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CHILDREN'S HCBS COLLABORATIVE STAKEHOLDER MEETING

DECEMBER 12, 2024

PURPOSE

To provide a forum for Children's Home and Community Based Service (HCBS) Providers, Medicaid Managed Care Plans (MMCPs), Health Homes (HHs), and Care Management Agencies (CMAs) to share insights, align on key issues, and collaboratively address concerns.

Provide an opportunity for Children's HCBS stakeholders to **discuss barriers** and be a part of the **problem-solving discussion**.

Specific Stakeholder Group Topics can be discussed in a monthly meeting with that stakeholder group

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AGENDA

- ✓ Survey Topics
- ✓ Purpose of HCBS
- ✓ HCBS Workflow:
  - Care Manager (CM) Role
  - HCBS Provider Role
  - MMCP Role & Fee-for-Service (FFS) Authorization Process
- ✓ Communication Between Entities
- ✓ Discussion
- ✓ Next Meeting & Contact Information

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SURVEY TOPICS

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STAKEHOLDER SURVEY

*Thank you to everyone who completed the Collaborative Stakeholder Meeting Survey. The Department received **131 responses**. The following questions were asked to solicit agenda items for today's meeting:*

Please select your Organization/Agency type:

1. MMCP
2. HHSC
3. HCBS Provider
4. CMA

Please provide contact information for the individual completing this survey:

- Name of Organization
- Name of Person Completing Survey
- Email Address
- Phone Number

Please choose up to three (3) topics you would like to discuss:

- ❑ HCBS Authorization Process
- ❑ Incident Reporting and Management System (IRAMS)
- ❑ Referral & Authorization Portal
- ❑ Consents
- ❑ HCBS Referrals
- ❑ Communication Between Entities
- ❑ HCBS Eligibility
- ❑ K-codes
- ❑ HCBS Services (definitions, allowances, etc.)
- ❑ Other (please specify)

If there are additional details or context related to the topics you would like to cover during the meeting, please provide below:

_____

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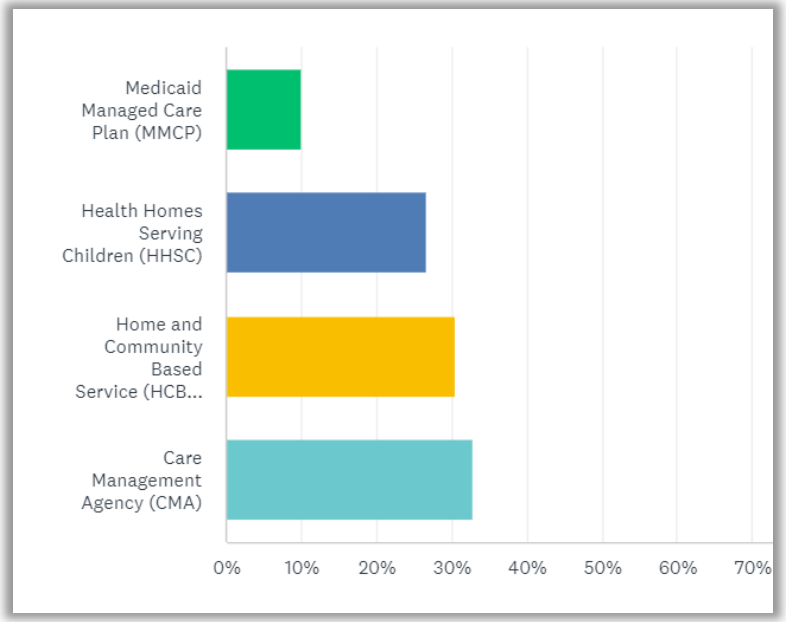
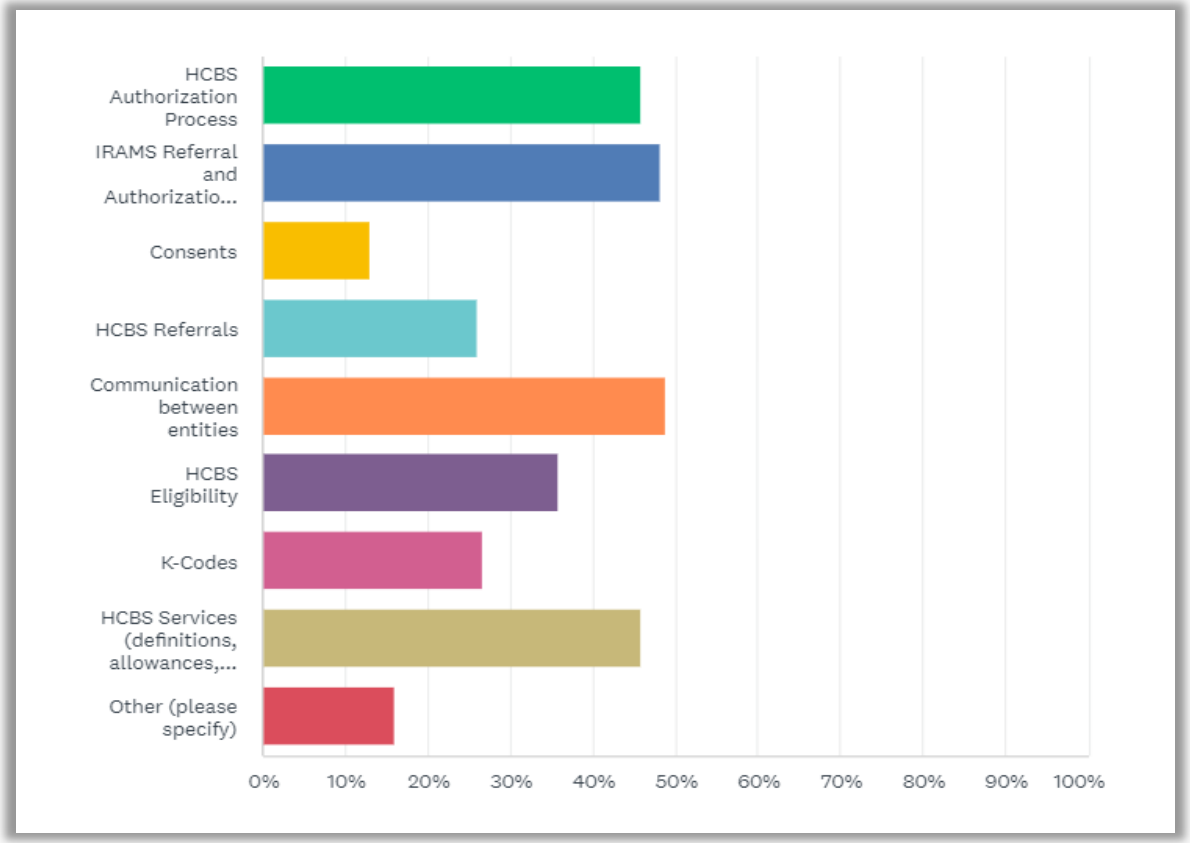
STAKEHOLDER SURVEY

*Thank you to everyone who completed the Collaborative Stakeholder Meeting Survey. The Department received **131 responses**. The following questions were asked to solicit agenda items for today's meeting:*

Please select your Organization/Agency type:



Please choose up to three (3) topics you would like to discuss:



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STAKEHOLDER SURVEY

*Taken from **394 selections** and **131 total respondents**, the top suggested agenda topics include:*

1. **Communication Between Entities** (48.85% - 64 selections)
2. **HCBS Authorization Process** (45.04% - 59 selections)
3. **HCBS Eligibility** (34.35% - 45 selections)

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PURPOSE OF HCBS

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PURPOSE OF HCBS

To be eligible for HCBS, participants must have a medical condition, developmental disability, and/or serious mental health disorder impacting their daily functioning that places them at imminent risk of hospitalization or institutionalization, or results in the need for supports to return safely home and to their community after discharge from an institutional level of care.

Participants must be under 21 years of age and enrolled in Medicaid or eligible for Medicaid.

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For more information, please reference the HCBS Eligibility & Enrollment Policy

What are your most pressing questions about the purpose of HCBS?

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CARE MANAGER ROLE

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CARE MANAGER

Determine if the participant is in need of HCBS due to high needs/high risk of institutionalization.

Considerations prior to conducting HCBS Eligibility:

- ✓ What other interventions and services have been tried or can be utilized prior to HCBS?
- ✓ Based upon the need of the participant, can other State Plan Services meet their need(s)? *State Plan services **MUST** be used prior to HCBS.*
- ✓ Have the other involved providers/practitioners been consulted and in agreement that HCBS is needed to support the other services involved?

*HCBS should **not** be the only service the participant is receiving to support their high needs/high risk.*

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CARE MANAGER

The care manager is responsible for the **coordination of care, services, and supports** for the participant. The care manager also conducts the **HCBS Eligibility Determination and develops the Plan of Care (POC)**.

Coordination includes education of care management and Waiver services, and the ability to obtain the appropriate and required documentation needed to support enrollment in Health Home and Waiver services.

*Concerns regarding the participant's HCBS eligibility by the MMCP or HCBS provider, should be brought to the attention of the lead Health Home/Children and Youth Evaluation Services (C-YES) and the Department **simultaneously** for follow-up.*

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HCBS REFERRAL

The care manager must know and understand each HCBS, and which service can address the participant's assessed need(s).

When making a referral:

- ✓ The need(s) that the participant want to address must be defined,
- ✓ Specific goal(s) must be identified, and
- ✓ Referrals and goals must align with the service purpose and how they can be provided

Once an HCBS provider is selected, there should be ongoing communication between the care manager and HCBS provider. The care manager should share information beyond the referral and ensure that the HCBS provider is invited to Interdisciplinary Team (IDT) meetings.

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PARTICIPANT/FAMILY EDUCATION

The care manager must educate the participant and family on the following:

- ✓ Purpose of HCBS,
- ✓ participant's requirement to receive other services beyond HCBS,
- ✓ Requirement to conduct an annual HCBS eligibility assessment,
- ✓ Requirement for State Plan services to be utilized prior to HCBS,
- ✓ HCBS are supportive and short-term intervention services,
- ✓ Requirement for the participant and family to participate in services and in the development of the service plan, and
- ✓ All services must be delivered in accordance with the Waiver.

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What are your most pressing questions about the role of the care manager?

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HCBS PROVIDER ROLE

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HCBS PROVIDER

HCBS providers must have knowledge and understanding of the HCBS they are designated to provide.

Referral Evaluation:

- ✓ Are the participant's high needs/high risk clearly outlined?
- ✓ Are the need(s) of the participant identified?
- ✓ Can the identified need(s) be addressed by the referred service?
- ✓ Are the goal(s) outlined, able to be addressed by the service, and align with the service definition?
- ✓ Is there enough information regarding the participant, including their condition, schedule, etc.?

The HCBS provider should only accept the referral, if they believe they can serve the participant and have enough information to schedule a first appointment.

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INITIAL SERVICE PERIOD – SERVICE PLAN

The HCBS provider will work with the care manager and participant/family to schedule the first appointment and subsequent appointments, as needed, and notify the MMCP, if appropriate.

During the initial service period, the HCBS provider will work with the participant and family to:

- ✓ Conduct an intake assessment, identifying how the referred service will help address the identified need(s),
- ✓ Educate the participant and family on the HCBS,
- ✓ Work with the care manager to gather information and documentation,
- ✓ Participate in Interdisciplinary Team meetings and collaborate with other involved professionals/services,
- ✓ Finalize service goals and objectives,
- ✓ Determine appropriate frequency, scope, and duration (F/S/D) for the service, **and**
- ✓ **Develop the HCBS Service Plan, within 30 days of the first appointment.**

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IDENTIFYING SERVICE DELIVERY

The participant and family must be involved in the development of the Service Plan and provide feedback surrounding service delivery. However, they **do not dictate** the F/S/D or how the service is provided.

The HCBS provider will validate the participant's need(s) and that the referred service is appropriate to meet the need(s).

The HCBS provider **will document the approach to service delivery** on the HCBS Service Plan, **outlining goals, objectives, and F/S/D** to address the need(s).

The HCBS provider will specifically outline the activities (curriculum) that will be provided to meet the specific need(s).

Services must be provided in accordance with the service definition, purpose, and Waiver requirements. **F/S/D is dependent upon the need and the specific identified activities and objectives to be provided to achieve the goal(s).**

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AUTHORIZATION DEVELOPMENT

The HCBS Provider must know and understand each HCBS and which service can address the participant's assessed need(s).

When developing the authorization:

- ✓ The need(s) that the participant want to address must be defined
- ✓ Specific goal(s) must be identified,
- ✓ Objectives/activities must be outlined that indicate **specifically** how the service will be provided to reach the goal,
  - More than one objective can be identified with different timelines to meet a goal,
- ✓ Goals and objectives must align with the service purpose and how they can be provided.
- ✓ **Frequency/Scope/Duration align with the identified implementation of the objectives/activities and service purpose.**

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INITIAL SERVICE PERIOD – SERVICE PLAN

The HCBS Provider must make any needed updates to the service plan as a result of the authorization determination.

REQUEST FULLY APPROVED or DENIED

Notification of authorization finalization is sent through the Portal to the care manager.

REQUEST PARTIALLY APPROVED

The HCBS Provider must notify the care manager outside of the Portal of any adjusted F/S/D. The care manager will use the information provided by the provider to update the Plan of Care.

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What are your most pressing questions about the role of the HCBS Provider?

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MMCP ROLE & FFS AUTHORIZATION PROCESS

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NOTIFICATION OF FIRST APPOINTMENT

Once scheduled, the **HCBS provider informs the care manager and MMCP** of the first appointment.

Upon receipt of notification of the first appointment, the **MMCP will establish the provider in their claim systems** to authorize payment up to 60 days/96 units/24 hours.

The Initial Service Period of 24 hours/60 days/96 units begins on the **first date of billable service delivery**.

This will be the date the initial intake assessment takes place.

*The notification of the first appointment is **not completed through a formal authorization request** generated in the Portal. This brief notification should take place through a mechanism agreed upon between the MMCP and the HCBS provider and should include only the information needed for the MMCP to configure their system for claims submission.*

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AUTHORIZATION

The MMCP/FFS staff must have knowledge and understanding of the HCBS.

Authorization Evaluation:

- ✓ Are the need(s) of the participant identified?
- ✓ Can the identified need(s) be addressed by the service?
- ✓ Are the goal(s) outlined, able to be addressed by the service, and align with the service definition?
- ✓ Are there clear objectives/activities outlined to understand how the service would be provided?
- ✓ Is there the enough information regarding the participant, including their condition, schedule, etc.?
- ✓ Does F/S/D align with the objectives/activities and other information provided above?

The MMCP/FFS should only approve authorizations that align with the purpose of HCBS, service definition/purpose, DOH policy, and Waiver requirements.

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COLLABORATION

MMCP/FFS should work with HCBS providers regarding the completion of authorization, the documentation needed to support Frequency/Scope/Duration and ensuring appropriate service delivery according to needs of the participant and Waiver requirements.

MMCP/FFS should utilize the care manager's Plan of Care, information within the Uniform Assessment System (UAS) and the Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS) to support other information needed about the participant/family regarding needs and service history

MMCP should participate in interdisciplinary team meetings or other conference calls with HCBS providers and care managers to address service delivery needs and barriers the participant encounters with services.

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What are your most pressing questions about the role of the MMCP?

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CONTINUITY OF CARE: MMCP TO MMCP

What to do when a participant transfers from one MMCP to another:

For a participant who has a current active/approved authorization, the HCBS provider will continue to provide services based on the formerly approved F/S/D up to 60 days from the date of enrollment or end of the existing authorization period, whichever comes first.

The new MMCP must honor the existing authorization for 60-days from the date of enrollment or end of the existing authorization period, whichever comes first.

HCBS provider must notify the new MMCP and submit a **copy of the previous MMCP's approved authorization** and **letter**, including the authorization period and approved F/S/D within **5 days** of becoming aware of the enrollment change.

If there is a continued need for HCBS beyond the transition period, the HCBS provider must submit a new authorization request **14 days prior** to the end of the existing authorization period/60 days.

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CONTINUITY OF CARE: FFS TO MMCP

What to do when a participant transfers from FFS to an MMCP:

The HCBS provider will **continue to provide services according to the F/S/D** submitted to the care manager on the Children's HCBS Authorization Request for up to 90-days from the date of enrollment in the MMCP or until the end of the existing F/S/D period, whichever comes first.

PLEASE NOTE: With FFS now being in the Referral & Authorization Portal, this process will be updated to align with the 60-days MMCP process, if the previous authorization is in the Portal.

The **HCBS provider must notify the new MMCP** and submit a **copy of the previous approved authorization**, including the authorization period and approved F/S/D within **5 days** of becoming aware of the enrollment change.

If there is a continued need for HCBS beyond the transition period, the HCBS provider must submit a new authorization request **14 days prior** to the end of the existing authorization period/90-days.

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CONTINUITY OF CARE: MMCP TO FFS

What to do when a participant transfers from an MMCP to FFS:

For a participant who has a current active/approved authorization, the HCBS provider will continue to provide services based on the approved F/S/D up to 60-days from the date of enrollment or end of the existing period, whichever comes first.

DOH will honor the existing authorization for 60-days from the **date of enrollment in FFS Medicaid** or until the end of the exiting authorization period.

The HCBS provider must notify the Department and submit a **copy of the previous MMCP's approved authorization** and **letter**, including the authorization period and approved F/S/D within **5 days** of becoming aware of the enrollment change.

If there is a continued need for HCBS beyond the transition period, the HCBS provider must submit a new authorization request **14 days prior** to the end of the existing authorization period/60-days.

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FEEDBACK REQUESTED: WHEN IS A NEW AUTHORIZATION REQUIRED?

Event	Authorization Request Generated in Portal	Notification to MMCP	Notification to the Department (FFS enrollees)
Notification of first service date	No - an Authorization Request generated through the portal is not used to notify of the first service date.	Yes - the HCBS provider must notify the MMCP outside of the portal of the first date of service.	No – there is no requirement to notify DOH of the first service date. This information will be included on an authorization request, once submitted.
Updated F/S/D of services	Yes - if a new F/S/D is needed for services, a new Authorization Request must be submitted.	No - the updated Authorization request will be issued to the MMCP; no separate notification is required.	No - the updated Authorization request will be issued to the Department; no separate notification is required.
Updated service goals	No - if service goals change after an authorization is approved, this change is not required to be reported in the Portal.	No - if service goals change after an authorization is approved, this change is not required to be reported to the MMCP.	No - if service goals change after an authorization is approved, this change is not required to be reported to the Department.
CFASS staffing change	Maybe - Refer to Appendix C of the HCBS Authorization Instructional Guide for further information.	Maybe - Refer to Appendix C of the HCBS Authorization Instructional Guide for further information.	No - an alert to the Department is not required for CFASS staffing changes that occur to FFS enrollees.
Updated Service Modality	Yes - if there is a change in service modality (e.g., individual to group sessions), a new authorization request must be submitted.	No - the updated Authorization request will be issued to the Plan; no separate notification is required.	No - the updated Authorization request will be issued to the Department; no separate notification is required.

What are your most pressing questions about the authorization process?

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REFERRAL & AUTHORIZATION PORTAL

FEEDBACK, IDEAS, SUGGESTIONS

Contact us
Please email *Health Homes* with a subject line:
"IRAMS Questions Only – No PHI*"

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**Protected Health Information (PHI)*

COMMUNICATION BETWEEN ENTITIES

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COMMUNICATION EXPECTATIONS

From determining eligibility for HCBS, obtaining service authorization, and service provision, it is imperative that all involved individuals and organizations maintain lines of communication to efficiently support the needs of the participant.

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CARE TEAM/INTERDISCIPLINARY TEAM

Care Team or Interdisciplinary Team: The providers, identified family supports, family members, MMCP, and other individuals or entities that the participant/family identified to be involved in the participant's care coordination and service provision.

The care manager is responsible for determining eligibility for HCBS and facilitating collaboration between IDT members.

The IDT is responsible for **communicating as a group** and **serving in the best interest** of the participant to determine eligibility for HCBS and ensure the participant receives the proper services based on identified needs.

If the participant is disenrolled from the Children's Waiver, the care manager is **responsible for notifying HCBS providers, MMCPs, and all other team members** of the disenrollment.

The care manager will **schedule care team meetings, invite the HCBS provider(s) and MMCP,** and update the Plan of Care (POC), as appropriate.

MMCP and HCBS providers can request an IDT.

HCBS providers and MMCPs who are unable to attend an IDT meeting have the ability to provide feedback to the care manager outside the IDT.

EXPLICIT COMMUNICATION REQUIREMENTS

Communication with the family may be **by phone** or other **regular communication methods** *(unless otherwise outlined)*

C-YES (light-touch) must contact the family, MMCP, and HCBS Provider *at least* **once per quarter** (three months)

Health Home Care Managers (HHCMs) (intensive) must contact the family per acuity and need. HCBS provider *at least* **once per month.** HHCMs must contact the MMCP whenever there are barriers to service.

Note: *These required, periodic check-ins may be combined with a regularly scheduled meeting or contact with the participant and family.*

If there is a concern regarding the participant and family's **interest in continuing HCBS,** and regularly occurring issues, then the care manager or MMCP, as applicable, should review HCBS with the participant, family, and care team quarterly to determine if HCBS should be continued, terminated, or changed, and/or if a referral to a different provider or service is needed.

REFERRAL & AUTH. PORTAL COMMUNICATION

The Referral & Authorization Portal is **not** intended to replace the need for communication between Health Home (HH)/C-YES care managers and HCBS Providers.

Care managers and HCBS providers are expected to maintain open communication outside of the system.

HCBS providers **should be obtaining feedback** from the CM and other involved IDT members on the development of the HCBS Service Plan including service goals and F/S/D.

If **HCBS providers have questions about a participant's eligibility**, the provider should reach out to the care manager outside of the Referral & Authorization Portal.

If **providers are struggling to contact the care manager,** the provider should reach out to the participant's lead HH.

Continued contact concerns with any specific CMA or C-YES should be directed to the New York State Department of Health (the Department) at *HealthHomes@health.ny.gov*.

COMMUNICATION METHODS

Care Team contact information should be added to the Child Case Page in the **HCBS Referral & Authorization Portal** in the Incident Reporting and Management System (IRAMS) **including contact name, role, email address, and phone number**.

MMCP contact information may be accessed through the ***MMCP Contact Matrix***.

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What barriers to communication exist? What other questions are there about communication?

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NEXT MEETING & CONTACT INFORMATION

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NEXT MEETING & CONTACT INFORMATION

Next Scheduled Stakeholder Collaborative Meeting:

- February 10th, 2025, from 10:00 AM – 12:00 PM
  - **Registration Link:**
    https://meetny-gov.webex.com/weblink/register/r746a76973fd23e12ed8501598bb85af5

The Department would like to discuss topics of interest to the HCBS providers, MMCPs, and CMAs and hear suggestions and ideas for improvement.

Please submit your questions to BH.Transition@health.ny.gov.

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CONTACT US

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

For the **Referral & Authorization Portal, Staff Compliance, and HCBS Service Critical Incidents/Grievances** questions, email *Health Homes* with a subject line of "IRAMS Questions Only – No PHI"

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

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

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APPENDIX

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WORKFLOW: ELIGIBILITY TO AUTHORIZATION

1. The care manager completes the initial Level of Care (LOC) Eligibility Determination
2. The care team develops the Person-Centered POC, discusses and decides on relevant HCBS
3. The care manager submits a referral to an HCBS provider; HCBS provider accepts referral
4. Initial service period (24 hours/60 days/96 units); HCBS provider completes intake and develops the Service Plan with the participant and family
5. HCBS provider submits an authorization request to deliver HCBS; the MMCP or the Department (for Fee-for-Service), issue an authorization determination
6. No later than six months later, the HCBS provider will submit a new authorization (re-auth) to continue to deliver the service, if needed
7. Once determined appropriate, the participant may be discharged and potentially disenrolled from the Children's Waiver; the participant and family have the right to a Fair Hearing with Aid to Continue
8. If enrolled in the Children's Waiver, the annual HCBS Eligibility Determination is completed by the care manager

DEVELOPING SERVICE GOALS & OBJECTIVES

1. Goals must be Specific, Measurable, Attainable, Relevant, and Timely (SMART).
2. Goals must be specific to the Service definition and what is allowable for the service. Goals should have an overall projected timeframe.
3. Objectives must be specific in how the service will be provided. There may need to be multiple objectives to accomplish one goal, and each objective might have different timeframes based on the specific activities or tasks that will be provided.
4. Reference Resource: Children's Waiver HCBS Authorization and Care Manager Notification Form Instructional Guide (ny.gov)

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DEVELOPING SERVICE GOALS & OBJECTIVES

5 All goals and objectives must be linked to the service description.

6 Services cannot duplicate or replace services otherwise available to a child (e.g., Private Duty Nursing (PDN), Child and Family Treatment and Support Services (CFTSS), Applied Behavior Analysis (ABA), etc.).

7 If a participant has needs for supports outside the scope of the referred service, the provider should connect with the CM for assistance in connecting the family to a more appropriate resource to meet that need.

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