NEW YORK STATE | Department of Health | Office of Mental Health | Office of Alcoholism and Substance Abuse Services | Office of Children and Family Services | Office for People With Developmental Disabilities

Children's HCBS POC Workflow
&
MMCP Service Authorization
For HCBS Providers

October 18, 2019

Agenda

- ❑ Timeline
- ❑ Background, Purpose, and Uses
- ❑ Responsible Entities
- ❑ Steps to Receiving HCBS & POC Process
- ❑ MMCP Service Authorization
- ❑ Continuity of Care and Utilization Review
- ❑ Appendix

Children's Medicaid System Transformation Timeline	Scheduled Date
• Implement three of the six new Children and Family Treatment and Support Services (CFTSS) (Other Licensed Practitioner, Psychosocial Rehabilitation, Community Psychiatric Treatment and Supports) in Managed Care and Fee-For-Service	January 1, 2019 **COMPLETED**
• Waiver agencies must obtain the necessary LPHA recommendation for CFTSS that crosswalk from historical waiver services and revise service names in Plan of Care for transitioning waiver children. This is the last billable date of waiver services that crosswalk to CPST and/or PSR.	January 31, 2019 **COMPLETED**
• Transition from Waiver Care Coordination to Health Home Care Management	January 1- March 31, 2019 **COMPLETED**
• 1915(c) Children's Consolidated Waiver is effective and former 1915c Waivers no longer active	April 1, 2019 **COMPLETED**
• Implement Family Peer Support Services as State Plan Service in managed care and fee-for-service • BH services already in managed care for adults 21 and older are available in managed care for individuals 18-20 (e.g. PROS, ACT, etc.) • OMH licensed SED designated clinics serving children with SED diagnoses are carved-in to managed care • SSI children begin receiving State Plan behavioral health services in managed care • Three-year phase in of Level of Care (LOC) expansion begins	July 1, 2019 July 1, 2019 July 1, 2019 July 1, 2019 July 1, 2019 **COMPLETED**
• 1915(c) Children's Consolidated Waiver Services carved-in to managed care • Children enrolled in the Children's 1915(c) Waiver are mandatorily enrolled in managed care*	October 1, 2019 October 1, 2019 **COMPLETED**
• Implement Youth Peer Support and Training and Crisis Intervention as State Plan services in managed care and fee-for-service	January 1, 2020
• Voluntary Foster Care Agency Article 29-I per diem and services carved-in to managed care • Children residing in a Voluntary Foster Care Agency are mandatorily enrolled in managed care • 29-I Licensure becomes effective for Voluntary Foster Care Agencies	February 1, 2020 February 1, 2020 February 1, 2020

Background, Purpose, and Uses

HCBS Workflow Purpose and Process

Workflow's Purpose: To define how an HCBS Eligible child will be referred to and access Home and Community Based Services (HCBS) and providers through the Children's Waiver, which became effective April 1, 2019

- Outlines the specific roles for Children and Youth Evaluation Service (C-YES), Health Home Care Manager (HHCM), the MMCP and
    - This process does not apply to AT/VMODS/EMODs
    - This process does not apply to Non-Medical Transportation

HCBS POC Webinar held on August 28, 2019

Finalized Policy Issued September 19, 2019

- Updated forms continue to be posted – Here under the Plan of Care tab

Who is a Candidate for the Children's Waiver HCBS?

Children/youth enrolled in Medicaid (or Medicaid eligible) who are believed to be HCBS eligible and or in need of HCBS

HCBS is available to all children/youth under the age of 21 that meet eligibility, there is no exclusion group

Children/youth who have:

- Complex medical needs – Medically Fragile (MF) Target Population
- Mental Health condition - Serious Emotional Disturbance (SED) Target Population
- Developmental Disability (DD) and complex medical needs - DD/MF Target Population
- Developmental Disability (DD) and in Foster Care at the time of HCBS eligibility – DD Foster Care Target Population

❖ Developmental Disability (DD) condition alone are not eligible for the Children's Waiver

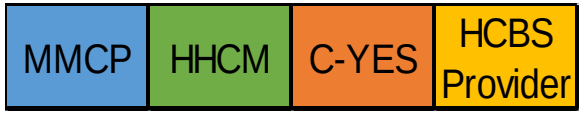
HCBS Eligibility Determination Criteria

HCBS purpose:

1. Enable children to remain at home, and/or in the community, thus decreasing institutional placement
2. To safely return a child from a higher level of care, back to the community with services to maintain them at home and/or in the community
3. Expand service options currently available to children and adolescents for better outcomes

**Institutionalization refers to children at risk of being admitted to a higher level of care such as out of home residential settings, hospitalization, ICF-I/D, or Nursing Facility*

HCBS Care Management



Children/youth receiving HCBS services through the Children's HCBS Waiver are required to also receive Care Management. This requirement can be met one of three ways:

Health Home

- Comprehensive care management; care coordination and health promotion; comprehensive transitional care; enrollee and family support; and referral to community and social supports
- HH maintains the POC for children who are FFS or enrolled in Medicaid Managed Care Plan (MMCP)

C-YES

- Since Health Home Care Management is optional, children/youth can opt out and receive HCBS Care Management from C-YES, who will develop a HCBS POC from the HCBS LOC determination to identify goals and work with the child to ensure the POC is achieving those goals
- C-YES will maintain the POC for children who opt-out of Health Home who are not enrolled in MMCP

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 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

Responsible Entities

Children's HCBS Workflow

Responsible Entities

Legend: MMCP | HHCM | C-YES | HCBS Provider

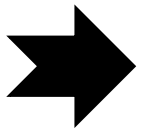
Responsible entity				
Milestone event	Enrolled in MMCP		FFS Medicaid	
	Enrolled in HH	Opt-out of HH, Served by C-YES	Enrolled in HH	Opt-out of HH, Served by C-YES
HCBS Provider referral	HHCM	C-YES	HHCM	C-YES
Notifies MMCP and HHCM of First Appointment	HCBS Provider	HCBS Provider	N/A	N/A
On-going POC 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

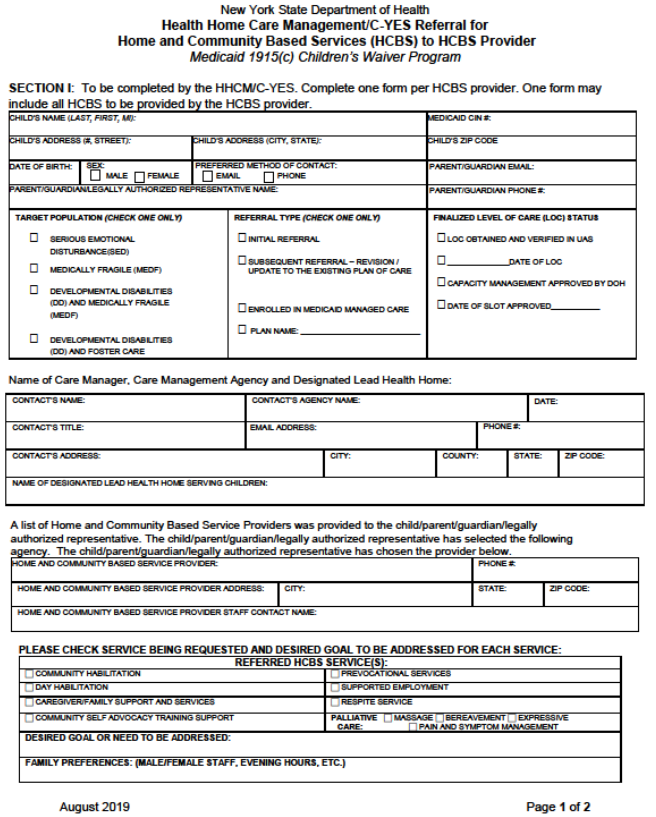
Steps to Obtaining HCBS & the POC Process

Step 1: Referral to Identified HCBS Providers / Services

MMCP	HHCM	C-YES	HCBS Provider

- HHCM/C-YES determines HCBS/LOC Eligibility; develops person-centered POC with HCBS
- Once child/family chooses HCBS and HCBS providers
  - HHCM/C-YES assists the child/family in setting up first appointment with identified HCBS providers
  - HHCM/C-YES directly refers by utilizing the ***Referral for Home and Community Based Services (HCBS) to HCBS Provider*** form
    - This form needs to be completed and sent to the chosen HCBS provider(s) within four (4) calendar days of the HCBS referral request





New York State Department of Health
Health Home Care Management/C-YES Referral for Home and Community Based Services (HCBS) to HCBS Provider
Medicaid 1915(c) Children's Waiver Program

SECTION I: To be completed by the HHCM/C-YES. Complete one form per HCBS provider. One form may include all HCBS to be provided by the HCBS provider.

CHILD'S NAME (LAST, FIRST, MI): | MEDICAID CIN #:
CHILD'S ADDRESS (#, STREET): | CHILD'S ADDRESS (CITY, STATE): | CHILD'S ZIP CODE
DATE OF BIRTH: | SEX: ☐ MALE ☐ FEMALE | PREFERRED METHOD OF CONTACT: ☐ EMAIL ☐ PHONE | PARENT/GUARDIAN EMAIL:
PARENT/GUARDIAN/LEGALLY AUTHORIZED REPRESENTATIVE NAME: | PARENT/GUARDIAN PHONE #:

TARGET POPULATION *(CHECK ONE ONLY)*
- ☐ SERIOUS EMOTIONAL DISTURBANCE(SED)
- ☐ MEDICALLY FRAGILE (MEDF)
- ☐ DEVELOPMENTAL DISABILITIES (DD) AND MEDICALLY FRAGILE (MEDF)
- ☐ DEVELOPMENTAL DISABILITIES (DD) AND FOSTER CARE

REFERRAL TYPE *(CHECK ONE ONLY)*
- ☐ INITIAL REFERRAL
- ☐ SUBSEQUENT REFERRAL – REVISION / UPDATE TO THE EXISTING PLAN OF CARE
- ☐ ENROLLED IN MEDICAID MANAGED CARE
- ☐ PLAN NAME: _____

FINALIZED LEVEL OF CARE (LOC) STATUS
- ☐ LOC OBTAINED AND VERIFIED IN UAS
- ☐ _____DATE OF LOC
- ☐ CAPACITY MANAGEMENT APPROVED BY DOH
- ☐ DATE OF SLOT APPROVED_____

Name of Care Manager, Care Management Agency and Designated Lead Health Home:

CONTACT'S NAME: | CONTACT'S AGENCY NAME: | DATE:
CONTACT'S TITLE: | EMAIL ADDRESS: | PHONE #:
CONTACT'S ADDRESS: | CITY: | COUNTY: | STATE: | ZIP CODE:
NAME OF DESIGNATED LEAD HEALTH HOME SERVING CHILDREN:

A list of Home and Community Based Service Providers was provided to the child/parent/guardian/legally authorized representative. The child/parent/guardian/legally authorized representative has selected the following agency. The child/parent/guardian/legally authorized representative has chosen the provider below.

HOME AND COMMUNITY BASED SERVICE PROVIDER: | PHONE #:
HOME AND COMMUNITY BASED SERVICE PROVIDER ADDRESS: | CITY: | STATE: | ZIP CODE:
HOME AND COMMUNITY BASED SERVICE PROVIDER STAFF CONTACT NAME:

PLEASE CHECK SERVICE BEING REQUESTED AND DESIRED GOAL TO BE ADDRESSED FOR EACH SERVICE:

REFERRED HCBS SERVICE(S):	
☐ COMMUNITY HABILITATION	☐ PREVOCATIONAL SERVICES
☐ DAY HABILITATION	☐ SUPPORTED EMPLOYMENT
☐ CAREGIVER/FAMILY SUPPORT AND SERVICES	☐ RESPITE SERVICE
☐ COMMUNITY SELF ADVOCACY TRAINING SUPPORT	PALLIATIVE CARE: ☐ MASSAGE ☐ BEREAVEMENT ☐ EXPRESSIVE ☐ PAIN AND SYMPTOM MANAGEMENT

DESIRED GOAL OR NEED TO BE ADDRESSED:
FAMILY PREFERENCES: (MALE/FEMALE STAFF, EVENING HOURS, ETC.)

August 2019 Page 1 of 2

- Referrals are made to in-network MMCP providers if the child/youth is enrolled in a MMCP
- **No Level of Care approval** (as required in adult HCBS process)

When Referring the Child/Youth for HCBS

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
  - Multiple identified HCBS providers, a separate form for each HCBS provider
  - One HCBS provider providing multiple HCBS, then only one form needed
- 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 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 HCBS

MMCP	HHCM	C-YES	HCBS Provider

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 OR
- There is a new service requested OR
- 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 MMCP is maintaining the POC, the MMCP is required to utilize the ***Referral for Home and Community Based Services (HCBS) to HCBS Provider*** as well

Step 2: Establishment of First Appointment and Notification to the MMCP *(if the child 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 with the following information:

- Appointment Date,
- Identified Services, and
- Desired goal or need to be addressed

❖ MMCP ensure HCBS in POC are accessible with no prior authorization for the first 60 days, 96 units, or 24 hours

MMCP	HHCM	C-YES	HCBS Provider

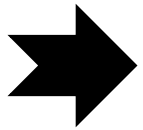
Step 3: Authorization of Requested/Continued HCBS and Care Manager Notification

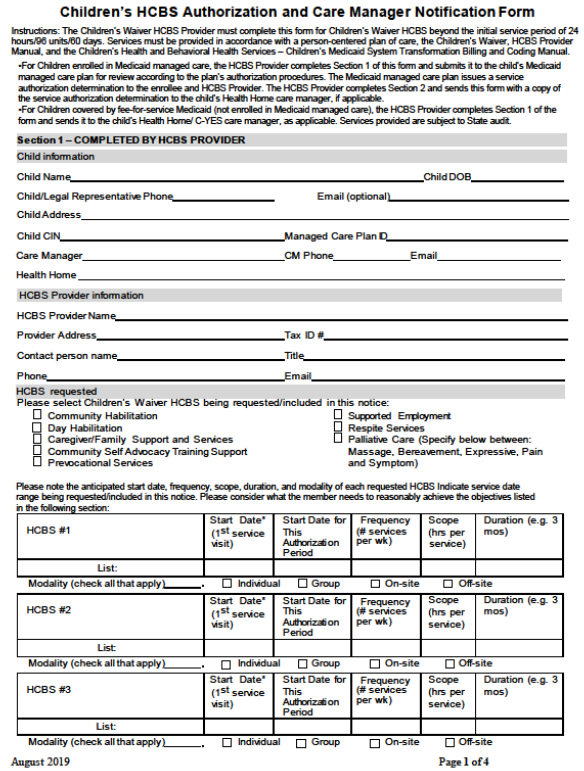
MMCP | HHCM | C-YES | HCBS Provider

The HCBS Provider conducts a service intake/assessment to determine appropriateness of the service and frequency, scope, and duration (f/s/d)

Once HCBS Provider determines f/s/d; HCBS Provider request authorization for the service or for continued services using ***Children's HCBS Authorization and Care Manager Notification*** form

- The MMCP may request additional information
- MMCP makes service authorization determination within the MMC Model Contract Appendix F-timeframes for concurrent review, in accordance with HCBS UM guidelines and the POC





Children's HCBS Authorization and Care Manager Notification Form

Instructions: The Children's Waiver HCBS Provider must complete this form for Children's Waiver HCBS beyond the initial service period of 24 hours/96 units/60 days. Services must be provided in accordance with a person-centered plan of care, the Children's Waiver, HCBS Provider Manual, and the Children's Health and Behavioral Health Services – Children's Medicaid System Transformation Billing and Coding Manual.

- For Children enrolled in Medicaid managed care, the HCBS Provider completes Section 1 of this form and submits it to the child's Medicaid managed care plan for review according to the plan's authorization procedures. The Medicaid managed care plan issues a service authorization determination to the enrollee and HCBS Provider. The HCBS Provider completes Section 2 and sends this form with a copy of the service authorization determination to the child's Health Home care manager, if applicable.
- For Children covered by fee-for-service Medicaid (not enrolled in Medicaid managed care), the HCBS Provider completes Section 1 of the form and sends it to the child's Health Home/ C-YES care manager, as applicable. Services provided are subject to State audit.

Section 1 – COMPLETED BY HCBS PROVIDER

Child information

Child Name_____ Child DOB_____

Child/Legal Representative Phone_____ Email (optional)_____

Child Address_____

Child CIN_____ Managed Care Plan ID_____

Care Manager_____ CM Phone_____ Email_____

Health Home_____

HCBS Provider information

HCBS Provider Name_____

Provider Address_____ Tax ID #_____

Contact person name_____ Title_____

Phone_____ Email_____

HCBS requested

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

☐ Community Habilitation
☐ Day Habilitation
☐ Caregiver/Family Support and Services
☐ Community Self Advocacy Training Support
☐ Prevocational Services
☐ Supported Employment
☐ Respite Services
☐ Palliative Care (Specify below between: Massage, Bereavement, Expressive, Pain and Symptom)

Please note the anticipated start date, frequency, scope, duration, and modality of each requested HCBS Indicate service date range being requested/included in this notice. Please consider what the member needs to reasonably achieve the objectives listed in the following section:

	Start Date* (1st service visit)	Start Date for This Authorization Period	Frequency (# services per wk)	Scope (hrs per service)	Duration (e.g. 3 mos)
HCBS #1					
List:					
Modality (check all that apply)_____ ☐ Individual ☐ Group ☐ On-site ☐ Off-site					
HCBS #2					
List:					
Modality (check all that apply)_____ ☐ Individual ☐ Group ☐ On-site ☐ Off-site					
HCBS #3					
List:					
Modality (check all that apply)_____ ☐ Individual ☐ Group ☐ On-site ☐ Off-site					

August 2019 Page 1 of 4

Please Note: HCBS Provider develop a Service Plan

Children's HCBS Authorization and Care Manager Notification form

The Purpose and Requirement for the ***Children's HCBS Authorization and Care Manager Notification*** form:

1. Must be utilized regardless of the child/youth being enrolled in a MMCP
2. Notifies the MMCP of the HCBS requested or need for continuance
3. Informs HHCM/C-YES and MMCP (as appropriate), of frequency, scope and duration
4. Informs updates to the POC by the MMCP, HHCM, or C-YES (as appropriate)
5. Assists in the tracking of HCBS being provided, authorized and as a notification

HCBS Authorization and Care Manager Notification Process

For the Child/Youth Enrolled in a MMCP:

If the child/youth is enrolled in a MMCP and in Health Home:

1. HCBS provider completes Section 1 of the Form and sends to MMCP
2. The MMCP completes service authorization review and issues determination to the HCBS provider
3. Then the HCBS provider completes Section 2 of the Form and sends copy of form **AND** service authorization determination to HHCM.
4. HHCM updates POC and distributes POC as outlined

HCBS provider must notify the HHCM **within five (5) calendar days** after receiving MMCP authorization for Frequency, Scope, and Duration of HCBS, then the HCBS provider completes section 2 of the form as formal notification

HCBS Authorization and Care Manager Notification Process

For the Child/Youth Enrolled in a MMCP:

If child/youth is enrolled in a MMCP and not in Health Home:

1. HCBS provider completes Section 1 of the Form and sends to MMCP
2. The MMCP completes service authorization review and issues determination to the HCBS provider
3. MMCP care manager updates POC and distributes the POC.
4. The MMCP will share the POC with C-YES at least quarterly.

If the child 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

HCBS Authorization and Care Manager Notification Process

Ongoing Services when enrolled with MMCP

- 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 previous 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

HCBS Authorization and Care Manager Notification Process

For the Child/Youth NOT Enrolled in MMCP:

If child/youth is Not Enrolled in MMCP and is in a Health Home:

1. HCBS provider completes Section 1 of the Form and sends to HHCM
2. HHCM updates POC and distributes POC as outlined

If child/youth is Not Enrolled in MMCP and is in C-YES (not Health Home):

1. HCBS provider completes Section 1 of the Form and sends to C-YES care manager
2. C-YES updates POC and distributes POC as outlined

It is necessary for the HHCM/C-YES to update the POC after the HCBS provider has determined F/S/D even if the child is not enrolled in a MMCP. Therefore, the ***Children's HCBS Authorization and Care Manager Notification*** Form will be utilized even if the child is not enrolled in a MMCP and sent to the HHCM/C-YES

❖Note: In this case section 2 of the Form is not necessary and will not be completed

HCBS Authorization and Care Manager Notification Process

Ongoing Services when NOT enrolled in MMCP:

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: Developing, Updating, and Distributing the POC

HHCM/CYES meets with the child/youth and family and identified care team, discussing strengths and needs using the person-centered planning guideline principles

POC is based on the assessment of needs through interacting with the child, family, and supports

Utilize CANS-NY (HH), Health Home Comprehensive Assessment (HH), and HCBS/LOC Eligibility Determination

POC must be a collaborative work between the family, family identified supports, HCBS providers , other child-serving systems, and MMCP (if enrolled)

Each HCBS a child receives must be listed in the POC with a defined goal

HCBS POC Development

MMCP	HHCM	C-YES	HCBS Provider

The POC is:

✓Flexible

✓Never Stagnant

✓Meets needs, situation, and choice

1. The POC must be signed at minimum: initially, during the annual review, and if there is a significant change in the POC with newly identified need, goal, service, and/or provider,
2. 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
3. The POC does not need to be continually re-signed for previously identified needs, goals, and choice of services in the POC

HCBS POC Development

- The POC will change and evolve over time as goals are met/change and services change
- The POC is a fluid document that can be developed incrementally and updated at any time
- It must be reviewed every six months, during CANS-NY reassessment (HH), or earlier if there is a significant life event, as well as during the HCBS/LOC eligibility determination reassessment
- Must be signed by the child, if age appropriate, and/or the parent guardian or legally authorized representative
  - Age appropriate means being able to understand and contribute to their own POC
  - All involved parties must be given the opportunity to contribute and sign the document with the informed consent of the child/parent/guardian/legal representative when the POC is developed

HHCM Timeframes for Sharing the POC

The HHCM is required to complete a POC with HCBS within **thirty (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**

- Child/Youth first in HH prior to HCBS – Comprehensive HH POC
- Child/Youth first with C-YES – HCBS only POC
- Child/Youth new to HH and referred for HCBS – HCBS only POC

For children enrolled in an MMCP, within thirty (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

Please note: ***There is only one POC, inclusive of HCBS***

HHCM Timeframes for Sharing the POC

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 HCBS 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 ten (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

HCBS Updating the POC

Possible updates to the child'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's condition (for example, admitted to a higher level of care or being discharged from a higher level of care)
- Whenever the child experiences a significant life event
- Whenever a change that will impact the POC is requested (for example, requests to change service or provider, added HCBS due to a newly identified need)

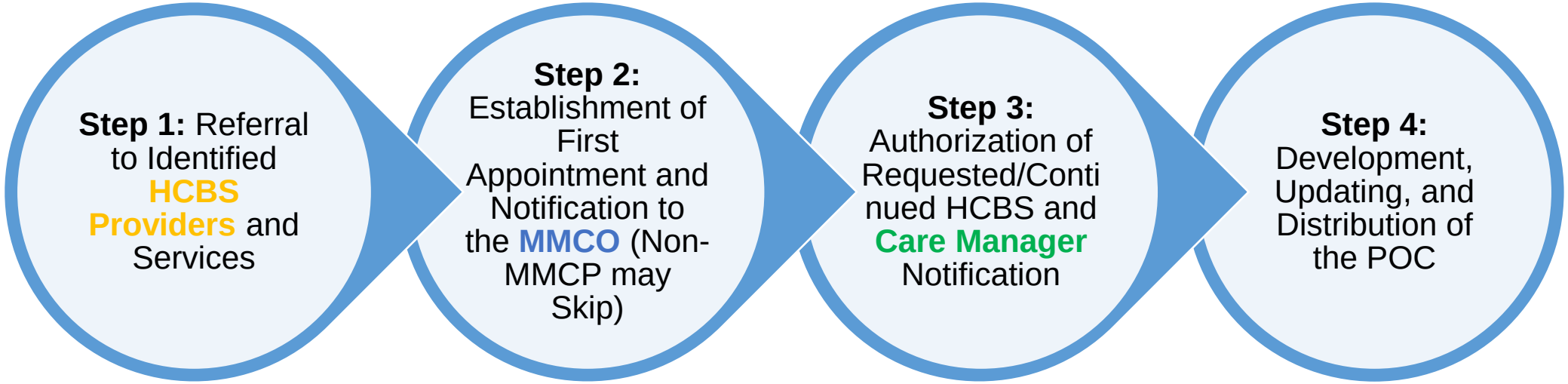
If the POC needs to be updated, whenever possible, all involved HCBS providers, family- identified supports, other child-serving systems, and MMCP, should be involved in a person-centered multidisciplinary team (care team) meeting to discuss the need to revise the POC

POC must include:
changes in the child's needs, goals, HCBS/LOC Eligibility, and/or service needs, including relevant impact of change with regard to the HCBS Settings Rule

MMCP	HHCM	C-YES	HCBS Provider

Steps for Updating/Sharing POC

MMCP	HHCM	C-YES	HCBS Provider



MMCP Service Authorization

October 2019

Notification, Authorization and Utilization Review

- **Notification** to an MMCP allows the plan to:
  - update care management and claims systems with the information a child is eligible for HCBS and will be accessing services
  - permits the named provider to claim for the initial period (60 days/96 units/24 hours)
- **Authorization** is a general term that indicates:
  - the MMCP has “opened” the claim window for the child to receive services from named provider; or
  - any approval in the MMCP’s systems for the child to receive services

Notification, Authorization and Utilization Review

- The Children's System Transformation includes several requirements for MMCPs to "automatically" authorize services without prior approval or utilization review, including the "60 day clock" for some HCBS
- Authorization must be put in place for any HCBS claim to pay. Even where no prior approval is required, claims for services provided without notification may be denied as the MMCP has had no opportunity to put the authorization in place for a specific child and provider
- Authorization will be needed for any out of network provider – an agreement must be established and the provider entered on the MMCP's system to allow payment

Notification, Authorization and Utilization Review

- **Utilization Review** is a review to determine if the services are medically necessary or appropriate for the child
  - Clinical decisions must be made by health professionals based on written clinical criteria
  - The Children's System Transformation has set specific parameters on when the MMCP can conduct utilization review
  - Utilization Review is not an assessment of the child's eligibility for HCBS – but whether the specific proposed HCBS is appropriate for the individual child and likely to achieve the goals indicated in the POC
  - By law, MMCPs may not conduct utilization review at unreasonable frequency – i.e., approval for a 30 day treatment program cannot be reviewed every 3 days for continued authorization

Service Authorization - Managed Care Environment

- All authorizations are provided in writing; the provider usually receives an electronic notification
- Once authorized, authorization may not be changed without receipt of new information, fraud or loss of coverage
- MMCP authorization determinations are made in accordance with federal rule, NYS law and regulation, and Appendix F of the MMC Model Contract
- Current time frames for MMCP decisions are available here:
  https://www.health.ny.gov/health_care/managed_care/plans/appeals/2018-2-2_timeframe_comparison.htm

Selected MMCP Determination Timeframes

- Where initial period of HCBS is covered for 60 days/96 units/24 hours, a request for continued HCBS will be usually be handled under concurrent review timeframes
- A concurrent review is when the request for additional services is made **before** the current authorization period expires.
- For a concurrent review, the MMCP must decide and notice in
  - Expedited, 1 bd from all info and no more than 72 hours from request
  - Standard, 1 bd from all info and no more than 14 days from request
- The above timeframes **may be extended up to 14 days** if:
  - MMCP needs more info and it is in enrollee's best interest to extend review; or
  - Enrollee or provider requests extension

Selected MMCP Determination Timeframes

- For HCBS requiring prior approval, such as for vehicle modifications, a request for HCBS will be usually be handled under prior authorization review timeframes
- A **prior authorization** review generally applies when:
  - there is a requirement to receive prior approval from the MMCP before getting a service, and
  - the request is for new service before the service has been provided, or
  - the request is for additional services after the current authorization period has expired (except for long term services and supports)
- For a prior authorization review, the MMCP must decide and notice in
  - Expedited, 72 hours from request
  - Standard, 3 business days from all info and no more than 14 days from request
- The above timeframes **may be extended up to 14 days** if:
  - MMCP needs more info and it is in enrollee's best interest to extend review; or
  - Enrollee or provider requests extension

Disagreements About Service Requests

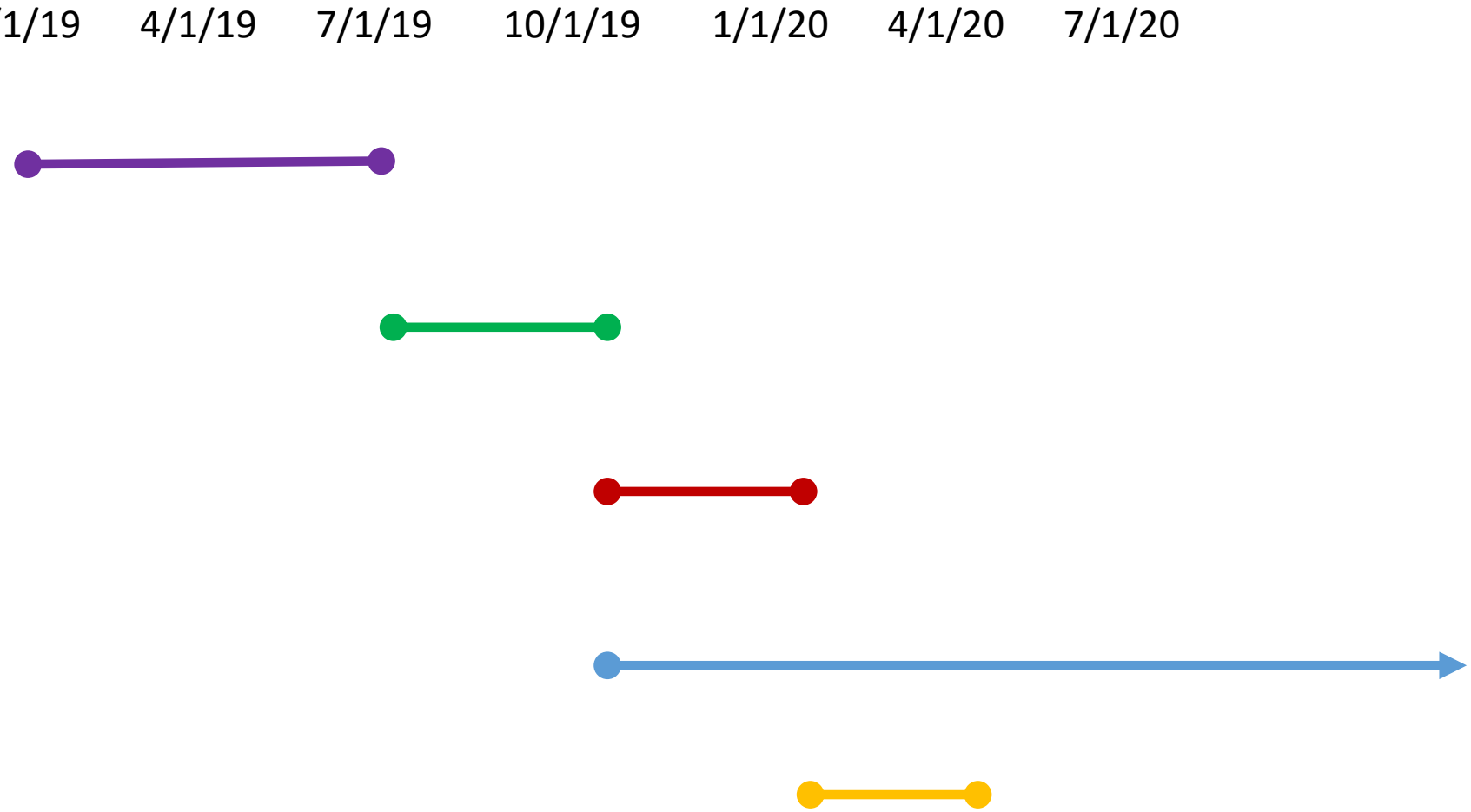
- MMCP may issue adverse determinations – denial, reduction, suspension or termination of services
- MMCP must provide written notice and detailed reason
- If denied as not medically necessary, clinical rationale must demonstrate
  - Review of enrollee specific data
  - Specific criteria not met
  - Be sufficient to enable judgment for basis of appeal
- Enrollee right to appeal, external appeal and fair hearing described in notice – all may be expedited
- Providers have appeal rights on own behalf
- More information on appeal process in MMCP member handbook and provider manuals

Disagreements About Service Requests

- Possible next steps:
  - Discuss alternate service options with MMCP care manager
  - Request specific written clinical review criteria used; request peer to peer review (reconsideration)
  - File appeal with MMCP; include documented support for requested service (providers must have written authorization to file appeal on enrollee's behalf)
  - After exhausting MMCP appeal process, may file external appeal or fair hearing
  - Contact NYS Department of Health for issues with process, access to or quality of care

Continuity of Care and Utilization Review

Continuity of Care Provisions for Children's Medicaid System Transformation



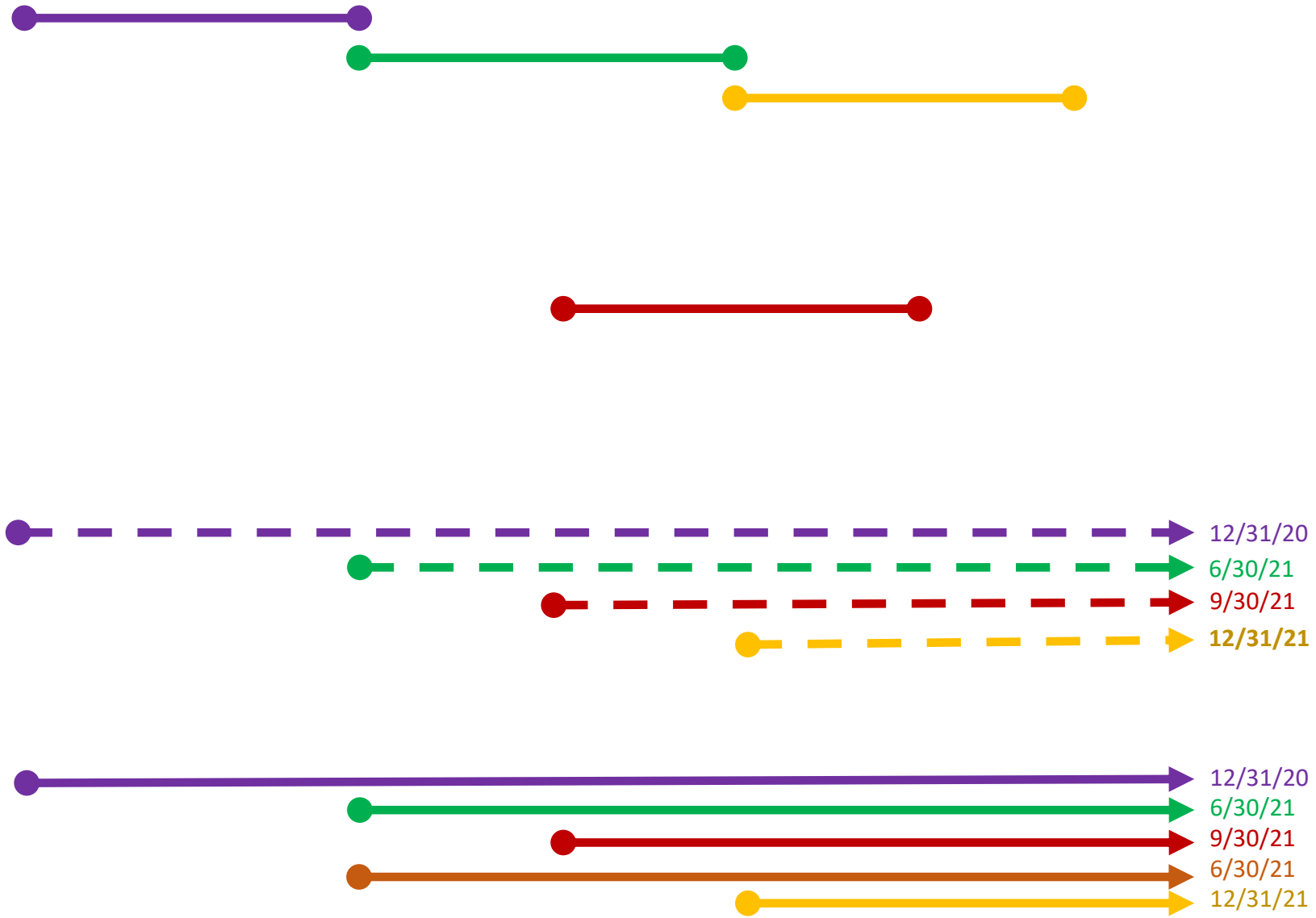
October 2019

Continuity of Care Provisions for Children's Medicaid System Transformation

For Child from 1915c waivers or participating in Children's Waiver with POC, MMC does not conduct UR for CFTSS added to POC, and does not change LTSS in POC, for 180 days from CFTSS carve in

For Child participating in Children's Waiver, no POC change for HCBS, LTSS or CFTSS added to POC for 180 days from **HCBS** carve in

For new enrollee with HCBS, no POC change for HCBS/LTSS for 180 days from enrollment, for 24 months from CFTSS or **HCBS** carve in



Same provider/same service for 24 months from any BH including **SPA** benefit inclusion for episode of care

Continuity of Care – When Does Utilization Review Begin?

- Transitioning child in receipt of HCBS prior to October 1, 2019
- No authorization or utilization review for the first 180 days of the transition – 10/1/19- 3/31/20
  - MMCP will use existing POCs to authorize existing services the child is currently receiving
  - MMCP will not review HCBS, CFTSS or LTSS added to the POC for medical necessity or appropriateness during this time period
  - NEW services added to POC during this period – provider must notify plan of first appointment and will be authorized until end of period

EXAMPLE TIMELINE

Day 1 – auth in place existing services for 180 days

Day 30 – notify new service appointment as per POC (no UR)
- Auth for 150 days

By Day 180 - Request continuing all services – plan may conduct UR

Continuity of Care – When Does Utilization Review Begin?

- 10/1/19 and thereafter, for an enrolled child found **newly eligible for HCBS – HCBS workflow applies**
  - Provider must notify plan of first appointment
  - MMCP will not review services in the POC for medical necessity or appropriateness for the first 60 days/96 units/24 hours
- After the initial period, the plan may begin to review requests for additional services for medical necessity/appropriateness

EXAMPLE TIMELINE

Day 1 – no prior approval – initial auth 60 days from 1st appt

By Day 60 – request continuing services for 90 days – plan may conduct UR

By Day 150 - Request continuing services for 90 days – may conduct UR


Q
&
A

Department of Health Complaints

- Enrollees and providers may file a complaint regarding managed care plans to DOH
  - 1-800-206-8125
  - managedcarecomplaint@health.ny.gov
- When filing:
  - Identify plan and enrollee
  - Provide all documents from/to plan
  - Medical record not necessary
- Issues not within DOH jurisdiction may be referred
- DOH is unable to arbitrate or resolve contractual disputes in the absence of a specific governing law
- File Prompt Pay complaints with Department of Financial Services: https://www.dfs.ny.gov/insurance/provlhow.htm

Children and Youth Evaluation Service
Your Connection to Home and Community-Based Services

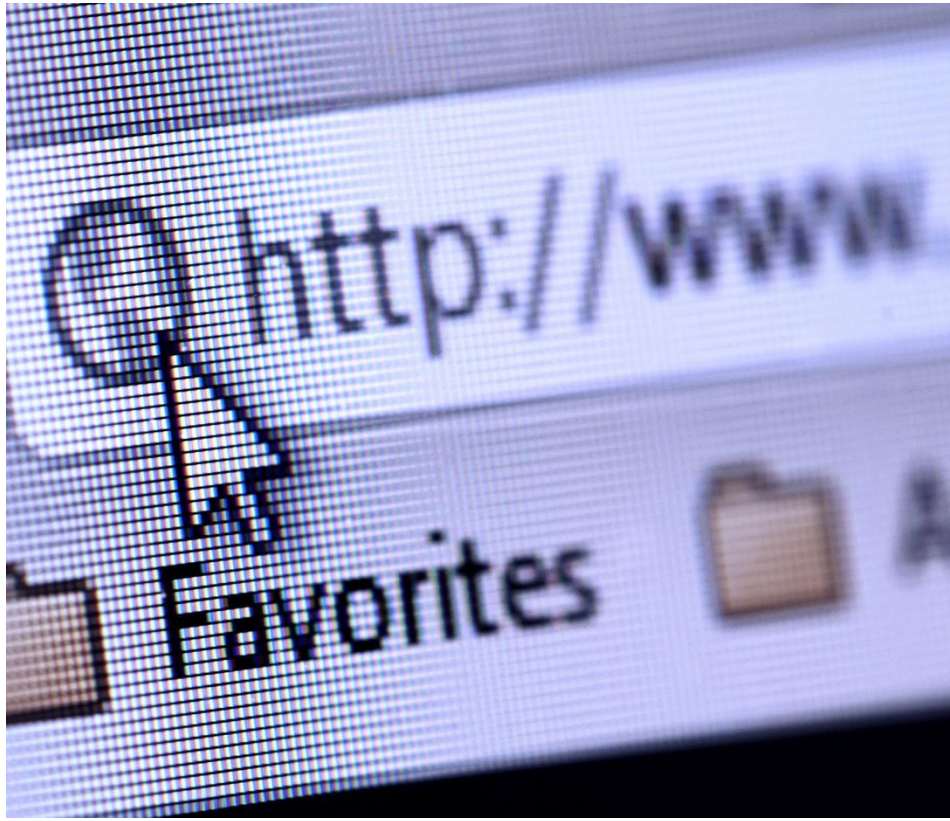
- # Referral Form Instructions
- The Children and Youth Evaluation Service (C-YES) accepts referrals from individuals and providers including a parent, wider family member, doctor, therapist, school guidance counselor, CBOs and others:
- Individuals and families should call C-YES so that we can send you a Referral Form and a pre-paid return envelope in the mail right away! You can mail back the form in the envelope at no cost to you. Call C-YES at 1-833-333-CYES (1-833-333-2937). TTY: 1-888-329-1541
- Providers and Organizations with secure email protocols can download the Referral Form below. Return the form to: CYESREFERRAL@MAXIMUS.COM. Be sure to include the child/youth's name and contact information!
  - C-YES Referral Form

Questions? Call 1-833-333-CYES (1-833-333-2937). TTY: 1-888-329-1541.

Resources and Questions

- HHCMs and HH CMAs should first talk with their Lead Health Home regarding questions and issues they may have
- Questions, comments or feedback on Health Homes Serving Children to: hhsc@health.ny.gov or contact the Health Home Program at the Department of Health at 518.473.5569
- Specific Questions/Comments regarding Transition services BH.Transition@health.ny.gov
- Subscribe to the HH Listserv

  http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/listserv.htm



Additional Information and Support

UAS-NY Support Desk
uasny@health.ny.gov
or
518-408-1021, option 1
Monday – Friday
8:30 AM – 12:00 PM
1:00 PM – 4:00 PM

CANS-NY Training
support@CANSTraining.com
Or
www.canstraining.com and click on contact us

MAPP Customer Care Center
MAPP-customercarecenter@cma.com
Phone: 518-649-4335

Commerce Accounts Management Unit (CAMU)
866-529-1890

Appendix

Definitions

- **Family:** Within this document the term “family” is used and defined as the primary caregiving unit inclusive of the wide diversity of primary caregiving units in our society. 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
- **HCBS/LOC Eligibility Determination:** is a tiered assessment where multiple factors must be met for child’s HCBS/LOC eligibility to be determined. To access Children’s HCBS, a child 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:** Means New York State designated Health Home Serving Children
- **Medicaid managed care plan (MMCP):** Means the mainstream Medicaid Managed Care Plan or HIV Special Needs Plan in which the child is enrolled on the date of service, or which the child has selected for enrollment and has provided written consent to share protected health information with prior to enrollment
- **Parent, guardian, or legally authorized representative:** Are the individuals who have custody/guardianship of the child and who are able to consent to the child’s services, when the child is not of age to self-consent or does not have the mental capacity to self- consent to services. (Children 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, C- YES and HCBS)

Definitions LPHAs

Licensed Practitioner of the Healing Arts: An individual professional who is Licensed psychoanalyst, Licensed psychologist, Licensed Clinical Social Worker, Nurse Practitioner, Physician, Physician Assistant or Psychologist and practicing within the scope of their State License.

- 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.
- 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.
- Nurse Practitioner is an individual who is currently certified and currently registered as a nurse practitioner by the New York State Education Department.
- Physician is an individual who is licensed and currently registered as a physician by the New York State Education Department.
- Physician Assistant is an individual who is currently licensed and registered as a physician assistant by the New York State Education Department.
- 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 the Board.

Link to Licensed Practitioner of the Healing Arts (DOH-5275): https://www.health.ny.gov/forms/doh-5275.pdf

Definitions F/S/D

- **Frequency:** Outlines how often the service will be offered to the child and/or family. Services may be delivered on a weekly, bi-weekly, or monthly basis, according to the needs of the child/family
- **Scope:** the service components and interventions being provided and utilized to address the identified needs of the child
- **Duration:** How long service will be delivered to the child and or family. The duration of the service will correspond to the abilities of the child/family and be reflective of the billing unit identified by service

Continuity of Care Provisions for Children's Medicaid System Transformation

- The Plan may not apply utilization review criteria for a period of 90 days from the implementation date of the transition of children's specialty benefits for all services newly carved into managed care. See dates and services in detail tabs. NOTE: This is extended to 180 days for OLP, CPST, and PSR
- For children transitioning from a 1915c waiver, the Plan must continue to authorize covered HCBS and LTSS in accordance with the most recent POC for at least 180 days following the date of transition of children's specialty services newly carved into managed care. Service frequency, scope, level, quantity and existing providers at the time of the transition will remain unchanged (unless such changes are requested by the enrollee or the provider refuses to work with the Plan) for not less than 180 days, during which time, a new POC is to be developed
- During the initial 180 days of the transition, the Plan will authorize any children's specialty services newly carved into managed care that are added to the POC under a person-centered process without conducting utilization review

Continuity of Care Provisions for Children's Medicaid System Transformation

- For 24 months from the date of transition of the children's specialty services carve-in, for FFS children in receipt of HCBS at the time of enrollment, the Plan must continue to authorize covered HCBS and LTSS in accordance with the most recent POC for at least 180 days following the effective date of enrollment. Service frequency, scope, level, quantity, and existing providers at the time of enrollment will remain unchanged (unless such changes are requested by the enrollee or the provider refuses to work with the Plan) for not less than 180 days, during which time a new POC is to be developed
- For continuity of care purposes the Plan must allow children to continue with their care providers, including medical, BH and HCBS providers, for a continuous Episode of Care. This requirement will be in place for the first 24 months of the transition. It applies only to episodes of care that were ongoing during the transition period from FFS to managed care

Ineligible Individuals

HCBS Ineligible Individuals

If an eligible child declines HCBS, this workflow is not completed. However, the HHCM/C-YES must record the decision. Example reasons include:

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

HHCM will document the decision in the child's case record and work with the child/family in their capacity as a HHCM

HCBS Ineligible Individuals (Continued)

C-YES does not provide service coordination for children who are ineligible for or opt-out of HCBS and would refer the child to community and other natural supports, including the county where applicable

HHCM/C-YES will send Notice of Determination Form to the family/child indicating the outcome
Link to NOD

At any time, a child 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