Policy Title: Provider Service Delivery Documentation Policy for Children's Waiver Home and Community Based Services (HCBS)
Policy Number: CW0017
Effective Date: September 1, 2024
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Applicable to: Providers of Home and Community Based Services (HCBS) under the 1915(c) Children's Waiver.

This policy supersedes other guidance and webinar presentations issued prior to this policy. Documentation requirements contained within this policy have been effective since the inception of the Children's Waiver in 2019. This policy consolidates and clarifies the existing requirements while adding specific timeframes and due dates associated with individual documentation items. Adherence to the timeframes for completion of documentation requirements are the responsibility of the HCBS provider by the effective date noted above.

Purpose

This policy outlines documentation requirements when billing NYS Medicaid for HCBS provided under the 1915(c) Children's Waiver. This policy is supplemental and in addition to all other requirements, including those described in 18 NYCRR 504.3(a), which apply to all Medicaid providers. Medicaid providers must also comply with documentation guidelines outlined in New York State Medicaid Information for All Providers. HCBS provider documentation must comply with all state and federal Medicaid requirements and the 1915(c) Children's Waiver.

Documentation must be maintained by Children's Waiver HCBS providers regarding all HCBS billed to Medicaid in accordance with this policy. This includes, but is not limited to, documentation that supports the need for services such as the rationale for changes in needs, goals, interventions, scope, frequency, and duration that may occur.

Scope

Children's Waiver HCBS providers are responsible for completing and maintaining documentation for all participants referred to HCBS and to whom they are providing services, as described in this policy. This includes (1) intake documentation, (2) education and choice of the participant/family, (3) determination of service necessity, (4) the HCBS Service Plan; inclusive of frequency, scope, and duration, (5) progress notes, (6) health and safety documentation, and
(7) discharge plan. Other documentation may be required for certain participants, such as a transition plan, safety/crisis plan, and documentation of reportable incidents, grievances, and complaints. Additionally, HCBS provider agencies are responsible for completing and maintaining administrative documentation and documentation that demonstrates compliance with policies outlined in the *Children's Waiver Designation Attestation*, the *Children's Home and Community Based Services Manual,* the *HCBS Final Rule Compliance Policy* and *Children's HCBS Providers Final Rule Documentation Worksheet*.

Contents

I. Participant Records

Children's Waiver HCBS providers must maintain a case record for each HCBS participant served by the agency. Each case record should include information on the specific participant only. Maintaining Protected Health Information (PHI) or other information about multiple participants in one case file is not permissible.

A. Intake Documentation

Once HCBS and HCBS provider(s) have been identified, with the input of the participant/family through the care management person-centered planning process, the HCBS provider(s) will set an initial intake appointment with the participant/family[1]. During the initial intake appointment, the HCBS provider will conduct an intake assessment to determine the needs, goals, and strengths of the participant/family based upon the referral made by the care manager. The intake assessment includes information indicating the need for service(s) in relation to the participant's HCBS Target Population and assessed functional limitations.

The HCBS provider will document the need for the service(s) and the goal(s) to be achieved through the delivery of the service. The HCBS provider must retain any assessments, along with any notes/documentation from the initial intake appointment, the referral, and any other professional communication/multi-disciplinary team meetings, etc. that occur. Involvement of the participant/family and other involved professionals in the development of the HCBS goals must be documented in the participant's case record. Additional information on the development of service goals and determination of Frequency, Scope, Duration (F/S/D) can be found in the HCBS Manual.

B. Consent

During the initial intake appointment, the HCBS provider agency must also obtain signed consent from the participant/family to receive services from the indicated agency, and to grant the HCBS provider agency the ability to share information with other involved parties such as care managers, Medicaid Managed Care Plans (MMCPs), community and/or specialty providers, and other members of the interdisciplinary team. The HCBS provider must retain documentation of these conversations and all associated signed materials in the participant's case file.

Children's HCBS providers must develop a consent form to document participant/caregiver agreement to allow the HCBS provider agency to share information with identified care team members related to the participant's involvement with HCBS. The consent form must also include consent to participate in HCBS as outlined in the HCBS Service Plan.

Consent forms must be updated at least annually, and more frequently, if needed to add and remove providers/professionals deemed appropriate by the participant/family. When an update to the consent is made, the participant/family must re-sign the consent form and/or initial the change indicating their agreement with any changes made. HCBS providers cannot use the Health Home 5201 form as their HCBS Consent Form. It is the responsibility of the designated

[1] For the purposes of this policy, "family" refers to family members, caregivers, and/or legal guardians.

provider agency to consult their licensing, regulatory, and applicable legal advisors to determine requirements for inclusion on the agency HCBS consent form.

Further details regarding information sharing are located in the "Information Sharing" section at the end of this policy.

C. Education and Documented Choice of the Participant/Family

The HCBS provider must retain the documentation that demonstrates that the participant/family has been informed of the following:

- A description of the service(s) they will receive, their purpose, and limitations,
- Applicable state and federal requirements,
- How the HCBS will be provided in accordance with frequency, scope, and duration (F/S/D),
- The frequency and duration for which the service(s) will be provided and the need for authorization,
- Coordination requirements with the Health Home or Children and Youth Evaluation Service (C-YES) care manager and their MMCP, if applicable, and
- Their rights as an HCBS participant, including rights and protections regarding their options to receive care, how to report a complaint and/or grievance, how to report abuse or suspected abuse, and when and how to request a fair hearing.

Refer to the following policies and processes for additional guidance: *Children's Waiver Participant: Rights and Responsibilities, Complaint and Grievance Policy for HCBS Providers #CW0008, and Conflict-Free Case Management Policy #HH0012*.

D. Documentation of Service Necessity

The HCBS provider must maintain documentation that clearly supports and substantiates the need for services to support the child/youth remaining in the home/community and in alignment with the identified goals and how the goals will be achieved through the proposed frequency, scope, and duration. The HCBS provider should work with the participant's other involved care professionals and the care manager to obtain documentation to support the proposed level of service provision and appropriateness for the type and amount of service being offered to meet the participant's identified need and goals. Service utilization that exceeds the soft limits (i.e., annual, daily, dollar amount), as outlined in the Children's Home and Community Based Services Manual, must be necessary to prevent institutionalization and support the child remaining in the home/community, and must be justified by documentation provided by a third-party entity

All information demonstrating need for each service must be kept on file in the participant's record, such as assessments completed by the HCBS provider, applicable evaluations conducted by a licensed practitioner, test results, school information, documentation of presenting problem(s), demonstration of functional limitations, and/or the participant/family's reported need for services.

E. HCBS Service Plan inclusive of Frequency, Scope, and Duration (F/S/D)

Based on the individualized determination of needs, the results of the initial intake assessment, and information provided by the participant/family, care manager, and other involved professionals, the HCBS provider must document the approach for service provision on an HCBS Service Plan for the services they expect to provide. The Service Plan is established for no longer than a six-month duration and should be monitored every month that services are delivered to ensure service goals and interventions remain appropriate and progress towards goals is documented.

The purpose of the HCBS Service Plan is to outline each service that will be provided by the HCBS provider, as referred by the care manager, with corresponding goals and objectives/tasks/activities that describe the need for the service based on the participant's identified needs, goals to be achieved to address the need, and the anticipated benefit to the participant/family. The HCBS Service Plan clearly defines the focus of each service, the goal and outcome the service is intended to achieve, the F/S/D to which each service will be provided, and criteria for discharge from the service. If the participant is referred to more than one HCBS provider, then each HCBS provider will have their own Service Plan for the service(s) they will provide to the participant. The Service Plan must be updated to reflect any changes in F/S/D, changes to services, goals, and/or objectives of the service.

The HCBS provided must align with the F/S/D as outlined in the Service Plan. If HCBS is provided outside the approved frequency than what is outlined in the Service Plan, there must be a detailed explanation for the lack of alignment between the Service Plan, how it will be addressed, if necessary, and actual service provision in the participant's case record, including related communications with the participant/family, HHCM/C-YES, and the MMCP, if applicable. If the initially referred and authorized F/S/D are not being provided, then F/S/D must be re-evaluated by the HCBS provider, along with the participant/family. If an updated F/S/D is needed, the HCBS provider will collaborate with all relevant parties to develop and share information about the new schedule for service delivery; this collaboration should be documented in the participant's record and a new service authorization submitted.

Whenever a modification is made to the Service Plan, it must be reviewed in totality with the participant/family. Documentation of this review will be maintained in the participant's record. Additionally, the HHCM/C-YES and the Medicaid Managed Care Plan, if appropriate, must be notified regarding any changes to types of services provided, F/S/D, or goals to the Service Plan so that the HHCM/C-YES can determine whether a change is needed to the participant's Plan of Care (POC).

F. Progress Notes

HCBS providers are required to complete a progress note for every contact with the participant/family, involved care team members, other support individuals as identified by the participant/family, and service delivered to an HCBS participant, within 10 business days of the encounter. Medicaid requires that service documentation be contemporaneous with service provision; thus, progress notes must be completed when the provider delivers a direct service to the participant/family; conducts coordination or collaborative contact with another provider, including non-billable activities; and/or when significant life events occur.

Progress notes provide a record of the child/youth's progress towards established service goals and an overview of the interventions utilized during service delivery in alignment with the Service Plan. Progress Notes may include recommendations or justification for changes and/or additions to current goals, objectives, and methods/services outlined in the participant's Service Plan, and describe newly identified strengths, needs, and barriers. Providers must ensure that progress notes are complete, contemporaneous, accurate, and related to and in accordance with the services provided and the goals/objectives/tasks/activities identified in the participant's Service Plan. Progress notes must support the frequency, scope, and duration of services provided.

Progress notes should not refer to multiple services, multiple days of service delivery, or contain information about services delivered by multiple staff members. For example, if a participant receives Planned Respite on Tuesday for two hours and then again on Wednesday for two hours, a progress note for Tuesday's Planned Respite session would need to be completed separately from the progress note completed for Wednesday's Planned Respite session. Similarly, if multiple staff members provide different or the same HCBS to the same participant on the same day, each staff member would develop their own progress note for the service they provided. If a participant receives Supported Employment on the same day that they receive Prevocational Services, a separate progress note for each service provided must be completed.

Components of HCBS Progress Notes

Progress notes provide a narrative history of the participant's progress and must include, at a minimum, the following components:

a) Date the note is being recorded
b) Date of service/contact
c) Name of the staff member and associated agency providing the service
d) Duration of service (start/end time)
e) Type of contact (e.g., telephonic; in-person)
f) Modality (e.g., individual; family; group)
g) Type of HCBS provided
h) Location where the service was provided
i) Participants or other(s) (to whom the service was provided) and present at the time-of-service delivery
j) Objectives/tasks/activities to meet the identified goals
k) The participant's/family's response to the objectives/tasks/activities
l) Goal(s) and objective(s) that were addressed, progress made, and any potential barriers identified
m) Plan or next steps regarding changes to the service or continuation of service
n) Signature of individual completing the note (electronic signatures are permitted)

The following components should be included in progress notes, as appropriate:

a) Description of any significant events or unusual circumstances that relate to the participant's progress toward meeting the goals and objectives of the Service Plan
b) Recommendations/justifications to changes or additions to current goals, objectives, and/or methods/services of the Service Plan
c) Description of newly identified strengths, needs, and/or barriers

d) Plan of action (e.g., plan for the continuing work; follow up plan needed to address any changes in functioning or symptoms; safety measures to be taken; rationale for changes or additions needed to current goals, objectives, and interventions)
e) Overall safety and well-being of the participant. If there is a safety plan in place, the status of such plan.

In addition to documenting the services being directly provided, HCBS providers must also document instances of communication/coordination with the care manager, MMCP, and other providers and/or significant individuals involved in the participant's care, with proper consent, such as when the HCBS provider recognizes the need for an assessment that is not within the provider's scope to conduct. In these instances, the progress note must contain:

a) The name(s) of person(s)/agency with whom services were coordinated
b) The rationale for coordination, outcome of coordination, and connection with the HCBS Service Plan
c) The provider must clearly document the actions taken to ensure linkage of the participant/family to the appropriate resource, its outcome, and any follow-up action(s) needed

A Progress Note template or form can be utilized to capture the above information consistently. An example of a template progress note, PC-COP:

PC – Purpose of Contact
C – Content of the Contact
O – Observations and Noted Progress
P – Plan or Next Steps

Progress Notes for Group Services

In addition to the general progress note requirements above, progress notes for group services must clearly indicate "group" as the service modality provided, the number of participants, and the number of service providers present. To deliver a group service, this modality must be clearly identified as an intervention in the Service Plan associated with the specific objectives and in accordance with requirements of the specific HCBS being provided (e.g., Community Habilitation; Caregiver/Family Advocacy and Support Services).

A group progress note must be written for each group session for each participant and must include all components listed above for individual service delivery. Names and other PHI should not be placed in other participant's case files/records, regardless of whether other participants are also HCBS participants.

G. Health and Safety Planning

The HCBS provider must document any health and safety concerns that arise when meeting with the participant or discussing with other care team members.

It is incumbent upon the HCBS provider to ensure that there are no identified health or safety risk to the participant during service delivery. HCBS providers are mandated to report abuse, neglect, and maltreatment and are required to report critical incidents, grievances, and complaints. Steps may be taken within the HCBS Service Plan to identify potential risks and

determine strategies for the child/youth to stay safe and mitigate the risk of future harm. When health and safety concerns are identified, a plan to address these issues must be documented in a health and safety plan and/or Service Plan and discussed with the HHCM/C-YES. Refer to *Health & Safety Planning Requirements for the Children's Waiver (ny.gov)* for additional guidance.

H. Discharge Plan

HCBS providers will establish discharge plans for participants in accordance with the *Children's Home and Community Based Services (HCBS) Waiver Disenrollment and Discharge Policy* . Discharge criteria are collaboratively reviewed in accordance with the participant's progress toward stated goals and considers the participant's/family's circumstances and preferences. The discharge plan also identifies the need for follow-up and/or aftercare services, if warranted. The participant's discharge plan can be included as part of the Service Plan or as a separate HCBS discharge plan document. Further information pertaining to the discharge process and criteria can be located in the *Children's Home and Community Based Services (HCBS) Waiver Disenrollment and Discharge Policy*.

Discharge Summary
Upon discharge from the HCBS, a documented discharge summary must be completed that describes the services provided, the participant's response, progress toward goals, circumstances of discharge, and efforts to re-engage if the discharge was not planned. Additionally, how the HHCM/C-YES, the MMCP, and other members of the interdisciplinary team were notified of the discharge.

In all instances of individual service discharge, whether accompanied by disenrollment from the Children's Waiver or continuation of alternative HCBS, both the HHCM/C-YES and HCBS provider(s) must document the discharge planning process in the case record. There are two types of discharge plans:

1) Discharge from HCBS – *occurs in instances when the participant has achieved their goals OR the participant/family requests to be discharged from the specific HCBS*
2) Transfer discharge – *occurs in instances where the participant transfers from one HCBS provider to a different HCBS provider but has not yet achieved all of their goals and is still in need of HCBS*

Discharge from HCBS
The HCBS provider, in collaboration with the participant/family, HHCM/C-YES, MMCP, and other members of the interdisciplinary team, will determine the participant's readiness for discharge from HCBS once the criteria required for discharge outlined in the participant's Service Plan has been met. In all instances of discharge from HCBS, the provider must execute and document the discharge planning process for the particular service(s) in the participant's case record within 30 days.

Transfer Documentation
In some cases, a participant may be discharged from an individual HCBS, but they may remain in receipt of other needed HCBS. When an HCBS provider is notified of a request and/or need to transfer to a new HCBS provider, the reason and process for the change in provider must be documented in the participant's case record. It is the responsibility of the HHCM/C-YES to lead

the process of referring the participant to a new provider and will document details of discussions with the HCBS provider(s), participant and family, and MMCP, outlining the reason for the requested change, the participant/family's consent to the change, referral(s) to new provider(s), and multidisciplinary meetings with the new provider(s) and other involved parties, as appropriate.

Managed Care Enrollment Change
In the event a participant wishes or needs to transfer from one MMCP to another, from Medicaid FFS to managed care, or from managed care to Medicaid FFS, any changes in MMCP must be documented in the participant's case file. A new *Children's HCBS Authorization and Care Manager Notification Form* is required if the participant is enrolling in a new MMCP as outlined in the *Medicaid Managed Care Plan (MMCP) Transfer Continuity of Care Requirements*. Additionally, the Service Plan and/or additional consent documentation may need to be updated to reflect this change.

I. Children's HCBS Authorization and Care Manager Notification

If the participant will require more than the initial 60 days, 96 units, or 24 hours of HCBS to achieve identified goals, then the HCBS provider must request authorization by completing the *Children's HCBS Authorization and Care Manager Notification Form*; use of alternative versions of this form developed by providers or Plans is not permitted. This form must be kept on file by the HCBS Provider agency for any participant receiving HCBS more than the initial 60 days/96 units/24 hours. Providers must submit the request for authorization no later than 14 days before the expiration of the initial service period, as outlined in *Utilization Management Guidance*.

Details on requirements for completion and submission of the *Children's HCBS Authorization and Care Manager Notification Form* can be found in the *Home and Community Based Services (HCBS) Plan of Care Workflow Policy*.

J. Electronic Visit Verification System (EVV) Notes

An EVV system is used to electronically collect service delivery information to verify:

- Service type
- Individual receiving the service
- Date of service
- Location of service delivery
- Individual providing the service
- Begin and end times of service

For the Children's Waiver, EVV requirements do not apply to Day Habilitation; however, EVV requirements always apply to Community Habilitation and may apply to Respite. EVV requirements apply to Respite when the service is provided under any of the following circumstances:

- During service provision, staff provide assistance/support with Activities of Daily Living (ADLs) & Instrumental Activities of Daily Living (IADLs).
- The service begins or ends or is delivered entirely or partially in the participant's home.
- The service is not provided in an applicable congregate facility.

EVV program requirements, including considerations for selecting an EVV system can be found on the *EVV website*.

K. Information Sharing

Ongoing communication with the HHCM/C-YES and MMCP regarding service delivery, progress, and concerns is essential to providing comprehensive care to Children's Waiver participants. HCBS providers must communicate with the HHCM/C-YES at least monthly regarding service delivery to participants; this communication must be documented in the participant's record. Any updates relating to a change in type of service, F/S/D, or goals that the HCBS provider makes to the Service Plan must be communicated to the HHCM/C-YES so that those updates can be carried over to the POC, if applicable.

Any communication with the HHCM/C-YES, participant/family, MMCP, or other involved professional related to the delivery of HCBS must be documented in the participant's case file.

Appendix A – HCBS Documentation Required

Document Name	Required v. Situational	Created By	Timeframe for Completion
Initial intake assessment (other assessment tools specific to the service to be delivered)	Required	HCBS Provider	As soon as possible, based on provider/family availability and taking into consideration the participant's need and risk
Education and Documented Choice of the Participant/Family	Required	HCBS Provider	Upon intake and then as needed to support additional units of service as appropriate beyond the initiate service units
Documentation of service necessity	Required	HCBS provider and can be supported HHCM/C-YES, and/or other providers' documentation	Upon intake and then as needed to support additional units of service as appropriate beyond the initial service units
HCBS Service Plan *inclusive of Frequency, Scope, and Duration*	Required	HCBS Provider	Within 30 days of the first in-person service date with the participant/family
Children's HCBS Authorization and Care Manager Notification Form	Situational	HCBS Provider	No later than 14 days prior to exhausting the initial or approved service period, as outlined in Utilization Management Guidance
Progress Notes	Required	HCBS Provider	Within 10 business days of the encounter
Health and Safety Plan	Situational	HCBS Provider along with the support of HHCM/C-YES or other involved professionals	As needed when health and safety concerns arise when meeting with the participant
Discharge Plan or Transfer Documentation	Situational	HCBS Provider	As needed in alignment with the HCBS Disenrollment and Discharge Policy
Documentation of reportable incidents	Situational	HCBS Provider	Documentation within IRAMS within 24 hours of notification of discovery
Documentation of Information Sharing	Required	HCBS Provider and HHCM/C-YES	Must communicate with each other at least monthly. Documentation of these communications should be completed within 10 days.
Documentation of complaint/grievance	Situational	HCBS Provider	Documentation within IRAMS within 72 hours of receiving the complaint/grievance
Transition Plan for Transition-Age Youth	Situational	HHCM/C-YES, with input from HCBS Provider	As soon as possible and no later than age 17. Required for all youth ages 14 and older.

Appendix B – Home and Community Based Services (HCBS) Provider Checklist

Initial Activities

☐ Verify the child/youth's Medicaid eligibility/MMCP enrollment **plus** HCBS enrollment (via k-code through ePACES) **prior to providing services and billing**.

☐ Inform the HHCM/MMCP of the first scheduled appointment with the child/family, including if the appointment was missed and/or rescheduled.

☐ Contact MMCPs to provide information regarding type, amount, frequency, duration, and scope of HCBS by completing Section 1 of the ***Children's HCBS Authorization and Care Manager Notification Form***.

☐ Complete Section 2 of the ***Children's HCBS Authorization and Care Manager Notification Form*** and send this and the Service Authorization Determination that was issued by the MMCP to the HHCM **within five days** of authorization of f/s/d.

☐ Create HCBS Service Plan within 30 days of the first face-to-face appointment with the child/ youth and/or family/caregiver. Make updates to Service Plan, if necessary, based on F/S/D approval from MMCP.

Ongoing Activities

☐ Provide HCBS as per the frequency, scope, and duration outlined in the Service Plan.

☐ Document progress notes for each client contact, including any newly identified needs for new services and/or discrepancies in service delivery not in alignment with the f/s/d outlined in the POC.

☐ Actively participate in the family's care team and person-centered POC development, monitoring, and planning:

- 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
- maintain awareness of care management requirements to facilitate an effective conversation with the child/youth

☐ Notify the Care Manager (Health Home Care Manager, C-YES, or MMCP) of any changes in the Service Plan.

☐ Formally review the Service Plan **every six months**, or more frequently if there is change in the child/youth's functioning, status, or a significant life event.

☐ Contact the MMCP to request authorization of additional HCBS as needed using the ***Children's HCBS Authorization and Care Manager Notification Form***.

☐ Complete the ***Children's HCBS Authorization and Care Manager Notification Form*** **at least 14 calendar days** prior to the existing HCBS authorization period ending if further services are determined to be necessary and appropriate.