For questions about the **Referral and Authorization Portal, Staff Compliance, and HCBS Critical Incidents/Grievances** email Health Homes with a subject line of "IRAMS Questions Only – No PHI"

Questions regarding the **HCBS Settings Final Rule** can be directed to ChildrensWaiverHCBSFinalRule@health.ny.gov.

NYS Department of Health Managed Care Complaint Line
1-800-206-8125 or managedcarecomplaint@health.ny.gov.

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HCBS DISCUSSION

- **What part of the Children's Home and Community-Based Waiver process would you like us to highlight?**
- **What topics would you like DOH to discuss and review?**

We'd like to know! Please send recommendations for discussion to BH.Transition@health.ny.gov

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