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

State Discussion with Children's Waiver HCBS Providers

November 2023

Agenda

- ✓ eFMAP ARPA Funding
- ✓ Waiver Amendment Updates
- ✓ Updated Claims Submission Process
- ✓ Electronic Referral Process & Form
- ✓ Relative Definition
- ✓ HCBS Eligibility Clarification
- ✓ HCBS Provider Case Review

Purpose

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

eFMAP ARPA Funding

eFMAP ARPA Funding

State-only funds were released directly to eligible providers on **September 13, 2023.**

Per guidance issued on September 14, 2023, Plans received funding on **September 20, 2023**, and must distribute awards to eligible providers within their networks by **October 20, 2023**.

Additional information on final award amounts & eligible uses of funds **were provided to eligible providers at the end of August**.

Providers have until **September 30, 2024** to spend funds.

Questions should be directed to BH.Transition@health.ny.gov

Waiver Amendment Updates

Waiver Amendment Updates

Effective 11/1/2023

Cost of Living Adjustment (COLA)

- Adds language to address prospective Cost of Living Adjustments (COLA).
- Includes the permanent adoption of the 25% and 5.4% COLA rate increases that were implemented during the Public Health Emergency (PHE) for HCBS providers.
- Implements an additional 4% COLA, per the 2023-2024 NYS Enacted budget

Group Respite Rate Revision

- The size of allowable groups for the currently established Group Respite is no more than 3 children/youth.
- The amendment establishes a new rate for Group Respite involving two children/youth.

Driver Vehicle Modifications

- Includes driver modifications as a component within the Vehicle Modification service description with an annual cap of $65,000

Waiver Amendment Updates – *cont.*

Effective 11/1/2023

Palliative Care Qualification & Definition Adjustment

- The amendment removes references to "life threatening", "terminal" and "end of life" in all Palliative Care service definitions,
  - The references to Bereavement Counseling and Support Services after the passing of a child and End-of-Life per episode payments remain in Palliative Care: Counseling and Support Services.

- The amendment adjusts Palliative Care provider qualifications to reduce the years of experience required to serve the medically fragile pediatric populations from three years to one year to improve workforce availability. This includes:
  - Palliative Care – Massage Therapy
  - Palliative Care – Pain and Symptom Management
  - Palliative Care – Counseling and Support Services
  - Palliative Care – Expressive Therapy

Waiver Amendment Updates – *cont.*

Single Point of Access (SPOA) Mental Health Connection

- The amendment updates the qualifications of professionals permitted to perform HCBS Level of Care Eligibility Determinations to include C-SPOA through the Local County Departments of Mental Health for children/youth meeting Serious Emotional Disturbance (SED) criteria.

Rural Rates

- Effective December 1, 2023, the amendment authorizes higher rates for HBCS provided in seven rural counties: Allegany, Clinton, Delaware, Essex, Franklin, Hamilton, and St. Lawrence.
  - More information to be issued

Pending Approval:

Transition of Environmental Modifications (EMod), Vehicle Modifications (VMod), Adaptive and Assistive Technology (AT) to a Financial Management Services (FMS)

- *In collaboration with CMS, approval of the FMS is dependent upon a submission of another amendment, which is in process.*

Updated Claims Submission Process

Updated Claims Submission Process – Effective 12/1/23

Change

Services MUST be billed where the service is delivered and **not** the address of the agency's physical administrative office.

The new billing guidance outlines billing by county Locator Code 2023-09-05_bill_req_update_child.pdf (ny.gov)

HCBS providers must follow the updated billing guidance for claims with Dates of Services on or after December 1, 2023

NYS DOH hosted a webinar Children's Services Billing Change Webinar for Providers (Recording) - October 19th, 2023

Designation Requirements

Services must be provided in counties where the HCBS provider is designated.

If a provider serves a member (from their designated county) and **occasionally** crosses into a county that they are not designated for (i.e.; to attend a community event, etc.), then the claim should have the county locator code where the member lives.

Agencies are not permitted to provide services on a **regular basis** in a county they are not designated for.

Agencies should not serve members who live in a county they are not designated for.

Additional Guidance

Agencies should request designation in all counties where they expect to provide services on a regular basis or serve members from those counties.

Expanding designation to other counties is based on the agency's ability and capacity to serve the members in the county they want to expand to.

These billing changes impact **HCBS and CFTSS providers**. These billing requirements do not apply to services on the 29-I OLHRS fee schedule.

Questions regarding billing issues should be directed to 1915cr@health.ny.gov

Electronic Referral Process & Form

Electronic Referral Process & Form – Stakeholder Feedback

DOH continues to work with Plans, providers, and care managers to **update the HCBS electronic Referral Form and Referral process**

The implementation of the HCBS Referral and Authorization Portal within IRAMS is slated for **late 2023 – January 2024.**

DOH's will hold another workgroup meeting in December with the HHs, CMAs, and HCBS providers to receive an overview of the Portal and give more feedback

Authorization form will be populated in the Portal but providers will still need to send the form how they do today

In 2024, the Authorization form will also become electronic

DOH is drafting an **FAQ and updated User Guide** to be sent out prior to implementation.

A webinar will also be held.

Obtaining and Meeting F/S/D

- It is important that Frequency/Scope/Duration (F/S/D) is clearly defined for each service provided and based upon:
  - The member's need(s)
  - The goal to be accomplished
  - How the service provided will accomplish the goal and meet the need
  - Choice and participation of the member
  - Must be supported by Medically Necessity

- Members/families may express what they want, but it must be supported by the need, goal, service requirements, and medical necessity.
- Service F/S/D is determined and must be provided a majority of the time as it is outlined
  - If there is a continuation of not meeting F/S/D, then it should be discussed with the member and F/S/D adjusted

- Care managers should be monitoring F/S/D and collaborating with HCBS providers
- F/S/D must be on the care manager's Plan of Care and therefore communicated by the HCBS provider
- Once the Authorization determination by the MMCP is obtained by the HCBS provider or F/S/D is determined by the member/family/HCBS provider (for FFS members), then the HCBS provider must enter F/S/D in the Referral Portal for F/S/D to be known to the care manager and placed on the Plan of Care.

HCBS Agency Creates Frequency, Scope, and Duration for Authorization

Referral F/S/D Objectives

HCBS Service

First Date of Service* | Authorization Begin Date* | Authorization End Date* | Type*

New Extension

Add Authorization

Add Scope/Frequency

Scope* Hours | Frequency* Every Week | Modality* Individual Group

Scope*
Hours
- Hours
- Minutes

Frequency*
Every Week
- Every Week
- Every 2 Weeks
- Every 3 Weeks
- Every Month

- The **HCBS Provider must input information on F/S/D** when creating an Authorization.
- The MMCP will authorize the services **using their current process**, and the HCBS providers will need **to come into Referral Portal to document the final authorization.**

**Data within these slides have been fabricated for the purpose of this webinar and do not reflect actual PHI*

Examples of Frequency, Scope, and Duration in the Electronic Authorization Form in IRAMS

First Date of Service*	Authorization Begin Date*	Authorization End Date*
01/01/2022	01/01/2023	06/30/2023

Scope*		Frequency*		Modality*
1	Hours	3	Every Week	Individual (selected) / Group
4	Hours	1	Every Month	Individual / Group (selected)
90	Minutes	5	Every 2 Weeks	Individual (selected) / Group

MMCPs to confirm whether frequency of "every two weeks" would work from a system perspective

- The three examples to the left read as:
  - **1 hour, 3 times a week for individual sessions**
  - **4 hours, 1 time a month for a group session**
  - **90 minutes, 5 times every other week for individual sessions**

**Data on this slide has been fabricated for the purpose of showing examples and do not reflect actual PHI*

Clean up of the Current Waitlist

On 11/17/23 HCBS providers received an email:

The current waitlist information in the IRAMS capacity tracker needs to be updated and current.

To ensure only appropriately enrolled, referred, and waitlisted members are moved over to the new Referral and Authorization Portal, HCBS providers should plan to update their waitlist information **no later than Monday, November 20th**.

This can be done, by reviewing HCBS providers current waitlist information within IRAMS:
- Removing members who no longer have K-codes
- Removing members who do not have a current HCBS Eligibility Determination
- Removing members who do not have Medicaid
- Removing members where it is indicated that they are receiving the service from another provider

HCBS providers should be communicating with the HH/CYES care managers regarding waitlisted members and their status.

**DOH plans to move the waitlist over to the new Portal

Implementation & Current Members being Served

Upon implementation of the Portal, current members who are being served must be entered.

Potential Options:

- Care managers may have to enter a referral all their members and HCBS providers would have to re-accept them
- Communication between care managers and HCBS providers to determine entry
- Required team meeting to review member’s services and status prior to entry

Who at your agency manages the waitlist capacity tracker?
Who will be reviewing referrals and will accept/decline/waitlist the member?

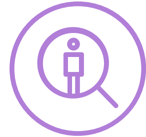
Relative Definition

Relative Definition

To ensure a Children's Waiver enrollee's autonomy, preserve Freedom of Choice requirements and reduce the potential for conflicts of interest, ***staff providing Children's HCBS cannot be the following list of individuals:*** immediate family members, individuals that are legally or financially responsible for the HCBS-enrolled child/youth or an individual residing in the same residence as the HCBS enrolled child/youth.

HCBS Staff

All staff providing HCBS must be employed by a Designated Provider agency and meet staff qualification requirements as outlined in the HCBS Manual.



Conflicts of Interest

Conflicts of interest are not limited to the list of individuals above and may exist in relationships beyond those included.

If a relationship with an individual, such as a distant relative or friend could affect the enrollee/family's freedom of choice or present a conflict of interest, then that individual should not provide HCBS to the enrollee.

Overall Staffing

It is the responsibility of the Designated HCBS Provider to determine if a potential conflict of interest is present in a potential staffing relationship (due to family, social, personal, or other reasons) and make staffing decisions accordingly.

An announcement on this topic is available on the DOH website: HCBS Staffing Allowances Clarification

HCBS Eligibility Clarification

HCBS Eligibility – Overview

There have been many questions submitted through the BML related to annual HCBS eligibility.
DOH is drafting an FAQ on this topic for providers to reference.

Care Manager Communication

HCBS providers are reminded to continue connecting with their Care Managers about all issues that arise. Care Managers should be communicating with HCBS providers about updates such as status of annual HCBS eligibility assessments, family pursuit of Fair Rights Hearings related to HCBS eligibility, etc.

K-Code Verification

HCBS providers are required to check K-codes **at least monthly.**

Frequently Asked Questions (FAQs)

Q: Can we provide HCBS to a child whose LOC is expired?

Q: Can we continue to provide a child with HCBS if they don't have K-codes?

Q: Can we still provide services to a child who doesn't have A codes if they do have K-codes?

Q: What should we do if a child has been found ineligible for HCBS during the annual reassessment and the family is pursuing a Fair Rights Hearing? Can we continue to provide HCBS to this member?

HCBS K-Codes

Children's Waiver HCBS K-codes and KK-codes are placed and removed using distinctive automated processes and are based on different eligibility determinations.

K-Codes Placement

Children's Waiver HCBS K-Codes (K1, K3, K4, K5, K6) are placed on the member's file, after a HHCM/C-YES has completed an HCBS Eligibility Determination. This is an automated process with DOH Waiver Capacity Management and Eligibility Teams.

K-Codes Removal

Removal of these K-codes occur when either the HHCM/C-YES **notifies the DOH Capacity Management Team or through an automated process** with the MAPP Health Home Tracking System (HHTS) by the CM.

Important Note

At this time, **a child/youth who is found HCBS eligible and enrolled**, can continue to maintain their K-codes while awaiting HCBS.

Family of One – KK-code

- The Family of One KK-code is placed on the member's file by the LDSS/HRA based upon **an income eligibility determination** only after:
    1. The child/youth is found HCBS eligible and
    2. Community Medicaid income requirements cannot be met, so a Family of One income eligibility determination occurs.
- The KK-code is also removed by the LDSS/HRA **when notified that the child/youth is no longer eligible or enrolled** in HCBS, or the Family of One **income eligibility is not met**.

HCBS Provider Case Review

Previous HCBS Provider Case Review

It is a requirement of the Children's Waiver to conduct an annual case review and fiscal audit

Waiver Year 2021-2022 was the first year that HCBS providers were reviewed

A number of challenges occurred:

- Due to the findings, all HCBS providers received a corrective action plan (CAP)
- Many providers had their CAPs returned to them due to not meeting Waiver requirements
- A number of providers needed a conference call due to their processes, systems, policies, or documentation not aligned with the Children's Waiver
- There were concerns with some providers amount of claiming and F/S/D
- Providers with various lines of business, HCBS, CFTSS, care management, etc. had challenges having distinct policies and procedures

HCBS Provider Case Review

Process:

- A group of providers received approval of their CAP and should have implemented their CAP
- A group of providers received approval of their CAP with recommendations and should have implemented their CAP
- A group of providers still have not received final approval of their CAP

Next Steps:

- Those providers without CAP approval will receive their CAP with recommendations
- This group of providers will be slated for a case review beginning January 2024
  - Information will be sent to these providers in December about the review
  - Providers will also be given a spreadsheet of their CAP items to identify if any of their recommend changes in their CAP was implemented
- Other providers will be reviewed in the Summer and Fall of 2024
  - These providers will receive prior to the review, a spreadsheet of their CAP items to identify how and the timeframe of implementation of the CAP items

Provider Support

Any provider at any time, can request a meeting with DOH by reaching out to BH.Transition@health.ny.gov regarding their CAP, to ask questions, get technical assistance, etc.

Future Meetings & Contact Information

Future Meetings & Agenda Items

- Next Scheduled Monthly Meeting:
  - *December 20th 1:00 – 2:30 PM*
    - *Registration Link:* https://meetny.webex.com/weblink/register/rdd7b9ac05ed6f54e7698b3b19f51fc12

- **These meetings have moved to Webex. Each monthly meeting will have its own registration link. Participants will be required to register for each monthly meeting individually. Registration links for 2024 meetings will be released shortly.**

- DOH would like to discuss topics of interest to the HCBS providers and also hear suggestions and ideas for improvement.

- Please submit your agenda requests, suggestions, or questions to BH.Transition@health.ny.gov.

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

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

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