Department of Health | Office of Mental Health | Office of Addiction Services and Supports | Office of Children and Family Services | Office for People With Developmental Disabilities

State Discussion with Children's Waiver HCBS Providers

September 20, 2023

Purpose

- For the Department of Health (DOH) to share updates, guidance, and policy changes, and obtain feedback from Home and Community Based Service (HCBS) providers.
- Provide an opportunity for HCBS providers to discuss barriers and be a part of the problem-solving discussion.
- Have an open dialogue to communicate issues and concerns.

Agenda

- ✓ eFMAP Funding Approval
- ✓ Recently Issued Announcements/Guidance:
  - ✓ Extension of Non-Risk Minimum Payment Requirement for Children's HCBS
  - ✓ Updates to Billing Requirements for Children's HCBS, CFTSS, and 29-I OLHRS
  - ✓ Children's HCBS MMCP Transfer Continuity of Care Requirements
- ✓ Overview of the Electronic HCBS Referral Process & Updated Referral Form
- ✓ Updates to the Children's HCBS Authorization and Care Manager Notification Form
- ✓ CFASS Staffing Changes and Authorization
- ✓ Documentation Requirements for HCBS Providers
- ✓ Manual Updates

eFMAP Funding Approval

ARPA eFMAP Funding

- DOH is pleased to announce that Workforce & Infrastructure funds for children's behavioral health providers as part of Section 9817 of the American Rescue Plan Act (ARPA) of 2021 have been **approved** for release.
- State-only funds were released directly to eligible providers on **September 13, 2023.**
- Per guidance issued on September 14, 2023, Plans will receive funding on **September 20, 2023**, and must distribute awards to eligible providers within their networks by **October 20, 2023**.
- Additional information on final award amounts & eligible uses of funds were provided to eligible providers at the end of August.

➢ Please reach out to BH.Transition@health.ny.gov with questions

Extension of Non-Risk Minimum Payment Requirement for Children's HCBS

Announcement

In 2020 and 2022, due to the Public Health Emergency (PHE),
DOH **extended the requirement for MMCPs** to pay government rates without a specific end date.

DOH has again extended the deadline required for MMCPs to pay government rates for Children's Waiver HCBS effective for dates of service through **March 31, 2024.**

- Payment of Children's HCBS by MMCPs will continue to be **non-risk** while this requirement is in effect.
- MMCPs should **continue to submit claims** for Children's HCBS **with dates of service on or before March 31, 2024**, to eMedNY via the established rate codes.
- For HCBS providers, this means the rates set by NYS DOH must be paid by the MMCPs, if the services are authorized.
- Additional guidance will be issued if this requirement is extended further.

MMCP regarding non-risk minimum payment for Children's Waiver Home and Community Based Services (ny.gov)

Updates to Billing Requirements for Children's HCBS, CFTSS, and 29-I OLHRS

Billing Updates

Billing Requirement Updates	Additional Key Details
DOH will **implement a billing change to allow claims** for Children's HCBS, Article 29-I Health Facility Other Limited Health-Related Services (OLHRS), and Children and Family Treatment Support Services (CFTSS) **to be paid based on the county in which services were provided**.	Change will be in effect **as of December 1, 2023,** to align with the Centers for Medicare and Medicaid Services (CMS) billing requirements, which dictate that services must be reimbursed based on the location of service delivery, not administrative offices of providers.
DOH has assigned a **Federal Information Processing Standards (FIPS) code*** and a proxy locator code to each county in New York State. The county FIPS and proxy locator codes can be found here	Applicable FIPS (if submitting electronically) or proxy locator (if submitting on paper) county code, indicating service location, must be included on **all** Children's HCBS, CFTSS, and 29-I OLHRS claims submitted for dates of service on or after December 1, 2023.
To assist with this change, provide additional details, and answer questions, **DOH will host two webinars in October/November.**	The two webinars include one for **providers** and one for **MMCPs**.

Announcement is located here: 2023-09-05_bill_req_update_child.pdf (ny.gov)

Submitting Claims & System Updates

Submitting Electronic Claims

When submitting an electronic claim for Children's HCBS, CFTSS, or 29-I OLHRS with dates of service on or after December 1, 2023, providers must enter **Value Code 85 plus the applicable FIPS code.** Providers must continue to include any other value code that is necessary to accurately report the claim (e.g., rate code) in this box.

Submitting Paper Claims

When submitting paper claims for dates of service on or after December 1, 2023, providers must enter **Value Code 61 plus the applicable proxy locator code** in the Value Code box of the claim. Providers must continue to include any other value code that is necessary to accurately report the claim (e.g., rate code) in this box.

Systems Updates

The **eMedNY system is being reconfigured** to associate FIPS codes to the correct proxy locator codes.

MMCPs must configure their systems **to be able to accept the new billing changes**

- MMCPS have **until 12/1/23** to configure their systems to align with these requirements
- MMCPs are **not permitted to halt or delay payments** to providers while this reconfiguration is in process

Children's HCBS MMCP Transfer Continuity of Care Requirements

MMCP Transfer Continuity of Care

Purpose of the guidance: To ensure continuity of service delivery when HCBS providers are serving Children's Waiver members who transfer from FFS Medicaid to a MMCP, or from one MMCP to another MMCP.

Continuity Care Transition Period

Transfer from one MMCP to Another - *60 days continuity of care provision from the date of enrollment in new MMCP.*

Transfer from FFS to MMCP - *90 days continuity of care provision from the dare of enrollment in new MMCP.*

Delivery of HCBS must not be delayed or halted in any way as the result of a Plan transfer.

Guidance Document: 2023-09-05_childrens_hcbs_mmcptccr.pdf (ny.gov)

Notify MMCP

The HCBS provider must connect with the new MMCP ***within 5 business days*** after becoming aware of the enrollment change and submit a copy of the most recent Authorization Form and MMCP approval letter from the previous MMCP, if applicable, regarding approved F/S/D.

If HCBS is to continue beyond the existing authorization/day transition period, a new Authorization Form must be ***submitted 14 days prior to the expiration of the 60/90-day transition period*** or existing Authorization period, whichever comes first.

Verify Waiver and Plan enrollment

HCBS providers are expected ***to verify Waiver and Plan enrollment in ePACES at least once per month***.

Providers cannot submit requests for authorizations retroactively, outside of the transition period. MMCPs ***cannot deny claims for HCBS provided during the transition period*** for reasons related to authorization.

The first appointment date notification requirement is waived during the transition period for ***members who have an active authorization***.

Overview of the Electronic HCBS Referral Process & Updated Referral Form

Overview

DOH continues to work with Plans, providers, and HH/care managers to **update the HCBS Referral Form and referral process**.

- The implementation of the electronic HCBS Referral Portal within IRAMS is tentatively slated for November/December 2023.
- Based upon feedback from HCBS providers when reviewing the updated Children's HCBS Authorization and CM Notification form, the HCBS Referral Form completed by HHCM/C-YES is also being updated to give more information to HCBS providers that is required on the Authorization Form.
- HHCM/C-YES will be required to complete the version of this form that will be available in IRAMS once the electronic functionality is live.
- Please submit your feedback regarding the Updated HCBS Referral Form to BH.Transition@health.ny.gov.

HCBS Referral Form – Updates

Additions:

- Parent, Guardian, Legally Authorized Representation Field
- Resident County, Fiscal County, and Medical Consenter Fields
- Local District of Social Services (LDSS) County Representative Field
- Number of Siblings Residing in Home Field
- Requirement of the participant’s school or education/vocational program schedule
- Closure of Services Section
- Barriers, Obstacles, or Strategies related to all HCBS requested
- Summer Programming Schedule Field
- Requirement to provide the rationale for Medical Necessity for each HCBS
- Optional field for Other Services related to a Participant's Goal

Removals:

- HCBS Provider Information as a field to be completed (field will be automatically populated per the Participant’s Record)
- Referral Type Field

Updated HCBS Referral Form - Sections

Instructions:

All fields must be completed unless listed as optional or as applicable.

Section 1 – Completed by HHCM/C-YES

Participant Information

Participant Name ________________________________ Participant DOB ____________________

Participant Phone ____________________ Participant Email (optional)____________________

Participant Address ____

Participant CIN ______________ ☐ Check this box if the Participant is in Foster Care

If selected 'Participant is in Foster Care' above, Name of 29-I Foster Care Agency________________________

Residence County ____________________________

Fiscal County ____________________________

Fiscal County Representative ____________________________

Medical Consenter ____________________________

Note: Highlighted fields in green will be auto populated by the Electronic Health System

DRAFT

Updated HCBS Referral Form - Sections

Parent/Guardian/Legally Authorized Representative (P/G/LAR) Information

P/G/LAR # 1 – Please check one of the following

☐ **Parent** ☐ **Guardian** ☐ **Legally Authorized Representative**

P/G/LAR Name ______________________ P/G/LAR Email (Optional) ______________________

P/G/LAR Phone ______________________ ☐ Check this box if the Child and P/G/LAR live together

P/G/LAR Relationship to Child ______________________

P/G/LAR Address ______________________

☐ Check this box if this is Local District of Social Services (LDSS) County Representative

P/G/LAR # 2 – Please check one of the following

☐ **Parent** ☐ **Guardian** ☐ **Legally Authorized Representative**

P/G/LAR Name ______________________ P/G/LAR Email (Optional) ______________________

P/G/LAR Phone ______________________ ☐ Check this box if the Child and P/G/LAR live together

P/G/LAR Relationship to Child ______________________

P/G/LAR Address (If different from above) ______________________

☐ Check this box if this is Local District of Social Services (LDSS) County Representative

Updated HCBS Referral Form - Sections

P/G/LAR # 3– Please check one of the following

☐ **Parent** ☐ **Guardian** ☐ **Legally Authorized Representative**

P/G/LAR Name ____ P/G/LAR Email (Optional) ___________________________

P/G/LAR Phone ____ ☐ Check this box if the Child and P/G/LAR live together

P/G/LAR Relationship to Child _____________________________

P/G/LAR Address ____

☐ Check this box if this is Local District of Social Services (LDSS) County Representative

Please indicate how many siblings currently reside in the home: _______

Out of the current siblings who reside in the home, how many are receiving HCBS? _______

Out of the current siblings who reside in the home, how many are receiving Health Home Care Management? _______

Updated HCBS Referral Form - Sections

☐ Check this box if the child attends school or other educational/vocational program

If applicable, please explain the child's school or educational/vocational program schedule below, including how many hours a week they attend the program in question (i.e., Mon-Fri 8am-1pm, etc.). Please also include other standing appointments, e.g., therapy, medical appointments, OT/PT/ST, CFTSS, PDN/PCA/CDPAS, Hospice, etc.

School/Education:

Regular appointments/programs:

Extracurricular/Community Activities:

Other Programming/Services/Activities:

For extracurricular or community activities, note how many hours a day, week, or month.

Summer Programming schedule

Updated HCBS Referral Form - Sections

Clinical Information

Child Primary ICD-10 Diagnosis ____

Child K-Code _______

Target Population ☐ SED ☐ Medically Fragile ☐ DD and Medically Fragile ☐ DD and Foster Care

Date LOC Eligibility Determination was Completed _______

Date of Expected Discharge from HCBS _______

Care Management, Care Management Agency, and Designated Lead Health Home Information

Contact's Name _______________ Contact's Agency Name _______________ Date _______________

Contact's Title _______________ Email _______________ Phone # _______________

Contact's Address ___________________________________

Name of Designated Lead Health Home Serving Children ___________________________________

Note: Highlighted fields in green will be auto populated by the Electronic Health System

Updated HCBS Referral Form - Sections

Requested HCBS, Goals, and Objectives

HCBS #1 Referral Request

Please select Children's Waiver HCBS being requested/included in this notice

- ☐ Community Habilitation
- ☐ Day Habilitation
- ☐ Caregiver/Family Advocacy and Supports Services
- ☐ Prevocational Services
- ☐ Supported Employment
- ☐ Respite Services (Specify below between Planned and/or Crisis
- ☐ Palliative Care (Specify below between: Massage Therapy, Counseling and Supports Services, Expressive Therapy, or Pain and Symptom Management)

Modality (Check all that apply) ☐Individual ☐ Group

Note: Form will have the ability to include as many service requests as needed.

Updated HCBS Referral Form - Sections

DRAFT

Desired Goal or Need to be addressed
Family Preferences (Staff Gender/Age/Primary Language, Evening/Weekend Appointments, Time Of Day, Etc.)

Other services member is receiving related to this goal (if applicable)

Describe any other barriers or obstacles to the member's goals/objectives, and strategies to address these barriers.

Updates to the Children's HCBS Authorization and Care Manager Notification Form

Authorization Form - Update

- NYS DOH has shared with the HCBS providers previously the updated DRAFT Authorization Form.
- The following updates have been made to the Authorization Form since last circulating to stakeholders:
  - Addition of multiple procedure codes (for CFASS only)
  - ‘Rationale’ and ‘Medical Necessity with supporting documentation’ is required for ***each HCBS*** instead of the previous requirement for each Objective
  - Description of barriers and/or obstacles to the member’s goals/objectives and strategies to address these barriers is now required once for ***all HCBS,*** instead of for each HCBS individually

Authorization Form – Update *cont.*

- The Authorization Form will be built into IRAMS and initially, populated and can be downloaded by the HCBS provider to send to the MMCP. March of 2024, this electronic form will be retrieved by the MMCP and will not need to be sent separately by the HCBS provider.
  - HCBS providers need to evaluate how the Authorization Form is completed and by whom to determine how this would work for their agency electronically
  - Who is currently completing this form for the HCBS provider?

- Some fields will be required to be completed and others will be optional
- Some of the fields populated by the HHCM/C-YES can be adjusted/updated by the HCBS provider, <u>example:</u> Requirement of the participant's school or education/vocational program schedule or summer programming
- HHCM/C-YES will now be able to see the HCBS provider Authorization Form, which will assist with the HHCM/C-YES to know what the F/S/D being requested and the goals/objectives of the service.

CM and MMCP Authorization Form - Sections

Section 1 – Completed by HCBS Provider

Participant Information

Participant Name ______________________________ Participant DOB ____________________

Participant Phone _______________ Participant Email (optional) __________________

Participant Address

____

Participant CIN ____________ ☐ Check this box if the participant is in Foster Care

Name of 29-I Foster Care Agency (if Foster Care box is checked) ______________________

Care Manager (CM) Name __________________ CM Phone ____________ CM Email ________

Name of Health Home/C-YES _________________________

Note: Highlighted fields in green will be auto populated by the Electronic Health System. Highlighted fields in blue have been populated by the HHCM/C-YES HCBS Referral and will be available on the Authorization Form

CM and MMCP Authorization Form - Sections

Parent/Guardian/Legally Authorized Representative (P/G/LAR) Information

P/G/LAR # 1 – Please check one of the following

☐ **Parent** ☐ **Guardian** ☐ **Legally Authorized Representative**

P/G/LAR Name ________________________ P/G/LAR Email (Optional) ________________

P/G/LAR Phone ________________________ ☐ Check this box if the child and P/G/LAR live together

P/G/LAR Relationship to Child ________________

P/G/LAR Address ________________________________

☐ Check this box if P/G/LAR is Local District of Social Services (LDSS) County Representative

P/G/LAR # 2 (Optional) – Please check one of the following

☐ **Parent** ☐ **Guardian** ☐ **Legally Authorized Representative**

P/G/LAR Name ________________________ P/G/LAR Email (Optional) ________________

P/G/LAR Phone ________________________ ☐ Check this box if the child and P/G/LAR live together

P/G/LAR Relationship to Child ________________

P/G/LAR Address ________________________________

☐ Check this box if this is Local District of Social Services (LDSS) County Representative

Note: Highlighted fields in green will be auto populated by the Electronic Health System. Highlighted fields in blue have been populated by the HHCM/C-YES HCBS Referral and will be available on the Authorization Form

CM and MMCP Authorization Form - Sections

P/G/LAR # 3 (Optional)– Please check one of the following

☐ **Parent** ☐ **Guardian** ☐ **Legally Authorized Representative**

P/G/LAR Name ______________________________ P/G/LAR Email (Optional) ____________________

P/G/LAR Phone ______________________________ ☐ Check this box if the child and P/G/LAR live together

P/G/LAR Relationship to Child ______________________

P/G/LAR Address ____

☐ Check this box if this is Local District of Social Services (LDSS) County Representative

County Representative's Name and Email (if known) ____

Please indicate how many siblings currently reside in the home_______

Out of the current siblings who reside in the home, how many are receiving HCBS? _______

Out of the current siblings who reside in the home, how many are receiving Health Home Care Management? _______

Note: Highlighted fields in green will be auto populated by the Electronic Health System. Highlighted fields in blue have been populated by the HHCM/C-YES HCBS Referral and will be available on the Authorization Form

CM and MMCP Authorization Form - Sections

☐ Check this box if the child attends school or other educational/vocational program

If applicable, please outline the child's school or educational/vocational program schedule below, including how many hours a week they attend the program in question (i.e., Mon-Fri 8am-1pm, etc.). Please also include other standing appointments, e.g., therapy, medical appointments, OT/PT/ST, CFTSS, PDN/PCA/CDPAS, Hospice, etc.

School/Education

Regular Appointments/Programs

Extracurricular/Community Activities

Other Programming/Services/Activities

For extracurricular or community activities, note how many hours a day, week, or month.

Summer Programming Schedule

Note: Highlighted fields in green will be auto populated by the Electronic Health System. Highlighted fields in blue have been populated by the HHCM/C-YES HCBS Referral and will be available on the Authorization Form

CM and MMCP Authorization Form - Sections

Clinical Information

Child Primary ICD-10 Diagnosis ____

Child/youth K-Code _______

Target Population ☐ SED ☐ Medically Fragile ☐ DD and Medically Fragile ☐ DD and Foster Care

Date of Expected Discharge from HCBS _______

Administrative Information (If applicable)

Date of First Appointment _______________

Date HCBS Provider Notified the Plan of First Appointment___________________

☐ By checking this box, I attest that the above appointment took place

Note: Notification can occur via email or phone

Note: Highlighted fields in green will be auto populated by the Electronic Health System. Highlighted fields in blue have been populated by the HHCM/C-YES HCBS Referral and will be available on the Authorization Form

CM and MMCP Authorization Form - Sections

HCBS Provider Information

HCBS Provider Agency Name ______________________________ NPI/Tax ID # ______________________________

Provider Address ____

Contact Person Name ______________________________ Contact Person Title ______________________________

Contact Person Phone ______________________________ Contact Person Email ______________________________

Secondary Contact Name______________________________ Secondary Contact Title ______________________________

Secondary Contact Phone ______________________________ Secondary Contact Email ______________________________

Note: Highlighted fields in green will be auto populated by the Electronic Health System. Highlighted fields in blue have been populated by the HHCM/C-YES HCBS Referral and will be available on the Authorization Form

CM and MMCP Authorization Form - Sections

The Authorization Form has been updated to include

two procedure code lines for Caregiver Family Advocacy and Support Services (CFASS) only.

Please select the Children's Waiver HCBS being requested/included in this notice

- ☐ Community Habilitation
- ☐ Day Habilitation
- ☐ Caregiver/Family Advocacy and Supports Services (CFASS)
- ☐ Prevocational Services
- ☐ Supported Employment
- ☐ Respite Services (Specify below between Planned and/or Crisis)
- ☐ Palliative Care (Specify below between Massage Therapy, Counseling and Support Services, Expressive Therapy, and/or Pain and Symptom Management)

HCBS #1	Start Date (1st service visit)	Start Date for This Authorization Period	Frequency	Scope	Duration	Explanation of variation in schedule (if applicable)
Procedure Code						
Procedure Code						

Multiple Procedure Codes are reported for Caregiver/Family Advocacy and Support Services (CFASS) only.

Modality (Check all that apply) ☐ Individual ☐ Group

CM and MMCP Authorization Form - Sections

The Authorization Form has been updated so that the need to provide

rationale and Medical Necessity with supporting documentation is required for each HCBS

Please provide rationale (Medical Necessity with supporting documentation) for the need for the service.

Each Goal should be written to be measurable or that is demonstrated as achievable by the specific HCBS, in accordance with the HCBS Manual. Each Goal must have at least one specific objective – what will the HCBS provider do or how the HCBS provider will work with the member to accomplish the Goal.

Goal 1
Objective 1
For re-authorization **Describe the status of the service goal/objective, including what has been accomplished, or what has been worked on. Outline what is still needed to be worked on with this objective.**

CM and MMCP Authorization Form - Sections

The Authorization Form has been updated so that the need to describe any ***barriers or obstacles to the member's goals/objectives and strategies to address these barriers is now required once for all HCBS*** instead of each HCBS individually.

Other services, outside of HCBS, member is receiving related to this goal (if applicable)

Describe any other barriers or obstacles to the member's goals/objectives, and strategies to address these barriers.

CFASS Staffing Changes and Authorization

Completing the Authorization Form for CFASS

To assist with MMCP system configuration and ensure proper payment for services delivered, ***CFASS should be requested on the HCBS Authorization and Care Manager Notification Form by service level*** (e.g., Level 1, Level 2, or a mix of both).

- HCBS providers should not be accepting referred members if they do not have a staff person available to deliver the service.
- Once the member's needs have been determined and a match to the HCBS staff person is made, then level 1 or level 2 should be added to the Authorization Form.
- In the case where a level 1 and level 2 staff will be utilized together because of workforce issues, then the updated Authorization Form will allow for this (extra line for the additional procedure code).
  - In these situations, F/S/D should be based on the needs of the member and the **total** Frequency units should be made and separated by the 2 staffing levels
  - It is not the NYS DOH expectation that 2 staff persons would be providing CFASS with the different staff levels, at the same time

Process When CFASS Staffing Changes Occur

If an Authorization Form has already been approved and effective, and there is a change to the staffing / staffing level, the following should occur:

- **If a permanent staff change results in a different level of CFASS, then:**
  - a new Authorization Form should be completed and submitted to the Plan at least ***14 days prior to submitting a claim*** for the service at a different level than what is currently authorized.
- **If a staff change occurs that is not permanent, then:**
  - the HCBS provider must notify the MMCP of this change at least ***14 days prior to submitting a*** claim for the service.
  - The notification will take place outside of the HCBS Authorization and Care Manager Notification Form, and can be via email, phone, or some other agreed upon mechanism between the MMCP and the provider, and should include the following information:
    - Participant Name
    - Participant CIN
    - HCBS Provider Agency Name
    - F/S/D of currently approved CFASS (including service level)
    - Newly requested CFASS level
    - Date(s) service has been/will be rendered by staff at a different service level

CFASS Staff Change Notification Requirements

- As long as the notification follows the requirements (detailed on the previous slide), and the participant has an active authorization in place for CFASS, then the MMCP must approve the request and update their system accordingly to pay the relevant claims.

- MMCPs and HCBS Providers must ***maintain documentation to support the request and approval*** of the request in their records.

- HCBS providers should connect with the participant's MMCP to determine if authorizations for CFASS need to take place at the Procedure Code level to comply with Plan configuration needs.

- This guidance does not apply to MMCPs who have configured their systems to allow for combinations of Level 1 and Level 2 service delivery.

Documentation Requirements for HCBS Providers

Documentation Policy Overview

Purpose of Documentation:

- Documentation requirements are **intended to serve as guidance for HCBS providers to help record the services that are being delivered** to Children's Waiver participants, progress toward goals, and significant life events.
- HCBS providers **must maintain documentation** to support any claims for services provided.

HCBS Documentation Expectations:

- Demonstrate **service quality and compliance** with regulatory requirements.
- Reflect **consistency in the need, focus, and direction** of the service.
- Support the **type, frequency, scope, and duration of the service and interventions** provided.
- Hold providers **accountable to the service goals and needs of participants** and support service claims.

Medicaid Documentation Requirements

Medicaid providers must comply with guidelines outlined in NYS Medicaid Program Information for All Providers including the following:

- All services provided are based on medical necessity. Services cannot be provided only because of a Medicaid member's personal preference. Documentation of medical necessity for service provision must be maintained
- Federal Law and State Regulations require providers to maintain financial and health records necessary to fully disclose the extent of services, care, and supplies provided to Medicaid enrollees. Providers must furnish information regarding any payment claim to authorized officials upon request
- The maintenance and furnishing of information relative to care included on a Medicaid claim is a basic condition for participation in the Medicaid Program

Required Documentation

HCBS **providers are responsible for creating, maintaining, and updating various forms of documentation**, listed below.

Intake Documentation

HCBS provider(s) should conduct an **intake assessment** to assess needs, goals, and strengths of participant/family

Education and Documented Choice

HCBS provider(s) must tell participant(s) **the services referred for, the service to be delivered, and what goal(s) is/are to be addressed**

Medical Necessity

HCBS provider(s) are responsible to **support the provision of services** in alignment with the F/S/D outlined for the participant and to meet their goals/needs

HCBS Service Plan

HCBS provider(s) will meet with the participant/family **to identify how the services will help address identified needs** and the F/S/D the service will be provided

Progress Note

A progress note is **required for every contact and service delivered** to an HCBS participant or for the purpose of the HCBS participant (e.g.: collateral contacts)

Health and Safety Planning

HCBS providers must **ensure/minimize identified and/or potential health or safety risks** during service delivery

Discharge Plan

HCBS providers must work with the participant/family **to plan for discharge and how to identify when goal(s) are met** as HCBS are short term services

HCBS Manual Updates

HCBS Manual Updates

Minimally, the HCBS Manual is updated on an annual basis to capture changes.

The HCBS Manual must also be updated when there is an update to the Children's Waiver, either the renewal of the Waiver (every 5 years) or an amendment to the Waiver.

- The first renewal of the Children's Waiver occurred in 2022
- There is a submitted Children's Waiver amendment pending CMS approval of an effective date on or after 11/1/23

Additionally, the Manual will be updated when changes occur to policies, process, and or clarification is needed. DOH is in the process of updating the manual to address:

- Clear service definition and purpose
- Allowable units of service

➢ Per HCBS provider's designation letter and signed HCBS program attestation, all HCBS providers must be aware and implement changes based upon Manual, policy, procedure, guidance updates and changes that occur for the HCBS Waiver

Future Meetings & Contact Information

Future Meetings & Agenda Items

- Next Scheduled Monthly Meetings:
  - *October 18th 1:00 – 2:30 PM*
  - *November 15th 1:00 – 2:30 PM*

- **Register for all these monthly meetings here**: Registration (gotowebinar.com)
- DOH would like to discuss topics of interest to the HCBS providers and also hear suggestions and ideas for improvement.
- Please submit your agenda requests, suggestions, or questions to BH.Transition@health.ny.gov.

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

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

New York State Department of Health Managed Care Complaint Line **1-800-206-8125** or managedcarecomplaint@health.ny.gov