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Children's System: Aligned Home and Community Based Services (HCBS)

Part 1

Archived

Introduction and Housekeeping

- Slides will be posted at MCTAC.org following the last training
- **Reminders:**
- Information and timelines are current as of the date of the presentation
- This presentation is not an official document. For full details please refer to the provider and billing manuals.

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Schedule of Offerings

Albany	June 13th
Rochester	June 19th
Binghamton	June 21st
New York City	June 25th



Agenda

- 9:30 – 9:45 am: Welcome and Housekeeping
- 9:45 – 10:30 am: Timeline and Overview of Key Concepts
- 10:30 – 10:45 am: Break
- 10:45 – 12:00 pm: Access to HCBS
- 12:00 – 12:30 pm: Lunch Break
- 12:30 – 1:15 pm: Case Scenarios
- 1:15 – 1:45 pm: Q&A
- 1:45 – 2:00 pm: Break
- 2:00 – 3:30 pm: Services
 - Community Self-Advocacy Training and Supports
 - Caregiver/Family Supports and Services
 - Prevocational Services
 - Supported Employment
 - Respite
 - Palliative Care
- 3:30 – 4:00 pm: Q&A





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Children's System Transformation



Overview of Children's Medicaid Redesign Timeline

Children's Medicaid Redesign Timeline

Subject to the availability of Global Cap Resources in Excess of Budget Restoration
Subject to timely CMS and other State Approvals

<ul style="list-style-type: none"> Implement three of Six New State Plan Services (Other Licensed Practitioner, Community Psychiatric Supports and Treatment Psychosocial Rehabilitation) All 1915(c) Children's Waiver Members Transition to Health Home (begins in October 2018) Most 1915(c) Waiver Children Transition to Managed Care New State Plan Services and New Array of HCBS in Managed Care Benefit B2H Waiver Children Discharged from FC to Managed Care 	January 2019
<ul style="list-style-type: none"> Implement Family Peer Supports State Plan Service Three Year Phase-in of Level of Care (LOC) eligibility for HCBS Begins (within limits of Global Spending Cap) Foster Care Population, including B2H Waiver children, transition to Managed Care Behavioral Health Benefits transition to Managed Care 	July 2019
<ul style="list-style-type: none"> Implement Remaining New State Plan Services in Managed Care Benefit (Youth Peer Support and Training and Crisis Intervention) 	January 2020



1915(c) Waivers Transition to 1115 Waiver

- The authority for all six 1915(c) children's waivers will transition to 1115 Waiver on January 1, 2019
 - The timing is consistent with State/CMS agreement to transition to the 1115 Waiver and continue conflict free case management standards
 - The six waivers include:
 - OMH SED
 - DOH Care at Home (CAH) I/II
 - OPWDD CAH
 - OCFS Bridges to Health (B2H) SED
 - OCFS B2H Developmentally Disabled
 - OCFS B2H Medically Fragile
- HCBS will be part of Managed Care benefit on January 1, 2019
- OMH SED, DOH CAH and OPWDD Care at Home will transition to managed care on January 1, 2019
- B2H children in foster care will transition to Managed Care on July 1, 2019, i.e., at the same time the VFCA population transitions to managed care
 - Between January 1, 2019 and July 1, 2019, B2H transitioning children will receive HCBS through fee-for-service
 - A child that is in B2H, receiving HCBS services and that is no longer in Foster Care will transition to Managed Care on January 1, 2019 and will receive their HCBS from the plan on January 1, 2019
- Children that are currently receiving Crisis Intervention, Family Peer and Youth Peer services under 1915(c) waivers and that will transition to the 1115 will continue to receive these services under the 1115 authority – this ensures no break in service for these children



1915(c) Waiver Providers will Transition to Health Home Care Management under the 1115 Authority

- To preserve the expertise of existing waiver providers in the Children's Transformation and in Health Homes, all existing care managers providing care management under the six waivers will transition to Health Homes
- 1915(c) Transitioning Children that will transition to Health Home care management will transition with their current care manager/agency (by choice and with consent)
- This linkage between care managers and children and families will preserve care manager relationships with the child and their family, continuity of care and help ensure a seamless transition
- Work to transition children to Health Home will begin October 2018
- The State will be scheduling in-person, regional transitional meetings with all waiver providers, Health Homes and Plans
- A survey was sent to 1915c Waiver providers transitioning to Health Home care management to verify proper linkages and system connections are in place and to identify providers that may need TA



Children’s Home and Community Based Services: Existing Services Moving into newly Aligned HCBS Benefit Array

	Health Home Care Management	Respite (Planned and Crisis)	Prevocational Services	Supported Employment	Caregiver/Family Supports and Services
Existing Services					
OMH SED Waiver	Individualized Care Coordination	Respite	Prevocational Services	Supported Employment	
OCFS B2H Waiver	Health Care Integration	Crisis and Planned Respite	Prevocational Services	Supported Employment	Family and Caregiver Support Services
CAH I/II Waiver	Care Coordination				
OPWDDCAH Waiver	Case Management	Respite			



Children’s Home and Community Based Services: Existing Services Moving into newly Aligned HCBS Benefit Array

	Community - Advocacy Training and Support	Habilitation	Adaptive and Assistive Equipment	Accessibility Modifications	Palliative Care	Customized Goods and Services	Non-Medical Transportation
Existing Services							
OMH SED Waiver							
OCFS B2H Waiver	Community Advocacy Training and Supports	Day Habilitation	Adaptive and Assistive Equipment	Accessibility Modifications			
CAH/II Waiver				Home and Vehicle Modifications	Palliative Care		
OPWDD CAH Waiver			Assistive Technology Adaptive Devices	Environmental Modifications			



Overview of Key Concepts



Overview

- HCBS and New Children and Family Treatment and Support Services are different and have different requirements, processes and paths to care.
- Aligned services are available based on need to all who are eligible for HCBS.
- Providers must be a designated to provide these services
- There's a different process for transitioning children and newly eligible children
- Build in flexibility to allow for creativity



Overview Continues

- Waiver Capacity/Slots: As of January 1st, all current slots will be combined and will remain the same until July 1st, 2019 when capacity expansion will begin. More information on capacity/slot management to come.
- Allows providers and state to leverage and partner with Managed Care Companies. For example, meeting network adequacy for services.
- Allowable service combination grid coming soon
- Overlapping scopes for different services allows continuity in staffing, flexibility and creativity going forward.



Core Principles

Child Centered

Family Focused

Community Based

Multi-System

Culturally Competent

Least Restrictive/Least Intrusive



Goals for Children's Design

- Keep children on their developmental trajectory
- Maintain child at home with support and services
- Maintain the child in the community in least restrictive settings
- Identify needs early and intervene
- Focus on recovery and building resilience
- Prevent escalation and longer term need for higher end services
- Maintain accountability for improved outcomes and delivery of quality care



HCBS Settings

Allowable settings in compliance with Medicaid regulations and the Home and Community Based Settings Final Rule (§441.301(c)(4) and §441.710) (see Manual Appendix F) will exhibit characteristics and qualities most often articulated by the individual child/youth and family/caregiver as key determinants of independence and community integration. Services should be offered in the setting least restrictive for desired outcomes, including the most integrated home or other community-based settings where the beneficiary lives, works, engages in services and/or socializes, while remaining inclusive of those in the family and caregiver network.

As per CMS final rule, HCBS services may not be provided in certain settings. In addition, some individuals might not be eligible to receive HCBS while residing in certain settings. This rule does not apply to new Children and Family Treatment and Support Services. More information to come.



Conflict Free Case Management

Care managers and HCBS providers must comply with conflict-free case management requirements:

1. Agencies that provide care management and direct services must ensure that the provider providing care management is not the same as the provider providing direct care services and that these individuals are under different supervisory structures.
2. Care managers are restricted from assessing a person for whom they have financial interest or other existing relation that would present conflict of interest.
3. Enrollees shall be provided with choice of providers among all the MMCP's network of providers of a particular service. Choice should be documented in the enrollee's Plan of Care.



Billing 101

Fundamentals

- If child in Medicaid Managed Care Plan (MMCP) – bill Managed Care Plan
- If child not in MMCP – bill Fee-For-Service
- In order to bill MMCP you need to be in-network
 - In order to be in network you have to be credentialed and contracted
 - [Managed Care Plan Matrix](#)



Billing

Fundamental Requirements

- All providers must be enrolled as Medicaid providers. Regardless if they plan to bill Medicaid or not.
- To be paid by Medicaid Managed Care providers must be in-network (both contracted and credentialed)
- Single Case Agreements (SCA) may be executed by Medicaid Managed Care for specific services for specific clients
- Beginning January 1, 2019, and upon the transition date of the respective services, MMCPs will be required to pay government rates [aka Medicaid fee-for-service rates] for at least 24 months, or however long NYS mandates



Break – 15 mins



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Access to HCBS

Archives

HCBS Workflow Stakeholder Feedback

- On May 23, 2018 The State Presented a webinar on the DRAFT HCBS Workflow
- Stakeholders were asked to provide feedback based on the presentation by May 30, 2018
- Your feedback is being reviewed and consolidated to inform finalization of the HCBS Workflow Policy and Guidance Document
- This presentation aims to provide additional clarification and should be reviewed in tandem with the May 23, 2018 presentation

https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/2018-05-23_draft_workflow.pdf



Pathways to HCBS

When the children's transformation begins on January 1, 2019:

- Children will be recommended for HCBS through from a variety of community and professional resources such as; transitioned 1915(c) or community providers, SPOA, Physicians, Hospitals or Schools
- Children and families in conjunction with their providers and trusted advocates will have the opportunity to begin the process to access HCBS through two pathways
 1. Health Homes Serving Children (including former 1915(c) Care Management)
 - Children enrolled in Health Home care management (HHCM) will engage with their Care Manager to discuss eligibility and available services
 - Children with Medicaid who appear to be eligible for Health Home or HCBS may continue to receive direct referral to Health Home (HH) or HH Care Management Agency (CMA)
 2. The State Designated Independent Entity (IE)
 - Children without Medicaid who appear to be eligible for HCBS will be provided referral to the State Designated Independent Entity
 - Children who opt out of HHCM may work with the IE to develop an HCBS POC
- It is a Federal requirement that service planning for HCBS be through a person-centered POC
- The State will provide information and training regarding the Role and Referral Process of the IE



Pathways to HCBS beginning 1/1/19

- The HHCM/IE will utilize a checklist to gather appropriate supporting documentation from the family, providers and other resources to support their HCBS/LOC Eligibility Determination
 - Existing supports, involved advocates, single point of access (SPOA), physicians offices and other natural supports may support the collection and submission of these materials to the HHCM or IE
- Once all documentation has been collected, the HHCM or IE will complete the HCBS/LOC Eligibility Determination
 - For children not in Medicaid working with the IE - In addition to completing the HCBS/LOC Eligibility Determination – once a child has been found HCBS/LOC eligible, the IE will support completion and submission of the Medicaid application to the LDSS
- Medicaid eligibility rules do not change because of this transition, Children and families may directly apply for Medicaid through regular pathways



HCBS/LOC Eligibility

- Children eligible for HCBS may be eligible for Medicaid under special rules - “family of one” and Children eligible for HCBS are eligible for Health Home
- Pending Federal approval, effective January 1, 2019 there are 4 categories of LOC
 - Serious Emotional Disturbance (SED)
 - Medically Fragile Children (MFC)
 - Developmental Disability (DD) and Medically Fragile
 - Developmental Disability (DD) and in Foster Care
- These are reflective of the 6 current 1915(c) Waiver populations transitioning
- Each category has specific outlined diagnoses, conditions and/ or requirements that must be obtained and documented within the individual’s case record prior to being able to move forward with the HCBS Eligibility Determination Process
- Once a child has been found HCBS/LOC eligible (and is Medicaid enrolled) the child is HCBS eligible for a 1 year period beginning on the date the HCBS/LOC Determination is signed and finalized within the UAS.



HCBS/LOC Eligibility

- The HCBS/LOC Determination will be within the Uniform Assessment System (UAS) which also houses the CANS-NY
 - Only a HHCM, the Independent Entity, or DDRO will be able to conduct an HCBS/LOC Eligibility Determination
 - HCBS Level of Care (LOC) Determination is comprised of meeting three factors: Target Population, Risk Factors, and Functional Criteria
 - Each of the 3 factors require collection of supporting documentation and materials
 - The HHCM, IE, or DDRO will not be able to complete the HCBS/LOC Determination in the UAS prior to obtaining those appropriate materials and supporting documentation
- **Please Note:** The State will host a separate webinar regarding HCBS/LOC Eligibility Determination



POC Development and Service Referrals

- All children and families will be engaged in the development of a person centered Plan of Care (POC)
 - HHCM — This document is referred to as the Comprehensive POC inclusive of HCBS
 - IE — This document is referred to as the HCBS POC
- Upon developing and/or updating the POC, the HHCM or IE will work with the family to identify available HCBS providers and obtain child/family consent for referrals.
 - If the child is enrolled in a health plan, the MMCP will provide information to assist in finding participating providers
- The HHCM or IE will document recommended services in the child's POC and simultaneously:
 - Submit the child's POC to the MMCP, if enrolled; and
 - Make referrals to service providers
- The HHCM or IE will follow up on referrals made and will work to keep the child and family engaged, ensuring linkage to service. Contacting the child and family throughout the referral/intake process



Capacity Management

- Expanding HCBS to any child that meets Level of Care (LOC) eligibility for HCBS will be phased in over three years.
- DOH, working in conjunction with State partners, will individually monitor all transitioning 1915(c) waiver children to Health Home care management or the IE (should an individual choose to opt out of comprehensive Health Home care management) prior to January 1, 2019. No transitioning child will lose services.
- The State Partners are working on developing Capacity Management protocols. The Department will utilize information within the UAS, the system used to record and track HCBS Eligibility Determination, to help manage capacity.
- The State will have communication protocols in place to communicate with HH CM, the IE and children and families about available capacity for children determined to be HCBS eligible



Frequency, Scope, and Duration (F/S/D)

- Once referrals are made by the HHCM or IE, and following linkage to the appropriate HCBS Providers is made, Frequency, Scope, and Duration (F/S/D) needs to be determined by the HCBS provider through:
 - any completed service assessment / intake process performed by the individual HCBS provider
 - informed by the established goals
 - the person-centered planning discussion between the child, family, and HCBS provider in development of a service plan
- Once F/S/D are determined, the HCBS provider informs the HHCM or the IE, as well as the MMCP if enrolled, through communication and forwarding of the HCBS Provider Service Plan
- The HHCM or IE will update the POC accordingly from all referred HCBS Providers



Collaboration Regarding Child's Needs

As the HCBS providers continue to work, build relationships and re-evaluate children they serve, there may be times where the HCBS provider identifies new needs/services for the child

If a non-HCBS identified:

- When this occurs, the HCBS provider would contact the HHCM or IE and ensure agreement regarding the new identified need
 - This notification can occur over the phone, at the next reassessment of the CANS-NY, multidisciplinary team meeting or POC review
- The new service if collaboratively discussed with the child/family
- Choice of services providers should be given to the family and the POC would be update and referral to the new service made



Collaboration Regarding Child's Needs

If a HCBS identified:

- When this occurs, the HCBS provider would contact the HHCM or IE regarding the new identified need
 - This notification can occur over the phone, at the next reassessment of the CANS-NY, multidisciplinary team meeting or POC review
- The HCBS provider would ensure agreement of the HHCM or IE **and** the MMCP
- The HHCM or IE will update the POC with the new service and the MMCP will be aware of the new identified service authorization forthcoming
- The HHCM or IE would work with the child/family to chose an appropriate provider (if the current HCBS provider provides the service, the family can chose to stay with the same provider for multiple services)
- Referral to the HCBS provider would be made by the HHCM if new provider
- Existing/new HCBS provider would notify the MMCP of the first appointment for the new service



Who does what?

HCBS/LOC Eligibility Determination within the UAS

- Health Home Care Management
- State Designated Independent Entity
- Developmental Disabilities Regional Offices (Specific circumstances only)

Establishment of Frequency/Scope/Duration

- HCBS Provider, informed by;
 - any completed service assessment / intake process performed by the HCBS provider
 - the person-centered planning discussion between the child, family, and HCBS provider in development of a service plan
 - established goals



Service Authorization

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Service Authorization – FFS Environment

- In the FFS Environment, the POC completed by the HHCM or IE serves as service authorization
- Following the specified service being reflected in the child's POC - services are accessible to the child and able to be claimed by the provider on the date of the first appointment
- Frequency Scope and Duration will be determined by the HCBS Provider, and informed by person-centered discussion with the child and family, any service assessment performed by the individual HCBS provider and the established goals
- These decisions will be communicated and shared with the HHCM or IE to inform and update the POC
- The expectation is the HHCM or IE will coordinate with the child, family and HCBS provider to ensure appropriate services reflective of goals within the POC are updated based on person-centered planning discussions
- FFS Service authorizations will be reviewed by the State as part of required ongoing monitoring



Service Authorization – Managed Care Environment

Difference between notification, authorization and utilization review

- **Notification** to an MMCP allows the plan to update their care management and claims systems with the information a child is eligible for HCBS and will be accessing services. This also permits the named provider to claim for the initial period.
- **Authorization** is a general term that indicates the MMCP has “opened” the claim window for the child to receive services from named provider. It can also refer to any approval in the MMCP’s systems for the child to receive services.
 - 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 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 MMCPs system to allow payment



Service Authorization – Managed Care Environment

Difference between notification, authorization and utilization review

- **Utilization Review** is a review to determine if the services are medically necessary or appropriate for the child.
 - 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.
- All authorizations are provided in writing; the provider usually receives an electronic notification



Service Authorization – Managed Care Environment

- Following completed linkage from the HHCM/ IE to a participating HCBS provider(s), the HCBS Provider will notify the MMCP when the first appointment with the child is to be held
- Upon notification, the plan will automatically authorize 96 units or a total of 24 hours of service (whichever comes first) for up to 60 days from the first appointment
- The clock for the 60 days, 96 units or 24 hours of service **begins** after the MMCP is notified by the **HCBS Provider** of a first appointment date
- The provider and MMCP should have a collaborative relationship
- Communication and notification of a child's first appointment by the HCBS provider is essential
- The HCBS provider, HHCM or IE, and the MMCP all communicate as needed to ensure the child and family are engaged and needed services are accessed.



Service Authorization – Managed Care Environment

- When a request for services is made to an MMCP, the MMCP must respond with certain timeframes, as provided by the MMC Model Contract (see appendix)
- During the initial period – within the 60 days/96 units/24 hours of service
 - The provider may contact the MMCP and HHCM/IE to inform these team members of the child's progress, update POC, and if additional services are needed
 - Authorization for additional hours/services may be requested within the 60 day period, in accordance with the needs of the child - do not have to wait for the initial period to be over
 - Additional services/hours may be authorized for more than the original 60 days, in accordance with the needs of the child
- After the initial period –
 - the provider must contact the MMCP to continue services beyond the 60 days/96 units/24 hours of service (whichever is first)



Service Authorization – Managed Care Environment

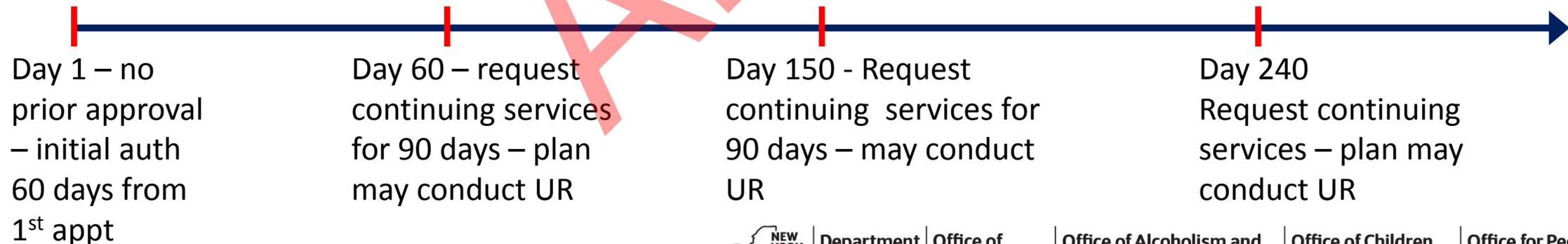
- The HCBS Provider will submit the *Authorization form* to the MMCP to identify the child/ family and provider agreed upon frequency and duration and request additional days/units/hours.
- **To avoid disruption in service, the HCBS provider is encouraged to submit this request as soon as it is apparent that the service will exceed the limit. Requests submitted less than 14 days before expiration of service may not be authorized before runout.**
- Duration of continuing authorizations (i.e., 60 or 90 days) are not set/limited. The frequency of ongoing reviews may be at reasonable intervals determined by the MMCP and provider, in accordance with the needs of the child
- Authorizations cannot exceed the benefit limits that are included in the service billing manual – such as units per day, or days per year.



Service Authorization – Managed Care Environment

- 7/1/19 and thereafter, for an enrolled child found newly eligible for HCBS
 - MMCP will not review services in the POC for medical necessity or appropriateness for the first 60 days
 - Provider must notify plan of first appointment
- After the first 60 days, the plan may begin to review authorization request for medical necessity/appropriateness – conduct utilization review

EXAMPLE TIMELINE

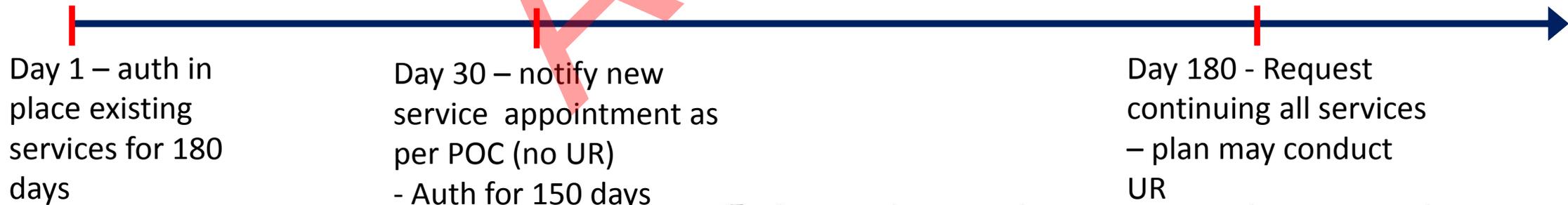


Service Authorization – Managed Care Environment

Continuity of Care Requirements for the Children’s System Transformation

- No authorization or utilization review for the first 180 days of the transition – 1/1/19-6/30/19
 - For a transitioning child, MMCP will not review services added to the POC for medical necessity or appropriateness during this time period
 - All POCs will be provided to the MMCP as part of the transition, and the MMCP will use this information to authorize existing services the child is currently receiving
 - 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



Lunch Break

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Case Scenarios

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Case Scenario - Samantha

Samantha is a 14 year old girl experiencing ongoing mental health difficulties and was recently seen in an emergency room for a psychiatric emergency. Upon discharge from the hospital, the family was informed that HCBS may be a support. Samantha is not currently enrolled in Medicaid, and agreed to be referred to the State Designated Independent Entity (IE) to determine whether she may be eligible. The hospital discharge coordinator facilitates a referral to the IE.

Upon receipt of Samantha's referral, the IE reaches out to Samantha and her family. The IE educates Samantha and her family on the role of the IE and HCBS. Samantha and her family confirm that they wish to complete the process to determine whether or not she is eligible for HCBS.



Case Scenario - Samantha

The IE meets with the family in their home, at a designated IE field office location or other community location as decided upon with the family. The IE works with the family to obtain appropriate materials to support and document that Samantha meet's one or more of the HCBS LOC Criteria and HH Eligibility. This coordination includes the IE identifying and reaching out to appropriate service providers for follow up and/or sending requests for information to appropriate sources.

Once the IE has obtained all appropriate documentation, the IE Completes the HCBS/LOC Eligibility Determination housed within the UAS with Samantha and her family.

The outcome of the eligibility determination finds that Samantha is HCBS/LOC Eligible under the SED LOC Target population. This determination will be included in the Medicaid application package the IE submits to the LDSS.

The IE will provide support in gathering additional appropriate materials and completing a Medicaid Application which is submitted to the LDSS with a cover letter identifying the package has been submitted to the LDSS by the IE and should be completed in a timely manner.



Case Scenario - Samantha

While awaiting the outcome of Medicaid Eligibility and having been found both HCBS and HH Eligible, the IE educates and informs Samantha and her family about the benefits and services available through the Health Home program. This will include identification of specifically available Health Home's within their County.

While discussing HHCM Samantha's family reminds the IE that they have an existing relationship with Parsons Child and Family Center. The IE informs the family that Parsons contracts with CHHUNY which is a HH within their County and verifies that CHHUNY contracts with the MMCP the family has selected during the Medicaid application process.

Samantha has been found Medicaid Eligible and enrolls with UnitedHealthcare. She and her family have agreed to enroll in HH and would like to enroll with CHHUNY for HHCM by Parsons.



Case Scenario - Samantha

The IE arranges a meeting between the IE, HH and family to finalize Samantha and her family's knowledge and understanding of HH and enrollment options. On the call, the family is pleased to be informed that CHHUNY is able to enroll Samantha in HH and that Parsons is able to serve as her Care Management Agency (with appropriate firewalls between her CM and any HCBS or Behavioral Health services in place). Samantha and her family are given ample opportunity to ask questions of CHHUNY and the IE.

With verbal consent, Samantha is referred to CHHUNY HH and is assigned a HHCM at Parsons. Samantha and her family are told that the assigned HHCM will reach out to them to enroll them in HH.



Case Scenario - Samantha

The HHCM completes a CANS-NY and Comprehensive assessment which will support the person-centered planning process.

Through the person-centered planning discussion, Samantha and her family identify interest in Community Self Advocacy and Training (CSAT) and Respite. The HHCM discusses goals Samantha wishes to achieve related to these services and updates the Comprehensive Plan of Care (POC) accordingly.

The HHCM also verifies or contacts UnitedHealthcare to identify within Samantha's County what CSAT and Respite providers are available. The completed comprehensive POC is signed by Samantha and her parents and other available providers.



Case Scenario - Samantha

The HHCM makes referral to CSAT and Respite providers and **SIMULTANEOUSLY** submits the Comprehensive POC to UnitedHealthcare.

UnitedHealthcare acknowledges receipt of the Comprehensive POC inclusive of the HCBS and can now anticipate that providers will be notifying them shortly of an initial appointment.

Upon notification of Samantha's first appointment with the CSAT provider UnitedHealthcare is prompted to begin the clock on her **immediate authorization of 96 units, 24 hours not to exceed 60 calendar days of CSAT Services.**

After several appointments the CSAT provider, Samantha and family agree on a frequency, scope and duration of service which is then communicated to the HHCM by submission of the HCBS Provider Service Plan to the HHCM. UnitedHealthcare is also informed as the CSAT provider has submitted an Authorization Form to extend the authorization period. Following receipt, a new authorization period is agreed upon by the MMCP and provider.

This same process occurs in relation to Respite, once the Respite provider notifies UnitedHealthcare of an initial appointment.



Case Scenario - Thomas

Thomas is a 9 month old boy who has been in the hospital since birth. Thomas has several medically fragile conditions and a suspected Developmental Disability. He will need medical support in order to leave the hospital and go home with his family. In order for Thomas to be discharged from the hospital, the hospital social worker reaches out to the Independent Entity. Upon receipt of Thomas' referral, the IE educates the family on the role of the independent entity and HCBS. The IE works with the family to obtain appropriate materials to support and document that Thomas meets one or more of the HCBS/ LOC Criteria and HH Eligibility. The IE then completes the HCBS/LOC Eligibility Determination Tool housed within the UAS with Thomas and his family. Based on this, Medically Fragile Level of Care eligibility is established. The IE will also coordinate with the LDSS to establish Medicaid eligibility.

In this scenario, HCBS for Thomas can be accessed based on Medically Fragile LOC. While Thomas also is suspected to have a Developmental Disability (DD), this determination is not necessary in order to access services. There will be a subsequent referral to the DDRO for additional follow-up related to eligibility for DD.



Questions?

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Break – 15 mins



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Core Principles -- Reminder

Child Centered

Family Focused

Community Based

Multi-System

Culturally Competent

Least Restrictive/Least Intrusive



Children's Home and Community Based Services: Existing Services Moving into newly Aligned HCBS Benefit Array

	Health Home Care Management	Respite (Planned and Crisis)	Prevocational Services	Supported Employment	Caregiver/Family Supports and Services
Existing Services					
OMH SED Waiver	Individualized Care Coordination	Respite	Prevocational Services	Supported Employment	
OCFS B2H Waiver	Health Care Integration	Crisis and Planned Respite	Prevocational Services	Supported Employment	Family and Caregiver Support Services
CAH I/II Waiver	Care Coordination				
OPWDDCAH Waiver	Case Management	Respite			



Children’s Home and Community Based Services: Existing Services Moving into newly Aligned HCBS Benefit Array

	Community - Advocacy Training and Support	Habilitation	Adaptive and Assistive Equipment	Accessibility Modifications	Palliative Care	Customized Goods and Services	Non-Medical Transportation
Existing Services							
OMH SED Waiver							
OCFS B2H Waiver	Community Advocacy Training and Supports	Day Habilitation	Adaptive and Assistive Equipment	Accessibility Modifications			
CAH/II Waiver				Home and Vehicle Modifications	Palliative Care		
OPWDD CAH Waiver			Assistive Technology Adaptive Devices	Environmental Modifications			



Community Self-Advocacy Training and Supports

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What is Community Self-Advocacy Training and Supports?

- Provides family, caregivers, and collateral contacts with techniques and information not generally available so that they can better respond to the needs of the participant.
- Training (one-on-one or group) for the child/youth and/or the family/caregiver regarding methods and behaviors to enable success in the community.
- Direct self-advocacy training in the community with collateral contacts regarding the child/youth's disability(ies) and needs related to his or her health care issues.
- Self-advocacy training for the child/youth and/or family/caregiver, including during community transitions.



Why Offer Community Self-Advocacy Training and Supports?

- Intended to assist the child/youth, family/caregiver, and collateral contacts in understanding and addressing the participant's needs related to their disability(ies).
- May be provided to support the child/youth experiencing difficulty in community settings.
- Improves the child/youth's ability to gain from the community experience, and enables the child/youth's environment to respond appropriately to the child/youth's disability and/or health care issues.



Staff Qualifications

- **Minimum:** An individual employed by the agency with a bachelor's degree plus two years of related experience
- **Preferred:** An individual employed by the agency with a Master's degree in education, or a Master's degree in a human services field plus one year of applicable experience



Supervision

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



Caregiver/Family Supports and Services



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What are Caregiver/Family Supports and Services?

Based upon the Caregiver/Family Supports and Services plan developed by the child/youth and caregiver/family team, this service provides opportunities to:

- Interact and engage with family/caregivers and children/youth to offer educational, advocacy, and support resources to develop family/caregivers' ability to independently access community services and activities;
- Maintain and encourage the caregivers'/families' self-sufficiency in caring for the child/youth in the home and community;
- Address needs and issues of relevance to the caregiver/family unit as the child/youth is supported in the home and community; and
- Educate and train the caregiver/family unit on resource availability so that they might better support and advocate for the needs of the child and appropriately access needed services
- Direct instruction and guidance in the principles of children's chronic condition or life threatening illness.

Note: This service is not the State Plan service of Family Peer Support Services which is required to be delivered by a certified/credentialed Family Peer with lived experience.



Why Offer Caregiver/Family Supports and Services?

- Enhance the child/youth's ability regardless of disability (developmental, physical and/or behavioral) to function as part of a caregiver/family unit
- Enhance the caregiver/family's ability to care for the child/youth in the home and/or community

*Family is broadly defined, and can include families created through: birth, foster care, adoption, or a self-created unit.



Staff Qualifications

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



Supervision

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



Prevocational Services



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What are Prevocational Services?

- Services are intended to develop and teach general skills. Examples include, but are not limited to:
 - ability to communicate effectively with supervisors, co-workers and customers;
 - generally accepted community workplace conduct and dress;
 - ability to follow directions;
 - workplace problem solving skills and strategies;
 - proper use of job-related equipment and general workplace safety.
- Prevocational Services may include volunteer work, such as learning and training activities that prepare a person for entry into the paid workforce.
- Prevocational Services include activities that are not primarily directed at teaching skills to perform a particular job, but at underlying habilitative goals (e.g., attention span, motor skills, interpersonal relations with co-workers and supervisors) that are associated with building skills necessary to perform work and optimally to perform competitive, integrated employment. Activities could include but are not limited to:
 - Resume writing, interview techniques, role play and job application completion.
 - Exploring career options, facilitating appropriate work habits, acceptable job behaviors, and learning job production requirements
 - Assisting in identifying community service opportunities that could lead to paid employment
 - Helping youth to complete college, technical school or other applications to continue formal education/training
 - Helping youth to apply for financial aid or scholarship opportunities



Why Offer Prevocational Services?

- Individually designed to prepare a youth (age 14 or older) to engage in paid work, volunteer work or career exploration.
- Not job-specific, but rather are geared toward facilitating success in any work environment for youth whose disabilities do not permit them access to other prevocational services.
- To enable each participant to attain the highest level of work in the most integrated setting and with the job matched to the participant's interests, strengths, priorities, abilities, and capabilities, while following applicable federal wage guidelines from the U.S. Department of Labor



Modality

- This service may be delivered in the following ways:
 - A one-to-one session, or
 - In a group setting of up to two or three participants



Limitations and Exclusions

Prevocational services will not be provided to an HCBS participant if:

- i. Special education and related services that are otherwise available to the individual through a local educational agency, under the provisions of the Individuals with Disabilities Education Act (IDEA).
- ii. Vocational rehabilitation services that are otherwise available to the individual through a program funded under section 110 of the Rehabilitation Act of 1973 (Access VR).
- iii. Vocational services that are provided in facility based work settings that are not integrated settings in the general community workforce.



Staff Qualifications

- **Minimum:** Qualifications of an Associate's degree with one year human service experience
- **Preferred:** Qualifications of a Bachelor's degree with one year experience in human services working with children/youth

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Supervision

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



Supported Employment



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What is Supported Employment?

- Provide assistance to participants with disabilities as they perform in a work setting
- Services may include any combination of the following: vocational/job-related discovery or assessment, person-centered employment planning, job placement, job development, negotiation with prospective employers, job analysis, job carving, training and systematic instruction, job coaching, benefits support, training and planning, transportation, career advancement services, and other workplace support services including services not specifically related to job skill training that enable the participant to be successful in integrating into the job setting.
- Supported employment services may also include services and supports that assist the participant in achieving self-employment



Supported Employment Service Components

Supported employment services include the following:

- Supervision and training that are not job-related
- Intensive ongoing support
- Transportation to and from the job site
- Interface with employers regarding the individual's disability(ies) and needs related to his or her healthcare issue(s)
- Other activities needed to sustain paid work (e.g., employment assessment, job placement, and/or adaptive/assistive equipment necessary for employment)
- Job finding and development training in work behaviors
- Assessing the interest and fit of an individual for particular job opportunities, staff work with employers and job sites preparing them to be able to make necessary and reasonable accommodations
- On-site support for the individual as they learn specific job tasks
- Monitoring through on-site observation through communication with job supervisors and employers.



Why Offer Supported Employment?

- Provides ongoing supports to participants who, because of their disabilities, need intensive on-going support to obtain and maintain an individual job in competitive or customized employment, or self-employment
- Individually designed to prepare youth with disabilities (age 14 or older) to engage in paid work
- The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals.



Modality

- This service can only be provided on an individual basis through a face-to-face intervention

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Limitations and Exclusions

- Medicaid funds may not be used to defray the expenses associated with starting up or operating a business.
- Supported Employment service will not be provided to an HCBS participant if:
 - i. Special education and related services that is otherwise available to the individual through a local educational agency, under the provisions of the Individuals with Disabilities Education Act (IDEA).
 - ii. Vocational rehabilitation services that are otherwise available to the individual through a program funded under section 110 of the Rehabilitation Act of 1973.
 - iii. Supported employment does not include facility based, or other similar types of vocational services furnished in specialized facilities that are not a part of the general workplace.
 - iv. Supported employment does not include payment for supervision, training, support and adaptations typically available to other workers without disabilities filling similar positions in the business.
 - v. Supported employment does not include volunteer work. Such volunteer learning and un-paid training activities that prepare a person for entry into the paid workforce are addressed through pre-vocational services.
- Medicaid funding cannot be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
 - Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment;
 - Payments that are passed through to users of supported employment services.



Staff Qualifications

- **Minimum:** Qualifications of an Associate's degree with one year human service experience
- **Preferred:** Qualifications of a Bachelor's degree with one year experience in human services working with children/youth

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Supervision

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



Respite

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What is Respite?

- Short-term assistance provided to children/youth regardless of disability (developmental, physical and/or behavioral) due to the absence of, or need for, relief of the child or the child's family caregiver.
- Such services can be provided in a planned mode or delivered in a crisis situation.
- Respite workers supervise the child/youth and engage the child/youth in activities that support his/her and/ or primary caregiver/family's constructive interests and abilities.



Why Offer Respite?

- Offer services with a level of expertise in understanding and implementing behavioral/developmental interventions required to support optimal functioning for children/youth.
- Through communication of the details of the child/youth's intervention plan there is a carryover of skill from the respite source to the caregivers and treatment providers.



Respite Service Components

- Planned
- Crisis

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Planned Respite

- Short-term relief for the child or family/primary caregivers that are needed to enhance the family/primary caregiver's ability to support the child/youth's functional, developmental, behavioral health and/or health care needs.
- This service is direct care for the child/youth by individuals trained to support the child/youth's needs.
- This may occur in short-term increments of time (usually during the day) or on an overnight or longer-term increment.
- Planned Respite activities support the plan of care goals and include providing supervision and activities that match the child/youth's developmental stage and continue to maintain the child/youth health and safety.



Modality

Planned Respite can be provided in the following ways:

- Non-Overnight
 - One to one; Individual
 - Small group up to three youth
- Overnight: Approved/Allowable setting
 - Can be delivered with the support of an additional one to one staffing to child ratio (1:1) when needed and indicated in the child's service plan overseen by the respite provider.



Crisis Respite

- Short-term care and intervention strategy for children/youth and their families that helps to alleviate the risk for an escalation of symptoms, a loss of functioning, and/or a disruption in a stable living environment.
- May be used when challenging behavioral or situational crises occur which the child/youth and/or family/caregiver is unable to manage without intensive assistance and support.
- Crisis Respite can also be used as a result of crisis intervention or from visiting the emergency room.
- Crisis Respite should be included on the POC to the extent that it is an element of the crisis plan or risk mitigation strategy.
- Services offered may include: site-based crisis residence, monitoring for high risk behavior, health and wellness skill building, wellness activities, family/caregiver support, conflict resolution, and other services as needed.
- At the conclusion of a Crisis Respite period, crisis respite staff, together with the child/youth and family/primary caregiver, and his or her established behavioral health or health care providers when needed, will make a determination as to the continuation of necessary care and make recommendations for modifications to the child's plan of care. Children are encouraged to receive Crisis Respite in the most integrated and cost-effective settings appropriate to meet their respite needs. Out of home Crisis Respite is not intended as a substitute for permanent housing arrangements.



Modality

Crisis Respite can be provided in the following ways:

- Non-Overnight:
 - One to one; Individual
- Overnight: Approved/Allowable overnight setting
 - Can be delivered with the support of an additional one to one staffing to child ratio (1:1) when needed and indicated in the child's service plan overseen by the respite provider.



Staff Qualifications

- Provision of service in child's residence or other community-based setting (e.g. park, shopping center, etc.):
 - Respite providers are paraprofessionals with a high school diploma or equivalent and with appropriate skills and training. It is the responsibility of the Care Coordinator to ensure that providers have adequate training and knowledge to address the individual child's needs (including but not limited to physical and/ or medical needs such as medications or technology).
 - has experience working with children/youth (preference given to those with experience working with children/youth with special needs);
 - A high school diploma, high school equivalency preferred or a State Education Commencement Credential (e.g. SACC or CDOS)



Allowable Settings

- Provision of service outside child's residence and in an allowable licensed/certified setting:
 - In a foster boarding home: Respite providers must be a Licensed Foster Parent pursuant to Part 435 of 18 NYCRR
 - In a OCFS licensed/certified setting: Respite providers are paraprofessionals with a high school diploma or equivalent and with appropriate skills and training. Settings include an agency boarding home, a group home, a group residence, or an institution
 - In an OMH-certified Community Residence (community-based or state operated), including Crisis Residence, which has an OMH Operating Certificate demonstrating compliance with 14 NYCRR 594: Respite workers must be staff of the licensed program.
 - In an OPWDD-certified setting: (community-based or state operated), Family Care Home; Intermediate Care Facility for Individuals with Intellectual and Developmental Disabilities (ICF/IDD); Individualized Residential Alternative (IRA); Community Residence (CR); or Free-Standing Respite facility under the auspices of OPWDD in compliance with 14 NYCRR Parts 633, 635 and 686.



Limitations and Exclusions

- *Note: Services to children and youth in foster care must comply with Part 435 of 18 NYCRR* Respite is not an allowable substitute for permanent housing arrangements. Children and youth in foster care may only receive *overnight respite* in a certified/licensed setting.
- For respite services that may be provided as crisis or overnight, Federal Financial Participation is not claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.
- Please note: It is the responsibility of the Care Coordinator upon referral to ensure that respite providers have adequate training and knowledge to address the individual child/youth's needs (including but not limited to physical and/ or medical needs such as medications or technology), *OR* have made arrangements for an appropriately trained and knowledge individual to address the individual child/youth's needs (including but not limited to physical and/ or medical needs such as medications or technology. Examples include arrangement of approved Private Duty Nurse for a technology dependent child while in a respite setting.



Supervision

- **Minimum:** a Bachelor's degree with one year experience in human services working with children/youth.

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Palliative Care

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What is Palliative Care?

- Specialized medical care focused on providing relief from the symptoms and stress of a chronic condition or life threatening illness.
- It is appropriate at any stage of a chronic condition or life threatening illness and can be provided along with curative treatment
- Types of activities included:
 - Pain and Symptom Management – Relief and/or control of the child's suffering related to their illness or condition.
 - Bereavement Service – Help for participants and their families to cope with grief related to the participant's end-of-life experience. Bereavement counseling services are inclusive for those participants in receipt of hospice care through a hospice provider.
 - Massage Therapy – To improve muscle tone, circulation, range of motion and address physical symptoms related to their illness.
 - Expressive Therapy (art, music and play) – Help children better understand and express their reactions through creative and kinesthetic treatment.



Why Offer Palliative Care?

- The goal is to improve quality of life for both the child and the family. Palliative care is provided by a specially-trained team of doctors, nurses, social workers and other specialists who work together with a child's doctors to provide an extra layer of support.
- Expanded service array and HCBS eligibility makes these services more accessible



Modality

- Pain and Symptom Management – 1:1
- Bereavement Service – 1:1, family eligible to participate
- Massage Therapy – 1:1
- Expressive Therapy (art, music and play) – 1:1



Limitations and Exclusions

- Palliative care benefits may not duplicate Hospice or other State Plan benefits accessible to participants.

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Agency Qualifications

- Certified Home Health Agency (CHHA);
- Hospice Organization; or
- Article 28 Clinic

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Staff Qualifications

- A minimum of three years working with the medically fragile population and at least one year of clinical experience with pediatric population, preferably involving end of life care.
- Varies by component
 - **Pain and Symptom Management:** Pediatrician or Family Medicine Physician, board certified in Pediatrics or Family Medicine licensed by the State of New York, a Nurse Practitioner licensed by the State of New York (Pain and Symptom Management)
 - **Bereavement Service:** A Licensed Clinical Social Worker (LCSW), a Licensed Master Social Worker (LMSW), a Licensed Psychologist or a Licensed Mental Health Counselor, that meet current NYS licensing
 - **Massage Therapy:** Massage Therapist currently licensed by the State of New York.
 - **Expressive Therapy (art, music and play):** Child Life Specialist with certification through the Child Life Council a Creative Arts Therapist licensed by the State of New York ,a Music Therapist with a Bachelor's Degree from a program recognized by the NYS Education Department, or a Play Therapist with Master's Degree, from a program recognized by the New York State Education Department and a current Play Therapist Registration conferred by the Association for Play Therapy (Expressive Therapy (Art, Music and Play)).



Questions?

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Resources

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Resources and Information

Please specify if kids system/managed care specific in subject line:

NYS OMH Managed Care Mailbox

OMH-MC-Children@omh.ny.gov

NYS OASAS Mailbox:

PICM@oasas.ny.gov

NYSDOH Health Homes for Children:

HHSC@health.ny.gov

NYS OCFS Mailbox:

OCFS-Managed-Care@ocfs.ny.gov

Children's Managed Care Design:

http://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health_reform.htm



Additional Resources

RESOURCES TO STAY INFORMED:

- Subscribe to children's managed care listserv
<http://www.omh.ny.gov/omhweb/childservice/>
- Subscribe to DOH Health Home listserv
http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/listserv.htm
- Health Home Bureau Mail Log (BML)
https://apps.health.ny.gov/pubdoh/health_care/medicaid/program/medicaid_health_homes/emailHealthHome.action



Additional Resources

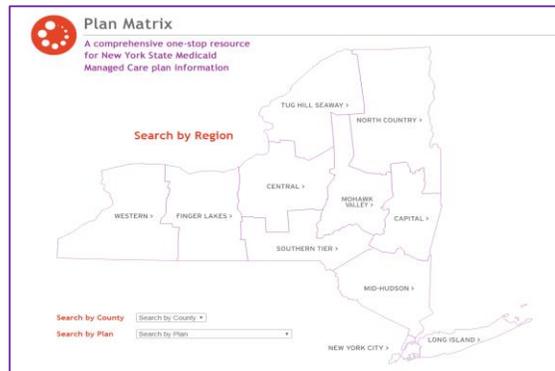
Webinars on Children's System Transformation

- April 19th Children's SPA/HCBS Provider Designation and Authorization Processes Webinar https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/2018-04-19_provider_designation_and_authorization.pdf
- April 24th Children's Medicaid Redesign and Transition to Managed Care Updates https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/childrens_medicaid_redesign_4.24.18.pdf
- May 23rd Children's Medicaid System Transformation DRAFT HCBS Workflow for Stakeholder Comment <https://ctacny.org/training/childrens-Medicaid-system-transformation-draft-hcbs-workflow>



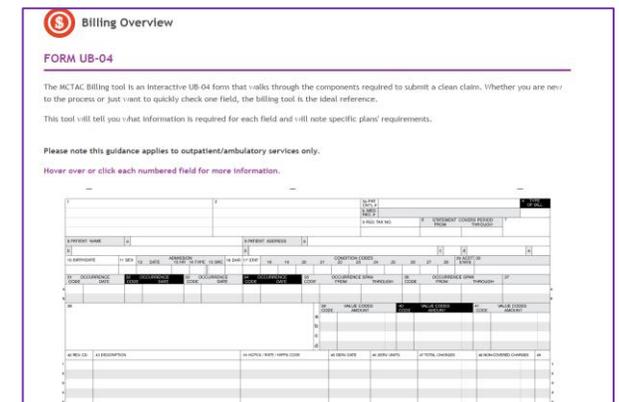
Tools

Select the **Tools** Tab at www.ctacny.org



Managed Care Plan Matrix – comprehensive resource for MCO contact information relevant to adults and children

Billing Tool – Children System specific updates –coming soon!



Output to Outcomes Database – access to standardized outcome measurement tools and metrics (database) designed to facilitate and improve use of evidence based practices.



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Questions

Please send questions to:
mctac.info@nyu.edu

Logistical questions
usually receive a response
in 1 business day or less.

Longer & more complicated
questions
can take longer.

We appreciate your interest and
patience!



Visit www.ctacny.org to view past trainings, sign-up for updates and event announcements, and access resources



APPENDIX

Medicaid Managed Care Service Authorization Review Process

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Medicaid Managed Care Service Authorization Review Process

- Where MMCP may make determinations of coverage, MMCPs must respond to service authorization requests in specified timeframes and with notice and appeal rights as per the Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract
- Effective May 1, 2018, review times and procedures have been revised to comply with federal regulations at 42 CFR 438 published May 6, 2016
- See the Department of Health's website for more information:
 - https://www.health.ny.gov/health_care/managed_care/plans/appeals/index.htm



Medicaid Managed Care Service Authorization Timeframes

- **New request**, MMCP must make determination and notice in
 - Expedited, 72 hours from request
 - Standard, 3 work days from all info and no more than 14 days from request
- **Concurrent Review** (request for more of or continued services) determine and notice in
 - Expedited, 1 work day from all info and no more than 72 hours from request
 - Standard, 1 work day from all info and no more than 14 days from request
- May be extended up to 14 days if:
 - plan needs more info and in member's best interest to extend
 - Enrollee or provider requests extension
- Verbal and written notice made to enrollee and provider
- Adverse determinations must include appeal rights



Medicaid Managed Care Service Authorization Review Process

- **Retrospective review:** 30 days after all information
- **Special timeframes for other requests:**
 - If enrollee is in the hospital or has just left the hospital and the request is for home health care: 72 hours of request (may be extended)
 - If enrollee is receiving inpatient substance use disorder treatment, and request for more services at least 24 hours before discharge: within 24 hours of request
 - If request is for mental health or substance use disorder services that may be related to a court appearance: within 72 hours of request
 - If request is an outpatient prescription drug: within 24 hours of request



Medicaid Managed Care Service Authorization Process

- Plan issues initial adverse determination when
 - Denying a request or claim for a service
 - Partially approving a requested service
 - Reducing/terminating an already approved service
- Plan reason for denial must 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



Medicaid Managed Care Service Authorization Process

- Possible next steps:
 - Discuss alternate service options with MMCO care manager
 - MMCOs must arrange for services to meet care needs
 - Request specific clinical review criteria used
 - File appeal with MMCO; include documented support for requested service
 - File external appeal or fair hearing (must file Plan Appeal first, with some exceptions)
 - Contact NYS Department of Health for issues with process, access to or quality of care



Medicaid Managed Care - Plan Appeals

- Enrollees have at least 60 days from the date of the initial adverse determination to request a Plan Appeal
- Plan determines appeal in:
 - Expedited, 2 work days all info and no more than 72 hours from appeal
 - Standard, 30 days from appeal
- All may be extended up to 14 days if:
 - plan needs more info and in member's best interest to extend
 - Enrollee or provider requests extension
- Notice to enrollee and provider:
 - Expedited verbal notice at time of decision, written in 24 hours.
 - Standard written notice within 2 work days of decision.



Medicaid Managed Care External Appeal

- External Appeal is conducted by clinical reviewer that doesn't work for the plan or State
- Available when MMCP denies a covered service as:
 - not medically necessary;
 - experimental/investigational;
 - not different from care available from a provider in the plan's network, or
 - available from a participating provider who has the correct training and experience to meet the enrollee's needs.
- Enrollees have 4 months to file external appeal after receiving the final adverse determination
 - Plan and enrollee may jointly agree to waive internal process, file EA within 4 months of this agreement
 - If filing expedited Plan Appeal, enrollee may file expedited external appeal at the same time
 - If plan does not follow the Plan Appeal process correctly, enrollee may directly file external appeal
- Providers have independent right to external appeal for concurrent and retrospective reviews – must file in 60 days from adverse determination



Medicaid Managed Care Fair Hearing

- Fair Hearing is conducted by an administrative law judge from the Office of Administrative Hearings.
- An enrollee has the right to ask the State for a Fair Hearing about a plan's initial adverse determination **after** the enrollee has first asked for a Plan Appeal **and**:
 - The enrollee receives a Final Adverse Determination. The enrollee will have 120 days from the date of the Final Adverse Determination to ask for a Fair Hearing;
- **OR**
 - The time for the MMCP to decide the Plan Appeal has expired, including any extensions (the MMCP response is late or is not received).
- If the enrollee asks for both external appeal and a fair hearing, the fair hearing is the final decision.



Medicaid Managed Care Fair Hearing

- Enrollees and providers may file a complaint regarding managed care plans to DOH
 - 1-800-206-8125
 - managedcarecomplaint@health.state.ny.us
- 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.

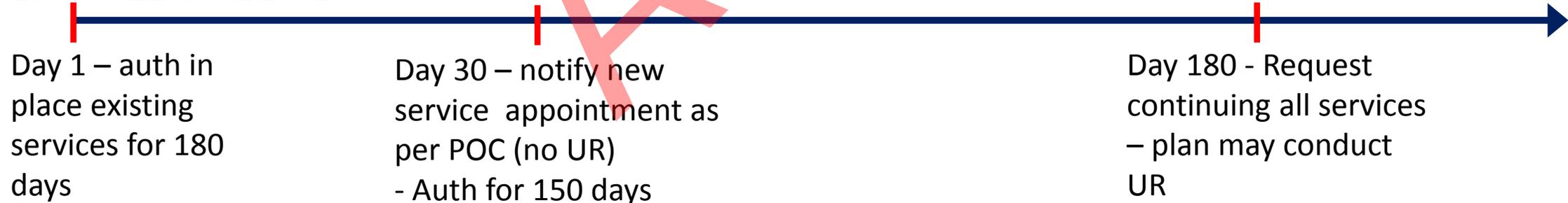


Service Authorization - Managed Care Environment

Continuity of Care Requirements for the Children's System Transformation

- No authorization or utilization review for the first 180 days of the transition – 1/1/19-6/30/19
 - For a transitioning child, MMCP will not review services added to the POC for medical necessity or appropriateness during this time period
 - All POCs will be provided to the MMCP as part of the transition, and the MMCP will use this information to authorize existing services the child is currently receiving
 - 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



Service Authorization - Managed Care Environment

Continuity of Care

- 7/1/19 and thereafter, no utilization review for the first 180 days for a child who is in receipt of HCBS is newly enrolled in the plan from FFS (for first two years of transition)
 - MMCP will use existing POC to authorize existing services the child is currently receiving
 - MMCP will not review services 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
- After the first 180 days, the plan may begin to review authorization request for medical necessity/appropriateness – conduct utilization review

EXAMPLE TIMELINE

