Children's Health and Behavioral Health Medicaid System Transformation

Children's Home and Community Based Services 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/youth and their families at home and in the community. HCBS are designed for people 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 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 (see Appendix C) and specifies transitional coverage requirements for children/youth 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 4) 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/youth to access HCBS benefits. This expansion addresses gaps in service for children/youth who may benefit from HCBS but do not meet the LOC criteria, or for children/youth 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 and is a reference tool for Health Homes, Health Home Care Managers, HCBS Providers, Medicaid Managed Care Plans (MMCPs), and the State's Independent Entity of Children and Youth Evaluation Services (C-YES) for care management and/or assist with the determination of Medicaid eligibility. All HCBS benefits are applicable in any home or community setting meeting federal HCBS

settings requirements (see Appendix B) 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/youth in non-institutionalized settings that enable them to remain at home and in the community or for children/youth being discharged from an institutional setting who require these services to safely return to their home and 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 physical 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/youth and family in their home and/or the community. The array of services is intended to assist children/youth 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 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.

Additional information can be found in the ***Requirements for Service Providers Delivering Children and Family Treatment and Supports Services (CFTSS) and Children's Home and Community Based Services (HCBS) and Working Collaboratively With Providers***, located at: https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/service_delivery_designation_guidance_cftss_hcbs.pdf

Health Homes are also designated by NYS and must adhere to the ***Health Home Standards and Requirements***, located at https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_mco_cm_standards.pdf.

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***, located at https://www.emedny.org/info/ProviderEnrollment/index.aspx.

Each provider delivering these services must be enrolled as a Medicaid provider with an active provider identification number. A list of provider types and the application can be found on the eMedNY website; questions can also be directed to the eMedNY Call Center at 1-800-343-9000. Additional information for designated HCBS providers can be found in the March 8, 2019 State Memo ***Medicaid Provider Enrollment for Individual Practitioners and Designated Agencies***, located at https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/provider_enrollment_npi_memo.pdf.

CRIMINAL HISTORY AND BACKGROUND CHECKS

The 2018-2019 Enacted Budget includes statutory requirements (Chapter 57 Laws of 2018) related to criminal history record checks, mandated reporter requirements, Statewide Central Register Database checks, and Staff Exclusion List checks for Health Home Care Managers and children's HCBS providers. The statute requires that Health Homes and Care Management Agencies that provide care management to enrollees under age 21 and HCBS providers authorized under the 1915(c) Children's Waiver to conduct the following on prospective employees:

- Criminal History Record Checks (CHRC), including finger printing through NYS Department of Health.
- Statewide Central Register (SCR) Database Checks through the Office of Children and Family Services,

- Staff Exclusion List (SEL) checks through the NYS Justice Center for the Protection of People with Special Needs

Such providers must also be mandated reporters.

Verification of compliance with these requirements is an element of the DOH surveillance process. At the time of surveillance, DOH 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 for Health Homes/CMAs can be found in the ***Health Homes Serving Children (HHSC) Background Check Requirements for Health Homes and Care Managers policy*** (HH0010), located at: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/docs/hh0010_background_checks_policy.pdf

HCBS ELIGIBILITY AND ENROLLMENT

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/LOC Eligibility Determination. Children/youth receiving HCBS through enrollment in a 1915(c) Medicaid waiver will have continued access to HCBS for as long as the child/youth continues to meet the eligibility criteria for the 1915(c) Medicaid waiver as listed below.

Children/youth 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/youth 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).

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/youth that meet institutional placement criteria

   There are four subgroups for children/youth within the LOC group:

1) Serious Emotional Disturbance (SED) with or without co-occurring Substance Use Disorders (SUD)
2) Developmental Disability in Foster Care
3) Medically Fragile
4) Medically Fragile with a Developmental Disability

2. Level of Need (LON): children/youth who are at risk of institutional placement (projected implementation date in 2021)

   There are two subgroups for children/youth within the LON group:
   a. 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 eligible children/youth once a Plan of Care (POC) is in place. Further information regarding the Plan of Care can be located in the ***Children's Home and Community Based Services (HCBS) Plan of Care (POC) Workflow Policy***, located at https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/childrens_hcbs_poc_workflow.pdf.

To access Children's HCBS, a child/youth must meet Level of Care criteria (target criteria, risk factors, and functional limits) 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), 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/youth a ***Notice of Decision***, which will memorialize document the outcome of the HCBS/LOC Eligibility Determination and provide information on State Fair Hearing rights.

The HCBS/LOC Eligibility Determination is an annual (12 month) 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 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.

The target criteria, risk factors, 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) must meet a needs-based criterion for Medicaid eligibility determination via the following process:

- The Independent Entity (C-YES) must complete the HCBS Eligibility Determination
- 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
- Whether a child meets the LOC or the LON criteria, eligible children/youth and their families will have access to all HCBS services

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

Please refer to Appendix J for further information regarding the impact of Family of One budgeting and Spenddown on HCBS eligibility and care management.

Notice of Decision

Once the Children's Waiver eligibility determination is complete, the HHCM/C-YES 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 HH/C-YES must issue an adequate Notice of Decision to accept or deny an application for enrollment as soon as possible. There should be documentation to

support the 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 2 of DOH-5287 form. HHCMs/CYES staff are expected to go over the entire form with the member and their family. Care managers and providers should know the process for Fair Hearings as well as who to contact in the event the family in interested in pursuing a Fair Hearing. Further information regarding the Fair Hearing process is outlined in the ***Health Home Notices of Determination and Fair Hearing Process,*** located at https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh0004_fair_hearing_nod_policy.pdf.

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

The HH/C-YES must issue an adequate Notice of Decision to discontinue services. This notice should be sent out within 1-2 business days of the decision made by the HHCM/C-YES, the lead Health Home, HCBS provider, and other care team members. 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. If the member files for continuing aid, the HCBS provider must continue to provide services to the member until the results of the Fair Hearing are determined. The members' Care Manager should inform the HCBS provider(s) of pertinent information concerning any changes in service eligibility and, if the results of the Fair Hearing support the decision to discontinue services, then the HHCM/C-YES should begin transition planning and documentation to support that 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. HHCM/C-YES are expected to go over the entire form with the member and their family.***

Additional Reasons for Notice of Decision Forms

- *If child/youth loses Medicaid*, the LDSS will send NOD and the HHCM/C-YES will work with family to reestablish Medicaid; if the child/youth is eligible for HCBS, the HHCM/C-YES will work with the family and LDSS/HRA to reestablish Medicaid
- *If the child is HCBS LOC eligible but no slot is available*, the family will receive a NOD from the HHCM/C-YES and when a slot is available, the HHCM/C-YES will send the family a letter notifying them of the available slot
- *If the DDRO completed the HCBS determination for 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; refer to the ***OPWDD DDRO Manual for Children Waiver*** for additional information:

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

HCBS ELIGIBILITY REAUTHORIZATION

The 1915(c) Children's Waiver for HCBS requires an annual (12 month) 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/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.

Note: For children/youth 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 a significant life event occurs for a child/youth while receiving HCBS, a new HCBS/LOC Eligibility Determination may be needed. A significant life event is something that occurs in a 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 include:

- Significant change in child/youth's functioning (including increase or decrease of symptoms or new diagnosis)
- Service plan or treatment goals were achieved
- Child/youth admitted, discharged or transferred from hospital/detox, residential setting/placement, or foster care
- Child/youth has been seriously injured in a serious accident or has a major medical event
- Child/youth'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 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 in the MAPP tracking system and follow the Health Home ***Continuity of Care and Re-engagement for Enrolled Health Home Members # HH0006*** policy, located at https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/docs/hh0006_continuity_of_care_policy.pdf.

Please also refer to Appendix K for guidance related to referring for HCBS while a child/youth is in a restricted setting, including a Residential Treatment Facility (RTF) or OMH State-operated Psychiatric Centers Serving Children (State PC). Health Home Care Managers should also refer to the ***Health Home Care Management Activities and Billing Protocols for Managing Newly Referred Individuals from Excluding Settings #HH0011*** policy, located at https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/docs/hh0011_hhcm_activities_billing_protocol_excluded_settings.pdf

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 HHCM/C-YES 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 Decision*
- Once a child/youth has been assigned a slot, they will have that slot until they are discharged from the waiver (refer to Appendix D for discharge criteria)

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 (refer to Appendix D for discharge criteria)
- 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 located at https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_children/docs/communication_with_doh_capacity_management.pdf and the ***Capacity Management Webinar***, located at https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/capacity_management_webinar_9.25.19.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 HCBS are required to receive care management. This requirement may be met in one of the following three ways:

- Health Home comprehensive care management: Children/youth 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 a 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 every six months and 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/youth 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/youth in receipt of HCBS. The Health Home will monitor access to care for children and youth 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/youth 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 HHCMs. This verification can be combined with a regularly scheduled meeting or care management contact with the child/youth and family. HHCM/C-YES 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 by the care management entity with HCBS providers must occur to ensure that appointment times and scheduling 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. HCBS providers should attend meetings that discuss the POC, communicate with care managers regarding the child/youth's progress toward goals and/or any changes in status/significant life events, and be aware of care management requirements to facilitate an effective conversation with the child/youth.

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 (see Appendix C). The POC development is based upon the assessment of needs which is determined through the interaction with the child/youth, 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/youth in reaching their defined goals and addressing identified needs. Each HCBS that the child/youth receives must be listed in their POC with a defined goal. HCBS providers must refer to the POC during service delivery to ensure that the services provided are in alignment with the POC. HCBS providers will also play a role in providing information to care managers regarding progress toward goals that will be used in updating the POC.

The POC will change and evolve over time as the child/youth 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 the HCBS/LOC Eligibility determination reassessment.

The POC must be signed by the child/youth, if age appropriate (i.e. 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*** located at https://www.health.ny.gov/health_care/medicaid/redesign/cfco/docs/2018-12-19_pcsp_guidelines.pdf.

The POC must also be developed following the ***Health Home Plan of Care Policy*** located at 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. HCBS providers should have a role in POC development prior to POC finalization.

When adding identified needs and services to a POC (initial and/or 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 indicated in this manual, 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 providers must also follow requirements to protect PHI.

HCBS Service Plan

Once a HCBS provider receives a referral from a care manager, the HCBS provider will meet with the child/youth 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(s) and the anticipated benefit to the child/youth and family. The HCBS Service Plan determines the focus of the service(s), 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. The HHCM/C-YES will coordinate multiple HCBS Service Plans in collaboration with HCBS providers.

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/youth 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/youth and family/caregiver to ensure that the goals outlined by the child/youth 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/youth 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/youth. The frequency of services should be in relation to other appointments or commitments the child/youth 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/youth.

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

signature), the parent/caregiver of the child/youth and the signature of the HCBS provider.

The initial Service Plan and any subsequent updates must be shared with the HHCM/C-YES and/or MMCP as described in the HCBS Plan of Care Workflow section. Information regarding the HCBS Service Plan can also be located at https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/hcbs_service_plan_1915c_children_waiver.pdf.

HCBS PLAN OF CARE WORKFLOW

The purpose of the HCBS Plan of Care (POC) Workflow is to facilitate information sharing between the HHCM/C-YES, HCBS providers, and MMCPs. Please refer to Appendix G for the full workflow process, which outlines the following steps.

Step 1: Referral to Identified HCBS Providers and Services using 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.

> ***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
>
> E-MODS:
> https://www.health.ny.gov/health_care/medicaid/redesign/cfco/emod_guidelines.htm
>
> V-MODS:
> 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

Step 2: Establishment of First Appointment and Notification to the MMCP - 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.

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. 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.

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. 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.

> ***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.***

If an eligible child/youth declines HCBS, this workflow is not completed but the HHCM or C-YES must record this decision. At any time, a child/youth 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/youth 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 HHCM/C-YES will provide information and discuss Freedom of Choice. The individual'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 and kept as part of the member's file with 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

Although care managers are responsible for providing information regarding Freedom of Choice, HCBS providers should understand and honor the family's right to the choice of services and document that those choices were provided.

FAIR HEARING

If a child/youth and/or family does not agree with the decision indicated on the ***Notice of Decision*** form, they have a right to a conference and/or Fair Hearing. Upon receiving a copy of a NOD from the Health Home, the member has 60 days to request a Fair Hearing if they disagree with the determination as stated on the NOD. Decisions regarding Medicaid eligibility and the provision of waiver services (e.g. denial/reduction of services; child/youth was not offered choice of services) can be addressed through the Fair Hearing process. Care managers should explain these rights and the process for requesting them to the participant and their parent/guardian/legally authorized representative.

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 and ***Health Home Notices of Determination and Fair Hearing Policy***.

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 must immediately review the facts and circumstances of the reported incident and complete the NYS HH Incident Report Form within 24 hours of notification. Care managers and providers should refer to ***Health Home Monitoring: Reportable Incidents Policies and Procedures*** for further information, located at 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.

MMCPs should refer to requirements for addressing and reporting grievances and complaints as outlined in the Model Contracts and 1915(c).

CONFLICT FREE CASE 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 case 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 care manager has potential to be conflicted.

For further information, refer to the ***Conflict Free Case Management Policy***, located at https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/docs/hh0012_conflict_free_care_management_policy.pdf.

SERVICE DEFINITIONS

COMMUNITY HABILITATION

Definition

Community Habilitation covers face-to-face services and supports related to the child/youth'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/youth 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/youth'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/youth'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/youth's 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/youth 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/youth 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, and/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/youth's goal(s)/outcome(s), health/safety needs required during the delivery of the service, and the necessary staff actions to assist the child/youth reach his/her Community Habilitation goal(s)/outcome(s), and health/safety needs; the activities are for the sole benefit of the child/youth and are only provided to the child receiving HCBS or to the family/caregiver in support of the child/youth
- The activities are designed to preserve or enhance independence or slow/reduce the loss of independence when the child/youth has a progressive medical condition; the activities provided are consistent with the child/youth's stated preferences and outcomes in the 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/youth 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/youth, which can be delegated or assigned by licensed healthcare 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, which can be found here: http://www.op.nysed.gov/prof/nurse/nurselaw.htm.

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/youth'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/youth. Foster Care children/youth 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/youth 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 hours of non-residential services (or its equivalent) daily. For school-age children/youth, 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/youth 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/youth 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 that 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/youth 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	• Mandated Reporter	• Prior to Service Delivery
	• Personal Safety/ Safety in the Community • Strength Based Approaches • Suicide Prevention • Domestic Violence Signs and Basic Interventions • Trauma Informed Care	• 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/youth 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/youth 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/youth's goal(s)/outcomes(s), health/safety needs required during the delivery of the service, and the necessary staff actions to assist the child/youth 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/youth receiving HCBS under this waiver may receive this service. Service necessity criteria for this service requires that the child/youth must have a developmental delay justifying the need for the provision of Day Habilitation, but the child/youth 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/youth 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 p.m. on weekdays.

Supplemental DH services are those services provided on weekends and/or on weekdays with a service start time after 3 p.m. 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 OPWDD.

OPWDD Regional Office

- 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 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	• Mandated Reporter	• Prior to Service Delivery
	• Personal Safety/ Safety in the Community • Strength Based Approaches • Suicide Prevention • Domestic Violence Signs and Basic Interventions • Trauma Informed Care	• 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 POC, 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/youth 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/youth 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 located at https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/billing_manual.pdf.

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/youth 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 that 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 Qualifications**: High school diploma, high school equivalency preferred or a State Education Commencement Credential (e.g. SACC or CDOS) with related human service experience
- **Preferred Qualifications:** Experience working with children/youth

Supervisor Qualifications:

- **Minimum Qualifications**: Bachelor's degree with one year of experience in human services working with children/youth
- **Preferred Qualifications**: Two years' experience in human services working with children/youth

Training Requirements

Service Type	Trainings Required	Requirement Completion Timeframe
Caregiver/Family Supports & Services	• Mandated Reporter	• Prior to Service Delivery
	• Personal Safety/ Safety in the Community • Strength Based Approaches • Suicide Prevention • Domestic Violence Signs and Basic Interventions • Trauma Informed Care	• 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/youth or the child/youth'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/youth 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.

Respite services may be delivered in a home or residence by qualified practitioners, out-of-home/residence by staff in community-based sites (e.g. community centers, camps, parks), or in allowable facilities.

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 healthcare 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/youth 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, Planned Overnight Respite, Crisis Day Respite, Crisis Overnight Respite:

These services may be delivered with support of staffing ratios necessary to keep the child/youth, and other children/youth in the environment, safe and as indicated in the child/youth's POC overseen by the respite provider.

Setting

Planned or Crisis Day Respite services can be provided in the home of an eligible child/youth or a community setting .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

- OCFS Licensed agency boarding home, a group home, a group residence, or an institution and certified foster boarding homes
- 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

- Services to children/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/youth 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/youth 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/youth'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/youth'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 Qualifications**: 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)	• Mandated Reporter	• Prior to Service Delivery
	• Personal Safety • Safety in the Community • Strength Based Approaches • OMH-recommended Suicide Prevention • Domestic Violence Signs and Basic Interventions • Trauma Informed Care	• 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 habilitative 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**: Associate's degree with one year of human service experience
- **Preferred Qualifications:** Bachelor's degree with one year of experience in human services working with children/youth

Supervisor Qualifications

- **Minimum Qualifications**: Bachelor's degree with three years of experience in human services
- **Preferred Qualifications**: 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	• Mandated Reporter	• Prior to Service Delivery
	• Personal Safety/ Safety in the Community • Strength Based Approaches • Suicide Prevention • Domestic Violence Signs and Basic Interventions • Trauma Informed Care	• 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 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
- 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**: Associate's degree with one year of human service experience
- **Preferred Qualifications**: Bachelor's degree with one year of experience in human services working with children/youth

Supervisor Qualifications

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

Training Requirements

Service Type	Trainings Required	Requirement Completion Timeframe
Supported Employment	• Mandated Report	• Prior to Service Delivery
	• Personal Safety/ Safety in the Community • Strength Based Approaches • OMH-recommended Suicide Prevention • Domestic Violence Signs and Basic Interventions • Trauma Informed Care	• 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 healthcare 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 in-eligible 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

- **Minimum Qualifications**: An individual employed by the agency with a Bachelor's degree plus two years of related experience
- **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

Supervisor Qualifications

- **Minimum Qualifications**: Master's degree with one year of experience in human services working with children/youth
- **Preferred Qualifications:** 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	• Mandated Reporter	• Prior to Service Delivery
	• Personal Safety/ Safety in the Community • Strength Based Approaches • Suicide Prevention • Domestic Violence Signs and Basic Interventions • Trauma Informed Care	• 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 – 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/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 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 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. This written order is to be included with the child/youth's POC and made available to the MMCP as needed.

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

Expressive therapy helps children/youth 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/youth 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 the child/youth they can hold onto - scrapbooks, paintings, or sculpture - mementos that tell their child/youth'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/youth 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 and/or 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

Individual Staff Qualifications

- **Minimum Qualifications**:
  - 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
  - Child Life Specialist with certification through the Child Life Council; Creative Arts Therapist licensed by the State of New York; Music Therapist with a Bachelor's Degree from a program recognized by the NYS Education Department; Play Therapist with a Master's Degree from a program recognized by the New York State Education Department; current Play Therapist Registration conferred by the Association for Play Therapy (Expressive Therapy (Art, Music, and Play))
  - Direct service workers must have background checks
  - Student interns practicing within the scope of the New York State Education law and supervised by a licensed practitioner in that profession can deliver HCBS; student interns and limited permittees can treat

Medicaid enrollees under the supervision of a licensed practitioners in that profession who must be enrolled as a Medicaid provider

Practitioners must operate in agencies which have been designated through the NYS Children's Provider Designation Review Team

Training Requirements

Service Type	Trainings Required	Requirement Completion Timeframe
Palliative Care	• Mandated Reporter	• Prior to Service Delivery
	• Personal Safety/ Safety in the Community • Strength Based Approaches • Suicide Prevention • Domestic Violence Signs and Basic Interventions • Trauma Informed Care	• 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/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 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 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. The written order is to be included with the child/youth's POC and made available to the MMCP 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/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 and/or 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

Individual Staff Qualifications

- **Minimum Qualifications:**
  - Massage therapist currently licensed by the State of New York
  - 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

Practitioners must operate in agencies which have been designated through the NYS Children's Provider Designation Review Team

Training Requirements

Service Type	Trainings Required	Requirement Completion Timeframe
Palliative Care	• Mandated Reporter	• Prior to Service Delivery
	• Personal Safety/ Safety in the Community • Strength Based Approaches • Suicide Prevention • Domestic Violence Signs and Basic Interventions • Trauma Informed Care	• 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/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 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 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. The written order is to be included with the child/youth's POC and made available to the MMCP 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/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 five 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 and/or 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

Individual Staff Qualifications

- **Minimum Qualifications**:
  - 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
  - Licensed Clinical Social Worker (LCSW), Licensed Master Social Worker (LMSW), Licensed Psychologist, Licensed Mental Health Counselor (LMHC), or Licensed Creative Arts Therapist (LCAT) that meet current NYS licensing guidelines
  - Student interns practicing within the scope of the New York State Education law and supervised by a licensed practitioner in that profession can deliver HCBS; student interns and limited permittees can treat Medicaid enrollees under the supervision of a licensed practitioners in that profession who must be enrolled as a Medicaid provider

Practitioners must operate in agencies which have been designated through the NYS Children's Provider Designation Review Team

Training Requirements

Service Type	Trainings Required	Requirement Completion Timeframe
Palliative Care	• Mandated Reporter	• Prior to Service Delivery
	• Personal Safety/ Safety in the Community • Strength Based Approaches • Suicide Prevention • Domestic Violence Signs and Basic Interventions • Trauma Informed Care	• 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/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 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 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. The written order is to be included with the child/youth's POC and made available to the MMCP as needed.

Pain and Symptom Management: Relief and/or control of the child/youth'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/youth is enduring. This management is not only an important part of humanely caring for the child/youth's pain and suffering but helping the child/youth 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/youth'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 and/or designated through the NYS Children's Provider Designation Review Team

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

Individual Staff Qualifications

- **Minimum Qualifications:**
  - 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
  - Pediatrician or Family Medicine Physician board certified in Pediatrics or Family Medicine licensed by the State of New York; 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

Training Requirements

Service Type	Trainings Required	Requirement Completion Timeframe
Palliative Care	• Mandated Reporter	• Prior to Service Delivery
	• Personal Safety/ Safety in the Community • Strength Based Approaches • Suicide Prevention • Domestic Violence Signs and Basic Interventions • Trauma Informed Care	• 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.

ADAPTIVE AND ASSISTIVE EQUIPMENT

Definition

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

Service Components

Adaptive and Assistive Equipment includes but not limited to:

- Direct selection communicators, alphanumeric communicators, scanning communicators, and encoding communicators
- Speech amplifiers and 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)) (for additional guidance regarding service dogs, please refer to Appendix N)
- 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 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); please reference the ***DME***

Manual (under 'Fee Schedule') for further information https://www.emedny.org/ProviderManuals/DME/index.aspx.

Adaptive Devices are expected to be a one-time only purchase. Replacements, repairs, upgrades, and/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, C-YES, or MMCP will ensure, that where appropriate, justification from physicians or other specialists or clinicians has been obtained.

Warranties, repairs, and/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) or third-party resources.

Cost Limits

All Adaptive and Assistive Equipment costs require prior approval from the LDSS in conjunction with DOH or the MMCP. 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 MMCP (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.

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

LDSS or MMCP secures a local vendor qualified to complete the required work. 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 MMCP once the equipment is verified as received and the amount billed is equal to the contract value.

LDSS or MMCP 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 MMCP 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/youth's needs

LDSS, in conjunction with DOH or the MMCP will determine the most cost-effective service that will meet the child/youth's needs.

For further information regarding assessing need, service authorization, service delivery, and payment, including process flows, please refer to the ***Environmental Modifications, Vehicle Modifications, and Adaptive and Assistive Technology Webinar***, located at https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/hcbs_emod_vmod_at_final_3.11.2020.pdf.

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/youth which, per the child/youth's POC, are identified as necessary to support the health, welfare, and safety of the child/youth or that enable the child/youth to function with greater independence.

Service Components

Modifications include but are not limited to:

- Portable electric/hydraulic and manual lift
- Ramps
- Foot controls
- Wheelchair lock downs/wheelchair floor
- 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
- Dashboard adaptations
- Other ancillary equipment or modifications necessary to guarantee full access to, and safety in, a motor vehicle.

The LDSS (for FFS enrollees) or MMCP (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/youth, and the most cost-effective approach to fulfill the child/youth'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 DOH (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 MMCP 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 MMCP or the LDSS in conjunction with DOH.***

Limitations/Exclusions

Other exclusions include the purchase, installation, and/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/youth. 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/youth. The vehicle may be owned by the child/youth or by a family member or non-relative who provides primary, consistent, and ongoing transportation for the child/youth. 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 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 DOH or the MMCP. 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 MMCP 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/MMCP 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/youth'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/youth 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.

For further information regarding assessing need, service authorization, service delivery, and payment, including process flows, please refer to the ***Environmental Modifications, Vehicle Modifications, and Adaptive and Assistive Technology Webinar***, located at https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/hcbs_emod_vmod_at_final_3.11.2020.pdf.

ENVIRONMENTAL MODIFICATIONS

Definition

Environmental Modifications provides internal and external physical adaptations to the home or other eligible residences of the enrolled child/youth which, per the child/youth's POC, are identified as necessary to support the health, welfare, and safety of the child/youth or that enable the child/youth to function with greater independence in the home and without which the child/youth would require and 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. These may also include 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 DOH if exceeding established limits or MMCP.***

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/youth. 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 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 DOH or the MMCP. For Environmental Modifications, the LDSS or MMCP 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/youth'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 DOH if exceeding established limits or MMCP.***

Certification/Provider Qualifications

Environmental Modification Contractor/Craftsman with licensure appropriate to trade.

LDSS or MMCP 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/MMCP 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/youth'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/youth 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 Environmental Modification contract by the LDSS/MMCP.

For further information regarding assessing need, service authorization, service delivery, and payment, including process flows, please refer to the ***Environmental Modifications, Vehicle Modifications, and Adaptive and Assistive Technology Webinar***, located at https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/hcbs_emod_vmod_at_final_3.11.2020.pdf.

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 MMCP 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 the child/youth's 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, MMCP, 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) 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 MMCP. If the child/youth is not yet enrolled in a plan, the Health Home Care Manger will send the Grid directly to Department of Health's Medicaid Transportation Manager for review.

The Grid can be located at
https://www.emedny.org/ProviderManuals/Transportation/index.aspx.

Medicaid Managed Care Plan (MMCP) Roles

The MMCP 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 MMCP 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 MMCP 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 MMCP will forward the completed Grid to the Transportation Manager any time there are changes to the Grid.

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 MMCP-provided Grid. Once the Grid is received from the MMCP, the Transportation Manager should assume that the MMCP 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%20Reimbursment%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

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 and 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: 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/youth 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/youth that becomes eligible for Medicaid through use of institutional eligibility rules for certain medically needy individuals. These rules allow a budgeting methodology for children/youth to meet Medicaid financial eligibility criteria as a "family of one," using the child/youth's own income and disregarding parental income.

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

HCBS/LOC Eligibility Determination: A tiered assessment where multiple factors must be met for child/youth's HCBS/LOC eligibility to be determined. To access Children's HCBS, a child/youth 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 Serving Children (HHSC): A State-designated program that provides comprehensive care management, care coordination and health promotion, comprehensive transitional care, patient and family support, referral to community supports, and the use of Health Information Technology (HIT) to link services for children/youth who meet Health Home eligibility criteria (i.e. 1) must be enrolled in Medicaid; 2) must have two or more chronic conditions or one single qualifying chronic condition of HIV/AIDS, Serious Mental Illness, Serious Emotional Disturbance, or Complex Trauma).

Home or Community Setting: Home setting or community setting means the setting in which children/youth 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/youth 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/youth and their family.

Licensed Occupational Therapist: An individual who is licensed and currently registered as an Occupational Therapist by the New York State Education Department that assists people across the lifespan to do the things they want and need to do through the therapeutic use of daily activities (occupations). Common occupational therapy interventions include helping children with disabilities to participate fully in school and social situations, helping people recovering from injury to regain skills, and provide customized interventions to improve the person's ability to perform daily activities and reach their goals.

Medicaid Eligible Child: Any child/youth 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): The mainstream Medicaid Managed Care Plan or HIV Special Needs Plan in which the child/youth is enrolled on the date of service, or which the child/youth 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: 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/youth and families. Natural supports can be short-term or long-term and are usually sustainable and available to the child/youth 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: The individuals who have custody/guardianship of the child/youth and who are able to consent to the child/youth's services, when the child/youth is not of age to self-consent or does not have the mental capacity to self-consent to services. (Youth 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).[1]

> ***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.*

[1] 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.

Person-Centered Care: Services should reflect a child/youth 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/youth'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.

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/youth.

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/youth 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)
- 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)
- 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)
- 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)

- 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 child/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 (i.e. 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.

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

APPENDIX C: PERSON-CENTERED PLANNING GUIDANCE

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

The Person Centered Service Planning (PCSP) process is required when enrollees/recipients are in need of Long Term Services and Supports (LTSS), Home and Community Based Services (HCBS), certain State Plan Services, or have Special Health Care Needs, 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.) Medicaid Managed Care Plans (MMCPs) and Local Departments of Social Services (LDSS) are responsible for ensuring that the Plan of Care (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.

Federal regulations 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.

These guidelines are intended to provide information regarding the requirements for the PCSP process for enrollees in Medicaid Managed Care (MMC), and individuals receiving services (recipients) through fee for service from LDSS.

Please refer to the full guidelines available here:
https://www.health.ny.gov/health_care/medicaid/redesign/cfco/docs/2018-12-19_pcsp_guidelines.pdf

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

Admission Criteria	Continued Stay Criteria	Discharge Criteria[2]
All of the following criteria must be met: 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.	All of the following criteria must be met: 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.	Criteria #1, 2, 3, 4, 5 or 6 are suitable; criteria #7 is recommended, but optional: 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.

[2] 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 file appeals when denied HCBS enrollment or receiving a denial or limitation for a requested service.

APPENDIX E: 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	Yes	$15,000 annual calendar year limit; addressed in separate guidance

Home and Community Based Services (HCBS)	Prior Authorization	Concurrent Authorization	Additional Guidance
Vehicle Modifications	Yes	Yes	$15,000 annual calendar year limit; addressed in separate guidance
Adaptive and Assistive Equipment	Yes	Yes	$15,000 annual calendar year limit; addressed in separate guidance
Palliative Care (Bereavement, Pain and Symptom Management, Expressive Therapy, Massage Therapy)	Yes	Yes	Palliative care benefits may not duplicate Hospice or other State Plan benefits accessible to participants. Expressive therapy limited to the lesser of four appointments per month or 48 units per calendar year. Massage therapy limited to no more than 12 appointments per calendar year. Bereavement Limited to the lesser of five appointments per month or 60 hours per calendar year. Limits can be exceeded when medically necessary.
Planned Respite	No	Yes	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. Respite billing is limited to six (6) hours (24 units) per child per day. For Individual Respite the maximum of six (6) hours (24 units) is equivalent to a daily individual per diem rate. Group Respite billing is limited to six (6) hours (24 units) per child per day. 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.
Crisis Respite	No	Yes	No prior authorization is needed; MMCP may require a notification of care and require concurrent review if utilization exceeds 72 hour stay.

APPENDIX F: 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 G: 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/youth/family present.

For MMCP enrollees, prior authorization is not required for the first 60 days, 96 units or 24 hours of HCBS.[3]

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, located at https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/childrens_hcbs_referral_hcbs_provider_fillable.pdf. This form needs to be completed and sent to the chosen HCBS provider(s) within four 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 an HCBS provider for MMCP members, then the HHCM/C-YES should contact the MMCP to notify them and obtain assistance.

> ***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
>
> E-MODS:
> https://www.health.ny.gov/health_care/medicaid/redesign/cfco/emod_guidelines.htm
>
> V-MODS:
> https://www.health.ny.gov/health_care/medicaid/redesign/cfco/vmod_guidelines.htm

[3] 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.

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

When Referring Child/Youth 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/youth 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:

- There is a request or need to change the HCBS provider
- There is a new service requested
- 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/youth 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

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*:**

- HCBS provider completes Section 1 of the ***Children's HCBS Authorization and Care Manager Notification Form*** and sends to MMCP
- The MMCP completes service authorization review and issues determination to the HCBS provider and the enrollee
- 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
- 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*:**

- HCBS provider completes Section 1 of the ***Children's HCBS Authorization and Care Manager Notification Form*** and sends to MMCP
- The MMCP completes service authorization review and issues determination to the HCBS provider and the enrollee.
- MMCP care manager updates POC and distributes the POC.
- The MMCP 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.[4] 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.

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*:**

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

[4] 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 Child/Youth is Not Enrolled in MMCP and is in C-YES (not Health Home)*:**

- 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 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. 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 to reflect HCBS within 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/youth enrolled in an MMCP, within 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.

- 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 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
- 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 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 receives the Children's HCBS Authorization and Care Manager Notification Form, the MMCP will contact the 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/youth in achieving those goals.

• For children/youth 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/youth who are enrolled in an MMCP and not in Health Home: C-YES must send the HCBS POC to the MMCP within 15 calendars 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/youth, 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/youth, and must meet all HHSC standards.

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

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

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/youth's community who can deliver the recommended service. For children/youth in a MMCP, all providers must be In-Network providers.[5] It is the responsibility of the HHCM/C-YES to verify the In-Network status of the HCBS provider.

[5] 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

- 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/youth's information before making a referral with HCBS providers, MMCP, LGU/SPOA, and other appropriate identified service providers.
- Record the child/youth's choice of HCBS provider in the child's case record.

Note: The HCBS provider is responsible for verifying the child/youth's MMCP status to validate that the child/youth 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/youth'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/youth's condition (e.g. admitted to a higher level of care or being discharged from a higher level of care)
- Whenever the child/youth experiences a significant life event
- Whenever a change that will impact the POC is requested (e.g. 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/youth'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/youth declines HCBS, this workflow is not completed. However, the HHCM or C-YES must record this decision. Example reasons include:

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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.

- Child/youth is found eligible for HCBS, but child/family do not feel HCBS will help them reach their identified goals and therefore decline HCBS
- Child/youth is found eligible for HCBS, but child/family choose to remain in a State Plan service already meeting their need(s)
- Child/youth 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")

The HHCM will document the decision in the child/youth'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/youth who are ineligible for or opt-out of HCBS and would refer the child/youth to community and other natural supports, including the county where applicable.***
>
> ***HHCM/C-YES will send Notice of Decision 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/do cs/nod_elig.pdf)***

At any time, a child/youth 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/youth could be found eligible at any time.

APPENDIX H: 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 *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. **	
Child/youth is 0-2	***Average/typical hours per week = 0** • 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 • Community Habilitation 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** • 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** • 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** • Focus on transition activities including increased independence/life skill building including skills such as riding the bus, grocery shopping, using the library, understanding health issues, personal appearance, and hygiene, • 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)
Child/youth is ages 18 up to 21st birthday	***Average/typical hours per week = 20** • Focus on increased independence/life skill building including skills such as riding the bus, grocery shopping, using the library, personal

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 *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. *****	
	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 (e.g. 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 I: TRAINING GRID

HCBS 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.

- For staff hired before April 1, 2019, training must be completed within six months of the 1915(c) Children's Waiver implementation
- For staff hired on or after April 1, 2019, training must be completed within six months of hire date

Training Required	Training Components Required
Mandated Reporter	**Staff members are required to completed Mandated Reporter training prior to delivering HCBS. Found here:** https://www.nysmandatedreporter.org/TrainingCourses.aspx
Personal Safety/ Safety in the Community	• 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	• 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.)

Training Required	Training Components Required
	• Identifying strengths, Protective Factors and Assets • Cultural and linguistic competence
Suicide Prevention	• 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	• 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	• 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.).

APPENDIX J: MEDICAID ELIGIBILITY GUIDANCE

Medicaid Eligibility Status Impact on HCBS Eligible Children

This guidance is to provide clarification regarding Medicaid eligibility related to the Children's Waiver and changes due to the approved 1115 Waiver. This guidance explains how the receipt of services are related to waiver and Medicaid eligibility for "*Family of One*" children. Specifically, the guidance explains when either Health Home Care Management or Home and Community Based Services (HCBS) are required for children to obtain eligibility for the Children's Waiver and Medicaid eligibility.

Together, the 1915(c) Children's Waiver and the 1115 MRT waiver authorities provide Medicaid eligibility for children meeting the HCBS eligibility criteria under the Children's Waiver. The 1915(c) Children's Waiver was implemented on April 1, 2019 and consolidated six children's HCBS waivers into one comprehensive waiver. The children's 1115 MRT waiver amendment was approved on August 2, 2019 to allow "*Family of One*" to children meeting the 1915(c) Children's Waiver criteria, who only receive Health Home Care Management services, to retain their Waiver eligibility status. This allows the child to have Medicaid eligibility determined under a "*Family of One*" budget if not otherwise eligible under community budgeting. The two authorities allow all children and youth eligible for the Waiver to have:

- Greater ease of enrollment into Children's Waiver
- Access to all HCBS (Home and Community Based Services) as needed
- Greater flexibility for HCBS to be delivered in natural environments for better outcomes
- Retain eligibility for Medicaid if "Family of One" and eligible for the Children's Waiver

HCBS Care Management:

All children/youth enrolled in the Children's Waiver need care coordination services. Health Home comprehensive care management provides the care coordination service required under the Children's Waiver. If a child/youth is eligible for the Children's Waiver, they automatically receive Health Home care management and a separate Health Home eligibility determination is not needed. As Health Home is an optional benefit, a child/family can opt-out of Health Home services. For a child/youth who opts-out of Health Home services, their care coordination will be provided by the independent entity of Children and Youth Evaluation Services (C-YES) and, if enrolled in Medicaid Managed Care Plan (MMCP), by the MMCP care manager. A child/youth who needs HCBS, but is not enrolled in Medicaid, will be referred to C-YES who will determine HCBS/LOC Eligibility and assist with establishing Medicaid eligibility. Once the child/youth is HCBS and Medicaid eligible, the child/family can choose who they would like to provide care coordination, Health Home or C-YES.

***"Family of One"* Medicaid Eligibility**:

"*Family of One*" is a phrase used to describe a child that becomes eligible for Medicaid through the use of institutional eligibility rules. If a child is not otherwise eligible for Medicaid when counting parental income (and/or resources, if applicable), these rules allow for the child to have Medicaid eligibility determined as a "*Family of One*", using only the child's own income (and resources, if applicable). If a child/youth is not currently receiving Medicaid due to parental income (and/or resources, if applicable) and the child/youth is in need of waiver services, when the child/youth is found HCBS/LOC eligible and able to obtain a capacity slot, then based upon waiver eligibility, the child will have Medicaid eligibility determined as a "*Family of One*".

Note: There is a hierarchy that must be used in determining a child/youth's Medicaid eligibility. This hierarchy requires that parental income information be included in the child's Medicaid application, even if the income is not ultimately used under a "*Family of One*" budget. If the child is in a medically fragile diagnostic group or certified disabled, parental resource information and any income of non-waiver siblings under age 18 will also need to be included on the Medicaid application. In addition, as part of the Medicaid eligibility determination, children/youth in a medically fragile diagnostic group will have a disability determination made by the State Disability Review Team, if disability status has not already been established by the Social Security Administration. Pending the disability determination, Medicaid coverage will be authorized for such children under an ADC-related "*Family of One*" budget, but the child/family will be required to comply with the disability determination.

Once a child/youth obtains Medicaid under "Family of One" they must be continually enrolled and receiving HCBS or Health Home care management services (as noted below) to continue their "Family of One" eligibility for the Medicaid. Any "*Family of One*" child/youth can also receive other Medicaid services (i.e. State Plan services) such as Private Duty Nursing, CFTSS (Children and Family Treatment and Support Services), pharmacy, hospital, physician, etc. Once a child/youth with "*Family of One*" Medicaid is no longer eligible for the Children's Waiver and/or doesn't receive HCBS or Health Home care management, they may lose their Medicaid eligibility altogether or they may have to meet a large spenddown each month in order to access Medicaid services.

"Community Eligible Medicaid" is when a child/youth is determined eligible for Medicaid based on a budget that includes family income (and resources when applicable) in the budget calculation (MAGI, ADC-related or SSI-related community budget) and is not tied to Children's Waiver eligibility.

"*Family of One*" and Care Management:

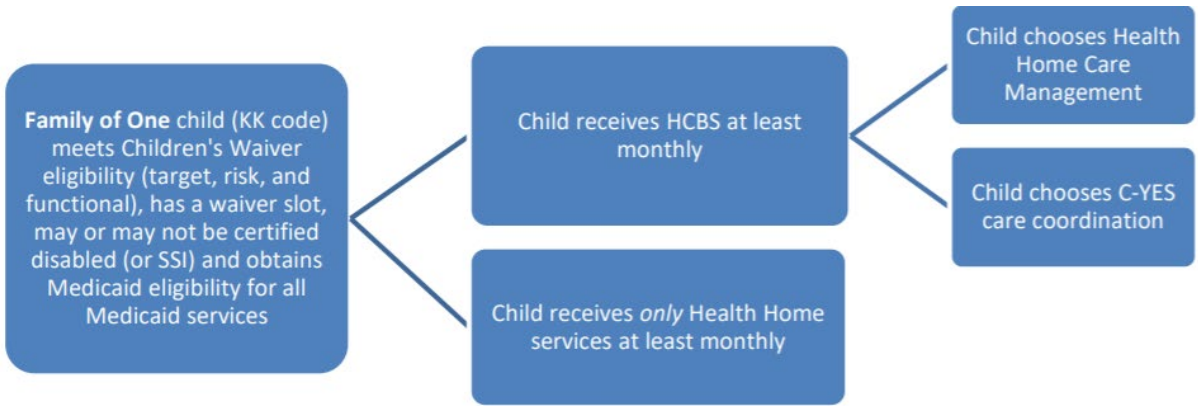
Children/youth who meet HCBS/LOC eligibility (target, risk and functional) and obtain a capacity slot, must be connected and in receipt of at least one HCBS on a monthly basis. Under the new Children's Waiver/1115 Waiver authorities, any "*Family of One*" (with a KK code) child/youth meeting the eligibility criteria for the 1915(c) Children's Waiver must receive Health Home care management services or HCBS.

For all children/youth whether Community Eligible or "*Family of One*" Medicaid, a determination of services necessary must be supported by an assessment of needs and strengths with the child/family and their identified care team as developed in the person-centered plan of care (POC). The Children's Waiver offers an expanded array of service options for children and families. Based on the needs and priorities of the family, the Health Home Care Manager can link the family with the appropriate services to best support their needs, including Private Duty Nursing under the Medicaid State Plan. HCBS found necessary to maintain the child/youth in their home should be supportive and appropriate for the child/youth's needs. The child/youth's care record must reflect the needs and necessary services through appropriate documentation.

If an HCBS/LOC eligible child/youth has no need for an HCB Service, **and** is only eligible for Medicaid under a "*Family of One*" budget, then similar to the previous HCBS Waivers, if the child/youth receives Health Home Care Management in order to be maintained in the home, the child/youth qualifies for the Children's Waiver. Health Home care management may be the sole service for a "*Family of One*" child/youth to continue waiver eligibility and have access to other needed Medicaid services. In these cases, **only** Health Home comprehensive care management with monthly face-to-face monitoring, regardless of acuity level, is allowable. C-YES/MMCP care coordination will not meet this requirement; this restriction must be explained to the child/family. In contrast, a community Medicaid eligible child must receive an HCBS waiver service monthly to continue waiver eligibility. See the separate document for more details regarding this policy: ***The Children's Waiver - HCBS Waiver Eligibility Service Requirements*** **guidance document**.

Health Home care management for an HCBS/LOC and "*Family of One*" eligible child/youth, in absence of any other HCBS waiver service, requires that the POC outline frequency, scope and duration for the Health Home care management services.

Figure 1: *"Family of One"* children may obtain waiver and Medicaid eligibility in two ways:

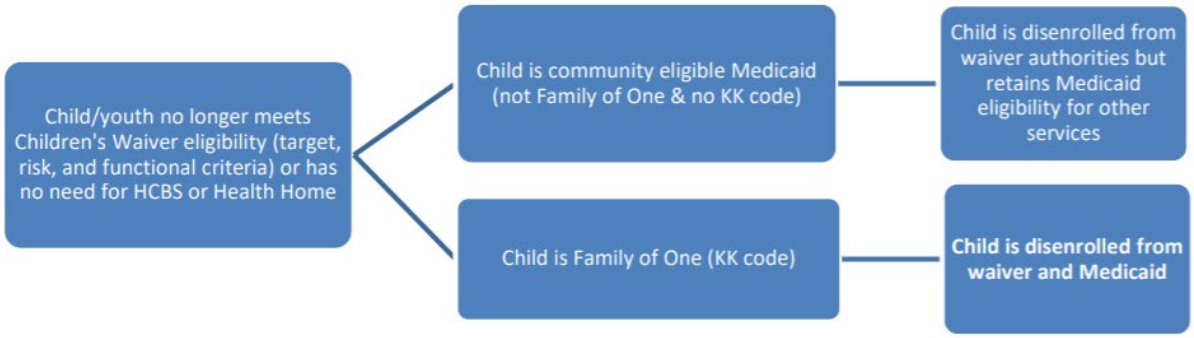


As noted in the figure above, children and youth meeting the Children's Waiver eligibility criteria, assigned to a capacity slot, and receiving HCBS, may receive care management either through Health Home or C-YES/MMCP based upon child/family choice. The difference between Health Home comprehensive care management and C-YES HCBS care coordination, with MMCP care management as applicable. must be explained to the child/family so an informed choice can be made.

<u>Disenrollment from Waiver</u>:

A child/youth who does not meet the Children's Waiver eligibility criteria and who has no need for HCBS or Health Home care management, should be disenrolled from the Children's Waiver. In addition, once a child/youth has been successful in reaching the goal of the HCBS (i.e. Environmental Modification) and no other HCBS is needed, possible discharge from the waiver authorities should be reviewed and determined if other HCBS goals are not appropriate.

Figure 2: Disenrollment from Waiver if child/youth does not meet Children's Waiver criteria or need HCBS/Health Home services.



"*Family of One*" children/youth (with a KK code) who do not require at least one HCBS monthly but continues to meet the eligibility criteria for the Children's Waiver must receive Health Home Care Management and have HCBS in their plan of care for health and welfare monitoring to maintain their Medicaid eligibility.

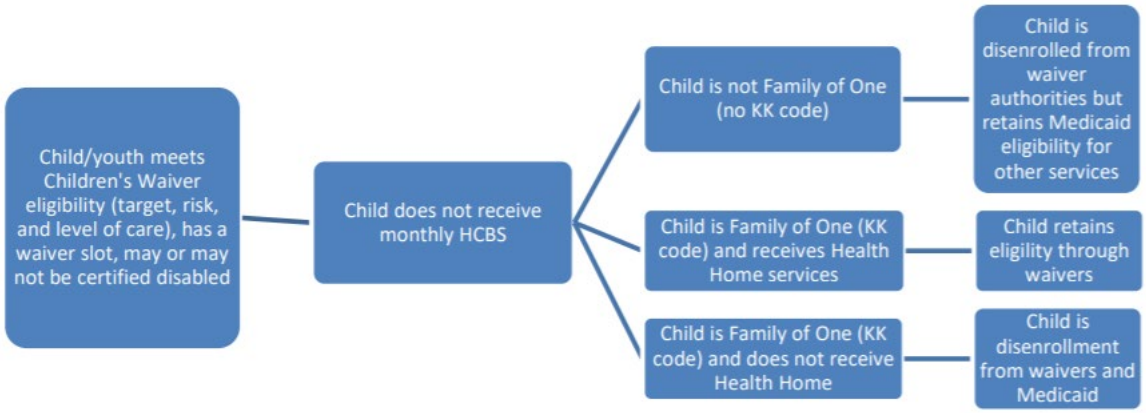
If a child/youth has community Medicaid (without a KK code) and does not need HCBS monthly but needs State Plan services or other supports to be safe and supported at home and in their community, will be disenrolled from the Children's Waiver. The child/youth will retain Medicaid eligibility to receive all other medically necessary Medicaid services.

Receipt of HCBS or Health Home Care Management Services:

If State Plan Services such as Children and Family Treatment and Support Services (CFTSS) or Community First Choice Options (CFCO) can meet a child/youth's needs, then these services must be accessed prior to HCB Services. This does not prohibit a child/youth from receiving both State Plan services and HCBS at the same time, as long as it is reflective of the child/youth's needs in the person-centered POC and does not result in duplicative services. The child/youth's needs should be continually monitored and reviewed with the family and treating service providers. If it is determined that the child/youth's needs are met via non-HCBS programs and/or services, HCBS discharge should be explored.

If State Plan or CFCO services alone meet the needs of the child/youth, then the child/youth **should not be** enrolled in the Children's Waiver unless the child/youth is only eligible for Medicaid under "*Family of One*" (KK code). A "*Family of One*" child/youth who meets the Children's Waiver eligibility criteria and receives HCBS and/or Health Home Care Management, can access other State Plan services such as Private Duty Nursing, and will continue to meet waiver and Medicaid eligibility requirements.

Figure 3: Disenrollment from waiver if child/youth doesn't receive monthly HCBS but continues to meet Children's Waiver criteria.



Process for Renewing and Establishing Medicaid for Children's Waiver Participants

Background – Enrollment in the Children's Waiver:

In preparation for the implementation of the Children's Waiver on April 1, 2019, a streamlined process was developed to determine Medicaid eligibility, Children's Waiver Home and Community Based Services (HCBS) eligibility, and subsequent entering of Children's Waiver Recipient Restriction Exception (RRE) codes (K-codes) for wavier enrolled children/youth.

Child/Youth ***with Active*** Medicaid

When a child/youth has active Medicaid, their HCBS eligibility determination is performed by the Health Home Care Management Agency's accessor/care manager (HHCM), unless the child/youth has opted-out of Health Home, in which case the HCBS eligibility determination would be conducted by C-YES. The Department of Health (DOH) Capacity Management Team (CMT) receives a report of all completed HCBS/Level of Care (LOC) eligibility determinations. The CMT will review the report for new eligible children/youth, notify the HHCM/C-YES accessor of slot availability, and enter the appropriate K-codes into eMedNY to indicate HCBS/LOC eligibility and target population.

The K-code of K1 in eMedNY, indicates to Medicaid Managed Care Plans, the Local Department of Social Services (LDSS), HCBS providers, and others, that the child/youth is eligible and enrolled in the HCBS Children's Waiver.

Children/youth who are enrolled in Health Home and want/need HCBS, the HHCM can complete and determine HCBS/LOC eligibility. If the child's/youth's Medicaid recertification is upcoming, if there is a concern that the child's/youth's Medicaid may lapse, or there is a need for "Family of One" (KK code) Medicaid budgeting, the HHCM can determine HCBS/LOC eligibility and work with the LDSS/HRA. *The HHCM should not refer an enrolled Health Home child/youth to C-YES for HCBS/LOC eligibility.* It is imperative that children/youth are not passed back and forth between Health Home and C-YES.

Child/Youth ***without Active*** Medicaid

When a child/youth who is not enrolled in a Health Home and does not have active Medicaid seeks HCBS eligibility, their HCBS eligibility determination must be performed by C-YES. The CMT receives a report of all completed HCBS/LOC eligibility determinations. The CMT will review the report for new eligible children/youth and will notify the C-YES accessor of slot availability. The LDSS is responsible for entering the appropriate K-codes after the child/youth is determined Medicaid eligible as outlined by Administrative Directive Memorandum.

Monitoring Active **Medicaid Status – Children Enrolled in Children's Waiver**
According to the *Health Home Standards and Requirements of Health Homes, Care Management Agencies, and Managed Care Organizations*, the HHCM must verify an individual's Medicaid eligibility/status on a regular basis and prior to billing for services. The HHCM should be aware of the member's Medicaid recertification date and should assist the member/family with Medicaid recertification whenever possible.

For children/youth enrolled in the HCBS Children's Waiver, it is imperative that HCBS providers verify the child/youth's Medicaid eligibility **plus** HCBS enrollment (through eMedNY), prior to providing services and billing. HCBS providers may not bill while the child/youth does not have active Medicaid. If the HCBS provider continues to deliver services while the child/youth's Medicaid enrollment is not active, the provider is at risk of not recovering those costs.

Loss of Active **Medicaid – Children Enrolled in Children's Waiver**
If an HCBS enrolled child/youth loses their Medicaid, the HHCM or C-YES should reach out to the LDSS to understand the reason for the loss of Medicaid and to share with the LDSS that the child/youth is enrolled in the HCBS Children's Waiver and has active K- codes. If the family's financial situation has changed so that they are no longer eligible for community Medicaid, the LDSS should conduct the "Family of One" (KK code) Medicaid budgeting to determine Medicaid eligibility for the child/youth, which, if found eligible, would allow the child/youth to remain in HCBS.

HCBS enrolled children/youth receiving Health Home care management who lose their Medicaid should *not* be referred to C-YES for assistance with Medicaid. It is the responsibility of the HHCM to assist in restoring active Medicaid status, if possible.

When a member's Medicaid is no longer active, the HHCM can continue to work with the member and the LDSS for up to 90 days to assist with the re-establishment of Medicaid. The HHCM may continue to work with the member but may not bill for services while the member's Medicaid is inactive. The Health Home may retroactively bill for care management services provided during this 90-day period prior to the date Medicaid is re-established, if the member is later deemed eligible, enrolled in Medicaid, and the Medicaid date is effective for this time period. If the HHCM learns that the member/family's Medicaid cannot be restored, the HHCM must initiate the Health Home discharge planning process.

For children/youth receiving HCBS care coordination through C-YES, C-YES may work with the member/family and/or LDSS to assist with re-establishing Medicaid eligibility.

Please refer to the *Children's Wavier Medicaid Eligibility Status Impact on HCBS Eligible Children* guidance document and the Children's HCBS Provider Manual for

additional information. For any questions, please reach out to your lead Health Home for assistance. NYS DOH Children's Transformation contact information: BH.transition@health.ny.gov or HHSC@health.ny.gov

Medicaid Excess/Surplus Income (Spenddown) Program Guidance for Children's Care Management and Home and Community Based Services (HCBS)

The following information outlines the Medicaid "Spenddown" program and its impact on Children's Health Home care management and/or Children's Waiver enrollment of HCBS.

What is the Spenddown Program?

The Spenddown program is a way for individuals with income over the Medicaid level (excess/surplus income) to receive Medicaid coverage. The individual must submit paid or incurred medically necessary bills equal to or greater than the monthly excess income amount. The individual may also pay the amount of their monthly excess to the local district (For Upstate the County Local Department of Social Services (LDSS) or in NYC HRA). This is called Pay-In.

How Does an Individual Satisfy or Meet Their Monthly Spenddown Amount?

When an individual has a monthly spenddown, it means the individual's income is above the Medicaid income limit and must "spenddown" to the Medicaid limit by submitting paid or unpaid medically necessary expenses, such as out-of-pocket medical costs (co-pays for doctor appointments and/or pharmacy). The individual can also choose to pay their monthly spenddown by cash/check/money order directly to their LDSS/HRA.

- Medically necessary costs and Waiver Services can be utilized for the monthly spenddown. The family and providers should work with the LDSS/HRA to understand which service costs can be utilized for spenddown.
- Health Home care management services cost cannot be utilized for spenddown.
- The individual can pay their spenddown monthly or pay months in advance.

Please note: *When a child/youth has Family of One Medicaid budgeting, parental medical expenses cannot be applied toward a child's/youth's spenddown*.

When an individual is determined Medicaid eligible with a monthly spenddown, the individual does not have Medicaid coverage until the monthly spenddown is met.

- Once the individual meets their monthly spenddown, s/he is eligible for Fee-for-Service (FFS) or regular Medicaid coverage only.

- Individuals participating in the spenddown program are not eligible to join a Medicaid Managed Care plan (MMCP).

What Occurs if an Individual Does Not Satisfy Their Monthly Spenddown Amount?

If the individual does not meet their monthly spenddown, then services rendered such as Health Home care management and other Medicaid services cannot be billed. Health Homes care managers, HCBS providers, and other Medicaid service providers should work with the family to assist in meeting their spenddown so services can be delivered. Providers should verify monthly that the family's monthly spenddown is met to provide services and be able to bill for those services.

- If an individual does not meet their spenddown for 90 days or longer, the LDSS/HRA may close the individual's Medicaid case, resulting in loss of Medicaid, Waiver Services, and Health Home care management services; therefore, care managers and providers should assist individuals not meeting their spenddown to avoid discharge.
- If an individual loses coverage, the LDSS/HRA, the care manager, and providers should work to connect the individual to other non-Medicaid services.

Children's Waiver participant and Spenddown:

When a child/youth is eligible for the Children's Waiver and their Medicaid eligibility is being determined, if they are found Community Medicaid eligible with a spenddown, then the LDSS/HRA will complete Family of One budgeting. In many cases, the child/youth found to be eligible for Medicaid through Family of One budgeting won't have a spenddown, therefore the required monthly Waiver Services can be delivered without concern for meeting a spenddown. In some cases, Family of One Waiver-eligible children/youth will have a spenddown that would have to be met prior to Waiver Services being provided.

How to Identify an individual Participating in the Spenddown Program:

To systematically identify an individual who has spenddown coverage in ePACES, upon entering the individual's Client Identification Number (CIN), the following messages will come up:

- ❖ ***"No Coverage-Excess Income"*** until the monthly spenddown is met

Once the individual meets their monthly spenddown, ePACES will reflect the following message:

- ❖ ***"Outpatient Coverage"*** or
- ❖ ***"Outpatient Coverage with Community-Based Long-Term Care"***

Outpatient care is sometimes referred to as ambulatory care. It is medical care or treatment that does not require an inpatient stay in a hospital or medical facility. Some examples of outpatient services are:

- Treatment and Preventative Health and Dental Care (Doctor, Dentist)
- Eye Exams, Eyeglasses
- Prescription Drugs
- Laboratory and X-Rays
- Medical Supplies
- Care in a Hospital that does not Result in the Individual Being Formally Admitted to the Hospital for an Inpatient Stay (Emergency Room/Observation)
- Transportation to and from Necessary Medical Services

If the individual meets their monthly spenddown for a six-month period, ePACES will reflect the following message:

❖ ***"Full Coverage" or "Community Coverage with Community Based Long-Term Care (CC with CBLTC)"***

Any questions or for further explanation concerning how to meet a monthly spenddown should be directed to the Medicaid case worker at the individual's LDSS/HRA. Upstate and NYC individuals can also contact the Medicaid Help Line at 1-800-541-2831 for assistance.

APPENDIX K: HCBS LOC ELIGIBILITY GUIDANCE

Care Management Requirements for HCBS Eligible Children

This guidance is to provide clarification regarding Home and Community Based Services (HCBS) requirements for care managers to ensure HCBS eligible children/youth obtain the services as required for the child/youth to maintain Waiver eligible. The 1915(c) Children's Waiver was implemented on April 1, 2019 and consolidated the six children's HCBS waivers into one comprehensive waiver. Each waiver had nuance differences and different HCB Services. Additionally, with the consolidated Children's Waiver now directly connected to Health Home Serving Children's program, there are an increased number of care managers coordinating care for HCBS eligible children, when previously they had not done so. As such, the following is to clarify the requirements for services of HCBS eligible children within the Children's Waiver.

HCBS Level of Care (LOC) Determination:

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

The Health Home care manager or C-YES staff are required to complete this eligibility determination prior to its annual expiration. The annual re-determination should begin 2 months prior to the expiration of the current HCBS/LOC determination. It is the Health Home care manager's or C-YES staff's responsibility to know and understand the requirements and necessary paperwork needed to make an HCBS/LOC eligibility determination. For the target populations of Developmental Disability in Foster Care and Developmental Disability Medically Fragile, it is imperative that the Health Home care manager or C-YES staff work with the OPWDD DDROs to establish timely HCBS redeterminations. (See here for HCBS determination reconciliation timeline)

If a child/youth experiences a significant life event, as defined as a significant impact/change to the child's or caregiver's functioning and their daily living situation, a new HCBS eligibility determination will be needed. With all new HCBS/LOC Eligibility Determinations, the annual determination timeline resets with the completion of a new assessment outcome. 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 enrolled in the Children's Waiver in such setting for up to 90 days.

During the 90 days stay:

- For children/youth in a Health Home, the MAPP segment would be "pended", and no billing would occur while the child was in the restricted setting. (Please refer to the HH Continuity of Care Policy)
- The Health Home, C-YES or Medicaid Managed Care Plan (MMCP) care manager, as applicable, should notify all care team members of the child's/youth's placement.
- The Health Home, C-YES or MMCP care manager, as applicable, will stay in contact with the hospital or HCBS restricted setting and request to be notified 30 days or as soon as possible, for shorter lengths of stay, prior to discharge.

Length of Stay – 90 days or shorter:

- The Health Home, C-YES or MMCP care manager, as applicable, will request to be notified when the child/youth will be discharged.
- Whenever possible, the Health Home or C-YES staff will conduct a new HCBS/LOC Eligibility Determination prior to discharge to ensure continuous waiver eligibility, will update the plan of care, as needed, and link the child/youth to service upon discharge.

Length of Stay – longer than 90 days:

- Once the child/youth's length of stay is beyond 90 days, the Health Home or C-YES staff will discharge the child/youth from the Children's Waiver providing proper notification to the child/family of the notice of decision, as well as notifying DOH Capacity Management. (*Those with "Family of One" Medicaid based upon waiver eligibility may lose their Medicaid*)
- The Health Home or C-YES staff will ask the hospital or HCBS restricted setting to notify when the child/youth is being discharged, if the child/youth will need and want HCBS upon discharge. An HCBS/LOC Eligibility Determination can be conducted to determine if the child/youth can be re-enrolled in the Children's Waiver.

Monthly HCBS Required:

Children/youth who meet HCBS/LOC eligibility (target, risk and functional) and obtain a capacity slot, must be connected and in receipt of HCBS on a monthly basis. The determination of services necessary must be supported by an assessment of needs and strengths with the child/family and their identified care team to develop a person-centered Plan of Care (POC). The Children's Waiver offers an expanded array of service options for children and families. Based on the needs and priorities of the family, the care manager will link the family with the appropriate services to best support their needs (including other Medicaid needed services). HCBS found necessary to maintain the child/youth in their home should be supportive and appropriate for the child/youth's

needs. The child/youth's care record must reflect the needs and necessary services through appropriate documentation.

If a child/youth has been determined eligible for HCBS and the child/family consents to receive HCBS, then at least ***one*** HCBS must be received monthly to maintain eligibility for the Children's Waiver. If the child/youth is not connected to an HCBS upon eligibility being determined or misses monthly HCBS, then the Health Home, C-YES or MMCP care manager, as applicable, must document efforts made to ensure access in the case record. If there is a concern regarding the child/family's interest in continuing HCBS and issues occur regularly, then the Health Home, C-YES, or MMCP care manager, as applicable, should review quarterly (three months) HCBS with the child/family and care team to determine if HCBS should be continued, terminated, or changed and/or if a referral to a different provider/service is needed.

Monthly HCBS Requirement and Accessibility:

Children/youth enrolled in the waiver who need at least one HCBS monthly to safely live in their home and community must receive the HCBS needed for health, safety, and welfare. Due to their high needs, children/youth with a Children's Waiver plan of care requiring HCBS cannot be placed on HCBS provider's waitlist for all their identified and referred HCBS.

If a child/youth has been assessed as needing HCBS to be maintained in the community, Health Home care managers, C-YES or MMCP must ensure the child/youth has access to the HCBS outlined on the plan of care. If the child/youth does not have access to monthly HCBS, then the Health Home care manager, C-YES or MMCP, as applicable, must document efforts made to ensure access in the case record.

Health Home care managers, C-YES, or MMCP, as applicable, must make every effort to find available HCBS and HCBS providers that meet the identified needs of the child/youth. The child/youth **must** be referred to another HCBS provider in their service area with the capacity to serve the child/youth instead of being waitlisted. If the child/family does not want another provider, the child/youth must receive **at least one** service monthly or be in jeopardy of losing their HCBS.

If the Health Home care manager or C-YES staff cannot find available HCBS, then they should contact the child/youth's Medicaid Managed Care Plan (MMCP), if applicable. The Health Home Care Management Agency (CMA) must contact the lead Health Home for assistance to ensure the health and welfare of the child. The lead Health Home should alert NYS DOH or the MMCP of the access issue and work with the care manager to provide necessary services to enrolled children.

If access issues occur regularly, then the Health Home, C-YES, or MMCP, as applicable, should review quarterly (three months) HCBS with the child/family and care team to determine if HCBS should be continued, terminated, or changed. Health Home care managers and care management agencies should contact their lead Health Home with questions or contact the NYS DOH HHSC@health.ny.gov.

Matching Services to Need

Due to the transformations staggered implementation timeline, children/youth may be receiving and or referred to multiple services of both the Children's Waiver and the new State Plan Services of Children and Family Treatment and Support Services (CFTSS). It is important to ensure that through a person-centered POC development and service review, that children/youth's needs are matched with specific services that they can obtain and regularly receive. This does not prohibit a child/youth from receiving both State Plan services and HCBS at the same time, as long as it is reflective of the child/youth's needs in the person-centered POC and does not result in duplicative services.

Specifically, community Medicaid eligible children/youth who have all of their needs met through only State Plan Services of CFTSS or Community First Choice Options (CFCO) services, should be disenrolled from the Children's Waiver. In addition, once a child/youth has been successful in reaching the goal of the HCBS (i.e. Environmental Modification) and no other HCBS are needed for the child to be maintained in the community, possible discharge from the Children's Waiver should be reviewed and determined if other HCBS goals are not appropriate.

Requirements Regarding the Children's Waiver Home and Community Based Services (HCBS) Participants Placed in a Restricted Setting

When a child/youth enrolled in the Children's Waiver is hospitalized or placed in an HCBS restricted setting (please see: *Children's Home and Community Based Services Provider Manual* – *Appendix B*), the child/youth may remain in such setting for up to 90 consecutive calendar days while maintaining enrollment in the Children's Waiver. If the waiver child/youth is also enrolled in the Health Home program when entering an HCBS restricted setting, the Health Home care manager must "pend" the enrollment segment in the MAPP tracking system. The Health Home and HCBS providers are not able to bill while the child/youth is in a restricted setting, unless otherwise noted below.

When the child/youth remains in a hospital or restricted setting for more than 90 consecutive calendar days, the child/youth must be discharged from the Children's Waiver. The family/child will be issued a Notice of Decision (NOD) explaining the reason for the disenrollment from the Children's Waiver. The Health Home care manager (HHCM) or Children and Youth Evaluation Service (C-YES) will notify the Department of Health Capacity Management Team through the Health Commerce System (HCS) regarding the Children's Waiver discharge following information outlined in the *Communication with NYS DOH Capacity Management for the Children's Waiver* guidance document. The Capacity Management team, upon receipt of the notification, will end date the K-codes on the child's/youth's case based upon the date given by the HHCM or C-YES.

In keeping with the *Continuity of Care and Re-engagement for Enrolled Health Home Members # HH0006* policy, in the 30 days prior to the member's discharge from the restricted setting, the care manager must participate in active discharge planning activities to re-engage the member, the member's enrollment segment must be changed to 'active' status in the MAPP tracking system, and the care management agency may bill for services provided during the 30-day period. The Health Home care manager must also conduct the HCBS/LOC Eligibility Assessment 30 days prior to discharge from the restricted setting, if possible, or within 30-days after discharge to determine HCBS re-eligibility (if previously discharged from HCBS) and to ensure an updated Plan of Care (POC) and necessary services are in place to assist the child/youth in transitioning back to their home and/or community.

Please refer to the *Children's HCBS Provider Manual* for additional information regarding the HCBS Notice of Decision, the HCBS/LOC Eligibility Assessment, and other requirements of the Children's Waiver.

For any questions, please reach out to your lead Health Home for assistance, NYS DOH Children's Transformation contact at BH.transition@health.ny.gov,or HHSC@health.ny.gov.

HCBS Determination for Children Discharging from OMH Residential Treatment Facility or Psychiatric Center

This guidance describes procedures for making 1915(c) Children's Waiver Home and Community Based Services (HCBS) referrals for children prior to or after being discharged from OMH Licensed Residential Treatment Facilities (RTFs) or OMH State Operated Psychiatric Centers Serving Children (State PCs).

When a child/youth enters an RTF or State PC, the Department of Health, in conjunction with OMH, is responsible for (re)determining Medicaid eligibility for the child/youth. When Medicaid eligibility is established, the child/youth is enrolled in Medicaid under District 97. This eligibility continues while the child/youth is in the RTF or State PC and continues ***for the month of discharge and one month after the month of discharge***. This extension is to prevent a gap in coverage and allow time for the Local Department of Social Services (LDSS, NYC HRA) to determine continued Medicaid eligibility.

For children/youth who have Medicaid coverage under OMH District 97, upon return to their county of residence post discharge, the LDSS will extend Medicaid coverage beyond the month after discharge, if necessary, to complete a redetermination of Medicaid eligibility. If the child/youth is not otherwise eligible for Medicaid based on household income and/or assets, but is eligible for HCBS, Family of One budgeting will be used to determine Medicaid eligibility. A new Medicaid application is not required upon RTF/PC discharge in these situations; however, the local district may require additional information in order to determine the continued eligibility of the child/youth.

> ***Note:*** *Children with SSI Medicaid have uninterrupted Medicaid through a separate automated process. OMH extends SSI Medicaid coverage for 10 days beyond the OMH Medicaid district 97 case closing transaction date, and the SSI Medicaid coverage is transitioned automatically to the discharge District of Fiscal Responsibility (DFR).*

When a child/youth enters an RTF or State PC, the OMH Patient Resource Office (PRO) will complete a Medicaid eligibility determination. There are 3 scenarios to consider when referring for HCBS and Medicaid Eligibility:

1. Child/youth enters the RTF or State PC with Medicaid
2. Child/youth enters the RTF or State PC without Medicaid and the OMH PRO determines Medicaid eligibility prior to discharge
3. Child/youth enters the RTF or State PC without Medicaid and is discharged before the OMH PRO determines Medicaid eligibility

The following outlines the process for connecting children/youth who are being discharged to a Health Home or the Children and Youth Evaluation Service (C-YES) for

purposes of an HCBS Eligibility Determination and access to HCBS in each of the three scenarios listed above when an identified need is established.

Scenario 1: **Child/youth enters the RTF or State PC <u>with</u> Medicaid**

Children/youth who are enrolled in Medicaid prior to admission to an RTF or State PC and have an identified need for high level services will be referred to a Health Home for care management services and an HCBS Eligibility Determination before being discharged, when possible. The referral can be made up to 30 days prior to discharge.

- If the child/youth is already connected to Health Home care management agency and or HCBS, a new referral is not needed if the child/youth has been inpatient for 90 days or less. Contact with the current Health Home provider is needed.

Health Home care managers are permitted to serve a child/youth 30 days prior to discharge to assist with discharge planning, to secure services, and to establish HCBS eligibility. If a child/youth in an RTF or State PC needs HCBS in order to be safely discharged to their home and community, then the HCBS/LOC Eligibility Determination must be completed before discharge. Coordination between the RTF or State PC and the Health Home is necessary to ensure children/youth are safely discharged.

In circumstances when the child/youth is referred to a Health Home after discharge, such as when the child's length of stay is less than 30 days, or when there is a change in the child/youth's discharge plan, the child should be enrolled in a Health Home immediately. The Health Home must complete an HCBS eligibility determination within 30 days of the referral.

Scenario 2: Child/youth enters the RTF or State PC <u>without</u> Medicaid and the OMH Patient Resource Office (PRO) determines Medicaid Eligibility before discharge

Children/youth who are enrolled in Medicaid prior to discharge will be referred to a Health Home for care management services and an HCBS eligibility determination. Once Medicaid eligibility is established by OMH, the referral can be made up to 30 days prior to discharge.

Once Medicaid is established by OMH, Health Home care managers are permitted to serve a child/youth immediately to assist with discharge planning, to secure services, and to establish HCBS eligibility. If the RTF/State PC unable to make a referral to the Health Home 30 days prior to discharge, the referral should be made immediately with the information regarding the discharge date. Once the referral to Health Home is made (which may occur at the time of discharge), the Health Home will need to work with the child/youth/family and the RTF or State PC to ensure proper documentation and information is obtained to complete the HCBS/LOC Eligibility Determination.

It is imperative that the Health Home care manager remembers that the Medicaid eligibility established by PRO under District 97 continues ***only*** for the month of discharge and one month after the month of discharge. The Health Home care manager will need to ensure that HCBS/LOC eligibility is completed prior to Medicaid eligibility ending and the NYS DOH Capacity Management is notified to enter the proper Recipient Restriction K-codes to ensure that if the Local District needs to conduct Family of One budgeting, they will be aware of the HCBS eligibility.

Scenario 3: Child/youth enters the RTF or State PC <u>without</u> Medicaid and the OMH Patient Resource Office (PRO) <u>cannot</u> determine Medicaid Eligibility before discharged

Up to 30 days prior to discharge, but no later than the date of discharge, the RTF or State PC will refer children/youth who are not already enrolled in Medicaid or cannot be determined Medicaid eligible under District 97 to C-YES for an HCBS Eligibility Determination and assistance with the Medicaid eligibility application.

Responsibilities of Each Party Involved

To ensure adequate services are available upon discharge and uninterrupted Medicaid coverage for children who may not be otherwise eligible for Medicaid, coordination is essential and the sharing of information critical for a successful transition.

RTFs/State PCs:

1. Determine when a child/youth will be ready for discharge.
2. As soon as possible, up to 30 days prior to discharge, work with the family/caregiver to identify their preferred Health Home or Health Home Care Management Agency and make a direct referral. If Medicaid will not be established prior to discharge, then make a referral to C-YES.
3. At time of referral, indicate Medicaid eligibility status and potential discharge date.
4. When a Health Home/C-YES care manager is assigned, ensure all necessary documentation is provided and forms are complete to facilitate completion of an HCBS Eligibility Determination (i.e. Diagnosis, Disability, LPHA form, etc.).
5. Continue to work collaboratively with the Health Home/C-YES care manager to ensure a seamless transition to the community and access to needed services.
6. Please note: For children who are being discharged from an RTF or State PC and are in foster care, it is expected that there is enhanced collaboration with the LDSS and the Voluntary Foster Care Agency, if applicable, to ensure access to needed Medicaid services and to promote a safe and stable discharge. For children in foster care, the LDSS will enroll them in Medicaid using the foster care Medicaid rules.

OMH Patient Resource Office (PRO) and LDSS:

1. For children/youth who have been determined Medicaid eligible by the OMH PRO, OMH PRO will transition the OMH Medicaid (District 97) case to the LDSS District of Fiscal Responsibility.
    a. For SSI Medicaid eligible children/youth, PRO will transfer the OMH Medicaid coverage to the new district through the Auto-State Data Exchange (SDX) process.
    b. For all other children/youth:
        i. PRO will initiate the closing of the child/youth's OMH Medicaid case.
        ii. PRO will change the child/youth's residence address to their discharge address, and a closing notice will be sent to this the discharge address. The notice will advise that the coverage will be transferred to the new district and will identify the effective date that the OMH Medicaid case will end.
        iii. PRO will mail a Relocation Referral Form and pertinent case information to the Medicaid Director in the new district of residence.
        iv. The Relocation Referral Form sent by the PRO will indicate whether the child is enrolled in Waiver services or that a referral has been made.
2. Upon receipt of the Relocation Referral Form, the LDSS District of Fiscal Responsibility (DFR) will establish uninterrupted coverage for the case, transitioning the Medicaid coverage from OMH Medicaid to the county.
3. LDSS District of Fiscal Responsibility (DFR) will issue the appropriate opening notice.
4. DOH will notify the LDSS of the approval for HCBS eligibility and enter the appropriate Recipient Restriction K-code on eMedNY to indicate participation in the Children's Waiver. This will provide necessary information to the LDSS for purposes of redetermining Medicaid eligibility for the child/youth; including the authorization to use Family of One budgeting, if necessary.

C-YES:

1. The RTF or State PC will refer children/youth to C-YES who are not already enrolled in Medicaid or cannot be determined Medicaid eligible under District 97 for an HCBS Eligibility Determination and assistance with the Medicaid eligibility.
    a. The assigned C-YES family support worker will contact the RTF/State PC 48 hours after they are assigned to notify the referring RTF/State PC of the assignment.
    b. C-YES will gather the necessary information to follow up with the family prior to the discharge of the child/youth, whenever possible.
    c. C-YES will stay in contact with the RTF/State PC staff who can assist with necessary information and the LPHA form to conduct the HCBS/LOC Eligibility Determination.

d. C-YES must also notify the RTF/State PC assigned OMH Patient Resource Office (PRO) when a child is determined eligible for HCBS.
e. When developing the person-centered POC and referring to HCBS, C-YES will notify HCBS providers that the child/youth was discharged from the RTC/State PC.
f. C-YES must follow their established processes in addition to the steps outlined above.

Health Home:

2. The RTF or State PC will refer children/youth to Health Home who have Medicaid eligibility prior to entering care or if PROs established OMH District 97 Medicaid eligibility prior to or at discharge for an HCBS Eligibility Determination.
    a. After verifying Medicaid eligibility, the assigned Health Home care manager will contact the RTF/State PC 48 hours after they are assigned to notify the referring RTF/State PC of the assignment.
    b. Health Home care manager will gather the necessary information to follow up with the family prior to the discharge of the child/youth, whenever possible.
    c. The Health Home care manager will schedule an appointment to meet with the child/youth, family, and RTF/State PC staff to gather the necessary information to conduct the HCBS/LOC Eligibility Determination and complete appropriate consents.
    d. If the child/youth is determined HCBS eligible, the Health Home care manager will follow the HCBS process to obtain a slot with Capacity Management and issue the appropriate Notice of Decision.
    e. The Health Home care manager must also notify the RTF/State PC assigned OMH Patient Resource Office (PRO) when a child is determined eligible for HCBS. This notification will be made prior to the child's discharge, wherever possible, and no later than 30 days from the date of the referral.
    f. When developing the person-centered POC and referring to HCBS, the Health Home care manager will notify HCBS providers that the child/youth is being discharged from the RTC/State PC to ensure the first appointment and services are in place after discharge, whenever possible.

APPENDIX L: HEALTH HOME SERVING CHILDREN POLICY INFORMATION

Health Home Policy Document	Link	Description
Comprehensive Assessment Policy #HH0002	https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/comprehensive_assessment_policy.pdf	Establishes standards and guidance regarding the Health Home comprehensive assessment that is required for all Health Home enrollees
Health Home Quality Management Policy #HH0003	https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/quality_management_program_policy.pdf	Describes the scope and required procedures for continuous quality improvement, monitoring, and oversight within the Health Home network
Health Home Notices of Determination and Fair Hearing Policy #HH0004	https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh0004_fair_hearing_nod_policy.pdf	Outlines the policies and procedures for issuing Notices of Determination for Health Home enrollment and the steps for requesting and attending a Fair Hearing
Health Home Monitoring: Reportable Incidents Policies and Procedures #HH0005	https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/docs/hh0005_reportable_incidents_rev_10_2019.pdf	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
Health Home Plan of Care Policy #HH0008	https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/docs/hh0008_plan_of_care_policy.pdf	Outlines standards and guidance for Plans of Care (POCs) completed by Health Home Care Managers
Access to/Sharing of Personal Health Information (PHI) and the Use of Health Home Consents	https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/docs/hh0009_phi_and_consent_policy.pdf	Lists the various Health Home consents requirements and policies/procedures related to PHI protections
Health Home Care Management Activities and Billing Protocols for Managing Newly Referred Individuals from Excluded Settings #HH0011	https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/docs/hh0011_hhcm_activities_billing_protocol_excluded_settings.pdf	Addresses steps that must be taken to manage new referrals from excluded settings of potentially eligible Health Home and/or HCBS children/youth

Health Home Policy Document	Link	Description
Conflict Free Case Management Policy #HH0012	https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/docs/hh0012_conflict_free_care_management_policy.pdf	Outlines the federally-guided principles of Conflict Free Case Management (CFCM) and implementation strategies for each

APPENDIX M: BILLING AND CLAIMING RESOURCES

The following lists resources that HCBS providers, Health Home Care Managers, and Medicaid Managed Care Plans may find useful.

Resource	Link	Description
NPI Number Webinar	https://ctacny.org/training/npi-number-webinar	Guides agencies through the application process for an NPI number and explains a general overview of the significance and utility of the NPI number
Medicaid Provider Enrollment for New Children's SPA and HCBS Providers	https://ctacny.org/training/medicaid-provider-enrollment-new-childrens-spa-and-hcbs-providers	Walks through the steps providers need to take to enroll as a Medicaid provider to bill and be reimbursed by Medicaid
Understanding Paper Claims Submissions	https://ctacny.org/sites/default/files/Submitting%20Paper%20Claims%20Final%20Slides.pdf	Reviews the steps for submitting paper claims and walks through each component of the UB-04 claim form
Principles of Revenue Cycle Management and Utilization Management	https://ctacny.org/sites/default/files/trainings-slides/Children%27s%20RCM-UM%20draft%20slides%20Final%20%281%29.pdf	Provides background information, definitions, tips/tools related to revenue cycle management and utilization management
Billing Tool	https://billing.ctacny.org/	An interactive UB-04 form that walks through the components required to submit a clean claim

APPENDIX N: SERVICE ANIMAL GUIDANCE

The NYS Children's Waiver recognizes the importance of service animals in the lives of individuals with various disabilities such as those that substantially limit one or more major life activities. Service animals are more than pets, and more than companions; they are a working animal and the important work they do enhances independence for children/youth with physical, cognitive, and developmental disabilities. Service animals perform some of the functions and tasks that the individual with a disability cannot perform for him or herself.

Service animal is defined by the Americans with Disabilities Act (ADA) Title II (State and local government services) and Title III (public accommodations and commercial facilities) as, "any dog that is individually trained to do work or perform tasks for the benefit of an individual with a disability, including a physical, sensory, psychiatric, intellectual, or other mental disability." The work or tasks performed by a service animal must be directly related to the individual's disability. These tasks may include, but are not limited to:

- assisting individuals who are blind or have low vision with navigation and other tasks,
- alerting individuals who are deaf or hard of hearing to the presence of people or sounds,
- providing non-violent protection or rescue work,
- calming a person with Post Traumatic Stress Disorder during an anxiety attack,
- pulling a wheelchair,
- protecting a person who is experiencing a seizure,
- alerting individuals to the presence of allergens,
- retrieving items such as a telephone or medicine or reminding someone to take prescription medications,
- providing physical support and assistance with balance and stability to individuals with mobility disabilities, and,
- helping persons with psychiatric and neurological disabilities by preventing or interrupting impulsive or destructive behaviors.

Additional guidance on the ADA's service animal provisions can be found in the following publications:

Title III Regulation Supplement - Current as of January 17, 2017
Nondiscrimination on the Basis of Disability by Public Accommodations and in Commercial Facilities
https://www.ada.gov/regs2010/titleIII_2010/title_iii_reg_update.pdf

Frequently Asked Questions about Service Animals and the ADA
https://www.ada.gov/regs2010/service_animal_qa.pdf

https://adata.org/factsheet/service-animals

Public Access Test Checklist for Service Animals
https://www.nsarco.com/public-access-test.html

Dogs whose sole function is to provide comfort or emotional support do not qualify as service animals under the ADA.

This definition does not affect or limit the broader definition of "assistance animal" under the Fair Housing Act or the broader definition of "service animal" under the Air Carrier Access Act.

U.S. Department of Housing And Urban Development: Service Animals and Assistance Animals for People with Disabilities in Housing and HUD-Funded Programs, FHEO-2013-01 (April 25, 2013)
https://www.hud.gov/sites/dfiles/FHEO/documents/19ServiceAnimalNoticeFHEO_508.pdf

49 U.S.C. § 41705; see "Nondiscrimination on the Basis of Disability in Air Travel," 14 C.F.R. Part 382 (United States Department of Transportation 2014) Nondiscrimination on the basis of disability in air travel
https://www.ecfr.gov/cgi-bin/text-idx?SID=aa072804eed9a56532223335f92e6b87&node=pt14.4.382&rgn=div5#se14.4.382_1117

The ADA requires that service animals be under the control of the handler at all times and be harnessed, leashed, or tethered, unless these devices interfere with the service animal's work or the individual's disability prevents him from using these devices. Individuals who cannot use such devices must maintain control of the animal through voice, signal, or other effective controls.

Policy
This policy provides guidance on the use and funding of service animals by New York Children's Waiver participants. Service animals funded by the New York Children's Waiver must meet the following criteria.

- The request for funding must following the Guidelines for Authorizing Assistive Technology including:
  - Documenting the need for assistance in the individual's plan of care (POC)
  - A physician's order stating the need for assistance

  - Clinical justification from the appropriate clinician and/or service specialist to assess the individual's need for the request service animal and to indicate how the service animal meets the needs of the individual in the most cost effective manner; the clinical justification must include a home environment assessment to determine if there are any obstacles to the use of the service animal in the home
  - Submitting the Description and Cost Project Form to the Managed Care Organization (MCO) or Local Department of Social Services (LDSS) as appropriate
- A licensed veterinarian shall be engaged to certify the following:
  - The service animal is trained to perform the activities needed by the individual as identified in the POC and clinical justification. See Appendix 1 for ADA requirements regarding training.
  - The service animal must pass obedience level 3 and/or the national public access test, be registered and licensed as required by local ordinance, and current on all vaccinations. See Appendix 2 for a National Public Access checklist for basic obedience requirements.
  - Assistance teams are tested initially and verified every 24 months to ensure they continue to work well together and accomplish the identified tasks. Additional training may be conducted if medical necessity is determined based on the changing needs of the individual.

Services include:

A. Evaluation of the assistive technology/service animal 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
B. Services consisting of purchasing assistive technology devices/service animal for the participant
C. Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices for the participant
D. Training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant
E. 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 participant

- Service animals are expected to be a one-time only purchase. Replacements will be paid if documented as a necessity and approved by the State or its designee. Maintenance will only be approved when it is the most cost effective and efficient means to meet the need, and other options are not available through the 1905(a) Medicaid State Plan or third-party resources.

- Refresher training for the service animal every 24 months is an allowable expense. Additional training for the service animal would be paid for if warranted by a change in the participant's condition and the appropriate documentation is provided.

- Services available through the Children's Wavier cannot duplicate services otherwise available through the 1915(a) Medicaid State Plan or other federal/state funding streams. Equipment must be beyond the scope of Durable Medical Equipment (DME). Vocational Rehabilitation funding must be sought prior to Medicaid funding.

- All service animal costs require prior approval from the LDSS in conjunction with NYS DOH or the MCO. As a type of Adaptive and Assistive Equipment, service animal requests are 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 participant's needs or capabilities.