spg SACHS POLICY GROUP
60 East 42nd Street, Suite 1762
New York, NY 10165
Phone: 212 827 0660
Fax: 212 827 0667

Children's Waiver Home and Community Based Services (HCBS) Manual Updates – March 2023

OVERVIEW

In March 2023, the New York State (NYS) Department of Health (DOH) posted an updated version of the Children's Waiver Home and Community Based Services (HCBS) provider manual. The following summary provides a broad overview of key changes in the updated HCBS manual, with a focus on areas of concern for HCBS providers, Health Home agencies, and other stakeholders. Please note that this document is **not** intended to be a comprehensive record of all changes.

The updated Children's HCBS manual can be found here. DOH has also published a more comprehensive list of all edited language in the manual, which can be found here.

SUBCONTRACTING

In the previous 2022 version of the HCBS manual, a section entitled "Outsourced Administrative Functions" stated:

> In an Employee/Provider Lease Agreement (ELA), a Medicaid-enrolled and MCO-credentialed provider act as the lead agency and subcontracts for services with other providers – all services are billed under the lead agency Taxpayer Identification Number. The agency providing the service must be designated to provide the services per the State Designation process. The lead agency takes primary responsibility for compliance and quality assurance of all subcontracted agencies, including administrative tasks such as record keeping and billing.

Additional language stated that direct support professionals/providers "must be employed by the designated agency."

In the updated manual, the section that focuses on "outsourced administrative functions", including employee leasing agreements – also known as subcontracting – has been removed entirely. The removal of this section is not mentioned in the State's guide that outlines the changes. This section was replaced with one line under the provider requirements overview, stating that providers must "have appropriate agreements in place for any outsourced administrative functions, if applicable." In addition, the updated manual removes language stating that individual staff providers must be "employed by the designated agency" under the individual staff qualifications for all services except for Community Habilitation.

SERVICE UTILIZATION AND AUTHORIZATION

The updated manual indicates that the duration of a service should not exceed six months at a time, at which point the provider should evaluate if the service meets the child/youth's needs and whether the service should be continued or discontinued. In addition to this duration requirement, HCBS may only

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be authorized for six months at a time based on each participant's unique needs. Regarding these billing limits, the manual states that:

> To exceed billing limits for children/youth enrolled in managed care, providers must contact the MMCP to receive guidance regarding the Plan's specific documentation requirements in these instances; for children/youth enrolled in FFS, HCBS providers must maintain documentation from a licensed professional that outlines the need to exceed the service limit.

The HCBS manual updates also state that HCBS cannot be provided during school/educational hours and cannot be duplicative or delivered at the same time as services otherwise available through a local educational agency.

RESPITE

The updated manual provides additional detail and clarity on the provision of respite services, including providing a definition of "Overnight Respite" as respite services provided to a person on two consecutive days when respite staff are providing oversight to a participant during nighttime hours. In addition, the manual clarifies that providers are allowed to provide and bill for another HCBS while Overnight Respite is also provided at the full per diem rate during the same day, provided that the child/youth is in the care of the respite provider for at least 12 cumulative hours.

The manual also clarifies when respite should be used, noting that it is not a substitute for child care and should only be used to enhance the family/primary caregiver's ability to support the child/youth's functional, developmental, behavioral health, and/or health care needs. Further, the needs of the child/youth must drive the provision of respite services, rather than the availability of the family/primary caregiver to supervise the youth.

The manual adds per diem billing guidance for respite, including details on annual unit limits for Planned and Crisis Respite:

- Annual units for Planned and Crisis Respite are limited to 14 days (full per diems) during the calendar year or 1,344 15-minute units annually.
- The cumulative total hours of all Planned and Crisis Respite services received may not exceed the 14 day/1,344 15-minute unit annual amount without medical necessity documented in the child's case record.
- The total Planned and Crisis Respite claims cannot total more than 336 hours within the calendar year.

ATTESTATION STANDARDS

HCBS providers are no longer required to complete an attestation each time additional services and/or sites are added to their designation. However, newly designated providers are still required to complete an attestation and return it to the State within 30 days of receipt and provider designations must be renewed at least every three years.

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TIMELINE CLARIFICATIONS AND UPDATES

The new HCBS manual updates language regarding service eligibility, assessments, and review timelines, as follows:

- Health Home Care Management (HHCM) agencies and C-YES must notify the child/youth of the HCBS Level of Care (LOC) eligibility determination within 3-5 business days.
- The Child Adolescent Needs and Strengths-NY (CANS-NY) assessment must be completed on a yearly cadence and may not coincide with the HCBS/LOC eligibility determination.
- The HCBS service plan should be monitored every month when services are delivered (previously providers were required to monitor regularly and review at least every six months).
- The Plan of Care (POC) must now be reviewed at least annually, instead of every six months. POCs must still also be reviewed at the request of the child/youth and/or parent/guardian, any time there is a significant life event, and during the HCBS/LOC eligibility determination reassessment.
- HCBS providers are required to communicate the scope, duration, and frequency of the service to the HHCM/C-YES and have regular contact regarding the service delivery, the service plan progress, and any changes.

NON-RISK PAYMENTS FOR HCBS

There have been several changes to the status of whether Managed Medicaid Care Plan (MMCP) capitation rates will include HCBS and whether MMCPs will be at-risk for payments for children's HCBS. The manual maintains that MMCPs will not be at-risk for Children's HCBS until at least September 30, 2023. MMCPs will continue to be reimbursed on a fee-for-service (FFS) basis outside the capitation rate by submitting claims for Children's HCBS to NYS under supplemental rate codes. All non-risk payment claims that have a valid delay reason code must be submitted to eMedNY within two years from the date of service.

OTHER

Additional updates to the Children's HCBS provider manual include the following:

- Clarification that HCBS are designed for children/youth stepping down from a long-term care facility or psychiatric inpatient care or would otherwise require that level of care, but is not for those "at risk" of elevating to that level of care.
- An additional section on "Annual Children's Waiver Case Review and Audit," which indicates that DOH will conduct a case review and audit of the previous waiver year's services and providers on an annual basis, including their policies, records, reporting, and claims/billing.
- New requirements for HCBS providers to complete the Children's Services Capacity Tracker survey every three weeks and maintain an ongoing waitlist within the system.
- New language indicating that the HHCM/C-YES must give notice to the HCBS providers, MMCPs, and other involved providers of the disenrollment/discharge of a participant.

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- Addition of “Non-Medical Transportation” as a service that does not require State designation.
- Clarification that while an individual HCBS provider may reside in a neighboring state, the HCBS must be provided in NYS by a provider that is located and designated in NYS.
- The manual replaces the previous use of “face-to-face” with “in-person” throughout the manual, clarifying that telehealth visits are insufficient for several types of visits.