Guide to Edits Included in the New York State Children's Home and Community Based Services (HCBS) Manual: March 2023

Update Made	Updated Text	Page
Provided further clarification about the purpose of HCBS	HCBS are designed for children/youth who, if not receiving 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, **as well as children/youth stepping down from a long-term care facility or psychiatric inpatient care.** ~~and for those at risk of elevating to that level of care.~~	**9**
Provided further clarification about the HCBS/LOC Eligibility Determination	1. Target **Population (TP)** criteria, 2. Risk factors **(for some TP),** 3. Functional criteria, and 4. Medicaid eligibility.	**10**
Added language about fiscal integrity to provider requirements	Service providers delivering Children's Home and Community Based Services (HCBS) must meet the following requirements: • […] • Be a fiscally viable agency and **maintain fiscal integrity**	**11**
Updated the language for Designated HCBS Provider Attestation standards and procedures	Newly designated providers must complete the Designated Home and Community Based Services (HCBS) Provider Attestation and return it to the NYS Children's Provider Designation Interagency Review Team within 30 days of receipt. If the provider's designation is altered (i.e. added/removed site(s), service(s), etc.), an updated Provider Attestation is not required. Providers must adhere to all requirements outlined in the attestation regardless of any designation alterations, unless the alterations result in a de-designation from all HCBS. ~~Additionally, providers will need to complete an Attestation each time additional services and/or sites are added to their designation. Providers who are designating or re-designating for HCBS are required to complete the Attestation and return it to the NYS Children's Provider Designation Interagency Review Team within 30 days of receipt.~~	**12**
Clarified that HHs are also "re-designated" by NYS	HHs are also designated **and re-designated** by NYS and must adhere to the Health Home Standards and Requirements.	**13**
Added language about de-designation requirements	If an HCBS provider determines to de-designate, they must notify the NYS Children's Provider Designation Interagency Team and establish a transition plan for any and all children/youth being provided services. […] Participation in State-led annual case reviews and submission of all required reporting documents remain requirements for providers that have provided services within the review period (i.e., Waiver year), even if the provider has been de-designated.	**13-14**
Replaced previous detailed description of CMS Final Rule on HCBS Settings with an overview of	<u>DOH Compliance Process</u> DOH assesses compliance with HCBS settings requirements for both existing designated providers and those seeking designation.	**16-17**

Update Made	Updated Text	Page
the DOH Compliance Process and a link to the CMS guidance	All designated Children's Waiver HCBS providers will need to be in compliance with the settings requirements of the Final Rule by March 17, 2023. For current sites the State believes overcome the presumption of institutionalization and meet the requirements of the Final Rule, the State will submit to CMS information or documentation ensuring all individuals served in that setting are afforded the degree of community integration required by the Final Rule. Sites that are not able to come into compliance by this date will be de-designated as a Children's Waiver HCBS provider. Additionally, during the annual case review and audit, HCBS providers will be continually monitored to ensure continued compliance with the Final Rule, including person-centered service planning and freedom of choice for participants. For new providers seeking designation to provide HCBS, NYS will conduct a review of the provider to ensure compliance with the HCBS Settings Rule through the following steps: Provider self-assessment Documentation review of policies/procedures Potential site visit <u>HCBS Settings Rule Resources</u> Please refer to Appendix B and the DOH website for more information about the CMS Final Rule. CMS also has an HCBS Requirements Compliance Toolkit.	
Added descriptive language for Criminal History Record Checks (CHRC) through DOH as a Required Clearance	The CHRC is a fingerprint-based, national FBI criminal history record check. CHRC is required for HCBS provider employees who provide direct care to members under the age of 21 (with limited exceptions).	**17**
Added documentation expectations within "Training Requirements"	Each HCBS provider agency must maintain documentation indicating that all staff who provided HCBS during the Waiver Year (including those staff no longer employed by the agency) meet all training, qualifications, and required employment check requirements based upon the designation of the agency and the service provided by the staff member. Designated HCBS provider agencies will be required to submit proof of this documentation to the State on at least an annual basis. This information is required to be reported to NYS DOH as part of the waiver case review and audit to meet performance measures within the Children's Waiver and reported to CMS.	**19**
Added new section for "Attestation for Foreign Education Documents"	<u>Attestation for Foreign Education Documents</u> HCBS designated provider agencies that employ staff who have obtained their education outside the United States must complete the Use of Foreign Education Documents to Verify HCBS Staff Qualification Requirements attestation for each applicable staff member. This attestation should be kept in the employee's file along with a copy of the relevant documentation.	**19**

Update Made	Updated Text	Page
Clarified that risk factors for HCBS eligibility and enrollment are "if applicable"	Children's HCBS eligibility is comprised of three components: 1) target criteria, 2) risk factors, **if applicable,** and 3) functional criteria.	**Throughout "HCBS Eligibility and Enrollment"**
Updated language in overview of "HCBS Eligibility and Enrollment" to reflect current guidance	Additionally, this trigger will send a report to DOH Capacity Management system to add the Recipient Restriction Exception (RR/E) Code K-codes to the child's/youth's Medicaid file demonstrating that the child/youth is **eligible and enrolled** in the Children's Waiver and can receive services […] The HHCM/C-YES will send the child/youth a Notice of Decision, which will document the outcome of the HCBS/LOC Eligibility Determination and provide information on State Fair Hearing rights. **HHCMs/C-YES must notify the child/youth of the HCBS/LOC eligibility determination within 3 – 5 business days of determining the eligibility outcome.** Once the HCBS/LOC Eligibility Determination outcome is complete within the UAS, it remains active for one year from the date of signature and finalization~~ed date~~, with three exceptions: 1. […] 2. […] 3. If the child/youth is **placed in a restrictive setting i.e.**, hospitalized or institutionalized for longer than 90 days and is disenrolled from the Waiver (as noted below) […] The target criteria, risk factors, **if applicable**, and functional limits must be documented in the UAS. Children/youth seeking HCBS who are not otherwise eligible for Medicaid (e.g. income and resources are above Medicaid eligibility allowances) should be referred to Children and Youth Evaluation Services (C-YES) and must meet a needs-based criterion for Medicaid eligibility determination via the following process: • C-YES must complete the HCBS/LOC Eligibility Determination • **If found HCBS/LOC eligible**, C-YES 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 **by choice of the child/youth/family** • ~~Whether a child meets the LOC criteria, eligible children/youth and their families will have access to all HCBS services~~ HHCM or C-YES must retain the letter of notification, LOC eligibility determinations, home assessments, plans of care, and all other information pertaining to the child/youth's **eligibility determination**, enrollment and continued eligibility for the Waiver in the applicant's file.	**20-22**

Update Made	Updated Text	Page
Clarified active timeframe for the HCBS/LOC Eligibility Determination outcome	Once the HCBS/LOC Eligibility Determination outcome is complete within the UAS, it remains active for one year from the date of signature and finalization ~~**date**~~.	**21**
Added language to emphasize the importance of timely submission of NOD to discontinue services	HHCM/C-YES must issue an adequate **and timely** NOD to discontinue services.	**23**
Updated information regarding DDRO Manual Reference	Deleted the following bullet in "Additional Reasons for NOD Forms": ~~"DD Med Frag or DD foster care, the DDRO will inform the HHCM/C-YES (and the family or caseworker if applicable) of the outcome of the ICF-I/ID LOC and the HHCM/C-YES will provide the family with an NOD that describes the Fair Hearing process; the HHCM/C-YES will notify the DDRO when the Fair Hearing is and the region they are communicating with."~~ Replaced with the following bullet: "**For children/youth in the Target Populations DD Med Frag or DD foster care, please refer to the OPWDD DDRO Manual for Children's Waiver for guidance for each applicable situation."**	**24**
Moved location of "Fair Hearing" section	Moved the "Fair Hearing" section to directly after the NOD section.	**24**
Added language on timeframe requirements for completion of HCBS LOC eligibility re-determination	All HHs, HH CMAs, and C-YES should audit their records of Waiver-enrolled children/youth to ensure all HCBS LOCs are up to date and **completed timely**. HHCM/C-YES staff should begin gathering annual re-determination supporting documentation two months prior to the re-determination due date to ensure enough time to complete the annual HCBS LOC **within the required timeframe (365 days).**	**25**
Clarified that the CANS-NY must be completed yearly.	**The CANS-NY is completed on a yearly cadence otherwise and may not coincide with the HCBS/LOC eligibility determination.** […] HH comprehensive care management ensures a holistic assessment, through the CANS-NY **(completed yearly)** and comprehensive assessments, of the child/youth's behavioral health, medical, community and natural supports as identified through a person-centered Plan of Care (POC) by the child/family.	**26, 30**
Updated description language for Capacity Management	Capacity Management is the process by which New York State manages the ~~**combined**~~ **allowable number of enrolled participants and available** slots for the 1915(c) Children's Waiver.	**26**
Updated language about the Capacity Management Process	The NYS DOH Capacity Management Team receives information from the Uniform Assessment System (UAS) daily reporting all completed HCBS/LOC Eligibility Determinations. This report allows the DOH Capacity Management Team to begin the process to place the K-codes on the participant's Medicaid file to notify HCBS providers and Medicaid Managed Care Plans that the	**26 - 27**

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	child/youth is eligible and enrolled within the Waiver. The Capacity Management Team will notify the HHCM/C-YES assessor of any newly assessed *(initial assessment only)* and eligible child/youth of their slot availability within one business day of the completed, signed/finalized assessment outcome. The HHCM/C-YES assessor will receive a Health Commerce System (HCS) Secure File Transfer (SFT) email with a subject line "Slot Availability" indicating if the child/youth has secured a slot prior to HCBS being provided or if the child/youth is on a waitlist. The HHCM/C-YES should not send Notice of Decisions or send HCBS referrals to providers until verifying the new member slot availability. It is necessary for HHCM/C-YES to also notify DOH Capacity Management Team when a participant is being disenrolled from the Waiver so the K-code can be removed from the participant's Medicaid file. There are specific requirements about how and when communication is required by HHCM/C-YES to Capacity Management, which are located in the Children's Waiver Communication to/from NYS Capacity Management Requirements and the Capacity Management and RR/E K-Codes Webinar.	
Added language about Capacity Tracker/Waitlist Requirements	All HCBS Providers are required to complete the Children's Services Capacity Tracker survey every three weeks. Due dates for the survey are on Friday~~'~~s at 11:59pm. The Children's Service Capacity Tracker is located within the Incident Reporting and Management System (IRAMS) system and is a requirement for compliance. In addition to the survey, providers are required to maintain an ongoing waitlist within the system. This Capacity Tracker is distinct from the DOH Capacity Management Process outlined in the previous section.	**27**
Added language to Disenrollment Process to reflect requirements	**The HHCM/C-YES must give notice to the HCBS providers, Medicaid Managed Care Plans, and other involved providers of the disenrollment/discharge of a participant.** The HHCM/C-YES must also communicate ~~any changes in status due to~~ **any** discharge and/or disenrollment to DOH Capacity Management in a timely manner and provide the date of discharge or disenrollment, reason for discharge or disenrollment, name, date of birth, CIN, and Target Population.	**29**
Clarified that children can remain in the Waiver if they continue to require some HCBS, after having been discharged from other HCBS	In some cases, a child/youth may be discharged from an individual HCBS that no longer meets the child/youth's goals, but the child/youth may remain in receipt of additional needed HCBS **and enrollment within the Waiver.**	**29**
Added language to reflect current guidance on care management	Care management is required for all participants receiving HCBS. The HCBS referred and provided cannot duplicate or replace existing and required care management services through HHCM/C-	**30**

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	YES. HCBS providers must communicate with HHCM/C-YES regarding any additional care management needs the participant/family may have; it is then the HHCM/C-YES's responsibility to coordinate such related services.	
Replaced "face-to-face" with "in-person"	Removed: ~~face-to-face~~ Added: in-person	**Throughout**
Added language on Medicaid Family of One	In-person meetings between the HHCM and the child/family are required based upon CANS-NY acuity or if the child/youth has Medicaid Family of One **budgeting and is not receiving a monthly HCBS.**	**31**
Added language about the POC development process and review timeline	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 guidelines/principles**. **The person- centered service planning process guides the delivery of services and supports towards achieving outcomes in areas of the individual's life that are most important to them (e.g., health, relationships, work, and home, etc.). HHCMs/C-YES and MMCPs 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 POC development is based upon the assessment of needs which is determined through interaction with the child/youth, their family, **the child/youth's representative (if applicable)**, and identified supports as well as through the multi-disciplinary team meeting/information, CANS-NY (for HH), HH Comprehensive Assessment, and HCBS/LOC Eligibility Determination.	**32**
Updated the timeline for the review of the POC to annually.	At a minimum, the POC must be reviewed **annually.** ~~six months~~, **The POC must also be reviewed any time** ~~if~~ the child/youth, and/or parent/guardian requests **a review** ~~it~~ **and any time** ~~or earlier if there is~~ a significant life event **occurs.**~~, as well as~~ **The POC must be reviewed** during the HCBS/LOC Eligibility determination reassessment.	**32**
Replaced the "Person Centered Service Planning Guidelines for Managed Care Organizations and Local Department of Social Services" section with a link to this guidance within "POC Development" section	Please see link within document.	**33**
Updated language about "Development of the POC and Referrals for HCBS"	HCBS providers should have a role in POC **updates and changes to the** ~~development prior to~~ POC.~~ finalization~~. **To obtain and document consent for the HCBS provider to communicate with care team members, HCBS providers must have their own consent form and related policy and cannot utilize the HH 5201 form.**	**33**

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Updated language for “HCBS Service Plan"	**The HCBS provider is required to communicate the scope, duration, and frequency of the service to** ~~When indicated,~~ the HHCM/C-YES **and have regular contact regarding the service delivery and the service plan progress.** ~~will coordinate multiple HCBS Service Plans in collaboration with HCBS providers.~~	**34**
Added note to clarify timeframes for “Components of a HCBS Service Plan”	Note: The duration of a service should not exceed 6 months at a time. This timeframe provides enough time for the HCBS provider to evaluate if the service(s) is meeting the child/youth’s needs and whether the service(s) should be continued or discontinued.	**34**
Updated timeframe for HCBS provider monitoring of the Service Plan	The HCBS Service Plan should be monitored regularly ~~and reviewed at minimum~~, every ~~six~~ month when services are delivered.	**35**
Updated language for “Expectations for the Development of a HCBS Service Plan”	The HCBS Service Plan **should begin with the service(s) referred to an HCBS provider** ~~and~~ **based upon the needs identified by the HHCM/C-YES. The HCBS Service Plan should continue the care manager’s discussion with the child/youth and family/caregiver while ensuring their involvement in the development of the Service Plan and** ~~should be developed in conjunction with the child/youth and family/caregiver to ensure~~ that the goals outlined by the child/youth and family/caregiver are captured in the plan. […] The frequency of services should be in relation to other appointments or commitments the child/youth may have, including but not limited to any educational or vocational placement, medical or behavioral health therapies, community activities, etc. **and not be delivered beyond “typical" hours available when these things are considered in addition to the child/youth’s age, attention span, and development. HCBS cannot be provided during school/educational hours** A plan, including the types of interventions provided and the goals to be achieved, ~~should~~ **must** be developed that is reflective of the developmental and physical needs of the child/youth. The HCBS Service Plan should be monitored regularly and reviewed at minimum, every ~~six~~ month~~s~~; **when services are delivered**. ~~however, if can be more often if appropriate.~~ […] **The HCBS provider must communicate with the HHCM/C-YES regarding any changes, so it can be determined if there is a change needed to the child/youth’s POC as well as the potential for other services needed.**	**35 – 36**

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	~~The initial Service Plan and any subsequent updates must be shared with the HHCM/C-YES and/or MMCP as described in the HCBS POC Workflow section.~~ **Note: Based on the 1915(c) Waiver amendment from April 2022, "Caregiver Family Supports and Services" (CFSS) was combined with "Community Self-Advocacy Training and Supports" (CSATS) into the consolidated service "Caregiver/Family Advocacy and Support Services." If a child had separate service plans for CFSS and CSTAS, these separate plans must be combined into one plan under the new service title. Please also note that when appropriate, a Service Plan may include all HCBS that a child/youth receives from an agency on one singular Service Plan.**	
Added new section on "Plan of Care Workflow" to replace previous Appendix reference.	Plan of Care Workflow DOH issued the HCBS POC Workflow Policy and the required use of related forms to facilitate information sharing between the HHCM/C-YES, HCBS providers, and MMCPs. Please refer to the HCBS POC Workflow Policy for the complete HCBS POC Workflow process.	**36**
Added documentation requirement within "Participants Rights and Protections" section	In compliance with CMS and the 1915(c) Children's Waiver, participants must be informed of their ~~Freedom of Choice~~ **rights and protections** 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. **Documentation indicating that this information has been provided must be included in the child/youth's case file maintained by the designated HCBS provider agency.**	**36**
Added examples of conflicts of interest that do not uphold the Conflict Free Case Management Policy	Further, for HHCMs who are also employed by an HCBS provider, that HHCM cannot provide HCBS to children/youth who are also on the HHCM's case load. Note: To maintain the enrollee's autonomy and Freedom of Choice, it is *not* allowable for a HHCM or HCBS Provider to be related by blood or marriage to the served child/youth. Further, an individual residing in the same residence as the HCBS-enrolled child/youth or in a relationship with someone residing in the same residence, would not be an appropriate HHCM or HCBS provider. It is up to the agency to determine if a conflict of interest is present in a potential staffing relationship beyond the specifics provided above, and whether the family believes there is an opportunity for Freedom of Choice. Subsequently, it is not appropriate and is a conflict to request that the child/youth/family/caregiver find and or obtain their own provider to then be employed by an HCBS provider.	**39**
Added new section on "Quality Monitoring and Oversight"	Quality Monitoring and Oversight	**39**

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	HCBS providers are responsible for developing policies, procedures, and processes that align with the requirements to deliver HCBS. HCBS providers are required to ensure all staff/employees/providers working for the designated agency are properly trained to all HCBS requirements and monitored for compliance with the requirements outlined in the Background Check Requirements for HCBS Providers policy. HCBS providers should have a process in place to monitor and regularly audit cases and the delivery of services.	
Added "Annual Children's Waiver Case Review and Audit" section	Annual Children's Waiver Case Review and Audit On an annual basis, the NYS DOH will conduct a case review and audit of the previous waiver year's (April 1st through March 30th) services and providers, inclusive of HCBS providers, Health Homes, Health Home care managers, and C-YES policies, records, reporting, claims/billing, and other HCBS requirements. This information is required to be reported to NYS DOH as part of the waiver annual case review and audit to meet performance measures within the Children's Waiver and reported to CMS. HHs, HH CMAs, C-YES, and HCBS providers must comply with all requests for records and files, as well as agency's/organization's practices as requested by NYS DOH or their designee. Agencies/organizations can be de-designated for care management services or HCBS if failing to meet these requirements.	**39 – 40**
Moved HCBS billing and coding information from combined standalone *New York State: Children's Health and Behavioral Health Medicaid System Transformation: Billing and Coding Manual* into this document. General information is captured in the "Billing and Coding for HCBS" section and service-specific details, such as rate codes, within the "Service Definitions" section.	Please see "Billing and Coding for HCBS" and "Service Descriptions" sections.	**40**
Added "Non-Medical Transportation" to the list of services that do not require State Designation	The following services do not require State designation; these will be coordinated between the Care Management agency/C-YES, LDSS/MMCP, and DOH. • Adaptive and Assistive Technology (AT) • Environmental Modifications (EMods)	**41**

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	• Vehicle Modifications (VMods) • **Non-Medical Transportation**	
Updated language about timeframe for MMCPs to pay government rates	~~Upon the transition date of the respective services,~~ MMCPs will be required to pay government rates ~~for at least 24 months or as long as governed by State law~~ **until otherwise notified.**	**42**
Added circumstantial exception to 90-day time filing rules for Medicaid FFS	Claim submissions need to adhere to the 90-day timely filing rules for Medicaid FFS, **unless the claim is delayed due to circumstances outside of the provider's control—for example, attempts to recover from a third-party insurer or legal proceedings against a responsible third-party.**	**42**
Updated language on process and requirements for "Medicaid Managed Care Plan Claiming"	~~NYS will give MMCPs a complete listing of all existing providers and the rate codes they bill under, as well as the rate amounts by MMIS provider ID, locator code and/or NPI and zip+4. This list will also be posted on the OMH and OASAS websites.~~ Billing requirements depend on the type of service provided; however, every claim submitted will require at least the following: • […] MMCPs will not pay claims if submitted without the applicable rate code, CPT code, and modifiers. If an individual service has multiple modifiers listed, they must all be included on the claim submission. **If an MMCP receives an HCBS claim for a child whose enrollment in the Children's Waiver cannot be verified by confirming a K1 Recipient Restriction/Exemption (RR/E) code on the child's record, and/or if the MMCP has not received an HCBS Authorization and Care Manager Notification Form for the billed service(s) provided beyond the initial 24 hours/60 days/96 units, the MMCP should deny the claim for lack of verification of Children's Waiver eligibility, enrollment, and approved service. The MMCP may also deny the claim if the units billed are not supported by the frequency, scope, and duration documented on the HCBS Authorization and Care Manager Notification Form.**	**44**
Added language on submission of non-risk payment claims	The MMCP capitation payment will not include Children's HCBS and MMCPs will not be at-risk for Children's HCBS until **at least** September 30th, 2023. DOH will confirm this date in writing. MMCPs will be reimbursed on FFS basis outside the capitation rate by submitting claims for Children's HCBS to NYS under supplemental rate codes. **All non-risk payment claims that have a valid delay reason code must be submitted to eMedNY within two years from the date of service. Please refer to eMedNY for further information regarding non-risk billing guidance.** **Non-risk payment claims must include the same fields as in all other claims (i.e., rate code, procedure code, modifier(s) as applicable, units of service, revenue codes). The rate code/CPT code/modifier code combinations for the services described in this document are shown within each "Service Billing Details" subheader in the Service Definitions section.**	**45**

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Added "Third-Party Health Insurance Denials" section	Third-Party Health Insurance Denials It is the provider's responsibility to determine the type of coverage (Medicare, Medicaid, or private insurance) that the member is eligible to receive. Medicaid is the payor of last resort and all Medicare and third-party coverage must be exhausted before payment for HCBS by Medicaid. Acceptable documentation of attempts to secure third party reimbursement as required under 18 NYCRR §540.6 includes documentation of a rejection by third party insurance for a date of service within the previous 12 months of the date of service being billed, or since a change in third party coverage, whichever is later. There are exceptions to this requirement for 29-I Health Facilities delivering HCBS to children/youth in foster care. Refer to the 29-I Billing Manual for additional details.	**45**
Added further guidance on "Services Delivered by Multiple Staff Members"	Services and staffing should be streamlined whenever possible. No more than two practitioners can provide HCBS to the child/youth and family members/resources on the same date and at the same time.	**44**
Added new section on "Services Provided During School/Day Time"	Services Provided During School/Day Time HCBS cannot be duplicative or delivered at the same time as services otherwise available to the individual through a local educational agency for educational services in grades K - 12 under the Individuals with Disabilities Education Act (IDEA) or Vocational Rehabilitation under the Rehabilitation Act of 1973. The schedule for HCBS delivery for children/youth who attend K-12 school in-person must be outside of regular school hours. For students who are home schooled or receiving virtual instruction, HCBS can be delivered during traditional school hours, but the services must be outside the scheduled time for educational instruction provided to the child. Support for adult education outside of K-12 education may be provided under the HCBS waiver. Technical schools, colleges, and other adult education settings are approvable HCBS settings because adult education and adult education settings are not addressed/prohibited under the IDEA. Please refer to "HCBS Versus State Plan Services Delivered During School/Day Time" for more information.	**46**
Updated billing examples that were moved from the combined *New York State Children's Health and Behavioral Health Medicaid System Transformation: Billing and Coding*	Please see "Billing and Coding Manual" section.	**Throughout**

<table>
<tr><th>Update Made</th><th>Updated Text</th><th>Page</th></tr>
<tr><td>Manual to reflect HCBS instead of CFTSS.</td><td></td><td></td></tr>
<tr><td>Added new section for “Out of State Services”</td><td><u>Out of State Services</u>
Only providers located in New York State are eligible to become designated HCBS providers. Children/youth must be enrolled in New York State Medicaid to receive Children’s HCBS, and the services must be provided in the state in which the Medicaid recipient is enrolled in Medicaid. As such, while an individual HCBS provider may reside in a neighboring state, the HCBS must be provided in New York State by an HCBS provider that is located in and designated in New York State.</td><td>47</td></tr>
<tr><td>Clarified the guidelines on claims for non-sequential time for the same service on the same day.</td><td>If the same service is delivered to the same child/youth on the same day but at non-sequential times, the total time spent on the service must <s>may</s> be submitted as a combined claim.</td><td>48</td></tr>
<tr><td>Removed the 90-day timeframe guideline for claims submission testing</td><td>Children’s HCBS providers are expected to test the claims submission process with MMCPs for all delivered services prior to the service implementation date and upon executing a new contract. <s>This should begin no later than 90 days prior to the implementation date.</s></td><td>49</td></tr>
<tr><td>Added new overview description to “Service Definitions” section about all HCBS</td><td>Please see “Service Definitions” section.</td><td>50 – 51</td></tr>
<tr><td>Removed requirement for staff to receive “Personal and Safety in the Community” training prior to service delivery</td><td>The provider agency must ensure that staff receive Mandated Reporting training <s>and Personal Safety in the Community training</s> prior to service delivery</td><td>All Services</td></tr>
<tr><td>Updated required timeframe for completing some staff trainings</td><td><table><tr><th>Trainings Required</th><th>Requirement Completion Timeframe</th></tr><tr><td>• Mandated Reporter</td><td>• Prior to service delivery</td></tr><tr><td>• Personal Safety/ Safety in the Community
• Strength Based Approaches
• Suicide Prevention
• Domestic Violence Signs and Basic Interventions
• Trauma Informed Care</td><td>• <s>For staff hired before April 1, 2019, training must be completed within six (6) months of the 1915(c) Children’s Waiver implementation.</s>
• <s>For staff hired on or after April 1, 2019,</s> Training must be completed within six (6) months of hire date.</td></tr></table></td><td>All Services</td></tr>
<tr><td>Added language about HCBS initial authorization timeframe and documentation requirements</td><td>HCBS should be authorized for no more than six months at a time and based on each participant’s unique needs. To exceed billing limits for children/youth enrolled in managed care, providers must contact the MMCP to receive guidance regarding the Plan’s specific documentation requirements in these instances ; for children/youth enrolled in FFS, HCBS providers must maintain</td><td>All Services</td></tr>
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	documentation from a licensed professional that outlines the need to exceed the service limit (e.g., copy of an assessment from a licensed professional; letter from a licensed professional that clearly describes the need for additional units of service, etc.).	
Updated group size for Community Habilitation billing	Community HCBS Habilitation – Group of 3 ~~or 4~~	**57**
Added new section on "Guidelines for Medical necessity Criteria for Children, Adolescents, and Young Children"	Please see "Guidelines for Medical necessity Criteria for Children, Adolescents, and Young Children" section.	**57-60**
Clarified that Day Habilitation is provided in an OPWDD certified setting	Day Habilitation (DH) services must be provided to a child/youth at **an OPWDD 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.~~ Day Habilitation (DH) services are provided to a child at **an OPWDD certified setting.** ~~NYS certified (e.g., OPWDD certified) setting.~~.	**61**
Removed duplicative guidance on allowable settings for Day Habilitation services	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.~~	**61**
Removed requirement for direct support professionals to be employed by a designated agency for Day Habilitation	Direct support professionals must ~~be employed by the designated agency and~~ have completed the training stipulated in 14 NYCRR Part 633.8 and the Direct Support Professionals Core Competencies curriculum.	**63**
Added clarification about utilization review and authorization	**In addition to requiring concurrent utilization review and authorization,** the MMCP may conduct post-payment administrative reviews to ensure services were provided appropriately.	**All Services**
Updated group size for Day Habilitation billing	Day HCBS Habilitation - Group of 3 ~~or more~~	**65**
Clarified that HCBS cannot duplicate or replace special education and related services	• **Caregiver/Family Advocacy and Support Services** cannot duplicate **or replace** 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)	**67**
Clarified that Caregiver/Family Advocacy and Support Services	• **Caregiver/Family Advocacy and Support Services cannot duplicate or replace existing and required care management services provided through HH/C-YES.**	**67**

Update Made	Updated Text	Page
cannot duplicate or replace HH/C-YES care management		
Added definition of overnight respite and provided guidance on when it should be used	Overnight Respite is defined as Respite services provided to a person on two consecutive days when Respite staff are providing oversight to a participant during nighttime hours. Overnight Respite should follow the general limits for respite (see below). Overnight Respite should be used in instances to enhance the family/primary caregiver's ability to support the child/youth's functional, developmental, behavioral health, and/or health care needs or to help alleviate the risk for an escalation of symptoms, a loss of functioning, and/or a disruption in a stable living environment. Overnight Respite is not a substitute for childcare.	**71 – 72**
Added example to clarify when respite should be used	Respite is not a substitute for child care and should only be used in instances to enhance the family/primary caregiver's ability to support the child/youth's functional, developmental, behavioral health, and/or health care needs. The needs of the child/youth should be driving this service and not the availability of the family/primary caregiver to supervise the child/youth. For example, accompanying a child/youth to a community activity at a local park from 5 PM – 7 PM would be billable if aligned with the child/youth's POC and in alignment with the f/s/d outlined in the HCBS Service Plan, whereas the provider staying in the home from 8 PM – 10 PM to provide supervision after bedtime would not be billable.	**73**
Added guidance on requirements to qualify for Overnight Planned or Crisis Respite	For Overnight Planned or Crisis Respite, the designated provider **must meet the Provider Agency Qualifications above AND** 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	**74**
Removed "employed by the designated agency" as a requirement for individual staff qualifications (except for Community Habilitation)	Please see "Service Descriptions" section.	**Throughout**
Added per diem billing guidance for respite	Annual units for Planned and Crisis Respite are limited to 14 days (full per diems) during the calendar year or 1,344 15-minute units annually. The cumulative total hours of all Planned and Crisis Respite services received may not exceed the 14 day/1,344 15- minute unit annual amount without medical necessity documented in the child's case record. If the child is enrolled in a MMCP, approval from the MMCP must also be documented in the child's case record. The following are examples of permissible Respite billing combinations (total 1,344 15-minute units OR 14 per diems during the calendar year):	**77**

Update Made	Updated Text	Page
	• 48 15--minute units/week for 28 weeks Two 24-hour per diem units and 22 15-minute units/week for 52 weeks with 104 additional 15-minute units to be used throughout the year • 24 hours for 14 days <u>Guidance on Per Diem Billing</u> It is permissible to provide and bill for another HCBS while overnight Respite is also provided at the full per diem rate during the same day, provided that the child/youth is in the care of the Respite provider for at least 12 cumulative hours. For example, a provider can bill for the per diem Crisis Respite rate while the child/youth attends a necessary and/or regularly scheduled medical appointment, provided that the child/youth is in the care of the Crisis Respite provider for at least 12 cumulative hours outside of the time the child/youth spent at the medical appointment. If the child/youth is in the direct care of the Respite provider for less than 12 cumulative hours while receiving other services (e.g., medical services/appointments), then the 6 – 12 hour or up to 6 hour rate should be billed. Providers must properly document why the break in service was needed and necessary during the provision of overnight respite. As indicated in the Respite limit guidance noted above, the total Planned and Crisis Respite claims cannot total more than 336 hours within the calendar year.	
Updated language around limitations/exclusions for receiving Prevocational Services	Prevocational services will not be provided to an HCBS participant if: • Special education and related services are otherwise available to the individual through a local educational agency, under the provisions of the Individuals with Disabilities Education Act (IDEA), **and the provision of HCBS Prevocational services would be duplicative of such services.** • Vocational rehabilitation services are otherwise available to the individual through a program funded under section 110 of the Rehabilitation Act of 1973 (Access VR), **and the provision of HCBS Prevocational services would be duplicative of such services.**	**79**
Updated language around limitations/exclusions for receiving Supported Employment services by an HCBS participant	Supported Employment service will not be provided to an HCBS participant if: • Special education and related services are otherwise available to the individual through a local educational agency, under the provisions of the Individuals with Disabilities Education Act (IDEA), **and the provision of Supported Employment would be duplicative of such services.** • Vocational rehabilitation services are otherwise available to the individual through a program funded under section 110 of the Rehabilitation Act of 1973, **and the provision of Supported Employment would be duplicative of such services.** • […]	**83 – 84**

Update Made	Updated Text	Page
	• Supported employment does not include payment for supervision, training, support, and**/or** adaptations typically available to other workers without disabilities filling similar positions in the business.	
Updated description of palliative care eligibility	Palliative Care is specialized medical care focused on providing relief from the symptoms and stress of a chronic **medical, physical, or developmental** condition or life-threatening illness. The goal of Palliative Care services is to improve quality of life for both the child/youth 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/youth's doctors to provide an extra layer of support. It is appropriate at any stage of a chronic **medical, physical, or developmental** condition or life-threatening illness and can be provided along with curative treatment. Children/youth must meet LOC functional criteria and suffer from the symptoms and stress of a chronic **medical, physical, or developmental** condition or life-threatening illness.	**Throughout**
Updated Counseling and Support Services language for Palliative Care	Counseling and Support Services can be ~~inclusive for~~ **provided to** ~~those~~ participants who are receiving services with a hospice care provider, if the services are not duplicative.	**94**
Updated Modality details for AT, VMods, and EMods.	The HHCM/C-YES will coordinate requests for [AT/VMod/EMod] with the LDSS in conjunction with DOH for children/youth enrolled in Fee-for-Service Medicaid. The HHCM/C-YES will coordinate requests for AT with the Medicaid Managed Care Plan for children/youth enrolled in a MMCP.	**103, 107, 111**
Clarified MMCP billing guidance for AT, VMods and EMods	The table below shows the rate code, CPT code, and modifier code combinations that will be required under Medicaid Managed Care. ~~Providers will use these coding combinations to indicate to the MMCP that the claim is for a children/youth's service and is to be paid at the government rate.~~ The procedure and modifier code combinations must be adhered to by ~~both provider and~~ the MMCP to ensure appropriate rate payment.	**101**
Updated the Service Billing Details for AT, VMods, and EMods to simplify the description and reflect current guidance.	When the LDSS requires upfront funds for an [AT/VMod/EMOD] service, the LDSS must submit the ***Pre-project Evaluation Payment Request Form*** **and/or the** *Description and Cost Projection Form,* ***as appropriate,*** with all supporting documents to the NYS DOH. NYS DOH's ~~CFCO-Children's Prior Approval~~ **Children's Waiver** staff will process the request for SPV funds, including requesting that a check be issued to the County Treasurer at the LDSS. Please note, the check will be issued from the Office of Temporary and Disability Assistance (OTDA). **If the request is not approved, the LDSS will be so notified. If additional information is needed, the disbursement may be delayed pending submission of the additional information.**	**105, 109, 113**
Updated limits for VMods	Contracts for Vehicle Modifications may not exceed $~~15~~**25,**000 per calendar year without prior approval from DOH or the MMCP.	**107**
Updated Service Billing Details for Non-Medical Transportation.	Non-Medical Transportation will be paid fee-for-service for eligible children/youth, **regardless of whether the child/youth is enrolled in Medicaid Managed Care. Please refer to the Medicaid Transportation Guidelines for more details.**	**117**

<table>
<tr><th>Update Made</th><th>Updated Text</th><th>Page</th></tr>
<tr><td>Added a footnote about the LPHA Attestation in “Appendix A: Glossary of Key Terms”</td><td>*The LPHA Attestation form is no longer required for the Target Populations of Medically Fragile (MF) or Developmental Disability who are Medically Fragile (DD/MF).</td><td>120</td></tr>
<tr><td>Removed previous “Appendix D: Utilization Management/Medical Necessity Guidelines for Children’s Aligned Home and Community Based Services”</td><td>Will be replaced with standalone guidance.</td><td></td></tr>
<tr><td>Removed “Person Centered Planning Guidance” and linked to document instead</td><td>Please see link to guidance within document.</td><td></td></tr>
<tr><td>Removed “HCBS Plan of Care Workflow” appendix and linked to document instead</td><td>Please see link to guidance within document.</td><td></td></tr>
<tr><td>Removed Policy and Webinar Grid from appendix and linked to documents as they appeared in the Manual instead</td><td>Please see link to each policy within document.</td><td></td></tr>
<tr><td>Removed RR/E Codes for the Children’s Waiver that is not in use currently</td><td><table><tr><th>RR/E Code</th><th>R/RE Code Description</th></tr><tr><td><s>K2</s></td><td><s>HCBS LON (not in use currently)</s></td></tr><tr><td><s>K7</s></td><td><s>HCBS Complex Trauma (not in use currently)</s></td></tr></table></td><td>161</td></tr>
<tr><td>Updated allowable HCBS combinations with Youth ACT</td><td>In Appendix M: Allowable Billing Combinations, updated the allowable combinations of HCBS with Youth ACT to “no” for all HCBS and added the following asterisk:

*Youth ACT has care management built in and is considered an all-inclusive program for Mental Health. As such, on-going co-enrollment with HCBS is not allowable because of the care coordination fo both services except for 30 days prior to discharge from Youth ACT.</td><td>163 – 164</td></tr>
</table>