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Office of Children
and Family Services

Office for People With
Developmental Disabilities

Children's Health and Behavioral Health Medicaid System Transformation

Children's Home and Community Based Services Provider Manual

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Send questions to
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INTRODUCTION

Home and Community Based Services (HCBS) are designed to allow children and youth to participate in developmentally and culturally appropriate services through Medicaid. New York State (NYS) is committed to serving individuals in the least restrictive environment possible by providing services and supports to children and their families at home and in the community. HCBS are designed for people who, but for these services, would require the level of care provided in a more restrictive environment such as a long-term care facility or psychiatric inpatient care and for those at risk of elevating to that level of care.

The Children's Medicaid System Transformation for individuals under the age of 21 includes the alignment of the following NYS children's waivers previously accessible under the authority of the 1915(c) amendment of the Federal Social Security Act: Office of Children and Family Services (OCFS) Bridges to Health (B2H) Serious Emotional Disturbance (SED), B2H Developmental Disabilities (DD), B2H Medically Fragile (MedF), the Office of Mental Health (OMH) SED Waiver, Office for People With Developmental Disabilities (OPWDD) Care at Home (CAH) IV Waiver, and the Department of Health (DOH) operated Care at Home (CAH) I/II Waiver.

The Office of Addiction Services and Supports (OASAS), OCFS, OMH, OPWDD, and DOH have collaborated to create a newly aligned service array of HCBS benefits for children meeting specific diagnostic and functional criteria. The new 1915(c) Children's Waiver and 1115 Medicaid Redesign Team (MRT) Waiver, with approval from the Centers for Medicare and Medicaid Services (CMS), provides NYS the authority for these HCBS benefits. The waiver includes person-centered planning requirements and specifies transitional coverage requirements for children enrolled in any of the aforementioned 1915(c) waivers at the time of transition.

HCBS eligibility includes: 1) target criteria, 2) risk factors, and 3) functional criteria, and Medicaid eligibility. Level of Care (LOC) has been expanded to include a new needs-based criteria category referred to as Level of Need (LON), allowing more children to access HCBS benefits. This expansion addresses gaps in service for children who may benefit from HCBS but do not meet the LOC criteria, or for children who require continued services to avoid regressing to a higher level of care.

This manual defines the specific composition of each service while outlining provider roles and responsibilities. All HCBS benefits are applicable in any home or community setting meeting federal HCBS settings requirements inclusive of the child or family environment, with some exceptions noted in this manual.

VISION AND GOALS

HCBS are designed to offer support and services to children in non-institutionalized settings that enable them to remain at home and in the community. HCBS provides a family-driven, youth guided, culturally and linguistically appropriate system of care that accounts for the strengths, preferences, and needs of the individual, as well as the desired outcome. Services are individualized to meet the health, developmental, and behavioral health needs of each child or youth. Participants have independent choice among an array of service options and providers. These services are provided in a flexible, complimentary package that evolves over time to meet the changing needs of the child or youth.

HCBS are intended to be provided to a child and family in their home and/or the community. The array of services is intended to assist children in being successful at home, in school, and in their other natural environments to help maintain them in their community and avoid higher levels of care and out-of-home placements.

It is the mission of NYS and its child and family serving agencies to improve health and behavioral health care access and outcomes for individuals served while demonstrating sound stewardship of financial resources.

PROVIDER REQUIREMENTS

DESIGNATION

The Children's Designation process is a multi-State agency process that includes the Department of Health (DOH), Office of Mental Health (OMH), Office of Addiction Services and Supports (OASAS), Office of Children and Family Services (OCFS), and Office for People With Developmental Disabilities (OPWDD) (i.e., the NYS Interagency Review Team). Any service provider delivering HCBS must be designated to do so by The NYS Interagency Review Team. Providers must be an OMH, OASAS, OCFS, DOH, or OPWDD provider, meet the qualifications as outlined in this manual and be identified as a child serving agency or agency with children's behavioral health and health experience that is licensed, certified, designated, and/or approved by OMH, OASAS, OCFS, OPWDD, or DOH or its designee to provide comparable and appropriate services referenced in the definition. NYS will initially verify provider designation status through the web-based online portal system, assuring providers are approved and active before they are authorized to provide waiver services. Provider designation will be reverified at least every three (3) years. Additional information on provider designation and access to the online application is available here:

https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/provider_design.htm

Health Homes are also designated by NYS and must adhere to the [Health Home Standards and Requirements](#).

MEDICAID ENROLLMENT

Prior to the delivery of HCBS, providers must be Medicaid enrolled. Providers who are not already Medicaid enrolled, must complete the NY Medicaid Provider Enrollment Form: <https://www.emedny.org/info/ProviderEnrollment/index.aspx>

CRIMINAL HISTORY AND BACKGROUND CHECKS

In accordance with Section 2899-a of the Public Health Law, any entity that provides Home and Community Based Services (HCBS) to enrollees who are under 21 years of age under a demonstration program pursuant to section 1115 of the Federal Social Security Act must request a criminal history record check by the New York State Department of Health (NYSDOH) and the New York State Division of Criminal Justice Services for each prospective employee who will provide HCBS services to such enrollees. Note: this program will operate concurrently with the State's 1115 MRT Waiver as approved by CMS.

The term "employee" does not include persons licensed pursuant to Title 8 of the Education Law or Article 28-D of the Public Health Law, provided that such persons are operating within their Title, meaning that such license was required for the position. Volunteers are not subject to this requirement. Part 402 of Title 10 of the Official Compilation of Codes, Rules and Regulations for the State of New York (NYCRR) Part 402 establishes the process for conducting the criminal history record checks and the standards for review by NYSDOH. Each provider must develop and implement written policies and procedures that include protecting the safety of persons receiving services from temporary employees consistent with the NYS statutory requirements and regulations (e.g., appropriate direct observation and evaluation).

Criminal history record checks are finger print-based, national Federal Bureau of Investigation (FBI) criminal history record checks, which require the prospective employee's fingerprints and two forms of identification. Providers must maintain and retain current records, including a roster of current employees who were so reviewed, to which NYSDOH shall have immediate and unrestricted access to the determination letters to ensure compliance with these provisions.

Verification of compliance with the criminal history record check regulations is an element of the NYSDOH surveillance process. At the time of surveillance, NYSDOH surveyors utilize a standardized tool to evaluate compliance with the criminal history background record check requirements. If a provider is found out of compliance, a statement of deficiency(ies) is issued, and the provider will be required provide a plan of correction.

Additional information can be found on the NYSDOH webpage [here](#).

HCBS ELIGIBILITY AND ENROLLMENT

Children who are eligible and appropriate for HCBS must have a physical health, developmental disability, or mental health diagnosis with related significant needs that place them at risk of hospitalization, institutionalization, or need to return safely home and to their community from a higher level of care. (Institutionalization refers to children at risk of being admitted to a higher level of care such as out-of-home residential settings, hospitalization, ICF-I/ID, or nursing facility).

To receive HCBS under Medicaid, a child or youth must be determined eligible based on meeting target population, risk factors, and functional criteria measured by the HCBS Eligibility Determination. Children receiving HCBS through enrollment in a 1915(c) Medicaid waiver will have continued access to HCBS for as long as the child continues to meet the eligibility criteria for the 1915(c) Medicaid waiver.

Children and youth must be under 21 years old and eligible for Medicaid to receive HCBS. HCBS eligibility is comprised of three components: 1) target criteria, 2) risk factors, and 3) functional criteria.

There are two HCBS eligibility groups:

1. Level of Care (LOC): children that meet institutional placement criteria

There are four subgroups within the LOC group:

- a. Children with Serious Emotional Disturbance (SED) with or without co-occurring Substance Use Disorders (SUD)
 - b. Children with a Developmental Disability in Foster Care
 - c. Children who are Medically Fragile
 - d. Children who are Medically Fragile with a Developmental Disability
2. Level of Need (LON): children who are at risk of institutional placement (projected implementation date in 2021)

There are two subgroups within the LON group:

- a. Children with Serious Emotional Disturbance (SED) with or without co-occurring Substance Use Disorders (SUD)
- b. Abuse, Neglect and Maltreatment or Health Home Complex Trauma

The services described in this document are accessible to the child/youth once a Plan of Care (POC) is in place.

To access Children's HCBS, a child/youth must meet Level of Care criteria using the HCBS/LOC Eligibility Determination which is housed within the Uniform Assessment System (UAS) along with the Child and Adolescent Needs and Strengths – NY (CANS-

NY) assessment. Only a Health Home Care Manager (HHCM), Children and Youth Evaluation Services (C-YES), or the OPWDD Developmental Disabilities Regional Office (DDRO; refer to the [DDRO Manual for Children's Waiver](#) for additional information) are given access in the UAS to complete the HCBS/LOC Eligibility Determination.

Upon signing and finalizing the HCBS/LOC Eligibility Determination within the UAS, the assessor will be presented with an outcome of either HCBS/LOC eligible or not HCBS/LOC eligible for the identified target population. The HHCM/C-YES will send the child a **Notice of Determination**, which will memorialize the outcome of the HCBS/LOC Eligibility Determination and provide information on State Fair Hearing rights.

The HCBS/LOC Eligibility Determination is a twelve (12) month (annual) determination. The annual determination date does not change according to the CANS-NY completed for the Health Home Serving Children program. Once the HCBS/LOC Eligibility Determination outcome is complete within the UAS, it remains active for one year from the date of signature and finalized date, with two exceptions:

- 1) Significant life event
- 2) In the event that a child that has been determined HCBS/LOC eligible and initially declines HCBS, but later requests HCBS, or if a child has been determined HCBS/LOC eligible, but has been placed on a waitlist due to capacity limitations of the Children's Waiver: a new HCBS/LOC Eligibility Determination is required if an approved/active HCBS/LOC Eligibility Determination is not utilized within six (6) months of the date the HCBS/LOC Eligibility Determination outcomes.

If a child/youth is found HCBS/LOC ineligible and there is a change in circumstances, the child/youth can be reassessed at any time, as there is no wait period between assessments.

For more information regarding HCBS requirements for independent assessment, see [Section 1915\(i\)\(1\)\(F\) of the Social Security Act](#).

The target criteria, risk factors, and functional limits must be documented in the UAS.

Children seeking HCBS who are not otherwise eligible for Medicaid (e.g. income and resources are above Medicaid eligibility allowances) must meet a needs-based criterion for Medicaid eligibility determination via the following process:

- The Independent Entity (Children and Youth Evaluation Services, C-YES) must complete the HCBS Eligibility Determination.
- The Independent Entity will assist families in completion of the Medicaid application and submission to the Local District of Social Services (LDSS) or New York City (NYC) Human Resources Administration (HRA) to determine Medicaid Eligibility.

- Once Medicaid is established, referral to appropriate care management will be completed.
- Whether a child meets the LOC or the LON criteria, eligible children, youth, and their families will have access to all HCBS services.

Notice of Decision

Once the Children's Waiver eligibility determination is complete, the care manager will send the child/youth/family a **Notice of Decision**, found here:

https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/nod_elig.pdf

Expectations for the Completion of Notice of Decision-Enrollment or Denial (NOD)

The Health Home/C-YES must issue an adequate notice of a decision to accept or deny an application for enrollment as soon as possible. There should be documentation to support enrollment/denial decision. The member has 60 days from the date of the Notice of Decision to request a Fair Hearing from the Office of Temporary and Disability Assistance (OTDA). Fair Hearing rights are located on page two (2) of DOH-5287 form. Health Homes are expected to go over the entire form with the member and their family. Care Managers should know the process for Fair Hearings as well as who to contact in the case the family is interested in pursuing a Fair Hearing.

Expectations for the Completion of Notice of Decision (NOD) - Discontinuance

The Health Home/C-YES must issue an adequate notice of a decision to discontinue services. This notice should be sent out within 1-2 business days of the decision made by the HHCM/C-YES and the Health Home should be alerted as well. The member has 10 business days from receiving the NOD of discontinuance to ask for a Fair Hearing and receive continuing aid until a decision has been made by OTDA. The HCBS provider must continue to provide services to the member until this determination. The Care Manager assigned to the member should inform the HCBS provider with pertinent information concerning any changes in service eligibility. The Care Manager should begin transition planning and documentation to support decision.

Note: The member has 60 days from the date of the Notice of Decision to request a Fair Hearing from the Office of Temporary and Disability Assistance (OTDA). Fair Hearing rights are located on page two of DOH-5287 form. Health Homes Care Managers are expected to go over the entire form with the member and their family.

Reasons for Notice of Decision forms to be sent to member

- If child/youth loses Medicaid – the LDSS will send NOD and the care manager will work with family to get back on Medicaid but if they can't will need to send a letter that waiver is ending due to loss of Medicaid.

- If the child is LOC eligible but no slot is available, the family will get a NOD but then when a slot is available, a form letter is sent notifying of available slot.
- If the DDRO completed the HCBS determination for DD Med Frag or DD foster care, the HHCM sends NOD and then needs to notify the Developmental Disability Regional Office (DDRO) when the Fair Hearing is and the region they were communicating with.

HCBS REAUTHORIZATION

The 1915(c) Children's Waiver for HCBS requires an annual (365 days) HCBS/LOC Eligibility Re-determination to be completed for the child/youth to remain in the Waiver and continue receiving Waiver services.

All Health Homes, Health Home care management agencies (CMAs) and C-YES, should audit their records of Waiver enrolled children/youth to ensure all HCBS LOCs are up-to-date. HHCM or C-YES staff should begin gathering annual re-determination supporting documentation two (2) months prior to the re-determination due date to ensure enough time to complete the annual HCBS LOC.

Note: For children requiring an ICF-IDD LOC from OPWDD Developmental Disabilities Regional Office (DDRO), it is important to remember this process can take up to a month to complete. Timely and on-going communication with the DDRO is encouraged.

Significant Life Event:

If there is a significant life event for a child/youth while receiving HCBS, a new HCBS/LOC Eligibility Determination maybe needed. A significant life event is something that occurs in child's/youth's life that impacts their functioning, daily living situation or those that care for the child/youth. Reasons for HCBS/LOC Reassessment Change of Circumstances:

- Significant change in child's functioning (including increase or decrease of symptoms or new diagnosis)
- Service plan or treatment goals were achieved
- Child admitted, discharged or transferred from hospital/detox, residential setting/placement, or foster care
- Child has been seriously injured in a serious accident or has a major medical event
- Child's (primary or identified) caregiver is different than on the previous HCBS/LOC
- Significant change in caregiver's capacity/situation

If the child/youth is also enrolled in the Health Home program, a significant life event may also require a full CANS-NY to be completed.

PARTICIPANT PLACED IN AN HCBS RESTRICTED SETTING

If a child/youth enrolled in the Children's Waiver is hospitalized or placed in an HCBS restricted setting, then the child/youth can remain in such setting for ninety (90) days prior to having to be discharged from the Children's Waiver program. If the Waiver child/youth is also enrolled in the Health Home program while entering an HCBS restricted setting, the Health Home care manager would "pend" the enrollment segment and follow the Health Home ["Continuity of Care and Re-engagement for Enrolled Health Home Members # HH0006"](#) policy.

CAPACITY MANAGEMENT

Capacity Management is the process by which New York State manages the combined slots for the 1915(c) Children's Waiver. Slot capacity is tracked by Target Population and by Region. Slot capacity is monitored to ensure that all regions have equitable access to the Children's Waiver. Should Capacity Management become concerned about waiver enrollment reaching a threshold, then a waitlist might occur and limits by Target Population and Region will be set.

Capacity Management Process

Once the care manager has conducted the HCBS/LOC Eligibility Determination and the child/youth has been found eligible, Capacity Management will review the HCBS Eligibility Report by the next business day.

- Capacity Management will notify the HHCM/C-YES through the HCS secure file transfer that a slot has been assigned to the child/youth – a child/youth must have a slot assigned to receive waiver services
- The HHCM/C-YES send the child/youth a *Notice of Determination*
- Once a child/youth has been assigned a slot, they maintain that slot until they are discharged from the waiver

The HHCM/C-YES must report changes in a child/youth's status to Capacity Management to ensure proper tracking of the Children's Waiver capacity.

The HHCM/C-YES should send a secure file email to Capacity Management when:

- Child/youth already receiving HCBS with slot and has a name or CIN # change
- Child/youth is discharged from HCBS due to goal reached or by choice
- Child/youth is disenrolled due to loss of Medicaid
- Child/youth is no longer HCBS eligible during re-assessment
- If the HHCM/C-YES is unsure of slot allocation
- Child/youth is transferring to/from one waiver to another

Detailed information on how and when to communicate with Capacity Management is located in the [Communication with NYS DOH Capacity Management for the Children's Waiver](#) document and the *Capacity Management Webinar*:

<https://ctacny.org/sites/default/files/Capacity%20Management%20Refresh%20FINAL.pdf>

CARE MANAGEMENT AND MONITORING ACCESS TO CARE FOR HCBS

Care Management

Children and youth who are enrolled in the Children's Waiver, are HCBS/LOC eligible, and are receiving Home and Community Based Services are required to receive care management. This requirement may be met in one of the following three ways:

- Health Home comprehensive care management: Children eligible for HCBS are eligible for Health Home services, including comprehensive care management; care coordination and health promotion; comprehensive transitional care; enrollee and family support; and referral to community and social supports. Health Home comprehensive care management ensures a holistic assessment, through the CANS-NY and comprehensive assessments, of the child/youth's behavioral health, medical, community and natural supports; as identified through a person-centered POC by the child/family.
- C-YES: If a child/youth and their family do not want Health Home care management (which is an optional benefit), they can opt-out of Health Home and receive HCBS care management from C-YES. C-YES will develop a HCBS POC using information from the HCBS/LOC Eligibility Determination, and a person-centered discussion that identifies personal goals and how specific HCBS may support the child in achieving those goals. C-YES will maintain the POC for children who opt of Health Home and are not enrolled in an Medicaid Managed Care Plan.
- Medicaid Managed Care Plan (MMCP): For children/youth who opt-out of Health Home and are enrolled with a MMCP, once C-YES establishes HCBS/LOC eligibility and the HCBS POC, the MMCP updates the POC as needed through a person-centered planning process. C-YES conducts the HCBS/LOC Eligibility Determination annually for children/youth who are managed by the MMCP.

Monitoring Access to Care

The State must ensure children participating in the Children's Waiver are able to access and receive HCBS identified in the POC. The MMCP will monitor access to care for all enrolled children in receipt of HCBS. The Health Home will monitor access to care for children in receipt of HCBS who are enrolled in the Health Home and are not enrolled in an MMCP. C-YES will monitor access to care for children in receipt of HCBS who opt out of Health Home and are not enrolled in an MMCP.

Monitoring access to care means that there is contact with the child/youth and family to ensure that they are receiving the HCBS indicated in the POC and contact with the HCBS providers to ensure child/youth and family are attending the appointment and working toward established identified goals.

Contact with the family may be by phone or other regular communication methods (unless otherwise outlined) and must occur at least once per quarter for C-YES and the MMCP and once per month for Health Home care management. This verification can be combined with a regularly scheduled meeting or care management contact with the child/youth and family. Care Managers should document this contact in a case note. The monitoring access to care requirement does not change the high-medium billable standard for Health Homes. Alternatively, MMCPs can combine monitoring of access to care with the plan's service verification activity.

Contact with HCBS providers must occur at minimum once (unless otherwise outlined) during the service duration timeframe to ensure that appointment times and schedule accommodates the family's schedule and ability to attend. Additionally, this contact occurs to verify that the service(s) is meeting the identified need and progressing towards established identified goals. The HCBS provider(s) need to be an active member in the family's care team and person-centered POC development, monitoring, and planning.

PERSON-CENTERED PLAN OF CARE

Plan of Care (POC) Development

To develop a POC, the HHCM/C-YES must meet with the child/youth and their family and their identified care team to discuss the strengths and needs of the child/youth, using person-centered planning guideline/principles. The POC development is based upon the assessment of needs which is determined through the interaction with the child, their family, and identified supports as well as through the multi-disciplinary team meeting/information, CANS-NY (for HH), Health Home Comprehensive Assessment (for HH), and/or HCBS/LOC Eligibility Determination. The POC is led by the HHCM/C-YES and involves collaboration between family, family-identified supports, providers, other child-serving systems, and the MMCP (if enrolled). The HHCM/C-YES will recommend services that can support the child in reaching their defined goals and addressing identified needs. Each HCBS that the child receives must be listed in their POC with a defined goal.

The POC will change and evolve over time as the child meets their goals or there is a need for new services/supports. The POC is a fluid document that can be developed incrementally and may be updated at any time. At a minimum, the POC must be reviewed every six months, during CANS-NY reassessment (for Health Home), or earlier if there is a significant life event as well as during HCBS/LOC Eligibility determination reassessment.

The POC must be signed by the child, if age appropriate (able to understand and contribute to their own POC) and/or the parent, guardian, or legally authorized representative. All involved providers must be given an opportunity to contribute to the POC and, with informed consent of the child/parent/guardian/legally authorized representative, sign the POC when it is developed.

POCs must be developed following the *NYS Person-Centered Planning Guidelines* (Appendix H), located here:

https://www.health.ny.gov/health_care/medicaid/redesign/cfco/docs/2018-12-19_pcsp_guidelines.pdf

Health Homes must also develop the POC following the *Health Home Plan of Care Policy* (Appendix I), located here:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/docs/hh0008_plan_of_care_policy.pdf

Development of the POC and Referrals for HCBS

At the time of the initial development of the POC, the POC must identify the need(s) of the child/family, the chosen HCBS, and goal/outcome to be attained. The POC must be reviewed with the child/family, signed by the child/family and copies given to the child/family and, with informed consent, to the involved multi-disciplinary team providers upon request.

When adding identified needs and services to a POC (initial/updated), it is not necessary to immediately identify the specific providers; providers should be specified once it is assured the HCBS provider identified and chosen has availability to accept the referral. Additionally, forms have been developed, as outlined below, to facilitate updating and sharing the POC. This process will also ensure that the HHCM/C-YES are compliant with the child/family specific Protected Health Information (PHI) requests regarding the sharing of the POC with various providers.

HCBS Service Plan

Once a HCBS provider receives a referral from a care manager, the HCBS provider will meet with the child and family/caregiver to identify how the services will help to address identified needs. Based on the determination of needs, the HCBS provider is responsible for documenting the approach for service provision on an HCBS service plan, for the services they expect to provide. The purpose of the HCBS Service Plan is to outline the service(s) that will/is provided with corresponding goals and objectives that describes the need for the service and the anticipated benefit to the child/youth and family. The HCBS Service Plan determines the focus of the services, while also documenting the scope, duration, and frequency to which each service will be provided. An HCBS Service Plan is required to outline each of the services the HCBS provider is

providing to the child/youth. If the child/youth is referred to more than one HCBS provider, then each HCBS provider will have their own Service Plan for the services they will provide to the child/youth.

Components of a HCBS Service Plan

As with any Service Plan, it is expected that the plan will be developed within 30 days of the first face to face appointment with the child and family/caregiver. The necessary components of the HCBS Service Plan should, at a minimum, include the following:

- a) Child's Name
- b) Child's home address and phone number
- c) Date of Birth
- d) CIN (Medicaid #)
- e) Managed Care Organization (if applicable) and Member ID
- f) Lead Health Home or C-YES
- g) Health Home Care Management Agency or C-YES
- h) Health Home Care Manager or C-YES staff, including their contact information
- i) HCBS Provider: The name of the agency delivering services as well as contact information for the agency/provider
- j) Service Plan Development Date
- k) Goals and Objectives of the service(s)
- l) Scope: The service components and interventions being provided and utilized to address the identified needs of the child
- m) Duration: Describes how long the service will be delivered to the child and/or family. The duration of the service should correspond to the abilities of the child/family and be reflective of the billing unit identified by service.
- n) Frequency: Outlines how often the service will be offered to the child and/or family. Services may be delivered on a weekly, biweekly or monthly basis, according to the needs of the child and family.

Expectations for the Development of a HCBS Service Plan

The HCBS Service Plan should be developed in conjunction with the child and family/caregiver to ensure that the goals outlined by the child and family/caregiver are captured in the plan. The development of this plan should begin during the first meeting with the child/youth and family/caregiver as the goals are discussed. The HCBS Service Plan must be completed within 30 days of the first face to face appointment with the child and family/caregiver. The duration and frequency of service delivery should not be dependent upon the availability of the provider, but rather, the availability and needs of the child. The frequency of services should be in relation to other appointments or commitments the child may have, including but not limited to and educational or vocational placement, medical or behavioral health therapies, community activities, etc. A plan, including the types of interventions provided and the goals to be achieved,

should be developed that is reflective of the developmental and physical needs of the child.

The HCBS Service Plan should be monitored regularly and reviewed at minimum, every 6 months; however, it can be more often if appropriate. If there is a significant change in the child's health, hospitalization, functioning, living situation, incarceration or other significant life event, the HCBS Service Plan must be reevaluated to determine whether or not the goals remain appropriate. The HCBS Service Plan may be modified at the request of the child and family/caregiver at any time. Whenever a modification is made to the HCBS Service Plan, it must be reviewed in total with the child and family/caregiver and appropriate signatures obtained, including the child (if appropriate, and if not, it should be specified that the child is unable to provide a signature), the parent/caregiver of the child and the signature of the HCBS provider.

When the Service Plan is developed and any update to the Service Plan, it must be shared with the care manager and/or MMCP as described in the HCBS Plan of Care Workflow section.

HCBS PLAN OF CARE WORKFLOW

Step 1: Referral to Identified HCBS Providers and Services

Once HCBS and HCBS provider(s) have been identified with the child/family through the person-centered POC process, the HHCM/C-YES will work with the identified HCBS provider(s) to set an initial intake appointment. This can be accomplished by making a phone call with or without the child/family present.

For MMCP enrollees, prior authorization is not required for the first 60 days, 96 units or 24 hours of HCBS.¹

Regardless of how the initial intake appointment is established/scheduled, the HHCM/CYES must complete the [Referral for Home and Community Based Services \(HCBS\) to HCBS Provider](#) form. This form needs to be completed and sent to the chosen HCBS provider(s) within four (4) calendar days of the HCBS referral request.

The HHCM/C-YES must ensure that referrals are made to in-network MMCP providers if the child/youth is enrolled in a MMCP. If the HHCM/C-YES is having difficulty finding HCBS provider for MMCP members, then the HHCM/C-YES should contact the MMCP to notify them and obtain assistance.

¹ Prior authorization is not required for Crisis Intervention. Prior authorization is not required for the first seven (7) calendar days of Planned Respite. Prior Authorization is not required for the first 72 hours of Crisis Respite.

Note: For Non-Medical Transportation, Environmental Modification (E-MODS), Vehicle Modification (V-MODS) and Assistive Technology (AT) needs identified through the person-centered planning process, refer to guidance and policy links below, as the [Referral for Home and Community Based Services \(HCBS\) to HCBS Provider](#) form and related process does not apply for these HCBS.

Non-Medical Transportation:

<https://www.emedny.org/ProviderManuals/Transportation/index.aspx>

EMODS:

https://www.health.ny.gov/health_care/medicaid/redesign/cfco/emod_guidelines.htm

VMODS:

https://www.health.ny.gov/health_care/medicaid/redesign/cfco/vmod_guidelines.htm

AT:

https://www.health.ny.gov/health_care/medicaid/redesign/cfco/at_guidelines.htm

When Referring Child for HCBS the First Time

Use the [Referral for Home and Community Based Services \(HCBS\) to HCBS Provider](#) form:

- This form must be completed by the HHCM/C-YES for each HCBS provider selected by the child/family. If there are multiple identified HCBS providers, then a separate form needs to be completed for each individual provider. If an HCBS provider will be providing more than one HCBS for the child/family, then only one form needs to be used for that provider.
- Each HCBS must be specified on the form, indicating the title of the HCBS identified and the desired goal or need to be addressed as identified by the child and family.
- The completed form is sent by the HHCM/C-YES to each identified HCBS provider as documentation that a referral for HCBS was made.
- HHCM/C-YES should keep a copy of the form(s) sent and document within the case record when the form(s) were sent.
- HHCM/C-YES will need to establish how the form will be sent with each HCBS provider, i.e. fax, secure email, US mail, etc.

New/Additional Referrals for Established Cases

The [Referral for Home and Community Based Services \(HCBS\) to HCBS Provider](#) form needs to be completed and sent to an HCBS provider when:

- o There is a request or need to change the HCBS provider OR

- o There is a new service requested OR
- o There is a new need identified, or the child/family chooses to now address an identified need. This can occur when updating/reviewing the POC or an occurrence of a significant life event.

If the POC is being maintained by the MMCP, it is required the MMCP use the [Referral for Home and Community Based Services \(HCBS\) to HCBS Provider](#) form to refer the child/family to a new HCBS provider to ensure information regarding the need and goal related to the HCBS is communicated to the provider.

If the HCBS provider working with a child/family identifies a need for a new service which they are designated to provide, then the HCBS provider documents in the record and the HHCM/C-YES/MMCP, as applicable, are included in the discussion for the service to ensure all parties are in agreement and that the child/family was presented options of choice of provider(s). The HHCM/C-YES/MMCP, as applicable, updates the POC accordingly and sends an updated Referral for Home and Community Based Services (HCBS) to HCBS Provider form with the new service to the chosen provider (either the original provider or different provider).

If the HCBS provider is not designated to provide the new identified service, then the HHCM/C-YES/MMCP, as applicable, will be notified so the child's care manager can identify a new HCBS provider by choice of the child/family, complete the [Referral for Home and Community Based Services \(HCBS\) to HCBS Provider](#) form, and send the referral to the chosen provider.

Step 2: Establishment of First Appointment and Notification to the MMCP (if the child is not enrolled in a MMCP, skip this step)

It is the responsibility of the referred HCBS provider(s) to ensure that the first scheduled appointment with the child/family is known by the HHCM/C-YES and the MMCP. The HCBS provider(s) will contact the MMCP to ensure their awareness of the first appointment. Should the first appointment be rescheduled, or the child/family misses their first appointment, the MMCP and HHCM/C-YES will need to be notified.

Notification to the MMCP regarding the HCBS appointment must be made **IMMEDIATELY** upon the first appointment being scheduled. The HCBS provider should not wait until they have exhausted the initial service amount of 60 days, 96 units, or 24 hours. When the HCBS provider is contacting the MMCP, they will need to know the following information:

- Appointment Date
- Identified Services
- Desired goal or need to be addressed

Contact with the MMCP for this purpose can occur by phone, or fax, however established between the MMCP and the HCBS provider.

If the first appointment will be rescheduled, the MMCP must be notified of the rescheduled first appointment **PRIOR** to the appointment, to ensure that the count will begin for the initial coverage of 60 days, 96 units, or 24 hours of any HCBS at the appropriate time. The HHCM/C-YES must be notified of the rescheduled first appointment to work with the child/family to ensure their attendance to the rescheduled first appointment and assist with any barriers of attending the first appointment.

Upon receipt of notification of the first appointment, the MMCP will establish the provider on their claim systems to ensure payment for 60 days, 96 units, or 24 hours.

Step 3: Authorization of Requested/Continued HCBS and Care Manager Notification

Once the referred HCBS provider has met with the child/family for the first appointment and any subsequent appointments needed to establish if the referred service is appropriate for the identified need/desired goal and how the service will be delivered, then the HCBS provider must request authorization of HCBS needed beyond the initial 60 days, 96 units or 24 hours. Providers should not wait until this initial service amount/period has been exhausted before proceeding with this step. To request continued authorization the HCBS provider will complete the [Children's HCBS Authorization and Care Manager Notification Form](#). This form must be completed and sent immediately upon the assessed and identified information of Frequency, Scope and Duration (F/S/D) is made, as outlined below.

For the Child/Youth Enrolled in a MMCP:

If the child/youth is enrolled in a MMCP and in Health Home:

- 1) HCBS provider completes Section 1 of the [Children's HCBS Authorization and Care Manager Notification Form](#) and sends to MMCP.
- 2) The MMCP completes service authorization review and issues determination to the HCBS provider and the enrollee.
- 3) When the authorization process is complete, the HCBS provider completes Section 2 of the [Children's HCBS Authorization and Care Manager Notification Form](#) and sends copy of form AND service authorization determination to HHCM.
- 4) HHCM updates POC and distributes POC as outlined below in **Development, Updating, and Distribution of the POC** section.

If child/youth is enrolled in a MMCP and not in Health Home:

- 1) HCBS provider completes Section 1 of the [Children's HCBS Authorization and Care Manager Notification Form](#) and sends to MMCP.

- 2) The MMCP completes service authorization review and issues determination to the HCBS provider and the enrollee.
- 3) MMCP care manager updates POC and distributes the POC.
- 4) The MMCO will share the POC with C-YES at least quarterly.

- The HCBS Provider and MMCP will need to establish how the form will be sent to the MMCP, i.e. fax, secure email, US mail, etc.
- The HCBS Provider will indicate on the form the title of the HCBS to be provided, the desired goal or need to be addressed by choice of the child and family and if this goal has been updated since previously form sent.
- The HCBS Provider will indicate the Frequency, Scope and Duration of each specific services that the provider was referred to provide and agrees is necessary based upon their intake assessment.
- The HCBS Provider should keep a copy of the form(s) sent and document within the case record when the form(s) were sent.
- The MMCP may request additional information to complete the review.

The MMCP will review the documentation provided and the child's POC, and issue a determination in accordance with the Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract (Model Contract): standard concurrent review is completed within 1 business day of all needed information received but not more than 14 calendar days from the request, unless the review is extended, which may add up to 14 calendar days to the review.² The MMCP must inform the HCBS provider and the child/family of the determination outcomes. If the MMCP denies or partially approves the services requested by the HCBS provider, the MMCP must issue an initial adverse determination with applicable appeal rights.

For a child/youth in Health Home, once the HCBS provider has received authorization for Frequency, Scope, and Duration of HCBS, the HCBS provider must notify the HHCM to add these details to the POC, within five (5) calendar days of notification. The HCBS provider will also notify if there is a change or denial by the MMCP to the requested continuance of HCBS and the frequency, scope, and duration. It is the responsibility of the HHCM to work with the HCBS provider, the MMCP and child/family to determine how to move forward with services and update the child's POC.

The HCBS provider completes Section 2 of the [Children's HCBS Authorization and Care Manager Notification Form](#) and forwards the Service Authorization Determination that was issued by the MMCP to the HHCM to communicate this information.

² For the purpose of this manual, concurrent review means a review of a request for authorization of continued, extended, or more services during a period in which the child is receiving series. See concurrent review timeframes as of 4/1/18 here:

https://www.health.ny.gov/health_care/managed_care/plans/appeals/2018-2-2_timeframe_comparison.htm

If the child/youth is not enrolled in a Health Home, then the MMCP CM will update the child's HCBS POC to include the approved frequency, scope, and duration.

Ongoing Services

Before the end of the authorization period, if the child/family and HCBS provider believe additional services are needed, the HCBS Provider completes the [Children's HCBS Authorization and Care Manager Notification Form](#) at least 14 calendar days prior to the existing HCBS authorization period ending, following the above process to obtain authorization and ensure the POC is updated. The HCBS provider may also contact the MMCP directly to discuss the continued service; however, the Children's [HCBS Authorization and Care Manager Notification Form](#) will need to be completed for documentation purposes.

For the Child/Youth NOT Enrolled in MMCP:

If child/youth is Not Enrolled in MMCP and is in a Health Home:

- 1) HCBS provider completes Section 1 of the [Children's HCBS Authorization and Care Manager Notification Form](#) and sends to HHCM.
- 2) HHCM updates POC and distributes POC as outlined below in **Development, Updating, and Distribution of the POC** section.

If child/youth is Not Enrolled in MMCP and is in C-YES (not Health Home):

- 1) HCBS provider completes Section 1 of the [Children's HCBS Authorization and Care Manager Notification Form](#) and sends to C-YES care manager.
- 2) C-YES updates POC and distributes POC as outlined below in **Development, Updating, and Distribution of the POC** section.

It is necessary for the HHCM/C-YES to update the POC after the HCBS provider has determined Frequency, Scope, and Duration even if the child is not enrolled in a MMCP. Therefore, the [Children's HCBS Authorization and Care Manager Notification Form](#) will be utilized even if the child is not enrolled in a MMCP and sent to the HHCM/C-YES.

Once the referred HCBS provider has met with the child/family for the first appointment and any subsequent appointments as needed to establish if the referred service is appropriate for the identified need/desired goal and how the service will be delivered, then the HCBS provider will complete the [Children's HCBS Authorization and Care Manager Notification Form](#). This form must be completed and sent immediately upon the assessed and identified information of Frequency, Scope and Duration is made, to the HHCM/C-YES as outlined below.

- The HCBS Provider will complete the [Children's HCBS Authorization and Care Manager Notification Form](#) and send to the HHCM/C-YES.

- The HCBS Provider will need to establish how the form will be sent the HHCM/CYES, i.e. fax, secure email, US mail, etc.
- The HCBS Provider will indicate on the form the title of the HCBS to be provided, the desired goal or need to be addressed by choice of the child and family and if this goal has been updated since previously form sent.
- The HCBS Provider will indicate the Frequency, Scope and Duration of each specific services that the provider was referred to provide and agrees is necessary based upon their intake assessment.
- The HCBS Provider should keep a copy of the form(s) sent and document within the case record when the form(s) were sent.
- The HHCM/C-YES should keep a copy of the received form(s) and document within the case record when the form(s) were received.

Ongoing Services

The HCBS Provider should use the above process to inform the HHCM/C-YES of continued F/S/D updates for the child's services. New service needs should be discussed with the HHCM/C-YES as in Step 1 above.

Step 4: Development, Updating, and Distribution of the POC

The POC is never stagnant and must be flexible to ensure it is meeting the child/family's changing needs, situation, and choice. Therefore, there are points in time in which the POC will need to be sent to the MMCP (if applicable) with the information that is the most up-to-date at the time and the HHCM/C-YES should not hold off sending to the MMCP while awaiting information. Additionally, HHCM/C-YES do not need to have the child/family along with other identified supports and involved professionals re-sign the POC if information is added **to previously identified** needs, goals, and choice of services in the POC. Updates to the POC, as a part of this process, should always be reviewed with the child/family at the next appropriate meeting to ensure agreement and to verify appropriate service delivery. If POC updates are not signed, proper documentation of how their input contributed to the update/revision must be recorded in the case record.

The POC must be signed at minimum during the annual review and if there is a significant change in the POC with newly identified need, goal, service, and/or provider.

Note: At a minimum, the child and/or the parent, guardian, legally authorized representative, and/or child must sign the POC at least once prior to submitting the completed POC to the MMCP.

The Health Home care manager is required to complete a POC with HCBS within thirty (30) days of the **initial** HCBS/LOC Eligibility Determination being conducted. A

child/youth can become eligible for HCBS at various times, therefore the type of POC may vary at this 30-day timeframe.

Types of POC within 30-days of HCBS/LOC Eligibility:

- Child/Youth first in Health Home prior to HCBS – Comprehensive Health Home POC
- Child/Youth first with C-YES – HCBS only POC
- Child/Youth new to Health Home and referred for HCBS – HCBS only POC

Both the HCBS and Health Home comprehensive POC must indicate the child's HCBS with Frequency, Scope, and Duration. Additionally, a Health Home comprehensive POC will include, behavioral health services, medical services, community and natural supports, actionable needs identified through the CANS-NY, and comprehensive assessments. The HHCM must facilitate a person-centered conversation with the child, family, and their identified care team to identify their personal goals based on actionable needs and to determine how specific HCBS may support the child in achieving those goals.

POC by Health Home Care Managers:

For children enrolled in an MMCP, within thirty (30) calendar days from the completion and signed (initial) POC, the HHCM must send the POC to the MMCP with whatever information is available at that time.

If the POC that is sent to the MMCP is an HCBS only POC, then when the HHCM develops a comprehensive POC that complies with Health Home Serving Children standards (within 60 days of Health Home enrollment), the POC must be re-sent to the MMCP.

If the F/S/D has not been reported from each of the providers or services, then the POC must still be updated and sent to the MMCP within the 30-calendar day timeframe.

- o Once the remaining providers and or services have been reported with F/S/D, then the POC will be updated again with the new information within ten (10) business days of being notified by the HCBS provider of the F/S/D on the Children's HCBS Authorization and Care Manager Notification Form and the updated POC is shared with the MMCP.

- o If a new need and or service is identified by the HHCM, child/family, involved providers, etc., then the above outlined steps would be followed and the HHCM sends the updated POC to the MMCP within thirty (30) calendar days of the revision.

Note: If the member is in urgent need of services and/or will go over the initial 60 days/96 units/24 hours prior to the POC being sent to the MMCP, once the MMCP

received the [Children's HCBS Authorization and Care Manager Notification Form](#) the MMCP will contact the HHCMA/HHCM to verify the POC.

POC by C-YES:

C-YES must develop an HCBS POC using information from the HCBS/LOC Eligibility Determination, and a person-centered discussion that identifies personal goals and how specific HCBS may support the child in achieving those goals.

- For children who are in fee-for-service Medicaid and not in Health Home: C-YES will develop an HCBS POC with Frequency, Scope, and Duration, updating the HCBS POC using the information provided by the HCBS providers from the [Children's HCBS Authorization and Care Manager Notification Form](#). C-YES will conduct person-centered meetings with the child and family at least quarterly or upon significant change and update the POC as necessary.
- For children who are enrolled in an MMCP and not in Health Home: C-YES must send the HCBS POC to the MMCP within 15 calendar days of its development with whatever information is available at that time. The MMCP is required to update the HCBS POC with the child/family using the information provided by the HCBS providers from the [Children's HCBS Authorization and Care Manager Notification Form](#) and related service authorization determinations. The MMCP will meet with the child and family as needed to maintain the POC with person-centered service planning and care management for children with special needs as per the Model Contract.

C-YES will determine annual HCBS/LOC Eligibility and conduct an annual review and will coordinate with the MMCP to update the HCBS POC, with signatures based upon the HCBS/LOC reassessment.

Referrals for HCBS

Referrals by Health Home Care Managers

The HHCM must follow up on referrals made and work to keep the child/family engaged, ensuring linkage to service. This may include sending reminders for appointments, arranging transportation, and contacting the child, family, and/or providers throughout the referral process. Additionally, the HHCM is responsible for making referrals and ensuring proper connectivity to any other service providers, to meet the comprehensive needs of the child, and must meet all HHSC standards.

Referrals by the Children and Youth Evaluation Service (C-YES)

For children in fee-for-service Medicaid who are not in Health Home, C-YES will be responsible for making referrals to HCBS providers and will retain responsibility for updating the POC.

For children enrolled in an MMCP who are not in Health Home, C-YES will make first referrals to the HCBS providers and send the MMCP the HCBS POC, the MMCP will assume responsibility for updating the POC, including changes to services, changes in HCBS provider, and changes in frequency, scope, and duration of a service.

Referrals to HCBS Providers

Prior to making any referral, the HHCM/C-YES must complete the following:

- Provide a choice of HCBS providers in the child's community who can deliver the recommended service. For children in a MMCP, all providers must be In-Network providers.³ It is the responsibility of the HHCM/C-YES to verify the In-Network status of the HCBS provider.
- Acquire a signed *Freedom of Choice* form, documenting the choice of HCBS providers. Link: <https://www.health.ny.gov/forms/doh-5276.pdf>
- Acquire signed DOH 5201/5055 consent or C-YES consent form to share the child's information before making a referral with HCBS providers, MMCP, LGU/SPOA, and other appropriate identified service providers.
- Record the child's choice of HCBS provider in the child's case record.

Note: The HCBS provider is responsible for verifying the child's MMCP status to validate that the child is in a MMCP that the HCBS provider participates with, prior to accepting the referral.

Updating the Plan of Care

The POC should be discussed with the family/child and all involved providers regularly to ensure active engagement surrounding work towards the POC's goals.

Possible updates to the child's POC must be discussed at the following intervals:

- Following the annual HCBS/LOC Eligibility Redetermination
- Following completion of the CANS-NY for Health Home program
- After a significant change in the child's condition (for example, admitted to a higher level of care or being discharged from a higher level of care)

³ During the managed care transition period for HCBS children, a child may continue to see their current HCBS provider for a continuous episode of care for up to 24 months from the date the child was enrolled in a MMCP or from the date the HCBS are part of the benefit package (October 1, 2019), regardless of whether that provider is in-network. Out-of-network providers must enter into single case agreements as needed to be reimbursed for services by MMCPs.

- Whenever the child experiences a significant life event
- Whenever a change that will impact the POC is requested (for example, requests to change service or provider, added HCBS due to a newly identified need)

If the POC needs to be updated, whenever possible, all involved providers, family-identified supports, other child-serving systems, and MMCP, should be involved in a person-centered multidisciplinary team (care team) meeting to discuss the need to revise the POC. If members of this multidisciplinary team are unable to attend, the POC must document how their input and needs drove revisions to the POC. The revised POC must be shared with the MMCP (if applicable) and other involved providers and supports, as appropriate.

Note: The following must be recorded in the POC: changes in the child's needs, goals, HCBS/LOC Eligibility, and/or service needs, including relevant impact of change with regard to the HCBS Settings Rule.

Individuals who are Ineligible for or Decline Children's HCBS

If an eligible child declines HCBS, this workflow is not completed. However, the HHCM or C-YES must record the decision. Example reasons include:

1. Child is found eligible for HCBS, but child/family do not feel HCBS will help them reach their identified goals and therefore decline HCBS.
2. Child is found eligible for HCBS, but child/family choose to remain in a State Plan service already meeting their need(s).
3. Child is found eligible for HCBS and resides in a setting that is not considered home and community based (see [NYS "HCBS Final Rule Statewide Transition Plan"](#))

HHCM will document the decision in the child's case record and work with the child/family in their capacity as a HHCM.

Note: C-YES does not provide service coordination for children who are ineligible for or opt-out of HCBS and would refer the child to community and other natural supports, including the county where applicable.

HHCM/C-YES will send Notice of Determination Form to the family/child indicating the outcome. (see Notice of Decision form for HH: https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/nod_elig.pdf)

At any time, a child who was previously found ineligible for HCBS, can request and/or be referred for another HCBS/LOC Eligibility Determination by contacting the Health Home care management agency or C-YES who previously conducted the HCBS/LOC

Eligibility Determination. Since circumstances and situations may change, a child could be found eligible at any time.

PARTICIPANTS RIGHTS AND PROTECTIONS

In compliance with CMS and the 1915(c) Children's Waiver, participants must be informed of their Freedom of Choice 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.

Health Homes and care managers must also adhere to guidance regarding protocols and reporting requirements intended to ensure the safety and well-being of waiver participants.

FREEDOM OF CHOICE

Eligible individuals must be informed of feasible alternatives for care and given the choice of either institutional or home and community-based services. During a face-to-face meeting, the care manager will provide information and discuss Freedom of Choice. The individual or applicant's parents/guardians/legally authorized represented must sign the **Freedom of Choice** form indicating their decisions and whether to participate in the HCBS 1915(c) Children's Waiver. This form must be witnessed and dated; kept as part of the member's file and a copy provided to the member upon request. The **Freedom of Choice** form is located: <https://www.health.ny.gov/forms/doh-5276.pdf>

Care managers are responsible for explaining the participant's options and reviewing the **Freedom of Choice** form. With this form, the participant will indicate their decision for the following choices:

- Choice between HCBS and an institution (such as a hospital, ICF-IDD, or nursing home)
- Choice to receive care coordination through Health Home or C-YES; if choosing Health Home, the participant may also choose their CMA/care manager
- Choice of service providers

FAIR HEARING

Information regarding the Right to a Conference and the right to Request a Fair Hearing are located on page 2 of the **Notice of Decision** form: https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/nod_discont_serv.pdf

Care managers should explain these rights and the process for requesting them to the participant and their parent/guardian/legally authorized representative.

INCIDENT REPORTING

Care managers and service providers must follow their agency processes for managing and recording *reportable incidents*, which include the following:

1. Allegation of abuse, including
 - Physical abuse
 - Psychological abuse
 - Sexual abuse/sexual contact
 - Neglect
 - Misappropriation of member funds
2. Suicide attempt
3. Death
4. Crime Level 1
5. Missing person
6. Violation of Protected Health Information (PHI)

Health Homes/CMAs should refer to Appendix J - *Health Home Monitoring: Reportable Incidents Policies and Procedures*, also located here:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/docs/hh0005_reportable_incidents_rev_10_2019.pdf

GRIEVANCES AND COMPLAINTS

Care managers and service providers must follow their agency processes for managing and reporting grievances and complaints. Grievances and complaints are external to, but not in lieu of, the existing right to request a Fair Hearing. Children's Waiver participants should be informed, by their care manager, of the process for submitting a grievance or complaint related to their HCBS, care coordination, or participation in the Children's Waiver.

CONFLICT FREE CARE MANAGEMENT

Per federal regulation §441.301(c)(1)(vi), states are required to separate case management (including the development of person-centered plans) from service delivery functions for services delivered under 1915(c) waivers. Care managers must implement conflict-free care management principles. A "conflict of interest" is defined as a "real or seeming incompatibility between one's private interests and one's public or fiduciary duties. When the same entity is both assisting an individual to gain access to services and providing services to that individual, the role of the case manager has potential to be conflicted.

SERVICE DEFINITIONS

COMMUNITY HABILITATION

Definition

Community Habilitation covers face-to-face services and supports related to the child's acquisition, maintenance, and enhancement of skills necessary to perform Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), and/or Health-Related Tasks delivered in the community (non-certified) settings.

Acquisition is described as the service available to a child who is seeking greater independence by learning to perform the task for him or herself. There should be a reasonable expectation that the individual will acquire the skills necessary to perform that task within the authorization period.

Maintenance is described as the service available to prevent or slow regression in the child's skill level and to prevent loss of skills necessary to accomplish the identified task.

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

ADL, IADL, skill acquisition, maintenance, and enhancement are face-to-face services that are determined by the person-centered planning process and must be identified in the child's Plan of Care (POC) on an individual or group basis. These identified services will be used to maximize personal independence and integration in the community, preserve functioning, and prevent the likelihood of future institutional placement. Skill acquisition, maintenance, and enhancement services are appropriate for children who have the capacity to learn to live in the community, with or without support. Community Habilitation may be delivered in individual or group modality.

Service Components

ADL, IADL skill acquisition, maintenance, and enhancement is related to assistance with functional skills and may help a child who has difficulties with these types of skills accomplish tasks related to, but not limited to:

- Self-care
- Life safety
- Medication and health management
- Communication skills
- Mobility
- Community transportation skills
- Community integration
- Appropriate social behaviors

- Problem solving
- Money management

See Appendix E: Community Habilitation Guidelines for additional service recommendations based on age of the child/youth.

Provider and Condition Requirements

ADL, IADL, skill acquisition, maintenance, and enhancement will be performed by a direct care worker, who shall include personal care aides, personal attendants, certified home health aides, direct service professionals who meet the licensure and certification requirements under NYCRR Title 18, or providers approved through the Office for People With Developmental Disabilities (OPWDD) to provide Community Habilitation.

ADL, IADL skill acquisition, maintenance, and enhancement must be provided under the following conditions:

- The need for skills training or maintenance activities has been assessed, determined, and authorized as part of the person-centered planning process.
- Provider agencies of Community Habilitation must develop a Community Habilitation service plan to document the child's goal(s)/outcome(s), health/safety needs required during the delivery of the service, and the necessary staff actions to assist the child reach his/her Community Habilitation goal(s)/outcome(s), and health/safety needs. The activities are for the sole benefit of the child and are only provided to the child receiving HCBS or to the family/caregiver in support of the child.
- The activities are designed to preserve or enhance independence or slow/reduce the loss of independence when the child has a progressive medical condition. The activities provided are consistent with the child's stated preferences and outcomes in the plan of care (POC).
- The activities provided are coordinated with the performance of ADLs, IADLs, and health related tasks.
- Training for skill acquisition, maintenance, and enhancement activities that involve the management of behaviors must use positive enforcement techniques.
- The provider is authorized to perform these services for HCBS recipients and has met any required training, certification, and/or licensure requirements.

Some specific ADL services available for training include, but are not limited to: bathing/personal hygiene, dressing, eating, mobility (ambulation and transferring), and toileting.

Some specific IADL services available for skills training include, but are not limited to: managing finances; assisting with transportation (as indicated in the POC); shopping for food, clothes, and other essentials; preparing meals; assisting with the use of the telephone and/or other communication devices; managing medications; light

housekeeping; environmental maintenance such as maintaining safe egress; and laundry.

If the POC indicates that learning how to navigate travel from one location in the community to another is a goal for the child, this service will include the assistance provided by a direct care worker to accompany the child while learning the skill. The face-to-face service time when a direct care worker is assisting or providing transportation to an individual may also be billed as part of the Community Habilitation service.

Health-related tasks are defined as specific tasks related to the needs of a child, which can be delegated or assigned by licensed health-care professionals under state law to be performed by a certified home health aide or a direct service professional. Health-related tasks also include tasks that home health aides or a direct service professional can perform under applicable exemptions from the Nurse Practice Act.

Some specific health-related tasks available for assistance include, but are not limited to: performing simple measurements and tests; assisting with the preparation of complex modified diets; assisting with a prescribed exercise program; pouring, administering, and recording medications; assisting with the use of medical equipment, supplies, and devices; assisting with special skin care; assisting with a dressing change; and assisting with ostomy care.

Modality

- Individual face-to-face service
- Group face-to-face service

Setting

These services can be delivered at any non-certified, community setting. Such a setting might include the child's home, which may be owned or rented, and work setting.

Allowable settings in compliance with Medicaid regulations and the Home and Community Based Settings Final Rule (§441.301(c)(4) and §441.710) (see Appendix B) will exhibit characteristics and qualities most often articulated by the individual child/youth and family/caregiver as key determinants of independence and community integration. Services should be offered in the setting least restrictive for desired outcomes, including the most integrated home or other community based settings where the beneficiary lives, works, engages in services, and/or socializes. While remaining inclusive of those in the family and caregiver network. Family is broadly defined, and can include families created through birth, foster care, adoption, or a self-created unit.

Limitations/Exclusions

Please note that this service cannot be substituted for vocational rehabilitation services provided under the Rehabilitation Act of 1973 or other Children's HCBS. Approved settings do not include an OPWDD certified residence, congregate or institutional settings, a social day care or health care setting in which employees of the particular setting care for or oversee the child. Foster Care children meeting LOC may receive these services in a home or community based setting where they reside that is not an institution. OCFS Licensed Institutions are defined in New York State Social Services law section 427.2(f) as a facility established for the 24-hour care and maintenance of 13 or more children and operated by a child care agency (Voluntary Foster Care Agency). Only those services not reimbursable under the Community First Choice Option (CFCO) State Medicaid Plan will be reimbursable under this HCBS Waiver.

Children living in certified settings may only receive this service on week days with a start time prior to 3 pm. And are limited to a maximum of six (6) hours of non-residential services (or its equivalent) daily. For school-age children, this service cannot be provided during the school day when a child/youth is participating or enrolled in a school program. Time spent receiving another Medicaid service cannot be counted toward the Community Habilitation billable service time. This service cannot be delivered nor billed while a child is in an ineligible setting, such as in a hospital, ICF/IID, or skilled nursing facility. Community Habilitation services provided under this waiver cannot be duplicative or delivered at the same time as services otherwise available to a child through a local educational agency including those services available under the Individuals with Disabilities Education Act (IDEA) or Rehabilitation Act of 1973.

Certification/Provider Qualifications

Provider Agency Qualifications

New York State Office for People With Developmental Disabilities (OPWDD) certified, not-for-profit habilitation provider agencies.

Practitioners must operate in agencies that have been designated through the NYS Children's Provider Designation Review Team. This requires agencies have appropriate license, certification, and/or approval in accordance with State designation requirements.

- Provider agencies and practitioners must adhere to all Medicaid requirements in this manual and in other applicable provider manuals, regulations, and statutes.
- Provider agencies must adhere to cultural competency guidelines.
- Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
- The provider agency must ensure that staff receive Mandated Reporting training and Personal Safety in the Community training prior to service delivery.

- The provider agency must ensure that practitioners maintain the licensure necessary to provide services under their scope of practice under State law, if applicable.
- The provider agency must ensure that any insurance required by the designating state agency is obtained and maintained.
- The provider agency must ensure that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.

Additional information and application for Children’s SPA/HCBS can be found on the DOH website:

https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/provider_design.htm

Individual Staff/Agency Qualifications

Providers must have appropriate license, certification, and/or approval in accordance with State requirements.

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.

Direct support professionals must have completed the training stipulated in 14 NYCRR Part 633.8 and the Direct Support Professionals Core Competencies curriculum.

Additional information can be found here:

https://opwdd.ny.gov/opwdd_careers_training/training_opportunities/core_competencies#definition

Training Requirements

Service Type	Trainings Required	Requirement Completion Timeframe
Community Habilitation	<ul style="list-style-type: none"> • Mandated Reporter 	<ul style="list-style-type: none"> • Prior to Service Delivery
	<ul style="list-style-type: none"> • Personal Safety/ Safety in the Community • Strength Based Approaches • Suicide Prevention • Domestic Violence Signs and Basic Interventions • Trauma Informed Care 	<ul style="list-style-type: none"> • For staff hired before April 1, 2019, training must be completed within six (6) months of the 1915(c) Children’s Waiver implementation. • For staff hired on or after April 1, 2019, training must be completed within six (6) months of hire date.

Additional information regarding training requirements can be found in Appendix F.

DAY HABILITATION

Definition

Assistance with acquisition, retention or improvement in self-help, socialization and adaptive skills including communication, and travel that regularly takes place in a non-residential setting, separate from the person's private residence or other residential arrangement. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, community inclusion, relationship building, self-advocacy, and informed choice. Day Habilitation (DH) services may be provided to a child at a NYS certified (e.g., OPWDD certified) setting typically between the daytime hours of 9 a.m. and 3 p.m. However, service delivery may include outings to community (non-certified) settings.

Service Components

Individual Day Habilitation (a one-to-one, individual-to-worker provided service with an hourly unit of service) and Group Day Habilitation services are furnished four or more hours per day on a regularly scheduled basis for one or more days per week or less frequently as specified in the participant's POC. Meals provided as part of these services shall not constitute a "full nutritional regimen" (three meals per day).

A supplemental version of Individual and Group Day Habilitation is available for children who do not reside in a certified setting. The supplemental Day Habilitation is provided outside the 9 a.m. to 3 p.m. weekday time period and includes later afternoon, evenings, and weekends. Day Habilitation and Supplemental Day Habilitation services cannot be delivered at the same time.

All Day Habilitation services (Group and Individual) have the same service description and focus on enabling the participant to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies in the POC. In addition, Day Habilitation services may serve to reinforce skills, behaviors, or lessons taught in other settings. Provider agencies of Day Habilitation must develop a Day Habilitation service plan to document the child's goal(s)/outcomes(s), health/safety needs required during the delivery of the service, and the necessary staff actions to assist the child in reaching his/her Day Habilitation goal(s)/outcomes(s), and health/safety needs.

Modality

- Individual face-to-face service
- Group face-to-face service

Setting

Day Habilitation (DH) services are provided to a child at a NYS certified (e.g., OPWDD certified) setting.

Allowable settings in compliance with Medicaid regulations and the Home and Community Based Settings Final Rule (§441.301(c)(4) and §441.710) (see Appendix B) will exhibit characteristics and qualities most often articulated by the individual child/youth and family/caregiver as key determinants of independence and community integration. Services should be offered in the setting least restrictive for desired outcomes, including the most integrated home or other community based settings where the beneficiary lives, works, engages in services, and/or socializes. While remaining inclusive of those in the family and caregiver network. Family is broadly defined, and can include families created through: birth, foster care, adoption, or a self-created unit.

Limitations/Exclusions

Group and Individual DH cannot be billed as overlapping services. Any child receiving HCBS under this waiver may receive this service. Service necessity criteria for this service requires that the child must have a developmental delay justifying the need for the provision of Day Habilitation, but the child may meet NF, ICF/IID, or Hospital LOC.

Day Habilitation services will not include funding for direct, hands-on physical therapy, occupational therapy, speech therapy, nutrition, or psychology services.

Children have a maximum daily amount of services that are available to individuals based upon their residence. Individuals residing in certified settings are limited to a maximum of six hours of non-residential services (or its equivalent) which must commence no later than 3 pm on weekdays.

Supplemental DH services are those services provided on weekends and/or on weekdays with a service start time after 3 pm. Supplemental DH services are not available to individuals residing in certified residential settings with paid, professional staff, because the certified residential habilitation provider is responsible for the habilitation needs of the individual on weekday evenings and anytime on weekends.

Certification/Provider Qualifications

Provider Agency Qualifications

New York State Office for People With Developmental Disabilities (OPWDD) Regional Office or non-profit organization certified by New York State Office for People With Developmental Disabilities (OPWDD)

- OPWDD Regional Offices may provide Day Habilitation HCBS waiver services directly through its Regional Offices.

- 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.

Non-Profit Organization

- Certified by the Office for People With Developmental Disabilities (OPWDD) to provide Day Habilitation.
- 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.
- Non-profit organizations include nonprofit corporations formed under New York State Law or authorized to do business in New York, local government units, or organizations created by an act of the New York State Legislature for charitable purposes, which include providing services to persons with developmental disabilities.
- If the provider agency employs professional clinical staff, that staff person must have the appropriate credentials stipulated by the OPWDD and/or the NYS Department of Education under the following regulations and laws:
 - Nursing (8 NYCRR Part 64 and Education Law Title 8, Article 139)
 - Speech Language Pathologist (8 NYCRR Part 75 and Education Law Title 8, Article 159)
 - Psychology (8 NYCRR Part 72 and Education Law Title 8, Article 153)
 - Social Work (8 NYCRR Part 74 and Education Law Title 8, Article 154)
 - Rehab Counselor (14 NYCRR Part 679.99)
 - Dietetics/Nutrition (8 NYCRR Part 79 and Education Law Title 8, Article 157)
 - Occupational Therapy (8 NYCRR Part 76 and Education Law Title 8, Article 156)
 - Physical Therapy (8 NYCRR part 77 and Education Law Title 8, Article 136)
 - Applied Behavioral Sciences Specialist (8 NYCRR Part 79 and Education Law Title 8, Article 167)
 - Behavioral Intervention Specialist (14 NYCRR part 633-16.b(32))

Practitioners must operate in agencies that have been designated through the NYS Children's Provider Designation Review Team. This requires agencies to have appropriate license, certification, and/or approval in accordance with State designation requirements.

- Provider agencies and practitioners must adhere to all Medicaid requirements in this manual and in other applicable provider manuals, regulations, and statutes.
- Provider agencies must adhere to cultural competency guidelines.

- Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
- The provider agency must ensure that staff receive Mandated Reporting training which is provided throughout New York State and Personal Safety in the Community training prior to service delivery.
- The provider agency must ensure that practitioners maintain the licensure necessary to provide services under their scope of practice under State law, if applicable.
- The provider agency must ensure that any insurance required by the designating state agency is obtained and maintained.
- The provider agency must ensure that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.

Additional information and application for Children's SPA/HCBS can be found on the DOH website:

https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/provider_design.htm

Individual Staff/Agency Qualifications

- Providers must have appropriate license, certification, and/or approval in accordance with State requirements.
- Direct support professionals must have completed the training stipulated in 14 NYCRR Part 633.8 and the Direct Support Professionals Core Competencies curriculum. Additional information can be found here:
https://opwdd.ny.gov/opwdd_careers_training/training_opportunities/core_competencies#definition

Training Requirements

Service Type	Trainings Required	Requirement Completion Timeframe
Day Habilitation	<ul style="list-style-type: none"> • Mandated Reporter • Personal Safety/ Safety in the Community • Strength Based Approaches • Suicide Prevention • Domestic Violence Signs and Basic Interventions • Trauma Informed Care 	<ul style="list-style-type: none"> • Prior to Service Delivery • For staff hired before April 1, 2019, training must be completed within six (6) months of the 1915(c) Children's Waiver implementation. • For staff hired on or after April 1, 2019, training must be completed within six (6) months of hire date.

Additional information regarding training requirements can be found in Appendix F.

CAREGIVER/FAMILY SUPPORTS AND SERVICES

Definition

Caregiver/Family Supports and Services enhance the child/youth's ability, regardless of disability (developmental, physical, and/or behavioral), to function as part of a caregiver/family unit and enhance the caregiver/family's ability to care for the child/youth in the home and/or community. Family is broadly defined, and can include families created through birth, foster care, adoption, or a self-created unit.

Note: this service is not the State Plan service of Family Peer Support Services which must be delivered by a certified/credentialed Family Peer with lived experience.

Service Components

Based upon the Caregiver/Family Supports and Services plan developed by the child/youth and caregiver/family team, this service provides opportunities to:

- Interact and engage with family/caregivers and children/youth to offer educational, advocacy, and support resources to develop family/caregivers' ability to independently access community services and activities
- Maintain and encourage the caregivers'/families' self-sufficiency in caring for the child/youth in the home and community
- Address needs and issues of relevance to the caregiver/family unit as the child/youth is supported in the home and community
- Educate and train the caregiver/family unit on available resources so that they might better support and advocate for the needs of the child and appropriately access needed services
- Provide guidance in the principles of children's chronic condition or life-threatening illness

When outlined in the child/youth's plan of care, the service can be delivered to multiple family members or other identified resources for the child/youth by more than one practitioner to address the child/youth's needs by educating, engaging and guiding their families to ensure that the child and family's needs are met. In instances where two practitioners are required to meet the needs of the child/family, and the encounters occur at the same date and time, the agency can bill for both practitioners in one claim by adding the time the service was delivered by each practitioner into a combined claim. If one practitioner delivers the services to a child and/or multiple family members/resources at the same date and time, the claim should reflect the exact time spent as a single encounter. For additional billing information please see the *NYS Children's Health and Behavioral Health Billing and Coding Manual*, and any subsequent updates found [here](#).

Modality

- Individual face-to-face intervention
- Group face-to-face intervention (no more than three HCBS eligible children/families)

Setting

Allowable settings in compliance with Medicaid regulations and the Home and Community Based Settings Final Rule (§441.301(c)(4) and §441.710) (see Appendix B) will exhibit characteristics and qualities most often articulated by the individual child/youth and family/caregiver as key determinants of independence and community integration. Services should be offered in the setting least restrictive for desired outcomes, including the most integrated home or other community-based settings where the beneficiary lives, works, engages in services, and/or socializes. While remaining inclusive of those in the family and caregiver network, family is broadly defined, and can include families created through: birth, foster care, adoption, or a self-created unit.

Limitations/Exclusions

- This service cannot be delivered nor billed while an enrolled child is in an ineligible setting, including hospitalization
- Special education and related services that are otherwise available to the individual through a local educational agency, under the provisions of the Individuals with Disabilities Education Act (IDEA)
- Caregiver Family Supports and Services are limited to three hours per day

Certification/Provider Qualifications

Provider Agency Qualifications

Practitioners must operate in agencies that have been designated through the NYS Children's Provider Designation Review Team. This requires agencies have appropriate license, certification, and/or approval in accordance with State designation requirements.

- Provider agencies and practitioners must adhere to all Medicaid requirements in this manual and in other applicable provider manuals, regulations, and statutes.
- Provider agencies must adhere to cultural competency guidelines.
- Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
- The provider agency must ensure that staff receive Mandated Reporting training which is provided throughout New York State and Personal Safety in the Community training prior to service delivery.

- The provider agency must ensure that practitioners maintain the licensure necessary to provide services under their scope of practice under State law, if applicable.
- The provider agency must ensure that any insurance required by the designating state agency is obtained and maintained.
- The provider agency must ensure that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.

Additional information and application for Children's SPA/HCBS can be found on the DOH website:

https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/provider_design.htm

Individual Staff Qualifications

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

Supervisor Qualifications:

- **Minimum** qualification of a Bachelor's degree with one year of experience in human services working with children/youth.
- **Preferred** two years' experience in human services working with children/youth.

Training Requirements

Service Type	Trainings Required	Requirement Completion Timeframe
Caregiver/Family Supports & Services	<ul style="list-style-type: none"> • Mandated Reporter • Personal Safety/ Safety in the Community • Strength Based Approaches • Suicide Prevention • Domestic Violence Signs and Basic Interventions • Trauma Informed Care 	<ul style="list-style-type: none"> • Prior to Service Delivery • For staff hired before April 1, 2019, training must be completed within six (6) months of the 1915(c) Children's Waiver implementation. • For staff hired on or after April 1, 2019, training must be completed within six (6) months of hire date.

Additional information regarding training requirements can be found in Appendix F.

RESPITE

Definition

This service focuses on short-term assistance provided to children/youth, regardless of disability (developmental, physical and/or behavioral), because of the absence of or need for relief of the child or the child's family caregiver. Such services can be provided

in a planned mode or delivered in a crisis situation. Respite workers supervise the child/youth and engage the child/youth in activities that support his/her and/ or primary caregiver/family's constructive interests and abilities.

Respite providers offer services with a level of expertise in understanding and implementing behavioral/developmental interventions required to support optimal functioning for children/youth. Respite providers regularly communicate the details of the child/youth's intervention plan so that there is a carryover of skill from the respite source to the caregivers and treatment providers.

Service Components

Planned

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

Crisis

Crisis Respite is a short-term care and intervention strategy for children/youth and their families that helps to alleviate the risk for an escalation of symptoms, a loss of functioning, and/or a disruption in a stable living environment. It may be used when challenging behavioral or situational crises occur that the child/youth and/or family/caregiver is unable to manage without intensive assistance and support. Crisis Respite can also be used for crisis intervention or from visiting the emergency room. Crisis Respite should be included on the POC to the extent that it is an element of the crisis plan or risk mitigation strategy.

Crisis Respite services may be delivered in a home or residence by qualified practitioners, out-of-home/residence by staff in community-based sites, or in allowable facilities. Services offered may include site-based crisis residence, monitoring for high risk behavior, health and wellness skill building, wellness activities, family/caregiver support, conflict resolution, and other services as needed.

Ongoing communication between child/youth or the family/primary caregiver receiving crisis respite for their child, the crisis respite staff, and the child/youth's established behavioral health and health care providers is required to assure collaboration and continuity in managing the crisis situations and identifying subsequent support and service needs.

At the conclusion of a Crisis Respite period, crisis respite staff, together with the child/youth and family/primary caregiver, and his or her established behavioral health or health care providers when needed, will make a determination as to the continuation of necessary care and make recommendations for modifications to the child's POC. Children are encouraged to receive Crisis Respite in the most integrated and cost-effective settings appropriate to meet their respite needs. Out-of-home Crisis Respite is not intended as a substitute for permanent housing arrangements.

Modality

Planned Day Respite: This service may be delivered with support of staffing ratios necessary to keep the child, and other children in the environment, safe and as indicated in the child's POC overseen by the respite provider.

Planned Overnight Respite: This service may be delivered with support of staffing ratios necessary to keep the child, and other children in the environment, safe and as indicated in the child's POC overseen by the respite provider.

Crisis Day Respite: This service may be delivered with support of staffing ratios necessary to keep the child, and other children in the environment, safe and as indicated in the child's POC overseen by the respite provider.

Crisis Overnight Respite: This service may be delivered with support of staffing ratios necessary to keep the child, and other children in the environment, safe and as indicated in the child's POC overseen by the respite provider.

Setting

Planned or Crisis Day respite services can be provided in the home of an eligible youth or a community setting (e.g. community centers, camp, and parks). Community settings may include areas where a child/youth lives, attends school, works, engages in services and/or socializes and is in compliance with CMS Final Rule (§441.301(c)(4) and (§441.710), HCBS Settings Rule (Appendix B).

Planned or Crisis Overnight settings include those licensed or certified by OCFS, OMH, or OPWDD and designated to provide respite services. Please note there is an exemption in the CMS HCBS Final Rule (March 16, 2014) for allowable respite care settings.

- OMH licensed Community Residence (community based or state-operated), including Crisis Residence, which has an OMH Operating Certificate demonstrating compliance with 14 NYCRR 594; OR
- OCFS Licensed agency boarding home, a group home, a group residence, or an institution and certified foster boarding homes; OR

- OPWDD certified residential setting where the individual does not permanently reside (i.e., Family Care Home; Intermediate Care Facility for Individuals with Intellectual and Developmental Disabilities (ICF/IDD); Individualized Residential Alternative (IRA) or Community Residence (CR); or Free-Standing Respite facility under the auspices of OPWDD.)

Limitations/Exclusions

- *Note: Services to children and youth in foster care must comply with Part 435 of 18 NYCRR.* Respite is not an allowable substitute for permanent housing arrangements.
- For respite services that may be provided as crisis or overnight, Federal Financial Participation is not claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.
- It is the responsibility of the Care Coordinator upon referral to ensure that respite providers have adequate training and knowledge to address the individual child/youth's needs (including but not limited to physical and/or medical needs such as medications or technology), OR have made arrangements for an appropriately trained and knowledgeable individual to address the individual child/youth's needs (including but not limited to physical and/or medical needs such as medications or technology). Examples include arrangement of an approved Private Duty Nurse for a technology dependent child while in a respite setting.

Certification/Provider Qualifications

Provider Agency Qualifications

Practitioners must operate in agencies that have been designated through the NYS Children's Provider Designation Review Team. This requires agencies have appropriate license, certification, and/or approval in accordance with State designation requirements.

- Provider agencies and practitioners must adhere to all Medicaid requirements in this manual and in other applicable provider manuals, regulations, and statutes.
- Provider agencies must adhere to cultural competency guidelines.
- Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
- The provider agency must ensure that staff receive Mandated Reporting training which is provided throughout New York State and Personal Safety in the Community training prior to service delivery.
- The provider agency must ensure that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable.

- The provider agency must ensure that any insurance required by the designating state agency is obtained and maintained.
- The provider agency must ensure that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.

Additional information and application for Children's SPA/HCBS can be found on the DOH website:

https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/provider_design.htm

For Overnight Planned or Crisis Respite, the designated provider must be one of the following:

- OMH-certified Community Residence: (community based or state operated) including Crisis Residence
- OCFS licensed/certified setting including agency boarding home, a group home, a group residence, or an institution
- OPWDD certified residential setting

Individual Staff Qualifications

- **Provision of service in child's residence or other community based setting (e.g. park, shopping center, etc.)**
 - Respite providers are paraprofessionals with a high school diploma or equivalent and with appropriate skills and training. It is the responsibility of the Care Coordinator to ensure that providers have adequate training and knowledge to address the individual child's needs (including but not limited to physical and/or medical needs such as medications or technology).
 - Experience working with children/youth (preference given to those with experience working with children/youth with special needs)
 - A high school diploma, high school equivalency preferred or a State Education Commencement Credential (e.g. SACC or CDOS)
- **Provision of service outside child's residence and in an allowable licensed/certified setting**
 - In a foster boarding home: Respite providers must be a Licensed Foster Parent pursuant to Part 435 of 18 NYCRR
 - In a OCFS licensed/certified setting: Respite providers are paraprofessionals with a high school diploma or equivalent and with appropriate skills and training.
 - In an OMH-certified Community Residence: (community based or state operated), including Crisis Residence, which has an OMH Operating Certificate demonstrating compliance with 14 NYCRR 594: Respite workers must be staff of the licensed program.

- In an OPWDD-certified setting: (community based or state operated), Family Care Home, Intermediate Care Facility for Individuals with Intellectual and Developmental Disabilities (ICF/IDD); Individualized Residential Alternative (IRA) or Community Residence (CR); or Free-Standing Respite facility under the auspices of OPWDD: Respite workers must be staff of the certified program.

Supervisor Qualifications

- Minimum qualification is a Bachelor's degree with one year of experience in human services working with children/youth.

Training Requirements

Service Type	Trainings Required	Requirement Completion Timeframe
Respite (Crisis/Planned)	<ul style="list-style-type: none"> • Mandated Reporter 	<ul style="list-style-type: none"> • Prior to Service Delivery
	<ul style="list-style-type: none"> • Personal Safety • Safety in the Community • Strength Based Approaches • OMH-recommended Suicide Prevention • Domestic Violence Signs and Basic Interventions • Trauma Informed Care 	<ul style="list-style-type: none"> • For staff hired before April 1, 2019, training must be completed within six (6) months of the 1915(c) Children's Waiver implementation. • For staff hired on or after April 1, 2019, training must be completed within six (6) months of hire date.

Additional information regarding training requirements can be found in Appendix F.

PREVOCATIONAL SERVICES

Definition

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

Service Components

Prevocational Services may include volunteer work, such as learning and training activities that prepare a person for entry into the paid workforce. Prevocational Services should enable each participant to attain the highest level of work in the most integrated

setting and with the job matched to the participant's interests, strengths, priorities, abilities, and capabilities, while following applicable federal wage guidelines from the U.S. Department of Labor. Services are intended to develop and teach general skills. Examples include, but are not limited to:

- Ability to communicate effectively with supervisors, co-workers, and customers
- Generally accepted community workplace conduct and dress
- Ability to follow directions
- Ability to attend to and complete tasks
- Punctuality and attendance
- Appropriate behaviors in and outside the workplace
- Workplace problem solving skills and strategies
- Mobility training
- Career planning
- Proper use of job-related equipment and general workplace safety

Prevocational Services include activities that are not primarily directed at teaching skills to perform a particular job, but at underlying rehabilitative goals (e.g., attention span, motor skills, interpersonal relations with co-workers and supervisors) that are associated with building skills necessary to perform work and optimally to perform competitive, integrated employment.

- Resume writing, interview techniques, role play, and job application completion
- Exploring career options, facilitating appropriate work habits, acceptable job behaviors, and learning job production requirements
- Assisting in identifying community service opportunities that could lead to paid employment
- Helping the youth to connect their educational plans to future career/vocational goals
- Helping youth to complete college, technical school, or other applications to continue formal education/training
- Helping youth to apply for financial aid or scholarship opportunities

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

Modality

This service may be delivered in a one-to-one session or in a group setting of two or three participants.

Setting

Allowable settings in compliance with Medicaid regulations and the Home and Community Based Settings Final Rule (§441.301(c)(4) and §441.710) (see Appendix B) will exhibit characteristics and qualities most often articulated by the individual

child/youth and family/caregiver as key determinants of independence and community integration. Services should be offered in the setting least restrictive for desired outcomes, including the most integrated home or other community based settings where the beneficiary lives, works, engages in services, and/or socializes. While remaining inclusive of those in the family and caregiver network, family is broadly defined, and can include families created through: birth, foster care, adoption, or a self-created unit.

Limitations/Exclusions

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

Prevocational services will not be provided to an HCBS participant if:

- Special education and related services that are otherwise available to the individual through a local educational agency, under the provisions of the Individuals with Disabilities Education Act (IDEA)
- Vocational rehabilitation services that are otherwise available to the individual through a program funded under section 110 of the Rehabilitation Act of 1973 (Access VR)
- Vocational services that are provided in facility-based work settings that are not integrated settings in the general community workforce.

Certification/Provider Qualifications

Provider Agency Qualifications

Practitioners must operate in agencies that have been designated through the NYS Children's Provider Designation Review Team. This requires agencies have appropriate license, certification and/or approval in accordance with State designation requirements.

- Provider agencies and practitioners must adhere to all Medicaid requirements in this manual and in other applicable provider manuals, regulations, and statutes.
- Provider agencies must adhere to cultural competency guidelines.
- Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
- The provider agency must ensure that staff receive Mandated Reporting training which is provided throughout New York State and Personal Safety in the Community training prior to service delivery.
- The provider agency must ensure that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable.
- The provider agency must ensure that any insurance required by the designating state agency is obtained and maintained.

- The provider agency must ensure that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.

Additional information and application for Children's SPA/HCBS can be found on the DOH website:

https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/provider_design.htm

Individual Qualifications

- **Minimum** qualifications of an Associate's degree with one year of human service experience
- **Preferred** qualifications of a Bachelor's degree with one year of experience in human services working with children/youth

Supervisor Qualifications

- **Minimum** qualification of a Bachelor's degree with three years of experience in human services
- **Preferred** qualification of a Master's with one year of experience in human services working with children/youth

Training Requirements

Service Type	Trainings Required	Requirement Completion Timeframe
Prevocational Services	<ul style="list-style-type: none"> • Mandated Reporter 	<ul style="list-style-type: none"> • Prior to Service Delivery
	<ul style="list-style-type: none"> • Personal Safety/ Safety in the Community • Strength Based Approaches • Suicide Prevention • Domestic Violence Signs and Basic Interventions • Trauma Informed Care 	<ul style="list-style-type: none"> • For staff hired before April 1, 2019, training must be completed within six (6) months of the 1915(c) Children's Waiver implementation. • For staff hired on or after April 1, 2019, training must be completed within six (6) months of hire date.

Additional information regarding training requirements can be found in Appendix F.

SUPPORTED EMPLOYMENT

Definition

Supported Employment services are individually designed to prepare youth with disabilities (age 14 or older) to engage in paid work. Supported Employment services provide assistance to participants with disabilities as they perform in a work setting.

Supported Employment provides ongoing supports to participants who, because of their disabilities, need intensive on-going support to obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals.

Supported Employment services are individualized and may include any combination of the following services: vocational/job-related discovery or assessment, person-centered employment planning, job placement, job development, negotiation with prospective employers, job analysis, job carving, training and systematic instruction, job coaching, benefits support, training and planning, transportation, career advancement services, and other workplace support services including services not specifically related to job skill training that enable the participant to successfully integrate into the job setting.

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

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

Service Components

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

- Supervision and training that are not job-related
- Intensive ongoing support
- Transportation to and from the job site
- Interface with employers regarding the individual's disability(ies) and needs related to his/her healthcare issue(s)
- Other activities needed to sustain paid work (e.g., employment assessment, job placement, and/or adaptive/assistive equipment necessary for employment)
- Job finding and development training in work behaviors
- Assessing the interest and fit of an individual for particular job opportunities, staff work with employers and job sites preparing them to be able to make necessary and reasonable accommodations
- On-site support for the individual as they learn specific job tasks

- Monitoring through on-site observation and through communication with job supervisors and employers

Modality

- Individual face-to-face intervention

Setting

Allowable settings in compliance with Medicaid regulations and the Home and Community Based Settings Final Rule (§441.301(c)(4) and §441.710) (see Appendix B) will exhibit characteristics and qualities most often articulated by the individual child/youth and family/caregiver as key determinants of independence and community integration. Services should be offered in the setting least restrictive for desired outcomes, including the most integrated home or other community based settings where the beneficiary lives, works, engages in services, and/or socializes. While remaining inclusive of those in the family and caregiver network, family is broadly defined, and can include families created through: birth, foster care, adoption, or a self-created unit.

Limitations/Exclusions

Medicaid funds may not be used to defray the expenses associated with starting up or operating a business.

Supported Employment service will not be provided to an HCBS participant if:

- Special education and related services that is otherwise available to the individual through a local educational agency, under the provisions of the Individuals with Disabilities Education Act (IDEA).
- Vocational rehabilitation services that are otherwise available to the individual through a program funded under section 110 of the Rehabilitation Act of 1973.
- Supported employment does not include facility based, or other similar types of vocational services furnished in specialized facilities that are not a part of the general workplace.
- Supported employment does not include payment for supervision, training, support, and adaptations typically available to other workers without disabilities filling similar positions in the business.
- Supported employment does not include volunteer work. Such volunteer learning and un-paid training activities that prepare a person for entry into the paid workforce are addressed through Pre-Vocational services.

Medicaid funding cannot be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

- Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment; or

- Payments that are passed through to users of supported employment services.

Supported employment is limited to three hours per day.

Certification/Provider Qualifications

Provider Agency Qualifications

Practitioners must operate in agencies that have been designated through the NYS Children's Provider Designation Review Team. This requires agencies have appropriate license, certification, and/or approval in accordance with State designation requirements.

- Provider agencies and practitioners must adhere to all Medicaid requirements in this manual and in other applicable provider manuals, regulations, and statutes.
- Provider agencies must adhere to cultural competency guidelines
- Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
- The provider agency must ensure that staff receive Mandated Reporting training which is provided throughout New York State and Personal Safety in the Community training prior to service delivery.
- The provider agency must ensure that practitioners maintain the licensure necessary to provide services under their scope of practice under State law, if applicable.
- The provider agency must ensure that any insurance required by the designating state agency is obtained and maintained.
- The provider agency must ensure that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.

Additional information and application for Children's SPA/HCBS can be found on the DOH website:

https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/provider_design.htm

Individual Qualifications

- **Minimum** qualifications of an Associate's degree with one year of human service experience
- **Preferred** qualifications of a Bachelor's degree with one year of experience in human services working with children/youth

Supervisor Qualifications

- **Minimum** qualification of a Bachelor's degree with three years of experience in human services
- **Preferred** qualification of a Master's with one year of experience in human services working with children/youth

Training Requirements

Service Type	Trainings Required	Requirement Completion Timeframe
Supported Employment	<ul style="list-style-type: none"> • Mandated Report 	<ul style="list-style-type: none"> • Prior to Service Delivery
	<ul style="list-style-type: none"> • Personal Safety/ Safety in the Community • Strength Based Approaches • OMH-recommended Suicide Prevention • Domestic Violence Signs and Basic Interventions • Trauma Informed Care 	<ul style="list-style-type: none"> • For staff hired before April 1, 2019, training must be completed within six (6) months of the 1915(c) Children's Waiver implementation. • For staff hired on or after April 1, 2019, training must be completed within six (6) months of hire date.

Additional information regarding training requirements can be found in Appendix F.

COMMUNITY SELF-ADVOCACY TRAINING AND SUPPORTS

Definition

Community Self-Advocacy Training and Support provides family, caregivers, and collateral contacts with techniques and information not generally available so that they can better respond to the needs of the participant. Community Self-Advocacy Training and Support is intended to assist the child/youth, family/caregiver, and collateral contacts in understanding and addressing the participant's needs related to their disability(ies).

The use of this service may appropriately be provided to prevent problems in community settings as well as when the child/youth is experiencing difficulty. The POC objectives must clearly state how the service can prevent as well as ameliorate existing problems and to what degree. This service cannot be used to develop an Individualized Education Program (IEP), the plan for students with disabilities who meet the federal and state requirements for special education, or to provide special education services to the child/youth. Participating in community events and integrated interests/occupations are important activities for all children/youth, including those with disabilities (developmental, physical, and/or behavioral health in origin). Success in these activities is dependent not only on the child/youth, but on the people who interact with and support the child/youth in these endeavors. Community Self-Advocacy Training and Support improves the child/youth's ability to gain from the community experience and

enables the child/youth's environment to respond appropriately to the child/youth's disability and/or health care issues.

Service Components

- Training (one-on-one or group) for the child/youth and/or the family/caregiver regarding methods and behaviors to enable success in the community. Each group must not exceed 12 participants (enrollees and collaterals).
- Direct self-advocacy training in the community with collateral contacts regarding the child/youth's disability(ies) and needs related to his or her health care issues.
- Self-advocacy training for the child/youth and/or family/caregiver, including during community transitions.

Modality

- Individual face-to-face intervention
- Group face-to-face intervention (No more than three HCBS eligible children/youth enrolled may attend a group activity at the same time)

Setting

Allowable settings in compliance with Medicaid regulations and the Home and Community Based Settings Final Rule (§441.301(c)(4) and §441.710) (see Appendix B) will exhibit characteristics and qualities most often articulated by the individual child/youth and family/caregiver as key determinants of independence and community integration. Services should be offered in the setting least restrictive for desired outcomes, including the most integrated home or other community based settings where the beneficiary lives, works, engages in services, and/or socializes. While remaining inclusive of those in the family and caregiver network, family is broadly defined, and can include families created through: birth, foster care, adoption, or a self-created unit.

Limitations/Exclusions

- This service may be provided in group settings but to no more than 12 participants (enrollees and collaterals). No more than three HCBS eligible children/youth may attend a group activity at the same time.
- This service cannot be delivered nor billed while an enrolled child is in an ineligible setting, including hospitalization.
- Special education and related services that is otherwise available to the individual through a local educational agency, under the provisions of the Individuals with Disabilities Education Act (IDEA).
- Community Self-Advocacy Training and Supports are limited to three hours a day.

Certification/Provider Qualifications

Provider Agency Qualifications

Practitioners must operate in agencies that have been designated through the NYS Children's Provider Designation Review Team. This requires agencies have appropriate license, certification and/or approval in accordance with State designation requirements.

- Provider agencies and practitioners must adhere to all Medicaid requirements in this manual and in other applicable provider manuals, regulations, and statutes.
- Provider agencies must adhere to cultural competency guidelines.
- Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
- The provider agency must ensure that staff receive Mandated Reporting training which is provided throughout New York State and Personal Safety in the Community training prior to service delivery.
- The provider agency must ensure that practitioners maintain the licensure necessary to provide services under their scope of practice under State law, if applicable.
- The provider agency must ensure that any insurance required by the designating state agency is obtained and maintained.
- The provider agency must ensure that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.

Additional information and application for Children's SPA/HCBS can be found on the DOH website:

https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/provider_design.htm

Individual Staff Qualifications

- **Preferred Qualifications:** An individual employed by the agency with a Master's degree in education, or a Master's degree in a human services field plus one year of applicable experience
- **Minimum Qualifications:** An individual employed by the agency with a bachelor's degree plus two years of related experience

Supervisor Qualifications

- **Minimum** qualifications of a Master's degree with one year of experience in human services working with children/youth
- **Preferred** two years of experience in human services working with children/youth

Training Requirements

Service Type	Trainings Required	Requirement Completion Timeframe
Community Self-Advocacy Training and Supports	<ul style="list-style-type: none"> Mandated Reporter 	<ul style="list-style-type: none"> Prior to Service Delivery
	<ul style="list-style-type: none"> Personal Safety/ Safety in the Community Strength Based Approaches Suicide Prevention Domestic Violence Signs and Basic Interventions Trauma Informed Care 	<ul style="list-style-type: none"> For staff hired before April 1, 2019, training must be completed within six (6) months of the 1915(c) Children's Waiver implementation. For staff hired on or after April 1, 2019, training must be completed within six (6) months of hire date.

Additional information regarding training requirements can be found in Appendix F.

NON-MEDICAL TRANSPORTATION

Definition

Non-Medical Transportation services are offered, in addition to any medical transportation furnished under the 42 CFR 440.17(a) in the State Plan. Non-Medical Transportation services are available for individuals to access authorized HCBS and destinations that are related to a goal included on the child/youth's POC.

Service Components

Examples where this service may be requested include transportation to: HCBS that a child/youth was determined eligible to receive, a job interview, college fair, a wellness seminar, a GED preparatory class, etc. This service will be provided to meet the child/youth's needs as determined by an assessment performed in accordance with the State's requirements and as outlined in the child/youth's POC.

The care manager must document a need for transportation to support an individual's identified goals. The Health Home Care Manager will include justification for this service within the Person-Centered POC. For individuals not enrolled in a Health Home, the Independent Entity or MCO Care Manager will be responsible for completing documentation of which goals in an individual's POC to which the trips will be tied. For each participant utilizing Non-Medical Transportation, the Transportation Manager will provide a monthly report of authorized trips to the State.

Limitations/Exclusions

Generally, the same rules used to determine reimbursement of trips to medical appointments should be followed when considering reimbursement of non-medical trips for eligible participants. Only those services not reimbursable under the Community First Choice Option (CFCO) State Medicaid Plan will be reimbursable under the HCBS Waiver.

The following guidelines apply to Non-Medical Transportation:

- **Transportation must be tied to a goal in the POC**
- Transportation is available for a specified duration
- Individuals receiving residential services are ineligible for Non-Medical Transportation
- Use transportation available free of charge
- Use the medically appropriate mode of transportation
- Travel within the common marketing area
- When possible, trips should be combined
- Justify need for travel outside the common marketing area

Vouchers submitted for personal vehicle mileage reimbursement must be submitted within 90 days of the date of service. Only when there are extenuating circumstances, will the Department allow payment for trips that are submitted after the 90-day time period. These requests will be considered on a case-by-case basis provided valid justification is given.

Reimbursement for travel can be denied when the destination does not support the participant's integration into the community.

A participant's POC outlines the general parameters of his or her Non-Medical Transportation needs. However, these needs can change or be amended based upon the participant's stated goals and/or successful ongoing integration into the community.

Certification/Provider Qualifications

Agencies interested in providing Non-Medical Transportation must be enrolled in the FFS program as a current Medicaid Transportation Provider. Please see the following links on information on Medicaid Transportation:

- Link to transportation provider manuals:
<https://www.emedny.org/ProviderManuals/Transportation/index.aspx>
- Link to transportation provider enrollment application:
<https://www.emedny.org/info/ProviderEnrollment/transportation/index.aspx>

Roles Related to a Participant's Access to Non-Medical Transportation

The following roles and guidelines serve to inform the Health Home Care Manager, Managed Care Organization (MCO), and the Transportation Manager of the procedures and rules surrounding an eligible participant's access to the Non-Medical Transportation benefit.

Health Home Care Manager Roles

Health Home Care Managers are responsible for conducting and developing the Person-Centered POC. If the care manager determines there is a need for

transportation to support an individual's identified goals, the Health Home Care Manager will include justification for this service within the Person-Centered POC. The Health Home Care Manager will complete the ***NYS DOH Plan of Care Grid for Non-Medical Transportation for Children's Home and Community Based Services (HCBS)*** (Grid)⁴ with all known information. It is possible that the complete trip destination details may not be known (e.g. exact appointment time and date). This information can be provided by the enrollee to the Transportation Manager upon request of transportation.

The CMA should at a minimum list the goal from the POC; specific activity, support, or task; provider of services (if applicable); start and end date. After completing the POC and the Grid, the Health Home Care Manager will send it to the MCO. If the child/youth is not yet in a plan the HH Care Manger will send the Grid directly to Department of Health's Medicaid Transportation Manager for review.

Managed Care Organization (MCO) Roles

The MCO is responsible for approving the Person-Centered POC and for forwarding the completed Grid to the Department of Health's Medicaid Transportation Manager.

For individuals not enrolled in a Health Home, the MCO will be responsible for completing the Grid based on the individual's POC and forwarding to the Transportation Manager. The Grid will include documentation for Non-Medical Transportation including documentation of which goals in an individual's POC the trips will be tied to.

The ***NYS DOH Plan of Care Grid for Non-Medical Transportation for Children's Home and Community Based Services (HCBS)*** is completed by the MCO based on the participant's POC and includes the following information:

- Participant information
- HCBS provider information
- Non-Medical Transportation service requested
- Supporting information includes:
 - Goal from the POC
 - HCBS or specific activity/support/task
 - Mode of transportation service needed
 - Trip destination/location
 - Start date/end date
 - Frequency

The MCO will forward the completed Grid with the Transportation Manager any time there are changes to this Grid.

⁴ The "NYS BH HCBS Transportation Grid" can be found at <https://www.emedny.org/ProviderManuals/Transportation/index.aspx>

Transportation Manager Roles

The Transportation Manager is responsible for authorizing transportation services in accordance with Medicaid policy, by approved Medicaid Transportation providers, and as supported on the MCO-provided Grid. Once the Grid is received from the MCO, the Transportation Manager should assume that the MCO has reviewed and approved the Non-Medical Transportation included in the individual's POC and that trips included in the Grid are appropriate. The Transportation Manager is responsible for ensuring adherence to the guidelines below for Non-Medical Transportation, which include assigning the most medically appropriate, cost-effective mode of transportation. Enrollees have freedom of choice regarding the transportation provider within the assigned mode (e.g. ambulette, taxi, public transportation, etc.).

Contact Information for Transportation Managers

NYC & Upstate: Medical Answering Services (MAS)

<https://www.medanswering.com/>

<https://www.medanswering.com/enrollee/enrollee-forms-resources/>

https://www.medanswering.com/documents/Doc-MAS_Public_Site--2015-11-11-15-48-44.pdf

Fax number for submitting all forms: (315) 299-2786

Secure email: Harp-info@medanswering.com

(When sending completed Grids: "Attn: Non-Medical Transportation for Children's Home and Community Based Services (HCBS)")

Long Island: LogistiCare Solutions, LLC

<http://www.logisticare.com/>

<http://www.longislandmedicaidride.net/>

<http://www.longislandmedicaidride.net/Portals/51/DOH%20Mileage%20Reimbursement%20Forms-Logisticare.pdf?ver=2015-05-22-123216-000>

Fax number for submitting mileage reimbursement forms: (866) 528-0462

(When sending completed Grids: "Attn: Non-Medical Transportation for Children's Home and Community Based Services (HCBS)")

Additional Contact Information:

NYS Department of Health Transportation Unit: medtrans@health.ny.gov

NYS Office of Mental Health: omh.sm.co.HCBS-Application@omh.ny.gov

ADAPTIVE AND ASSISTIVE EQUIPMENT

Definition

This service provides technological aids and devices identified within the child's Plan of Care (POC) which enable him/her to accomplish daily living tasks that are necessary to support the health, welfare, and safety of the child.

Service Components

Adaptive and Assistive Equipment includes but not limited to: direct selection communicators, alphanumeric communicators, scanning communicators, encoding communicators, speech amplifiers, electronic speech aids/devices; voice activated, light activated, motion activated, and electronic devices; standing boards/frames and therapeutic equipment for the purpose of maintaining or improving the participant's strength, mobility, or flexibility to perform activities of daily living; adaptive switches/devices, meal preparation and eating aids/devices/appliances, specially adapted locks, motorized wheelchairs; guide dogs, hearing dogs, service dogs (as defined in New York Civil Rights Law Article 47-b(4)), and simian aides (capuchin monkeys or other trained simians that perform tasks for persons with limited mobility); electronic, wireless, solar-powered, or other energy powered devices that demonstrate to the satisfaction of the commissioner, or designee, that the device(s) will significantly enable the participant to live, work, or meaningfully participate in the community with less reliance on paid staff supervision or assistance. Such devices may include computers, observation cameras, sensors, telecommunication screens, and/or telephones and/or other, telecare support services/systems that enable the participant to interact with remote staff to ensure health and safety. Such devices cannot be used for surveillance, but to support the person to live with greater independence including devices to assist with medication administration, including tele-care devices that prompt, teach, or otherwise assist the participant to independently self-administer medication routinely, portable generators necessary to support equipment, or devices needed for the health or safety of the person including stretcher stations.

Adaptive and Assistive Equipment Services include:

- Evaluation of the assistive technology needs of a participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant
- Services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for the participants
- Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices
- Training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant

- Training or technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of participants

Limitations/Exclusions

The adaptive and assistive equipment available through the HCBS authorities including both CFCO and the HCBS authorities cannot duplicate equipment otherwise available through the Medicaid State Plan under 1905(a) of the Social Security Act or other federal/state funding streams. Equipment must be beyond the scope of Durable Medical Equipment (DME). Only those services not reimbursable under the Community First Choice Option (CFCO) State Medicaid Plan will be reimbursable under the HCBS Waiver.

Adaptive Devices are expected to be a one-time only purchase. Replacements, repairs, upgrades, or enhancements made to existing equipment will be paid if documented as a necessity and approved by the State or its designee. Ongoing monitoring associated with telecare support services or other approved systems authorized under this definition may be provided if necessary for health and safety and documented to the satisfaction of the State or designee. The HHCM, IE or MCO care manager will ensure, that where appropriate, justification from physicians, or other specialists or clinicians has been obtained.

Warranties, repairs, or maintenance on assistive technology only when most cost effective and efficient means to meet the need and are not available through the Medicaid State Plan 1905(a), CFCO, or third-party resources

Cost Limits

All Adaptive and Assistive Equipment costs require prior approval from the LDSS in conjunction with NYSDOH or the MCO. Adaptive and Assistive Equipment is subject to a \$15,000 per calendar year soft limit. The State may consider exceptions when medically necessary, including but not limited to a significant change in the child's needs or capabilities.

Certification/ Provider Qualifications

For Adaptive and Assistive Equipment, the LDSS (for FFS enrollees) or MCO (for managed care enrollees) is the provider of record for billing purposes using the standard bidding process. Services are only billed to Medicaid once the equipment is procured and the amount billed is equal to the purchased value.

LDSS or MCO secures a local vendor qualified to complete the required work.

Health Home Care Managers/C-YES Coordinators will assist in determining the need for the service, identify the expected benefit to the child, the clinical justification (scope of the work), Securing bids and facilitating the completion of the Final Cost Form.

Standard provisions of the NYS Finance Law and procurement policies must be followed to ensure that vendors are qualified, and that State required bidding procedures have been followed. Services are only billed to Medicaid or the MCO once the equipment is verified as received and the amount billed is equal to the contract value.

LDSS or MCO staff verify the qualifications of Adaptive and Assistive Equipment vendor:

- Must be familiar with the Adaptive and Assistive Equipment policies permitted in the waiver program as described in the program manual; the LDSS or MCO should supply the evaluator with a copy of both prior to initiation of the evaluation.
- Must be able to communicate well with all parties involved with the purchase of the equipment and any training needed, e.g. consumers, contractors, and local government officials.
- Must be able to clearly describe in writing, and by design, the proposed purchase. Must have knowledge of assistive technology and specific adaptive equipment appropriate for the child's needs

LDSS in conjunction with NYSDOH or the MCO will determine the most cost effective service that will meet the child's needs.

VEHICLE MODIFICATIONS

Definition

Under this benefit, Vehicle Modifications are allowable (formerly called Home and Vehicle Modifications). This service provides physical adaptations to the primary vehicle of the enrolled child which, per the child's plan of care (POC), are identified as necessary to support the health, welfare, and safety of the child or that enable the child to function with greater independence.

Service Components

Modifications include but are not limited to: portable electric/hydraulic and manual lifts, ramps, foot controls, wheelchair lock downs, deep dish steering wheel, spinner knobs, hand controls, parking break extension, replacement of roof with fiberglass top, floor cut outs, extension of steering wheel column, raised door, repositioning of seats, wheelchair floor, dashboard adaptations and other ancillary equipment or modifications necessary to guarantee full access to, and safety in, a motor vehicle. The LDSS (for FFS enrollees) or MCO (for managed care enrollees) secures a local contractor and/or

evaluator qualified to complete the required work. In the case of vehicle modifications, the evaluators and modifiers are approved by the NYS Education Department's Adult Career and Continuing Education Services Rehabilitation (ACCES-VR).

Activities include and are not limited to: determining the need for the service, the safety of the proposed modification, its expected benefit to the child, and the most cost effective approach to fulfill the child's need. In FFS, the LDSS is the provider of record for Vehicle Modifications for billing purposes. The work is done by a contractor who is selected by the LDSS in conjunction with NYSDOH (for FFS) through a standard bid process, following the rules established by the Office of the State Comptroller. Standard provisions of the NYS Finance Law and procurement policies must be followed to ensure that contractors are qualified and that State required bidding procedures have been followed. In managed care, the plan is the payer and may contract with an approved network provider for the service. Services are only billed to Medicaid or the MCO once the contract work is verified as complete and the amount billed is equal to the contract value. Vehicle Modifications are limited to the primary vehicle of the recipient.

Note: This service does not duplicate other services available through the New York Medicaid State Plan. All services require prior authorization by the MCO or the LDSS in conjunction with NYSDOH.

Limitations/Exclusions

Other exclusions include the purchase, installation, or maintenance of items such as cellular phones, global positioning/tracking devices, or other mobile communication devices; repair or replacement of modified equipment damaged or destroyed in an accident; alarm systems; auto loan payments; insurance coverage; costs related to obtaining a driver's license, title/registration, license plates, emergency road service, or rental vehicles when a vehicle modification is in process.

Repair & Replacement of Modification

In most instances a specific type of Vehicle Modification is a one-time benefit to motor vehicles used by the child. However, in reasonable circumstances determined and approved by the State, a second modification may be considered for funding if the current modifications are in need of repair, worn-out, or unsafe. Replacements, repairs, upgrades, or enhancements made to existing equipment will be paid if documented as a necessity. In addition, when the modification must be replaced or repaired, a depreciation schedule will be used to determine the limit of the amount to be applied to the cost.

Vehicle Modifications are limited to the primary means of transportation for the child. The vehicle may be owned by the child or by a family member or non-relative who provides primary, consistent, and ongoing transportation for the child. All equipment and

technology used for entertainment is prohibited. Costs may not exceed current market value of vehicle.

Modification Limits

Only those services not reimbursable under the Community First Choice Option (CFCO) State Medicaid Plan, Medicaid State Plan under 1905(a) of the Social Security Act, or other federal/state funding streams will be reimbursable under the HCBS Waiver.

Contracts for Vehicle modifications may not exceed \$15,000 per calendar year without prior approval from the LDSS in conjunction with NYS DOH or the MCO. The State may consider exceptions when medically necessary, including but not limited to a significant change in the child's needs or capabilities.

Certification/Provider Qualifications

Modification Contractor / Craftsman with licensure appropriate to the trade.

LDSS or MCO staff verify the qualifications of vehicle modification providers present the following knowledge and skills:

- Must be familiar with the vehicle modification policies permitted in the waiver program as described in state guidance; the LDSS/HRA/MCO should supply the evaluator with a copy of both prior to initiation of the evaluation.
- Must be able to communicate well with all parties involved with the development of vehicle modifications, e.g. consumers, contractors, and local government officials.
- Must be able to clearly describe in writing, and by design, the proposed vehicle modification.
- Must know and be able to apply the New York State Building Code, Current Accessibility Standards, and the Federal Accessibility Guidelines found in the Fair Housing Amendment Act (as relevant to any vehicle modification).
- Must have knowledge of assistive technology and specific adaptive equipment appropriate for the child's needs.
- Must have skill in design/drafting in order to clearly describe the proposed modification.
- Must be able to complete all components of an On-Site Evaluation.

Contractors performing any adaptation for a child in the waiver program is required to:

- Be bonded
- Maintain adequate and appropriate licensure
- The ACCES-VR agency verifies the credential of vehicle modification providers pursuant to NYF Fire Prevention and Billing Codes, 00 OMM/ADM 4

Provider qualifications are verified at the beginning of the vehicle modification contract by ACCESVR.

ENVIRONMENTAL MODIFICATIONS

Definition

Environmental Modifications provides internal and external physical adaptations to the home or other eligible residences of the enrolled child which, per the child's plan of care (POC), are identified as necessary to support the health, welfare, and safety of the child or that enable the child to function with greater independence in the home and without which the child would require an institutional and/or more restrictive living setting.

Service Components

Modifications include but are not limited to: installation of ramps, hand rails, and grab-bars; widening of doorways (but not hallways); modifications of bathroom facilities; installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies needed for the welfare of the recipient; lifts and related equipment; elevators when no feasible alternative is available; automatic or manual door openers/bells; modifications of the kitchen necessary for the participant to function more independently in his/her home; medically necessary air conditioning; Braille identification systems; tactile orientation systems; bed shaker alarm devices; strobe light smoke detection and alarm devices; small area drive-way paving for wheel-chair entrance/egress from van to home; safe environment modifications for behaviorally challenged participants require the prior review of a behavioral specialist and include window protections, reinforcement of walls, durable wall finishes, open-door signal devices, fencing, video monitoring systems, and shatter-proof shower doors; and future technology devices that allow the participant to live more safely and independently to avoid possible institutional placement or placement in a more restrictive living environment, which are available at a reasonable cost in comparison to living in a more restrictive residential setting. The scope of environmental modifications will also include necessary assessments to determine the types of modifications needed.

Note: This service does not duplicate other services available through the New York Medicaid State Plan. All services require prior authorization by the LDSS in conjunction with NYSDOH if exceeding established limits or MCO.

Limitations/Exclusions

Excluded are those adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the child. Adaptations that add to the total square footage of the home's footprint are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair). Also excluded are

pools and hot tubs and associated modifications for entering or exiting the pool or hot tub.

Repair & Replacement of Modification

In most instances, a specific type of Environmental Modification is a one-time benefit. However, in reasonable circumstances determined and approved by the State, a second modification may be considered for funding as follows: if a person moves to another home; if the current modifications are in need of repair, worn-out, or unsafe; or if a participant wishes to spend considerable time with a non-cohabitating parent in their home and such modifications are required to ensure health and safety during these periods.

State policy places certain limitations on environmental modifications requested when the home/apartment is a leased space, including property owner sign-off on the modification and limitations on federal/state liability for the cost of removal/replacement/repair of items in public spaces of rental properties.

Modification Limits

Only those services not reimbursable under the Community First Choice Option (CFCO) State Medicaid Plan, Medicaid State Plan under 1905(a) of the Social Security Act, or other federal/state funding streams will be reimbursable under the HCBS Waiver.

All Environmental modifications require prior approval from the LDSS in conjunction with NYS DOH or the MCO. For Environmental Modifications, the LDSS or MCO is the provider of record for billing purposes. Contracts for Environmental Modifications may not exceed \$15,000 per calendar year. The State may consider exceptions when medically necessary, including but not limited to a significant change in the child's needs or capabilities.

Note: This service does not duplicate other services available through the New York Medicaid State Plan. All services require prior authorization by the LDSS in conjunction with NYSDOH if exceeding established limits or MCO.

Certification/Provider Qualifications

Environmental Modification Contractor / Craftsman with licensure appropriate to trade.

LDSS or MCO staff verify the qualifications of home modification providers present the following knowledge and skills:

- Must be familiar with the home adaptation policies permitted in the waiver program as described in state guidance; the LDSS/HRA/MCO should supply the evaluator with a copy of both prior to initiation of the evaluation.
- Must be able to communicate well with all parties involved with the development of home adaptations, e.g. consumers, contractors, and local government officials.

- Must be able to clearly describe in writing, and by design, the proposed home adaptation.
- Must know and be able to apply the New York State Building Code, Current Accessibility Standards, and the Federal Accessibility Guidelines found in the Fair Housing Amendment Act (as applicable to the home modification).
- Must have knowledge of assistive technology and specific adaptive equipment appropriate for the child's needs.
- Must have skill in design/drafting in order to clearly describe the proposed modification.
- Must be able to complete all components of an On-Site Evaluation.

Contractors performing any adaptation for a child in the waiver program is required to:

- Be bonded
- Maintain adequate and appropriate licensure
- Obtain any and all permits required by state and local municipality codes for the modification
- Agree that before final payment is made the contractor must show that the local municipal branch of government that issued the initial permit has inspected the work

Provider qualifications are verified at the beginning of the home modification contract by the LDSS/MCO.

PALLIATIVE CARE – EXPRESSIVE THERAPY

Definition

Palliative care is specialized medical care focused on providing relief from the symptoms and stress of a chronic condition or life-threatening illness. The goal is to improve quality of life for both the child and the family. Palliative care is provided by a specially-trained team of doctors, nurses, social workers, and other specialists who work together with a child's doctors to provide an extra layer of support. It is appropriate at any stage of a chronic condition or life-threatening illness and can be provided along with curative treatment.

Children must meet LOC functional criteria and suffer from the symptoms and stress of chronic medical conditions **OR** illnesses that put individuals at risk for death before age 21.

The Health Home Care manager or C-YES will assist the family with obtaining a Doctor's written order including justification for Expressive Therapy from a Physician, Physician Assistant, Nurse Practitioner, Occupational Therapist, Physical Therapist or Psychiatrist, be included with the child/youth's POC and made available to the Managed care plan as needed.

Expressive Therapy (art, music, and play) helps children better understand and express their reactions through creative and kinesthetic treatment.

Expressive therapy helps children to feel empowered in their own creativity, control, and aid in their communication of their feelings when their life and body may be rapidly changing during the stressful time of undergoing a chronic condition and/or life-threatening illness and the trauma that often comes with its treatment. Whether through music, art, and/or play therapy, the child may find an outlet that allows them to express their emotions safely and have a medium where they have complete control to play and explore with abandon. The family can participate as well, whether in the form of memories shared together or by tangible objects made by their child they can hold onto - scrapbooks, paintings, or sculpture - mementos that tell their child's life from their perspective and aid in their family's own journey of grief and loss.

Service Components

- **Expressive Therapy (art, music and play)** helps children better understand and express their reactions through creative and kinesthetic treatment.

Modality

- **Expressive Therapy (art, music and play)** – 1:1

Setting

Allowable settings in compliance with Medicaid regulations and the Home and Community Based Settings Final Rule (§441.301(c)(4) and §441.710) (see appendix B) will exhibit characteristics and qualities most often articulated by the individual child/youth and family/caregiver as key determinants of independence and community integration. Services should be offered in the setting least restrictive for desired outcomes, including the most integrated home or other community based settings where the beneficiary lives, works, engages in services, and/or socializes. While remaining inclusive of those in the family and caregiver network, family is broadly defined, and can include families created through: birth, foster care, adoption, or a self-created unit.

Limitations/Exclusions

Palliative care benefits may not duplicate Hospice or other State Plan benefits accessible to participants.

Limited to the lesser of four appointments per month or 48 units per calendar year. This limit can be exceeded when medically necessary.

Certification/Provider Qualifications

Provider Agency Qualifications

Certified Home Health Agency (CHHA), Hospice Organization or Article 28 Clinic

NOTE: For all staff providing Palliative Care Services, it is expected that they will have a minimum of three years working with the medically fragile population and at least one year of clinical experience with pediatric population, preferably involving end of life care.

Expressive Therapy (art, music, and play): Child Life Specialist with certification through the Child Life Council. A Creative Arts Therapist licensed by the State of New York, a Music Therapist with a Bachelor's Degree from a program recognized by the NYS Education Department, a Play Therapist with a Master's Degree from a program recognized by the New York State Education Department and a current Play Therapist Registration conferred by the Association for Play Therapy (Expressive Therapy (Art, Music, and Play)). Direct service workers must have background checks.

Practitioners must operate in agencies which have been designated through the NYS Children's Provider Designation Review Team. This requires agencies have appropriate license, certification, and/or approval in accordance with State designation requirements.

- Provider agencies and practitioners adhere to all Medicaid requirements in this manual and in other applicable provider manuals, regulations, and statutes.
- Provider agencies adhere to cultural competency guidelines
- Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
- The provider agency ensures that staff receive Mandated Reporting training which is provided throughout New York State and Personal Safety in the Community training prior to service delivery.
- The provider agency ensures that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable.
- The provider agency ensures that any insurance required by the designating state agency is obtained and maintained.
- The provider agency ensures that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.

Additional information and application for Children's SPA/HCBS can be found on the DOH website:

https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/provider_design.htm

Training Requirements

Service Type	Trainings Required	Requirement Completion Timeframe
Palliative Care	<ul style="list-style-type: none"> Mandated Reporter 	<ul style="list-style-type: none"> Prior to Service Delivery
	<ul style="list-style-type: none"> Personal Safety/ Safety in the Community Strength Based Approaches Suicide Prevention Domestic Violence Signs and Basic Interventions Trauma Informed Care 	<ul style="list-style-type: none"> For staff hired before April 1, 2019, training must be completed within six (6) months of the 1915(c) Children's Waiver implementation. For staff hired on or after April 1, 2019, training must be completed within six (6) months of hire date.

Additional information regarding training requirements can be found in Appendix F.

PALLIATIVE CARE – MASSAGE THERAPY

Definition

Palliative care is specialized medical care focused on providing relief from the symptoms and stress of a chronic condition or life-threatening illness. The goal is to improve quality of life for both the child and the family. Palliative care is provided by a specially-trained team of doctors, nurses, social workers, and other specialists who work together with a child's doctors to provide an extra layer of support. It is appropriate at any stage of a chronic condition or life-threatening illness and can be provided along with curative treatment.

Children must meet LOC functional criteria and suffer from the symptoms and stress of chronic medical conditions OR illnesses that put individuals at risk for death before age 21.

The Health Home Care manager or C-YES will assist the family with obtaining a Doctor's written order including justification for Massage Therapy from a Physician, Physician Assistant, Nurse Practitioner, Occupational Therapist, Physical Therapist or Psychiatrist, be included with the child/youth's POC and made available to the Managed care plan as needed.

Massage Therapy: To improve muscle tone, circulation, range of motion, and address physical symptoms related to illness as well as provide physical and emotional comfort, pain management, and restore the idea of healthy touch for children and youth who are dealing with treatments that may involve painful interventions and ongoing and/or past trauma.

Service Components

Massage Therapy – To improve muscle tone, circulation, range of motion and address physical symptoms related to their illness.

Modality

- **Massage Therapy** – 1:1

Setting

Allowable settings in compliance with Medicaid regulations and the Home and Community Based Settings Final Rule (§441.301(c)(4) and §441.710) (see appendix B) will exhibit characteristics and qualities most often articulated by the individual child/youth and family/caregiver as key determinants of independence and community integration. Services should be offered in the setting least restrictive for desired outcomes, including the most integrated home or other community based settings where the beneficiary lives, works, engages in services, and/or socializes. While remaining inclusive of those in the family and caregiver network, family is broadly defined, and can include families created through: birth, foster care, adoption, or a self-created unit.

Limitations/Exclusions

Palliative care benefits may not duplicate Hospice or other State Plan benefits accessible to participants.

Limited to no more than 12 appointments per calendar year. This limit can be exceeded when medically necessary.

Certification/Provider Qualifications

Provider Agency Qualifications

Certified Home Health Agency (CHHA), Hospice Organization or Article 28 Clinic

NOTE: For all staff providing Palliative Care Services it is expected that they will have a minimum of three years working with the medically fragile population and at least one year of clinical experience with pediatric population, preferably involving end of life care.

Massage Therapy: Massage Therapist currently licensed by the State of New York. Direct service workers must have background checks. Practitioners must operate in agencies which have been designated through the NYS Children's Provider Designation Review Team. This requires agencies have appropriate license, certification, and/or approval in accordance with State designation requirements.

- Provider agencies and practitioners adhere to all Medicaid requirements in this manual and in other applicable provider manuals, regulations, and statutes.
- Provider agencies adhere to cultural competency guidelines
- Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
- The provider agency ensures that staff receive Mandated Reporting training which is provided throughout New York State and Personal Safety in the Community training prior to service delivery.
- The provider agency ensures that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable.
- The provider agency ensures that any insurance required by the designating state agency is obtained and maintained.
- The provider agency ensures that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.

Additional information and application for Children's SPA/HCBS can be found on the DOH website:

https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/provider_design.htm

Training Requirements

Service Type	Trainings Required	Requirement Completion Timeframe
Palliative Care	<ul style="list-style-type: none"> • Mandated Reporter 	<ul style="list-style-type: none"> • Prior to Service Delivery
	<ul style="list-style-type: none"> • Personal Safety/ Safety in the Community • Strength Based Approaches • Suicide Prevention • Domestic Violence Signs and Basic Interventions • Trauma Informed Care 	<ul style="list-style-type: none"> • For staff hired before April 1, 2019, training must be completed within six (6) months of the 1915(c) Children's Waiver implementation. • For staff hired on or after April 1, 2019, training must be completed within six (6) months of hire date.

Additional information regarding training requirements can be found in Appendix F.

PALLIATIVE CARE – BEREAVEMENT SERVICE

Definition

Palliative care is specialized medical care focused on providing relief from the symptoms and stress of a chronic condition or life-threatening illness. The goal is to

improve quality of life for both the child and the family. Palliative care is provided by a specially-trained team of doctors, nurses, social workers, and other specialists who work together with a child's doctors to provide an extra layer of support. It is appropriate at any stage of a chronic condition or life-threatening illness and can be provided along with curative treatment.

Children must meet LOC functional criteria and suffer from the symptoms and stress of chronic medical conditions **OR** illnesses that put individuals at risk for death before age 21.

The Health Home Care manager or C-YES will assist the family with obtaining a Doctor's written order including justification for Bereavement Services from a Physician, Physician Assistant, Nurse Practitioner, Occupational Therapist, Physical Therapist or Psychiatrist, be included with the child/youth's POC and made available to the Managed care plan as needed.

Bereavement Service: Help for participants and their families to cope with grief related to the participant's end-of-life experience. Bereavement counseling services are inclusive for those participants in receipt of hospice care through a hospice provider.

Children and youth with chronic conditions and life-threatening illnesses and their families deal with grief and loss in a variety of ways and may need various kinds of support over time including counseling and support groups and other services. Bereavement counseling services are inclusive for those participants who are receiving services with a hospice care provider.

Service Components

Bereavement Service – Help for participants and their families to cope with grief related to the participant's end-of-life experience. Bereavement counseling services are inclusive for those participants in receipt of hospice care through a hospice provider.

Modality

- **Bereavement Service** 1:1 family eligible to participate

Setting

Allowable settings in compliance with Medicaid regulations and the Home and Community Based Settings Final Rule (§441.301(c)(4) and §441.710) (see appendix B) will exhibit characteristics and qualities most often articulated by the individual child/youth and family/caregiver as key determinants of independence and community integration. Services should be offered in the setting least restrictive for desired outcomes, including the most integrated home or other community based settings where the beneficiary lives, works, engages in services, and/or socializes. While remaining inclusive of those in the family and caregiver network, family is broadly

defined, and can include families created through: birth, foster care, adoption, or a self-created unit.

Limitations/Exclusions

Palliative care benefits may not duplicate Hospice or other State Plan benefits accessible to participants.

Limited to the lesser of 5 appointments per month or 60 hours per calendar year.

Certification/Provider Qualifications

Provider Agency Qualifications

Certified Home Health Agency (CHHA), Hospice Organization or Article 28 Clinic

NOTE: For all staff providing Palliative Care Services it is expected that they will have a minimum of three years working with the medically fragile population and at least one year of clinical experience with pediatric population, preferably involving end of life care.

Bereavement Service: A Licensed Clinical Social Worker (LCSW), a Licensed Master Social Worker (LMSW), a Licensed Psychologist, or a Licensed Mental Health Counselor, that meet current NYS licensing

Practitioners must operate in agencies which have been designated through the NYS Children's Provider Designation Review Team. This requires agencies have appropriate license, certification, and/or approval in accordance with State designation requirements.

- Provider agencies and practitioners adhere to all Medicaid requirements in this manual and in other applicable provider manuals, regulations, and statutes.
- Provider agencies adhere to cultural competency guidelines
- Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
- The provider agency ensures that staff receive Mandated Reporting training which is provided throughout New York State and Personal Safety in the Community training prior to service delivery.
- The provider agency ensures that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable.
- The provider agency ensures that any insurance required by the designating state agency is obtained and maintained.
- The provider agency ensures that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.

Additional information and application for Children's SPA/HCBS can be found on the DOH website:

https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/provider_design.htm

Training Requirements

Service Type	Trainings Required	Requirement Completion Timeframe
Palliative Care	<ul style="list-style-type: none"> Mandated Reporter 	<ul style="list-style-type: none"> Prior to Service Delivery
	<ul style="list-style-type: none"> Personal Safety/ Safety in the Community Strength Based Approaches Suicide Prevention Domestic Violence Signs and Basic Interventions Trauma Informed Care 	<ul style="list-style-type: none"> For staff hired before April 1, 2019, training must be completed within six (6) months of the 1915(c) Children's Waiver implementation. For staff hired on or after April 1, 2019, training must be completed within six (6) months of hire date.

Additional information regarding training requirements can be found in Appendix F.

PALLIATIVE CARE – PAIN AND SYMPTOM MANAGEMENT

Definition

Palliative care is specialized medical care focused on providing relief from the symptoms and stress of a chronic condition or life-threatening illness. The goal is to improve quality of life for both the child and the family. Palliative care is provided by a specially-trained team of doctors, nurses, social workers, and other specialists who work together with a child's doctors to provide an extra layer of support. It is appropriate at any stage of a chronic condition or life-threatening illness and can be provided along with curative treatment.

Children must meet LOC functional criteria and suffer from the symptoms and stress of chronic medical conditions **OR** illnesses that put individuals at risk for death before age 21.

The Health Home Care manager or C-YES will assist the family with obtaining a Doctor's written order including justification for Pain and Symptom Management from a Physician, to be included with the child/youth's POC and made available to the Managed care plan as needed.

Pain and Symptom Management: Relief and/or control of the child's suffering related to their illness or condition.

Pain and symptom management is an important part of aiding in providing relief from pain and symptoms and/or controlling pain, symptoms, and side effects related to chronic conditions or life-threatening illness a child is enduring. This management is not only an important part of humanely caring for the child's pain and suffering but helping the child and family cope and preserve their quality of life at a difficult time.

Service Components

Pain and Symptom Management – Relief and/or control of the child's suffering related to their illness or condition.

Modality

- **Pain and Symptom management** – 1:1

Setting

Allowable settings in compliance with Medicaid regulations and the Home and Community Based Settings Final Rule (§441.301(c)(4) and §441.710) (see appendix B) will exhibit characteristics and qualities most often articulated by the individual child/youth and family/caregiver as key determinants of independence and community integration. Services should be offered in the setting least restrictive for desired outcomes, including the most integrated home or other community based settings where the beneficiary lives, works, engages in services, and/or socializes. While remaining inclusive of those in the family and caregiver network, family is broadly defined, and can include families created through: birth, foster care, adoption, or a self-created unit.

Limitations/Exclusions

Palliative care benefits may not duplicate Hospice or other State Plan benefits accessible to participants.

Certification/Provider Qualifications

Provider Agency Qualifications

Certified Home Health Agency (CHHA), Hospice Organization or Article 28 Clinic

NOTE: For all staff providing Palliative Care Services it is expected that they will have a minimum of three years working with the medically fragile population and at least one year of clinical experience with pediatric population, preferably involving end of life care.

Pain and Symptom Management: Pediatrician or Family Medicine Physician, board certified in Pediatrics or Family Medicine licensed by the State of New York, a Nurse Practitioner licensed by the State of New York (Pain and Symptom Management).

Practitioners must operate in agencies which have been designated through the NYS Children’s Provider Designation Review Team. This requires agencies have appropriate license, certification, and/or approval in accordance with State designation requirements.

- Provider agencies and practitioners adhere to all Medicaid requirements in this manual and in other applicable provider manuals, regulations, and statutes.
- Provider agencies adhere to cultural competency guidelines
- Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
- The provider agency ensures that staff receive Mandated Reporting training which is provided throughout New York State and Personal Safety in the Community training prior to service delivery.
- The provider agency ensures that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable.
- The provider agency ensures that any insurance required by the designating state agency is obtained and maintained.
- The provider agency ensures that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.

Additional information and application for Children’s SPA/HCBS can be found on the DOH website:

https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/provider_design.htm

Training Requirements

Service Type	Trainings Required	Requirement Completion Timeframe
Palliative Care	<ul style="list-style-type: none"> • Mandated Reporter 	<ul style="list-style-type: none"> • Prior to Service Delivery
	<ul style="list-style-type: none"> • Personal Safety/ Safety in the Community • Strength Based Approaches • Suicide Prevention • Domestic Violence Signs and Basic Interventions • Trauma Informed Care 	<ul style="list-style-type: none"> • For staff hired before April 1, 2019, training must be completed within six (6) months of the 1915(c) Children’s Waiver implementation. • For staff hired on or after April 1, 2019, training must be completed within six (6) months of hire date.

Additional information regarding training requirements can be found in Appendix F.

FAMILY PEER SUPPORTS SERVICES

Effective 7/1/2019 Family Peer Supports Services (FPSS) will be available as a Children and Family Treatment and Support Service. Additional information can be found in the Children and Family Treatment and Support Services (CFTSS) Provider manual, Utilization Management, Standards of Care, a glossary of CFTSS terms, Knowledge Base Skills/Recommendations, Staffing Guidelines, and Cultural Competency and Language Access [here](#).

YOUTH PEER SUPPORTS

Effective 1/1/2020 Youth Peer Support and Training (YPST) will be available as a Children and Family Treatment and Support Service. Additional information can be found in the Children and Family Treatment and Support Services (CFTSS) Provider manual, Utilization Management, Standards of Care, a glossary of CFTSS terms, Knowledge Base Skills/Recommendations, Staffing Guidelines, and Cultural Competency and Language Access [here](#).

CRISIS INTERVENTION

Effective 1/1/2020 Crisis Intervention (CI) will be available as a Children and Family Treatment and Support Service. Additional information can be found in the Children and Family Treatment and Support Services (CFTSS) Provider manual, Utilization Management, Standards of Care, a glossary of CFTSS terms, Knowledge Base Skills/Recommendations, Staffing Guidelines, and Cultural Competency and Language Access [here](#).

APPENDICES

APPENDIX A: GLOSSARY OF KEY TERMS

Care Team or Multi-disciplinary Team: Are the providers, identified family supports, family members, managed care plan and other individuals or entities that the child/youth or family identified to be involved in the care coordination and service provision development.

Child/Children: Throughout this document, the term "child" or "children" refers to a child/youth under age 21.

Children and Youth Evaluation Service (C-YES): C-YES is the State-designated Independent Entity which conducts HCBS/Level of Care (LOC) eligibility determinations and provides Medicaid application assistance for children who are eligible for HCBS not yet enrolled in Medicaid. C-YES also develops an HCBS POC, refers eligible children for HCBS and monitors access to care for children who opt out of Health Home care management.

Cultural Competency: Is defined as attributes of a behavioral healthcare organization that describe the set of congruent behaviors, attitudes, skills, policies, and procedures that are promoted and endorsed to enable caregivers at all levels of the organization to work effectively and efficiently with persons and communities of all cultural backgrounds. An important element of cultural competence is the capacity to overcome structural barriers in healthcare delivery that sustain health and healthcare disparities across cultural groups.

Developmental Disability: Section 1.03(22) of the New York State Mental Hygiene Law is the legal base for eligibility determination and defines Developmental Disability as: A disability of a person that: (a)(1) Is attributable to an intellectual disability cerebral palsy, epilepsy, neurological impairment, familial dysautonomia, Prader-Willi syndrome or autism; (2) Is attributable to any other condition of a person found to be closely related to an intellectual disability because such condition results in similar impairment of general intellectual functioning or adaptive behavior to that of intellectually disabled persons or requires treatment and services similar to those required for such persons; or (3) Is attributable to dyslexia resulting from a disability described in (1) or (2); (b) Originates before such person attains age twenty-two; (c) Has continued or can be expected to continue indefinitely; and (d) Constitutes a substantial handicap to such person's ability to function normally in society.

Duration: Describes how long the service will be delivered to the child and/or family. The duration of the service should correspond to the abilities of the child/family and be reflective of the billing unit identified by service.

Evidence-Based: Services must utilize evidence-based practices where appropriate and provide or enable continuing education activities to promote uptake of these practices.

Family: Family is defined as the primary caregiving unit and is inclusive of the wide diversity of primary caregiving units in our culture. Family is a birth, foster, adoptive, or self-created unit of people residing together, with significant attachment to the individual, consisting of adult(s) and/or child(ren), with adult(s) performing duties of parenthood/caregiving for the child(ren) even if the individual is living outside of the home.

“Family of One”: A commonly used phrase to describe a child that becomes eligible for Medicaid through use of institutional eligibility rules for certain medically needy individuals. These rules allow a budgeting methodology for children to meet Medicaid financial eligibility criteria as a “family of one,” using the child’s own income and disregarding parental income.

Frequency: Outlines how often the service will be offered to the child and/or family. Services may be delivered on a weekly, biweekly or monthly basis, according to the needs of the child and family.

HCBS/LOC Eligibility Determination: is a tiered assessment where multiple factors must be met for child’s HCBS/LOC eligibility to be determined. To access Children’s HCBS, a child must meet target population, risk factors, and functional criteria as described in the Children’s Waiver. The HCBS/LOC Eligibility Determination is housed within the Uniform Assessment System (UAS).

Health Home (HH): Means New York State designated Health Home Serving Children

Home or Community Setting: Home setting or community setting means the setting in which children primarily reside or spend time, as long as it is not a hospital nursing facility, Intermediate Care Facility (ICF), or psychiatric nursing facility. Note: this is distinguished from a Home and Community based setting.

Licensed Practitioner of the Healing Arts: An individual professional who is a Licensed psychoanalyst, Licensed psychologist, Licensed Clinical Social Worker, Nurse Practitioner, Physician, Physician Assistant or Psychologist and practicing within the scope of their State license. LPHAs who sign off on the HCBS Attestation form must be able to diagnose within their scope of practice.

- a. **Licensed Psychologist** is an individual who is currently licensed and currently registered as a psychologist by the New York State Education Department from the New York State Education Department and who possesses a doctoral degree in psychology.

- b. **Licensed Clinical Social Worker (LCSW)** is an individual who is currently licensed and registered as a Clinical Social Worker by the New York State Education Department.
- c. **Nurse Practitioner** is an individual who is currently certified as a nurse practitioner by the New York State Education Department.
- d. **Physician** is an individual who is licensed and currently registered as a physician by the New York State Education Department.
- e. **Physician Assistant** is an individual who is currently registered as a physician assistant by the New York State Education Department.
- f. **Psychiatrist** is an individual who is licensed and currently registered to practice medicine in New York State, who (i) is a diplomat of the American Board of Psychiatry and Neurology or is eligible to be certified by that Board, or (ii) is certified by the American Osteopathic Board of Neurology and Psychiatry or is eligible to be certified by that Board.

Institutionalization: Admission to a hospital (medical or psychiatric), RTF, ICF/IID or nursing facility

Integrated: Success for children requires both integrated and effective treatment. Initial and on-going collaboration between providers and natural supports is fundamental to enhancing resiliency, meeting the imperatives of developmental stages, and promoting wellness for each child and their family.

Licensed Occupational Therapist: is an individual who is licensed and currently registered as an Occupational Therapist by the New York State Education Department

Medicaid Eligible Child: Any child in New York State who is eligible for Medicaid, whether eligible via income consideration, medically needy definitions or categorical eligibility (e.g., foster care).

Medicaid Managed Care Plan (MMCP): Means the mainstream Medicaid Managed Care Plan or HIV Special Needs Plan in which the child is enrolled on the date of service, or which the child has selected for enrollment and has provided written consent to share protected health information with prior to enrollment.

Medically Fragile: For the purposes of this manual and Children's HCBS a "medically fragile child" is defined as an individual who is under 21 years of age whose target population, risk factors, and functional criteria align with the Medically Fragile or Medically Fragile and DD LOC criteria.

Multisystem involved: two or more child systems including child welfare, juvenile justice, Department of Homeless Services and/or other homeless services, OASAS clinics or residential treatment facilities or institutions, OMH clinics or residential facilities or institutions, OPWDD services or residential facilities or institutions, or having an established IEP through the school district.

Natural Supports: Natural supports are individuals and informal resources that a family/caregiver can access, independent of formal services. These supports are a significant source of culturally relevant emotional support and caring friendships for children and families. Natural supports can be short-term or long-term and are usually sustainable and available to the child and family/caregiver after formal services have ended.

Out of Home placement: Residential Rehabilitation Services for Youth (RRSY), Residential Treatment Facility (RTF), Residential Treatment Center (RTC), or other congregate care setting, such as SUD residential treatment facilities, group residencies, institutions in the OCFS system or hospitalization.

Parent, guardian, or legally authorized representative: Are the individuals who have custody/guardianship of the child and who are able to consent to the child's services, when the child is not of age to self-consent or does not have the mental capacity to self-consent to services. (Children who are 18 years or older or under the age of 18 years old who are pregnant, married, or a parent can self-consent for the Health Home, CYES and HCBS).⁵

Note: When developing the POC, foster parents are encouraged to provide input. The final signature for the POC needs to be signed by the child/parent/guardian/legally authorized representative.

Person-Centered Care: Services should reflect a child and family's goals and emphasize shared decision-making approaches that empower families, provide choice, and minimize stigma. Services should be designed to optimally treat illness, improve clinical and psychosocial outcomes, and emphasize wellness and attention to the family's overall well-being and the child's full community inclusion. To be person-centered, services must be culturally appropriate, child/youth guided, and relevant.

Physical Disability: "Disability" under Social Security is based on one's inability to work. A person is considered disabled under Social Security rules if: they cannot do work that s/he did before; SSA decides that s/he cannot adjust to other work because of his/her medical condition(s); and his/her disability has lasted or is expected to last for at least one year or to result in death.

⁵ This guidance does not change or modify the applicability of any law, regulation, or court order regarding custody, guardianship, right to consent to health care, or right to protected health information.

Recovery-Oriented: Services should be provided based on the principle that all individuals have the capacity to recover from mental illness and/or substance use disorders. Specifically, services should support the acquisition of living, vocational, and social skills and be offered in home and community-based settings that promote hope and encourage each person to establish an individual path towards recovery.

Restoration: Returning to a previous level of functioning.

School Setting: The place in which a child/youth attends school.

Scope: The service components and interventions being provided and utilized to address the identified needs of the child.

Serious Emotional Disturbance (SED): A designated mental illness diagnosis according to the most current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) for a child or adolescent who has experienced functional limitations due to emotional disturbance over the past 12 months on a continuous or intermittent basis. The functional limitations must be moderate in at least two of the following areas or severe in at least one of the following areas:

- Ability to care for self (e.g. personal hygiene; obtaining and eating food; dressing; avoiding injuries); or
- Family life (e.g. capacity to live in a family or family like environment; relationships with parents or substitute parents, siblings and other relatives; behavior in family setting); or
- Social relationships (e.g. establishing and maintaining friendships; interpersonal interactions with peers, neighbors and other adults; social skills; compliance with social norms; play and appropriate use of leisure time); or
- Self-direction/self-control (e.g. ability to sustain focused attention for a long enough period of time to permit completion of age-appropriate tasks; behavioral self-control; appropriate judgment and value systems; decision-making ability); or
- Ability to learn (e.g. school achievement and attendance; receptive and expressive language; relationships with teachers; behavior in school).

Service Goal: A general statement of outcome relating to the identified need for the specific intervention provided.

Service Provider: Individuals/organizations that provide and are paid to provide services to the youth and family/caregiver.

Substance Use Disorder (SUD): A diagnosis of a substance use disorder is based on a pathological pattern of behaviors related to the use of the substance. The diagnosis of a substance use disorder is based on criteria defined in the current Diagnostic and Statistical Manual of Mental Disorders (DSM) and can be applied to all ten classes of

drugs including: alcohol; cannabis; hallucinogens; inhalants; opioids; sedatives, hypnotics, anxiolytics; stimulants; tobacco; and other (or unknown) substances.

Trauma-Informed: Trauma-informed services are based on an understanding of the vulnerabilities or triggers experienced by trauma survivors that may be exacerbated through traditional service delivery approaches so that these services and programs can be modified to be more supportive and avoid re-traumatization. All programs should engage all individuals with the assumption that trauma has occurred within their lives (SAMHSA, 2014).

Youth: Individuals generally 14 years of age and older.

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APPENDIX B: HCBS SETTINGS OVERVIEW

The CMS Final Rule (§441.301(c)(4) and §441.710) defines the qualities that all home and community-based settings must possess in order to be in compliance with the rule. In the final rule, CMS also clarifies which settings do NOT qualify as home and community-based settings.

According to CMS, settings that DO NOT MEET the definition of being home and community based are:

- A nursing facility;
- An institution for mental diseases;
- An intermediate care facility for individuals with intellectual disabilities;
- A hospital; or
- Any other locations that have qualities of an institutional setting, as determined by the Secretary.

In addition, the final rule 441.301(c)(5)(v) specifies that the following settings are presumed to have the qualities of an institution (and therefore likely do not meet the HCBS standard without documentation to support otherwise):

- Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment,
- Any setting that is located in a building on the grounds of, or immediately adjacent to, a public institution, or
- Any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS.

To continue receiving federal Medicaid funding, it is required that HCBS settings for Children's Waiver recipients:

- Are integrated in and support full access to the greater community;
- Are selected from among options by the individual;
- Ensure rights of privacy, dignity, respect, and freedom from coercion and restraint;
- Optimize an individual's autonomy and independence in making life choices;
- facilitate an individual's informed choice about their services and who provides them;
- Are physically accessible to the individuals supported;
- Provide freedom and support for individuals to control their own schedules and activities; and
- Provide individuals access to food (meals and/or snacks) and visitors at any time.

The last two standards are the only standards that are modifiable, under certain conditions.

For the last 2 standards, there cannot be restrictive rules that apply to all Children's Waiver recipients. Examples of restrictive rules include, set visitor hours in a residential setting, and only one time slot food/snacks are available. The two modifiable standards listed above may be modified on a case-by case basis for a specific individual if it is done:

- When there is a *specific need* that has been identified that a participant requires staff support with (i.e., a diagnosis is not enough information to support modifying a standard);
- On a time-limited basis (reassessing periodically to see if the modification is still needed);
- After less restrictive and more positive approaches were tried and failed.

Modification example: Jane requires assistance with managing her access to food/snacks due to her tendency to eat frequently, which raises her blood sugar levels. Staff tried counseling her but were not successful. With her (or her guardian/representative's) informed consent, staff will support her with accessing the snack cabinet for at least six months, documenting this in her plan.

In addition to the settings standards above, the federal HCBS rule also requires a person-centered planning process. This process must:

- Provide necessary information and support to the individual to ensure that they can direct their planning process as much as possible;
- Include people chosen by the individual;
- Be timely and occur at least annually at times and locations of the individual's convenience;
- Assist the person in achieving outcomes they define for themselves, and in the most integrated community setting(s) they desire;
- Ensure delivery of services in a manner that reflects personal preferences and choices;
- Help promote the health and welfare of those receiving services;
- Take into consideration the culture of the person served;
- Use plain language;
- Include strategies for solving disagreement(s);
- Offer choices regarding the services and supports the person receives, and from whom;
- Provide a method for the individual to request updates to their plan;
- Indicate what entity or person will monitor the primary or main person-centered plan;
- Identify individual's strengths, preferences, needs (both clinical and support), and desired outcomes.

HCBS Settings Rule Resources

The CMS Final Rule on the HCBS Settings Requirement can be found here:
<https://www.federalregister.gov/documents/2014/01/16/2014-00487/medicaid-program-state-plan-home-and-community-based-services-5-year-period-for-waivers-provider>

CMS has created a Settings Requirements Compliance Toolkit that may be found here:
<https://www.medicaid.gov/medicaid/hcbs/index.html>

Archive

APPENDIX C: PRIOR/CONCURRENT AUTHORIZATION GRID

Home and Community Based Services (HCBS)	Prior Authorization	Concurrent Authorization	Additional Guidance
Caregiver/Family Supports and Services	No	Yes	Eligibility determination and plan of care (POC) are the only required elements for initial authorization. MMCPs will reimburse for initial authorization of 96 units or a total of 24 hours of service for a period of 60 days from the time that the MMCP receives notification from the HCBS provider.
Community Self-Advocacy Training and Support	No	Yes	Eligibility determination and POC are the only required elements for initial authorization. MMCPs will reimburse for initial authorization of 96 units or a total of 24 hours of service for a period of 60 days from the time that the MMCP receives notification from the HCBS provider.
Community Habilitation	No	Yes	Eligibility determination and POC are the only required elements for initial authorization. MMCPs will reimburse for initial authorization of 96 units or a total of 24 hours of service for a period of 60 days from the time that the MMCP receives notification from the HCBS provider.
Day Habilitation	No	Yes	Eligibility determination and POC are the only required elements for initial authorization. MMCPs will reimburse for initial authorization of 96 units or a total of 24 hours of service for a period of 60 days from the time that the MMCP receives notification from the HCBS provider.
Prevocational Services	No	Yes	Eligibility determination and POC are the only required elements for initial authorization. MMCPs will reimburse for initial authorization of 96 units or a total of 24 hours of service for a period of 60 days from the time that the MMCP receives notification from the HCBS provider.
Supported Employment	No	Yes	Eligibility determination and POC are the only required elements for initial authorization. MMCPs will reimburse for initial authorization of 96 units or a total of 24 hours of service for a period of 60 days from the time that the MMCP receives notification from the HCBS provider.
Environmental Modifications	Yes		To be addressed in separate guidance.
Vehicle Modifications	Yes		To be addressed in separate guidance
Adaptive and Assistive Equipment	Yes		To be addressed in separate guidance.

Palliative Care (Bereavement, Pain and Symptom Management, Expressive Therapy, Massage Therapy)	Yes	Yes	To be addressed in separate guidance.
Planned Respite	No	Yes	<p>Eligibility determination and POC must include Planned Respite based on child and/or family needs. Billing for Respite must be based on face-to-face interactions with the Waiver child.</p> <p>Respite billing is limited to six (6) hours (24 units) per child per day.</p> <p>For Individual Respite the maximum of six (6) hours (24 units) is equivalent to a daily individual per diem rate.</p> <p>Group Respite billing is limited to six (6) hours (24 units) per child per day.</p> <p>Planned Respite will be authorized for utilization for no more than 7 consecutive days per calendar year. Anything beyond this utilization will require concurrent review.</p>
Crisis Respite	No	Yes	No prior authorization is needed; MCO may require a notification of care and require concurrent review if utilization exceeds 72 hour stay.

APPENDIX D: UTILIZATION MANAGEMENT/MEDICAL NECESSITY GUIDELINES FOR CHILDREN'S ALIGNED HOME AND COMMUNITY BASED SERVICES

Admission Criteria	Continued Stay Criteria	Discharge Criteria ⁶
<p>All of the following criteria must be met:</p> <ol style="list-style-type: none"> 1. The child/youth must meet Level of Care (LOC) Eligibility Determination criteria to be eligible for HCBS. 2. The child/youth must meet risk and functional criteria as evidenced by the completion and affirmative outcome of the HCBS Eligibility Determination tool or the ICF-IDD Level of Care determination. 3. The HCBS supports the child/youth's efforts to maintain the child in the home, community, and school and is reflected in the Plan of Care (POC). 4. The child/youth must be willing to receive HCBS. 5. There is no alternative level of care or co-occurring service that would better address the child/youth's clinical and functional needs. 6. The child/youth must live in an appropriate setting in accordance with Federal and State guidance. 	<p>All of the following criteria must be met:</p> <ol style="list-style-type: none"> 1. Child/youth continues to meet admission criteria and an alternative service would not better serve the child/youth. 2. A POC has been developed, informed and signed by the child/youth, Health Home care manager or Independent Entity, and others responsible for implementation. 3. Interventions are timely, need-based and consistent with evidence based/best practice and provided by a designated HCBS provider. 4. Child/youth is making measurable progress towards a set of clearly defined goals Or There is evidence that the POC and/or provider treatment plan are modified to address the barriers in treatment progression Or Continuation of services is necessary to maintain progress already achieved and/or prevent deterioration. 5. Family/guardian/caregiver is participating in treatment, where appropriate. 	<p>Criteria #1, 2, 3, 4, 5 or 6 are suitable; criteria #7 is recommended, but optional:</p> <ol style="list-style-type: none"> 1. Child/youth no longer meets admission criteria and/or meets criteria for another, more appropriate service, either more or less intensive. 2. Child/youth or parent/guardian withdraws consent for treatment. 3. Child/youth is not participating in the POC development and/or utilizing referred services. 4. Child/youth's needs have changed and current services are not meeting these needs. 5. Child/youth's goals would be better served with an alternate service and/or service level. 6. Child/youth's POC goals have been met. 7. Child/youth's support system is in agreement with the aftercare service plan.

⁶ As described in the NYS 1115 MRT Waiver, each child will receive the beneficiary protections granted under Medicaid including notices of denials and the right to grieve and file appeals when denied HCBS enrollment or receiving a denial or limitation for a requested service.

APPENDIX E: COMMUNITY HABILITATION GUIDELINES

Guidelines for Medical Necessity Criteria Person Centered Planning will define areas of skill & areas of need or support and may be defined in a Health Home Comprehensive Plan of Care (POC) or a Home and Community Based Service POC <i>NOTE: The ranges outlined below should be considered guidance for general support needs. Unique situations occur and upon justification the top of the recommended range can be exceeded. *</i>	
Child/youth is 0-2	*Average/typical hours per week = 0 <ul style="list-style-type: none"> • Skill building typically met through parental support/natural caregivers & use of services such as Early Intervention (EI) and educational/school programs. Services necessary at this age typically are provided by licensed practitioners including OT, PT, and ST. • CH will only be authorized if clear documentation exists of a lack of availability of EI services, EI Respite and/or OPWDD Respite and natural supports (e.g., parent has a disability and the provision of Community Habilitation supports the child and parent skill development or the family has significant stressors that impact ability to support child).
Child/youth is ages 3-9	*Average/typical hours per week = 3 <ul style="list-style-type: none"> • Supports to facilitate community inclusion, relationship building, & adaptive/social skill development. May include social skills groups, music or art programs where the child is working to develop specific goals on their person-centered plan such as appropriate social interaction and mimicking others. • Average hours and need for CH typically increase over the years to support a growing level of developmental independence • Not allowed during school/educational hours.
Child/youth is ages 10-13	*Average/typical hours per week = 10 <ul style="list-style-type: none"> • Supports to facilitate community inclusion, relationship building, & adaptive/social skill development • Average hours and need for CH typically increase over the years to support a growing level of developmental independence Not allowed during school/educational hours
Child/youth is ages 14-17	*Average/typical hours per week = 15 <ul style="list-style-type: none"> • Focus on transition activities including increased independence/life skill building including skills such as riding the bus, grocery

	<p>shopping, using the library, understanding health issues, personal appearance, and hygiene,</p> <ul style="list-style-type: none"> • Not allowed during school/education hours • If graduates/discontinues K-12 education services, CH can increase to meet additional need for skill building. (Utilize adult guidelines)
<p>Child/youth is ages 18 up to 21st birthday</p>	<p>*Average/typical hours per week = 20</p> <ul style="list-style-type: none"> • Focus on increased independence/life skill building including skills such as riding the bus, grocery shopping, using the library, personal appearance and hygiene, understanding health issues, assist in teaching skills for personal advocacy, buying healthy meals, spending money, and coping skills. • Allows for additional training and skill development for transition into adult services including work and education • If graduates/discontinues K-12 education services, CH can increase to meet additional need for skill building including developing adult educational or work skills and providing mentorship and personal support and practical assistance when needed. For example, assistance managing anxiety after graduation in new locations, seeking assistance with new situations and interacting with peers. assist the participant in learning to utilize resources when needed, teaching the participant how to schedule, organize materials, time management, planning and participation in activities and programs (Utilize adult guidelines)

APPENDIX F: TRAINING GRID

Providers must have the following in place:

- written policies and procedures that describe staff orientation,
- mandatory training and other offered trainings for staff.
- staff have the required training to provide care that is trauma informed, culturally competent, and appropriate to the developmental level of the population served.
- maintain documentation of staff completion of required trainings in accordance with the Children's HCBS Provider Manual and be able to provide training records to the State upon request to review. Additional information on State reviews will follow.

Mandatory training components can be delivered in one training or a series of trainings. The HCBS provider will need to maintain training records and training curriculum as evidence of meeting the requirements. Providers can seek community training available to them, partner with another agency and/or develop a training within their organization to address the required training components.

<ul style="list-style-type: none"> • For staff hired before April 1, 2019, training must be completed within six (6) months of the 1915(c) Children's Waiver implementation. • For staff hired on or after April 1, 2019, training must be completed within six (6) months of hire date. 	
Training Required	Training Components Required
Mandated Reporter	<p>Staff members are required to completed Mandated Reporter training prior to delivering HCBS. Found here: https://www.nysmandatedreporter.org/TrainingCourses.aspx</p>
Personal Safety/ Safety in the Community	<ul style="list-style-type: none"> • Safety Awareness/Office and Community Safety • Prevention/Risk assessment for the Field Visits • Use of Safety Technology (e.g. Use of Mobile Phones) • Transporting Children/Youth/Families • Safety Training/Self-protection strategies • De-escalation techniques • Emergency protocols and resources (includes agency policies that address emergency procedures while delivering HCBS in the community and resources available to staff in the event of an emergency e.g. 911, on-call supervision) • Post incident reporting and response (includes agency policies that address incident reporting and procedures for staff providing HCBS in the community) • To ensure safety and protection of child/ youth, trainings will address professional boundaries, relationship boundaries, trauma, and a code of ethics for staff working with children/ youth.
Strength Based Approaches	<ul style="list-style-type: none"> • What are Strength-based approaches? • Person-centered planning/Strength based information gathering • Collaboration with child/youth/family and community (e.g. family-guided, youth-driven, etc.) • Identifying strengths, Protective Factors and Assets

	<ul style="list-style-type: none"> • Cultural and linguistic competence
Suicide Prevention	<ul style="list-style-type: none"> • Myths and Misconceptions of Suicide • Risk Factors • High risk populations • Warning Signs • How to Help (assess for risk of suicide and harm, encourage appropriate professional help) • Action/Safety Planning identify resources in the community (i.e., emergency services and mental health professionals))
Domestic Violence Signs and Basic Interventions	<ul style="list-style-type: none"> • What is Domestic Violence? • Prevalence • Types of Abuse • Cycle of Violence/Pattern of Abuse • Domestic Violence Effects on Children • How to Help • Action/Safety Planning
Trauma Informed Care	<ul style="list-style-type: none"> • What is trauma? • Prevalence/Findings (e.g. ACES) • Impact of Trauma • Trauma informed care Approach (i.e., strength-based, person and family centered, culturally aware, meeting language needs, performing collaborative and coordinated care, etc.).

Child Adolescent Needs and Strengths – NY (CANS-NY) In-Person Training Requirement

Health Homes Serving Children care managers and supervisors must participate in an in-person CANS-NY general training; as well as an in-person supervisory training for all supervisors per guidance issued by the Department on September 10, 2019. Details of these requirements can be found here:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_children/docs/cans-ny_in-person_training_requirement.pdf

NYS believes attendance to the in-person trainings will help to address reliability in ratings and create consistency in how the CANS-NY and HCBS/LOC Eligibility Determination is completed.

APPENDIX G: TABLE OF RESPONSIBILITIES FOR HCBS WORKFLOW

Milestone event	Responsible entity			
	Enrolled in MMCP		FFS Medicaid	
	Enrolled in HH	Opt-out of HH, Served by C-YES	Enrolled in HH	Opt-out of HH, Served by C-YES
HCBS Provider referral	HHCM	C-YES	HHCM	C-YES
Notifies MMCP and HHCM of First Appointment	HCBS Provider	HCBS Provider	N/A	N/A
On-going POC updates	HHCM	MMCP	HHCM	C-YES
Request Authorization for Services	HCBS Provider	HCBS Provider	N/A	N/A
Major life event requiring POC update	HHCM	MMCP	HHCM	C-YES
Monitoring access to care	MMCP	MMCP	HHCM	C-YES
Annual reassessment	HHCM	C-YES	HHCM	C-YES

APPENDIX H: PERSON-CENTERED SERVICE PLANNING GUIDANCE FOR MANAGED CARE ORGANIZATIONS AND LOCAL DEPARTMENTS OF SOCIAL SERVICES

Person Centered Service Planning Guidelines For Managed Care Organizations and Local Departments of Social Services

I. Introduction

These guidelines are intended to provide information regarding the requirements for the Person Centered Service Planning (PCSP) process for enrollees in Medicaid Managed Care⁷ (MMC), and individuals receiving services (recipients) through fee for service from Local Departments of Social Services (LDSS). Please note that these PCSP guidelines are based on the following Federal regulation: 42 CFR Part 441.301, 42 CFR Part 441.540, and the Medicaid Redesign Team 1115 Demonstration Waiver Special Terms and Conditions Section V.4. Person Centered Planning requirements for entities certified by the Office for People With Developmental Disabilities (OPWDD) are described in 14 NYCRR Part 636.

PCSP is a process required when enrollees/recipients are in need of Long Term Services and Supports (LTSS); Home and Community Based Services (HCBS); certain State Plan Services⁸, or have Special Health Care Needs⁹, as directed by the state. The PCSP process guides the delivery of services and supports towards achieving outcomes in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home.) This process incorporates development of the enrollee/recipient's Plan of Care (POC), which addresses: physical health; behavioral health; social; and long-term support needs. Medicaid Managed Care Plans (MMCPs) and LDSS are responsible for ensuring that the POC is developed and services are authorized in accordance with the POC. The PCSP process and POC must reflect the person's choices, preferences, and goals, and support his or her inclusion in the community. The process and resulting written POC will assist the enrollee/recipient in achieving personally defined outcomes (outcomes the consumer defines for his or herself) in the most integrated community settings possible while contributing to the health and welfare of the person.

⁷ Including 1915(c) Waivers, Mainstream Medicaid Managed Care Plans, HIV Special Needs Plans, Health and Recovery Plans, Partial Capitation Managed Long Term Care Plans, Fully Integrated Duals Advantage Plans, Program of All-inclusive Care for the Elderly Plans, the Medicaid benefits under Medicaid Advantage, and Medicaid Advantage Plus

⁸ Including, but not limited to: Community First Choice Option (CFCO), and for Clotting Factor when covered by managed care

⁹ Including, but not limited to: Children with Special Health Care needs

During the PCSP process, the enrollee/recipient directs the planning of services and makes informed choices¹⁰ about the services and supports received, to the maximum extent possible. Federal regulations¹¹ require that the PCSP process be directed by the individual and, if the person has a representative, includes the representative. The enrollee/recipient also has the right to choose additional participants to contribute to the process.

II. Person Centered Service Planning Process

A. Elements of Person Centered Service Planning

During the PCSP process, the MMCP or LDSS must ensure that the process:

1. Includes people chosen by the enrollee/recipient, or the enrollee/recipient's representative;
2. Provides necessary information and support to ensure that the enrollee/recipient (and/or their representative) directs the process to the maximum extent possible, and is enabled to make informed choices and decisions;
3. Is timely and occurs at times and locations of convenience to the enrollee/recipient;
4. Reflects cultural considerations of the enrollee/recipient and is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons with limited English proficiency;
5. Offers informed choices to the enrollee/recipient regarding the services and supports they receive and from whom;
6. Ensures that the written plan of care (POC) is developed during the annual PCSP meeting, and updated as needed after re-assessment when the enrollee/recipient's support needs or circumstances change significantly;
7. Ensures that the POC is finalized and agreed to in writing by the enrollee/recipient, or the enrollee/recipient's representative¹². Signature is not required when there is a provider order change. If the enrollee/recipient or designated representative is not in agreement with the POC, the enrollee/recipient has dispute/appeal and fair hearing rights as for any service determination. The LDSS and MCO will follow the normal processes for dispute resolution/appeals;
8. Ensures that the finalized POC is distributed to the enrollee/recipient and other people involved in the POC, during the initial assessment process. It must also

¹⁰ choices individuals have the information and support to make for themselves

¹¹ 42 CFR Part 441.540; 42 CFR Part 438.208; 1115 Demonstration; 42 CFR Part 441.301

¹² Acceptable methods of agreement with the POC from the enrollee or designated representative are: 1) wet signature on the POC, either in person or mailed or 2) wet signature on a separate page with language indicating agreement with the current POC, either in person or mailed. All attempts to obtain signature should be documented on the POC by the care/case manager.

- be distributed whenever any changes are made to the original plan of care, and at reassessment prior to the service authorization period ending;
9. Includes a method for the enrollee/recipient to request updates to the POC; and
 10. Includes strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants.

B. Person Centered Planning Roles

The PCSP process may include an interdisciplinary team consisting of licensed professionals, other service providers, and supports, as the enrollee/recipient desires. A care/case manager (CM) is identified to coordinate the PCSP process. The CM may be an individual from a Health Home Care Management Agency, LDSS, or MMCP, depending on the enrollee/recipient's need and circumstances. (See Section VI. B.) As part of the process, the CM must consider the enrollee/recipient's support system including formal and informal supports. The formal supports in the interdisciplinary team involved in the planning and decision-making process must have adequate knowledge, training, and expertise regarding community living and person centered service delivery.

Informal supports include the enrollee/recipient's relatives, friends, significant others, neighbors, roommates, and other people from the community. Informal supports are determined to be available when such a person is willing to voluntarily provide the identified services and the enrollee is willing to accept services from the informal support. If the informal support is not willing or is unable to provide the identified services, or the enrollee/recipient is not willing to accept services from the informal support, the needed services will be provided by other formal supports. These do not include services or supports that are within the typical range of activities that a parent or legally responsible individual would perform on behalf of a child without a disability or chronic illness of the same age.

III. Assessment

A. Comprehensive Assessment

The PCSP process requires¹³ a face-to-face assessment of the enrollee/recipient's need, once the request for services or supports is received. States must conduct a face-to-face assessment of the individual's needs, strengths, preferences, and goals for the services and supports. The plan or LDSS is responsible for arranging this assessment of the enrollee/recipient. A Nurse or a Social Worker will conduct this face-to-face assessment using the Uniform Assessment System (UAS). The results of this assessment will document the enrollee/recipient's functional need for Long-Term Services and Supports (LTSS) as well as help inform the person centered plan of care (POC).

¹³ 42 CFR 441.720; 42 CFR 441.535; 42 CFR 441.300

Depending on individual circumstances, there may be competing needs for various service assessments. The CM should coordinate the assessments an enrollee/recipient requires to determine functional needs and to determine the scope of individual services necessary to complete the POC. For each enrollee/recipient determined eligible for an HCBS benefit, the State must provide for an independent assessment of needs in order to establish a plan of care (POC). **The results of the assessment(s) will inform the development of the POC.**

A CM who has been trained to perform person centered planning in accordance with state requirements will meet with each enrollee/recipient to assist with identifying strengths and needs. Together they will review all assessment data and identify measurable goals and desired outcomes based on the assessment tool(s) and the person centered planning process.

An assessment of the enrollee/recipient's functional, medical, environmental, and social needs must be conducted:

- 1) Upon request from an enrollee/recipient newly in need of LTSS/HCBS or identified as having Special Health Care Needs;
- 2) Upon request for a new LTSS or HCBS; and
- 3) For a new MMC enrollee in receipt of LTSS/HCBS or identified as having Special Health Care Needs, upon enrollment in the MMCP.

A re-assessment must be conducted at intervals as directed by the State for the covered service, e.g. for LTSS, reassessment is conducted at least once every twelve months.

Reassessments are also conducted upon a significant change in the enrollee/recipient's condition, or if requested by the enrollee/recipients. (See Section V.)

B. Risk Assessment

To ensure the health and safety of each enrollee/recipient, a risk assessment must be conducted during the initial comprehensive assessment and each subsequent re-assessment. The risk assessment will evaluate potential risks to the enrollee/recipient's health and welfare as well as the ability to calculate and manage risks in an appropriate manner. The risk assessment must be completed with the enrollee/recipient and anyone the enrollee/recipient wishes to attend. Safeguards and positive interventions for the enrollee/recipient's health and safety must be developed based on the enrollee/recipient's strengths and needs. Areas for evaluation include, but are not limited to:

1. fire safety and evacuation;
2. chronic medical conditions and allergies;
3. special dietary needs;
4. medication management;

5. level of supervision required at home and in the community;
6. ability to manage finances;
7. ability to give consent;
8. ability to travel independently;
9. level of safety awareness;
10. bathing safety;
11. mobility;
12. behaviors that present harm to self or others; and
13. natural disaster preparation.

Once the enrollee/recipient's risk assessment is completed, a risk management plan (described in section IV. D.) will be developed as part of the POC, incorporating areas of risk and the positive interventions and safeguards used to manage the identified risk.

IV. Plan of Care Requirements

Federal regulations describe the minimum requirements for plans of care (POC) developed through the person centered service planning process. These regulations state that this process results in a written POC with individually identified goals and preferences. These goals and preferences may relate to community participation, employment, income and savings, health care and wellness, or education. Every POC should reflect the services and supports (formal and informal), identify all providers, and indicate whether an enrollee/recipient chooses to self-direct his or her services. The POC will identify the specific services and the service providers used to meet stated goals, as well as their frequency, amount, and duration. Most importantly, the POC will be individualized and understandable to the enrollee/recipient. Please note that the POC must comply with other state guidance that applies to specific services such as Health Homes.

A. Elements of the Plan of Care

The written POC based on the comprehensive assessment of the enrollee/recipient will include:

1. personal and health care goals and desired outcomes identified by the enrollee/recipient;
2. enrollee/recipient's strengths and preferences;
3. types of all authorized covered services (including LTSS and HCBS) that will be delivered and their scope (description that determines which activities constitute billable activities), amount (units or hours) and frequency (number of times per week, days of the week and hours during the day);
4. services and supports not covered by the MMC plan or FFS that are necessary to maintain the POC;
5. informal services and supports that will assist the enrollee/recipient to achieve the identified goals including type, scope and frequency;

6. providers of each service and support;
7. clinical and support needs as identified through the assessment of functional need;
8. timeframes for completion of the expected outcomes;
9. back-up plan for when services and supports are temporarily unavailable;
10. identification of care manager responsible for monitoring the plan and business hours and after-hours emergency contact information for that care manager;
11. identification of unmet service needs and strategies to address them;
12. the setting in which the enrollee/recipient resides; and
13. risk factors and measures in place to minimize them.

B. Home and Community-Based Settings¹⁴

HCBS may only be provided in settings that meet the federal standards outlined in 42 CFR Part 441.301.¹⁵ Home and community-based settings must have certain qualities, based on the needs of the enrollee/recipient as indicated in their person centered POC. The POC should indicate that the home and community-based setting includes the following required qualities:

1. Setting is integrated in and supports full access of enrollees/recipients receiving HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
2. Setting is selected by the enrollee/recipient from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person centered POC and are based on the enrollee/recipient's needs, preferences, and, for residential settings, resources available for room and board.
3. Setting ensures an enrollee/recipient's rights of privacy, dignity and respect, and freedom from coercion and restraint.
4. 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.
5. Setting facilitates enrollee/recipient choice regarding services and supports, and who provides them.
6. For special populations receiving services under 42 CFR 441 Subparts G, and K modifications should be made on a case-by-case basis to the additional home and community-based settings standards within an enrollee's person centered plan. Such modifications may relate to a change in: status of written, legal agreements

¹⁴ The State is CMS working with to finalize the State Transition Plan. For definition of HCBS Settings, please refer to https://www.health.ny.gov/health_care/medicaid/redesign/home_community_based_settings.htm p.3030

¹⁵ HCB settings standards do not apply to PACE

to live in the current setting; privacy; lockable entrance doors with only individuals served and appropriate staff keeping keys/key codes; choice of roommate(s); freedom to furnish/decorate within legal agreements; control of own schedules and activities, and the ability to access food and receive visitors of the enrollee's choosing at any time.

Home and community-based settings do not include the following:

1. A nursing facility;
2. An institution for mental diseases;
3. An intermediate care facility for individuals with intellectual disabilities;
4. A hospital providing long-term care services; or
5. Any other locations that have qualities of an institutional setting.

C. Back Up Plan

The back up plan is a contingency plan put in place to ensure that needed assistance will be provided in the event that the regular services and supports in the enrollee/recipient's POC are temporarily unavailable. The back up care plan may include electronic devices, relief care, providers, other individuals, services, or settings and must also be included in the POC. Individuals available to provide temporary assistance include informal caregivers such as the enrollee/recipient's family member, friend or other responsible adult.

D. Risk Management Plan

Following the risk assessment, a risk management plan will be developed as part of the POC. If risk is identified, the positive interventions and safeguards used to mitigate or eliminate the risk are to be written in the risk management plan. The care/case manager must take into consideration the enrollee/recipient's rights, needs, and preferences, as well as the benefits and impact of the risk management on the enrollee/recipient. The risk management plan should include ways to empower enrollees/recipients to improve their ability to make informed decisions through education and self-advocacy skills. Possible resources and environmental adaptations that can allow the enrollee/recipient to take acceptable risks while reducing potential hazards must be included, as well.

The risk management plan must include a safeguarding section. This safeguarding section must identify the supports needed to keep the enrollee/recipient safe from harm

and actions to be taken when the health or welfare of the enrollee/recipient is at risk. Information in this section includes, but is not limited to, a description of the supervision and oversight that may be required in such areas as: fire safety, medication management, allergies, community inclusion activities, diet, behavioral concerns, financial transactions, and other vulnerabilities at home and in the community.

V. Person Centered Service Plan (PCSP) Review

The effectiveness of the POC is closely monitored through reassessment and care/case management. The POC must be reviewed and revised:

- 1) at least once every 12 months or as required by 42 CFR Part 441.301, 1115 Demonstration Section V.4 and 42 CFR Part 441.540 or the State;
- 2) upon reassessment of functional, behavioral, medical and social needs;
- 3) when the enrollee/recipient's circumstances or needs change significantly; and
- 4) at the request of the enrollee/recipient.

Review and revision of the POC may occur more frequently as warranted by the enrollee/recipients' condition.

The required annual POC review must occur in a face-to-face meeting that includes minimally, the enrollee/recipient, the enrollee/recipient's representative if they have one, whomever the enrollee/recipient invites, and an interdisciplinary team. As part of the POC review, a determination is made on whether the enrollee/recipient's goals are being met or whether the goals need to be reevaluated/revised.

VI. Care/Case Management Requirements

A. Conflict of Interest Standard

Federal regulations¹⁶ require that the POC development function of care/case management must be separate from the service delivery function. Individuals conducting the comprehensive assessment and person centered POC for an enrollee/recipient are not:

- a) A parent or spouse of the enrollee/recipient, or to any paid caregiver of the enrollee/recipient;
- b) Financially responsible for the enrollee/recipient;
- c) Empowered to make financial or health-related decisions on behalf of the enrollee/recipient;
- d) Individuals who would benefit financially from the provision of assessed needs and services; and
- e) Providers of Home and Community-Based Services (HCBS) for the enrollee/recipient, or those who have an interest in or are employed by a provider of HCBS for the enrollee/recipient.

Providers of HCBS for the enrollee/recipient, or those who have an interest in or are employed by a provider of HCBS for the enrollee/recipient must not provide case management or develop the POC. The State invokes the Conflict of Interest Exception

¹⁶ 42 CFR Part 438.58; 42 CFR Part 441.301; 42 CFR Part 441.555; 42 CFR Part 441.730

when the only willing and qualified entity performing assessments of functional need and/or developing the person centered POC also provide Home and Community-Based Services. Where it is demonstrated that the only willing and qualified entity to provide case management and/or develop POCs in a geographic area also provides HCBS, the PCSP process must include conflict of interest protections. This may include the separation within a provider entity of assessor, care/case manager, and provider functions.

As is required by 42 CFR 438, effective April 1, 2018, any service coordinator or service coordination provider agency will be restricted from providing any other waiver services including 1915(c) unless it is demonstrated that the provider meets the exemption standards for rural and /or cultural accommodation. Under no circumstances can a direct service provider determine eligibility for a service.

In the FFS environment, the Local Department of Social Services (LDSS) will ensure that there is separation between the function as case manager or assessor and the other functions the same individual performs at the LDSS or agency/provider. Firewalls ensure that the individual conducting the functional needs assessment and/or developing the person centered POC is independent of those who are providing the services. Accordingly, the case manager or assessor will not provide services as a direct care worker for the enrollee/recipient; nor have a majority ownership stake in the provider agency.

The Health Home model provides care management for FFS and managed care enrollees. Under the 1115 MRT Waiver, when a service provider is an approved Health Home provider and also a HCBS provider, this entity may conduct person centered service planning, care coordination, and provision of HCBS as long as firewalls are constructed between the service planning, care coordination, and service provision. As directed by the State, Health Home Care Managers (HHCM) and State Designated Entities (SDEs) may determine eligibility for certain HCBS through State required assessments. HHCMs and SDEs are restricted from assessing a person for whom they have financial interest or other existing relationship that would present conflict of interest.

Any agency in New York State that is not a Health Home may not provide both HCBS and care management unless the State has demonstrated that they are the only willing and qualified entity to provide case management and/or develop person centered service plans in a geographic area or the State has demonstrated that the provider is the only qualified provider due to its unique ability to deliver culturally or linguistically competent care to the enrollee/recipient.

Enrollees/recipients receiving services must be provided with a clear and accessible alternative dispute resolution process. In all cases, enrollees/recipients will be made

aware of appeals processes and due process protections to ensure their needs are met in the fairest manner possible.

B. Health Home Care Management

Health Home (HH) is a care management (CM) service model for individuals enrolled in Medicaid with complex chronic medical and/or behavioral health needs. Individuals who receive services from the Office for People with Developmental Disabilities (OPWDD) will be referred to Care Coordination Organization/Health Homes (CCO/HH)

For recipients in Fee For Service (FFS), Health Homes must partner with the LDSS with the emphasis on coordination among the two entities. The Health Home develops and maintains a POC that integrates physical and behavioral health services and includes LTSS and HCBS, as appropriate to the enrollee's needs. The LDSS continues to be responsible for authorizing the LTSS and HCBS (unless otherwise directed by the State) for FFS recipients enrolled in HH.

Health Home services are covered by mainstream Medicaid Managed Care Plans (MMCP), HIV Special Needs Plans and Health and Recovery Plans (HARP). Eligible persons enrolled in MMCPs may also be enrolled in a HH. If an enrollee is in a MMCP and HH or CCO/HH, the HH care manager is the primary provider of care management and the MMCP does not duplicate the service. The MMCP is responsible for arranging for LTSS and HCBS assessments, and authorizing the needed services in accordance with State direction for the covered benefit(s). The MMCP must communicate the outcome and coordinate the service authorization options with the HHCM and the member. The Health Home develops and maintains a POC that integrates physical and behavioral health services and includes LTSS and HCBS, as appropriate to the enrollee's needs.

It is expected that the MMCP care manager will coordinate with the HH care manager to ensure that one comprehensive POC is completed, and authorization of services is not delayed due to administrative barriers. Both care managers are part of the PCSP team. The MMCP is responsible for monitoring, on a regular basis, whether the services in the POC are being delivered as authorized in the POC and whether those delivered services meet the needs of the enrollee. MMCPs contracting with designated HHs to provide HH services must develop plan specific agreements with Health Homes for HH services, and may use the Department's Administrative Health Home Services Agreement (ASA) with the HH. This link is provided below

The Department of Health's Office of Health Insurance Programs (OHIP) is requiring MLTC Plans to ensure access to Health Homes on a statewide basis. HH care management services are carved out of the MLTC benefit package. The State requires a collaborative, team approach to service coordination between the Health Home and the Managed Long Term Care Plan. The MLTC Plan and the HH must clearly define

their respective roles in order to develop a comprehensive, integrated, person-centered care plan.

The assigned MLTC Plan care coordinator and the Health Home care manager will assure that duplication of care management service does not occur, and that any in-plan services recommended on the care plan are authorized by the MLTC Plan. MLTC Plans are responsible for coordination with the Health Home but are not responsible for Health Home management or performance or any services outside the scope of the MLTC Plan

benefit package. Please note, the assessment part of the PCSP process continues to be conducted by the MLTC Plan nurse.

The respective roles of the MLTC Plan and the Health Home must also be formalized by entering into a Statewide Administrative Health Home Services Agreement (ASA) using the template that has been developed by the Department. It will be the joint responsibility of both parties to determine which care manager will serve as the lead care manager for each enrollee. This decision will be based on the primary needs of the enrollee and must be documented on the Care Planning and Coordination form (see link to form below).

An ASA template has been developed for HH and Managed Long Term Care Plans (MLTC) to delineate their respective care management roles when both are serving recipients, to ensure that services are not duplicated. The template ASA allocates a primary role for the coordination of long term care services to the MLTC Plan and a primary role for the coordination of behavioral health care and other services and supports that are outside of the MLTC benefit package to the Health Home.

While the template ASA provided by the Department may not be altered, a description of the in-plan and out-of-plan services and the respective responsibilities of the MLTC Plan and the Health Home should be included as Appendix A to the ASA. A suggested template for Appendix A has also been developed by the Department.

This form should be completed in conjunction with each reassessment to ensure continuity of care and reflect the long term care expertise of the MLTC Plan and the behavioral health expertise of the Health Home.

The ASA template, Care Planning and Coordination form as well as a suggested care planning and coordination tool can be found at:
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/managed_care.htm

This guidance is effective upon posting. The Managed Care Plan in charge of monitoring your organization will commence monitoring activities to verify implementation of changes required by the HCBS Final Rule beginning as early as January 1, 2020. Beginning in 2019 DOH is sponsoring free provider trainings on person-centered thinking, planning, and practice. These training are strongly recommended in order to demonstrate movement towards regulatory compliance. More information can be found by emailing NYDOHPCPTraining@pcgus.com.

Archive

APPENDIX I: HEALTH HOME PLAN OF CARE POLICY

Policy Title: Health Home Plan of Care Policy

Policy number: HH0008 Effective date: August 1, 2019

Last revised: July 30, 2019

Approved by:

Date:

Purpose: To establish standards and clear guidance regarding Health Home person-centered plans of care, which will inform NYS Health Home and Care Management Agency policies and procedures.

Policy

Health Homes serving adults and children will establish and maintain policies and procedures that are based on State policy, including how and when the Plan of Care (POC) is created, implemented, updated, and distributed for all consented Health Home members. In addition, Health Homes will have clear and focused POC training requirements and must maintain a quality assurance program to ensure compliance.

NOTE: For children who are under the age of 18 and cannot self-consent, wherever "the member" is stated for this document, it represents the member and their parent/guardian/legally authorized representative unless specifically noted otherwise.

Elements of a Health Home Plan of Care

The Health Home POC should be used as an active tool to guide day to day care management work, as well as to support the required collaboration with others listed in the POC (e.g., care team, MMCP) to monitor member progress towards goals. Changes in goals and preferences, interventions, and member needs should be documented in the POC.

The Health Home will ensure that an individualized, person-centered POC is created concurrently with the Health Home comprehensive assessment within 60 calendar days of enrollment for all consented Health Home members, regardless of age. The Health Home care manager will be the single point of contact for the member's care coordination and will take full responsibility for the overall management of the member's POC.

The member (or their parent/guardian/legally authorized representative) must play a central and active role in the development and execution of their POC and must agree with the goals, interventions and time frames contained in the POC. The Health Home POC must contain goals and objectives that support the member's desire to address their qualifying diagnosis for Health Home; such as SMI, SED, SUD, HIV/AIDS or

chronic conditions (for children HCBS needs) and other healthcare and social needs, as the member deems necessary. The POC must be written in plain language and in a manner that is accessible to individuals with disabilities and persons with limited English proficiency and should reflect the cultural considerations of the member. Person centered service planning guidelines may apply for some populations¹⁷.

For additional guidance on person centered service planning:

https://www.health.ny.gov/health_care/medicaid/redesign/cfco/docs/2018-12-19_pcsp_guidelines.pdf

All plans of care must include the following:

- member's strengths and preferences related to identified needs, goals and interventions;
- specific, measurable, and obtainable member-stated wellness and recovery goal(s), including,
 - target time frames for attaining goals;
 - strategies by which the desired goals will be achieved;
 - actions describing how the goals will be achieved; and
 - supports (both paid and unpaid) that are needed to achieve the individual's desired goals;
- functional needs related to treatment, wellness and recovery goals (e.g. meal prep/needs assistance eating, etc.) as appropriate;
- barriers and strategies to overcome barriers related to achieving goals, including a description of planned care management interventions and time frames (e.g. Health Home Plus);
- documentation of participation by all key providers (of the interdisciplinary team/care team) in the development and updating of the POC;
- outreach and engagement activities that will support engaging individuals in their care and promote continuity of care;
- the member's signature documenting agreement with the POC (including a child who can self-consent or age-appropriate to participate, and/or their parent guardian, or legally authorized representative);

Use of Electronic Signatures: The practice of obtaining member signature via electronic means is acceptable as long as Health Homes and Care Management

¹⁷ Including 1915(c) Waivers, Mainstream Medicaid Managed Care Plans, HIV Special Needs Plans, Health and Recovery Plans, Partial Capitation Managed Long Term Care Plans, Fully Integrated Duals Advantage Plans, Program of All-inclusive Care for the Elderly Plans, the Medicaid benefits under Medicaid Advantage, and Medicaid Advantage Plus 2 Including, but not limited to: Community First Choice Option (CFCO), and for Clotting Factor when covered by managed care 3 Including, but not limited to: Children with Special Health Care needs 4 choices individuals have the information and support to make for themselves 5 42 CFR Part 441.540; 42 CFR Part 438.208; 1115 Demonstration; 42 CFR Part 441.301

Agencies are in compliance with all applicable New York State and Federal laws. For more information refer to the following links:

<https://its.ny.gov/electronic-signatures-and-records-act-esra>;

<https://www.law.cornell.edu/uscode/text/15/chapter-96/subchapter-1>

For all children's plans of care:

Children's Health Home has 10 required elements of POC as outlined in the "Health Home Standards and Requirements for Health Homes, Care Management Agencies, and Managed Care Organizations"

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_mco_cm_standards.pdf

Subsequently, when working with the member and their family, the children's POC should reflect that the "Health Home Comprehensive Assessment Policy" appendix C: "Required Components of the Health Home Comprehensive Assessment (Children)" have been reviewed and obtained as part of the development of the POC.

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/comprehensive_assessment_policy.pdf

Additionally, there are specific HCBS POC requirements also as outlined below that will be required for all Health Home POC:

- emergency contact and disaster plan for fire, health, safety issues, natural disaster, or other public emergency;
- other service plans as appropriate, such as Early Intervention Individual Service Plan and foster care Family Assessment Services Plan, which should be reviewed by the care team and appropriate items incorporated as needed;
- for youth over age 14, goals developing a participant's capacity to live independently, and the identification of available resources; and
- transitioning youth – those that will be aging out and moving to adult services must include transitional goal and services; specifically:
 - As physically disabled participants reach their 17th birthday, the HH/II will begin to assist the enrollees in planning for transition to other services and/or programs
 - For Foster Care enrollees, eighteen months prior to reaching the enrolled child's 21st birthday, the HH/IE generates a Transition Plan that identifies the action steps needed to connect with services each child needs in adulthood and the party responsible for conducting the action steps.

Where information can be obtained and transferred from the Health Home comprehensive assessment, this information can be used to populate the person-centered POC. For example, the elements of the POC may be collected within different documentation gathered and stored in the electronic health record. The Health Home will provide direction to support CMAs in understanding the link of each document and how it fulfills the POC requirements.

The CANS-NY assessment tool does not meet comprehensive assessment requirements and will not be a substitute for a person-centered POC. Please review the CANS-NY reference guides on the Health Home website for additional guidance:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_children/index.htm

The member or their parent/guardian/legally authorized representative must sign and be provided a copy of their POC. Contingent upon the member's consent and upon request, the POC will be made available to:

- their family member(s) or other supports,
- care team members, and
- service providers

Contingent upon the member's consent, the POC will be distributed to:

- HCBS providers (children)
- BH HCBS providers (adults)
- Health and Recovery Plans (HARPs), when applicable
- HIV Special Needs Plans (HIV/SNPs), when applicable
- Medicaid Managed Care Plans, when the POC includes services requiring service authorization, e.g. children's HCBS

NOTE: For Health Homes serving children, under Section 2 on the **DOH-5201 Consent Form: Health Home Consent Information Sharing For Use with Children and Adolescents Under 18 years of Age**, there are special implications for the comprehensive assessment and POC. If a minor/adolescent is between 10 and 18 years of age and has elected to not share health information with a parent, guardian, or legally authorized representative (as indicated in Section 2 of DOH-5201), the care manager must complete a separate section/page of the POC with only the minor/adolescent and not with the parent, guardian, or legally authorized representative present. The care manager will only obtain the minor/adolescent's signature for this section/page of the POC. This separate section/page of the POC should not be given to the parent, guardian, or legally authorized representative. If the child has elected to share health information with a parent, guardian, or legally authorized representative (as indicated in Section 2 of DOH-5201), the care manager would not need to fill out a separate section/page of the POC. The POC would be signed by the minor/adolescent and the parent, guardian, or legally authorized representative. Minors/adolescents who are in the exception categories (minor/adolescent who is pregnant, parent, married or 18 years and older) are able to self-consent into health homes, and therefore would be allowed to sign their POC.

BH HCBS Plan of Care and Federal Assurances (HARP Adults Only)

For adults enrolled in a Health and Recovery Plan (HARP) or HIV Special Needs Plan (HIV SNP and HARP-eligible) for found eligible and being referred to adult Behavioral Health Home and Community Based Services (BH HCBS), the POC must be shared with the HARP. There are additional requirements regarding how the person-centered planning process is documented and incorporated into the Health Home POC. This is necessary for compliance with the CMS Final Rule (79 FR 2947). These requirements can be found on the Documentation Requirements checklist found here:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hcbs_poc_fed_rules_regs.pdf

For more information regarding the development of an adult BH HCBS POC, please see Adult BH HCBS Workflow Guidance:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/workflow_guidance.htm

HCBS Plan of Care (Children Only)

For children who are found eligible for HCBS, care management of the member's POC will be by the Health Home or the Independent Entity Children and Youth Evaluation Services (C-YES) for members that opt-out of Health Home. HCBS eligible children do not need to prove Health Home eligibility and appropriateness separately.

For children who are determined HCBS eligible and were not previously enrolled in Health Home to have had a comprehensive POC, the Health Home care manager will initiate a preliminary POC with HCBS to meet the HCBS 30-day timeframe. Then ensuring that a completed person-centered Health Home POC is finalized with the member within the Health Home standard of 60 calendar days from Health Home enrollment.

Home and Community Based Services that are identified will only be referred to designated HCBS providers, who will determine frequency, scope and duration for each individual HCBS. The Health Home care manager will ensure that frequency, scope and duration of each HCBS is outlined in the POC.

Frequency

Health Homes will ensure that the POC is reviewed and updated as necessary, more frequently as warranted by a significant change in the member's medical and/or behavioral health or social needs. At a minimum, the children's POC must be reviewed and updated, if necessary every six months concurrently with a CANS-NY assessment. The POC for adults must be updated at least annually; however, updating concurrently with the HML assessment is best practice.

If the member experiences a significant change in medical and/or behavioral health or social needs, the care manager must evaluate the member's current status including rescreening for risk factors as discussed in the Health Home Comprehensive Assessment policy. For children only, the CANS-NY must also be updated by choosing the assessment type of "CANS-NY prior to six months" when there is a significant life change.

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/comprehensive_assessment_policy.pdf

The member's agreement with the POC and updates made should be indicated in the POC.

Training

Health Homes must have policies and procedures related to training for staff on person-centered care planning, and how to reflect that in a POC.

Quality Management Program

Health Homes must have a person-centered POC quality assurance process in place to comport with Health Home policies and procedures as outlined in the Health Home Quality Management Program policy.

Use of Health Information Technology (HIT)

Health Home must have a structured, interoperable health information technology (HIT) system, policies, procedures, and practices to support the creation, documentation, execution, and ongoing management of a POC for every member. The Health Home will use an electronic health record system that qualifies under the Meaningful Use provisions of the HITECH Act, which allows the member's health information and POC to be accessible to care team.

APPENDIX J: HEALTH HOME INCIDENT REPORTING POLICY

Policy Title: Health Home Monitoring: Reportable Incidents Policies and Procedures

Policy number: HH0005

Effective date: July 14, 2017

Revised: October 15, 2019

Supersedes: Health Home Monitoring: Reportable Incidents Policies and Procedures and Reporting Timeframes Policy #HH0001 (4/15/17)

Purpose

This policy defines the requirements for Health Homes to identify, receive, investigate, resolve and record Reportable Incidents, including a continuous quality improvement process to track and identify trends to reduce risk and minimize the potential for future occurrence of the same or related incidents.

A reportable incident is an event involving a member, which has, or may have, an adverse effect on the life, health, or welfare of the member. A list of reportable incidents can be found below.

Health Homes must have a system in place to effectively manage Reportable Incidents for their members. Health Homes must have policies and procedures in place that clearly define what is reportable and the responsibility for managing reportable incidents, including assurance that appropriate and timely intervention(s) occur and corrective action is implemented.

Policy

The Department will require that Health Homes have policies in place to handle any reportable incidents in compliance with the Health Home Standards outlined in the State Plan Amendment. The Department will work with the Health Home to ensure the HH establishes policies and procedures to:

- Identify, document, report and review individual incidents on a timely basis;
- Evaluate individual incidents against HH and Care Management Agencies (CMA) policies and procedures to confirm quality care coordination activities were provided;
- Review individual incidents to identify appropriate preventive or corrective action;

- 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; and
- Implement preventive and corrective action plans.

Health Homes must have a quality assurance process in place to ensure that CMA's comply with their policies and procedures.

If a HH member is also receiving services in a program under the jurisdiction of another State agency (e.g., Office of Mental Health (OMH); Office of Alcoholism and Substance Abuse Services (OASAS); Office for People with Developmental Disabilities (OPWDD); or Office of Children and Family Services (OCFS)) which has stated incident, abuse, neglect, or maltreatment reporting requirements, this policy does not relieve the obligation to report in accordance with such regulations. Such reporting is not the responsibility of the HH, although the organization should cooperate as necessary.

For HH members receiving court-ordered assisted outpatient treatment (AOT), Health Homes shall ensure CMAs comply with the requirements of AOT Health Home Plus (HH+), which states the CMA shall comply with all reporting requirements of the AOT Program as established by the Local Government Unit (LGU). Such requirements include the reporting of significant events. Though the LGU may have primary responsibility to investigate significant events involving an AOT individual, the HH shall cooperate as necessary.

The Protection of People with Special Needs Act requires persons who are Mandated Reporters under that Act to report abuse, neglect and significant incidents involving vulnerable persons to the Vulnerable Persons' Central Register (VPCR) operated by the NYS Justice Center for the Protection of People with Special Needs. For additional information and requirements, please see:

<https://www.nysmandatedreporter.org/NYSJusticeCenter.aspx>

N.Y. Social Services Law 413 – Persons and Officials Required to Report Cases of Suspected Child Abuse or Maltreatment require Mandated Reporters to report suspected child abuse or maltreatment to the New York State Office of Children and Family Services maintains the Statewide Central Register of Child Abuse and Maltreatment (SCR, also known as the “hotline”) for reports made pursuant to the Social Services Law.

<https://ocfs.ny.gov/main/cps/default.asp>

Care Management Agency Reporting Responsibilities

Health Home policies and procedures must mandate that the CMA inform the HH of a reportable incident within 24 hours of notification or discovery (or where applicable, by

the next business day), including the known facts and circumstances of the incident, the member's enrollment date, last contact date and type, and current location, if known.

The following is a list of reportable incidents. Please see page 5 for definitions of each of these incident types.

1. Allegation of abuse, including
 - Physical abuse
 - Psychological abuse
 - Sexual abuse/sexual contact
 - Neglect
 - Misappropriation of member funds
2. Suicide attempt
3. Death
4. Crime Level 1
5. Missing person
6. Violation of Protected Health Information (PHI)

Health Home Serving Children (HHSC) – Children's Home and Community Based Services (HCBS)

For children only receiving HCBS services through the Children's Waiver, the use of restrictive interventions, including restraints and seclusion, and exploitation are also considered reportable incidents and should be reported following the same process as other reportable incidents defined within this document.

Health Home Reporting Responsibilities

The HH must inform the Department within 24 hours of notification from the CMA (or where applicable, by the next business day), any reportable incident listed above, along with initial findings on the New York State Health Home Incident Report Form.

At a minimum, the HH must immediately review the facts and circumstances of the current incident with the CMA, along with all pertinent information and incident reports. The HH will provide oversight and direction to the CMA to ensure member safety and well-being as well as program integrity, overall programmatic expectations, and compliance with Health Home Standards.

For Health Home Serving Children, this oversight and direction to the CMA will occur within thirty days (30 days) of receiving the incident report on the New York State Health Home Incident Report Form.

The Department will review the incident reported by the HH and make recommendations, if necessary, to ensure that the Health Home's reportable incident policy is appropriate and in compliance with established HH Standards.

The Department will require HHs to submit, on a quarterly basis, the total number of reports in each of the categories noted on the Health Home Reportable Incident Form, due by the 10th business day after the end of the quarter:

- January – March, due April;
- April – June, due July;
- July – September, due October; and
- October – December, due January

This form can be found on the Health Home Reportable Incidents website at: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_home/s/incidents.htm - under: Reporting Forms (**Health Home Reportable Incidents Quarterly Report**)

Resource List

NYS Justice Center/Vulnerable Persons Central Registry	855-373-2122	https://www.justicecenter.ny.gov/
NYS Adult Home Hotline	866-893-6772	https://www.health.ny.gov/contact/doh800.htm
NYS Nursing Home Complaint Hotline	888-201-4563	https://apps.health.ny.gov/nursing_homes/complaint_form/complain.action
The Statewide Central Register of Child Abuse and Maltreatment	800-342-3720	https://ocfs.ny.gov/main/cps/

Definitions

Abuse: Any of the following acts by an individual service provider:

- 1) **Physical Abuse:** any non-accidental physical contact with a member which causes or has the potential to cause physical harm. Examples include, but are not limited to, hitting, kicking, biting, choking, smothering, shoving, dragging, throwing, punching, shaking, burning, cutting, or the use of corporal punishment.
- 2) **Psychological Abuse:** includes any verbal or nonverbal conduct that is intended to cause a member emotional distress. Examples include, but are not limited to, teasing, taunting, name calling, threats, display of a weapon or other object that could reasonably be perceived by the patient as a means of infliction of pain or

injury, insulting or coarse language or gestures directed toward a patient which subjects the patient to humiliation or degradation; violation of patient rights or misuse of authority.

- 3) **Sexual Abuse/Sexual Contact:** includes any sexual contact involving a service provider (e.g., HH staff, CMA staff, other provider) and a member. Examples include, but are not limited to, rape, sexual assault, inappropriate touching and fondling, indecent exposure, penetration (or attempted penetration) of vagina, anus or mouth by penis, fingers, or other objects. For purposes of this Part, sexual abuse shall also include sexual activity involving a member and a service provider; or any sexual activity involving a member that is encouraged by a service provider, including but not limited to, sending sexually explicit materials through electronic means (including mobile phones, electronic mail, etc.), voyeurism, or sexual exploitation.
- 4) **Neglect:** any action, inaction or lack of attention that breaches a service provider's duty and that results in or is likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of a member.
- 5) **Misappropriation of Member Funds:** use, appropriation, or misappropriation by a service provider of a member's resources, including but not limited to funds, assets, or property, by deception, intimidation, or similar means, with the intent to deprive the patient of those resources. Examples include the deliberate misplacement, theft, or wrongful, temporary, or permanent use of a member's belongings or money.

Crime Level 1: An arrest of a member for a crime committed against persons (i.e. murder, rape, assault) or crimes against property (i.e. arson, robbery, burglary) **AND** is perceived to be a significant danger to the community or poses a significant concern to the community.

Death: The death of a member resulting from an apparent homicide, suicide, or unexplained or accidental cause; the death of a member which is unrelated to the natural course of illness or disease.

Exploitation: taking advantage of a [participant] for personal gain through the use of manipulation, intimidation, threats, or coercion.

Missing Person: When a member 18 or older is considered missing AND the disappearance is possibly not voluntary or a Law Enforcement Agency has issued a Missing Person Entry, OR when a child's (under the age of 18) whereabouts are unknown to the child's parent, guardian or legally authorized representative.

Restrictive Interventions – According to the CMS Final Rule 42 CFR Part 482 (Federal Register/Vol 71, No. 236, pg. 71427):

- A **restraint** is any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely; or a drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition; a restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort).
- **Seclusion** is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior.

Suicide Attempt: An act committed by a member in an effort to cause his or her own death.

Violation of Protected Health Information: Any violation of a client's rights to confidentiality pursuant to State and Federal laws including, but not limited to, 42 CFR Part 2 or the Health Insurance Portability and Accountability Act (HIPAA), and Article 27F. The CMA has a responsibility to review to determine whether the incident is a breach of security vs. a breach of privacy.