GUIDELINES FOR AUTHORIZING ADAPTIVE AND ASSISTIVE TECHNOLOGY

These updated guidelines outline the process for authorizing Adaptive and Assistive Technology (AAT) under the 1915(c) Home and Community Based Services (HCBS) Children's Waiver with the transition of modifications to a Financial Management Servicer (FMS).

AAT is defined as an item, piece of equipment/technology, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or to improve the functional capabilities of the individual in performing activities of daily living (ADLs), instrumental activities of daily living (IADLs) and health-related tasks. AAT is intended to increase an individual's independence or substitute for human assistance, to the extent that expenditures would otherwise be made for human assistance.

AATs outlined in these guidelines are for children and youth up to the age of 21 years old, who are found HCBS eligible and enrolled in the Children's Waiver.

In an effort to streamline the review and payment process for these services, **effective March 1st, 2024**, review, approval and payment of all new Environmental Modification (EMod), Vehicle Modification (VMod), and Assistive and Adaptive Technology (AAT) requests for children/youth served under FFS Medicaid will be processed by FMS, in association with the New York State Department of Health (NYSDOH). NYSDOH may provide technical assistance and advisory support and review as requested by the FMS. The FMS will be responsible for new and transitioned projects. For projects that are already approved and funded, the Local Department of Social Services (LDSS) will continue these projects to completion under the current ADM. NYSDOH reserves the right to transition any projects to the FMS on a case-by-case basis.

Effective July 1, 2024, the review, approval and payment of all new Environmental Modification (EMod), Vehicle Modification (VMod), and Assistive and Adaptive Technology (AAT) requests for children/youth served under Medicaid Managed Care Plans (MMCPs) will be processed by FMS. NYSDOH may provide technical assistance and advisory support and review as requested by the FMS. The FMS will be responsible for new projects. EMod, VMod, and AAT requests already in process prior to July 1, 2024, with MMCPs will be retained by the MMCPs to completion.

For more information on project transfer and program implication, please refer to the General Information System (GIS).

AAT under the Children's Waiver is limited to those devices that are medically necessary and not available as Durable Medical Equipment (DME) under the Medicaid State Plan or through another available payment source or system. (A listing of DME covered under the Medicaid State Plan can be found at www.emedny.org under ***Provider Manuals***).

Examples of AAT may include, but are not limited to:

- Certain types of Positioning and Mobility devices
- Certain types of Augmentative Communication devices
- Certain types of Computer Accessibility devices
- Certain types of Assistive Demotics/Home Automation devices
- The evaluation of the AAT needs of the individual, including a functional evaluation of the impact of the provision of appropriate AAT to the individual in his/her customary environment
- Services consisting of purchasing or otherwise providing for the acquisition of AAT devices
- Training or technical assistance for the individual and any informal or formal support persons who will be assisting the individual in using the AAT device

Additional Adaptive and Assistive Technology Information

1. The request for AAT must be medically necessary and meet the individual's needs. A minimum of

three bids must be included with the request, or failing to secure three bids, the Care Manager's statement outlining their bid diligence efforts to obtain three bids and request to review the available bids.

2. Replacements, repairs, upgrades, or enhancements made to existing equipment/technology will be paid if documented as a medical necessity and with prior approval from the FMS.
3. Custom-fitting and repairs to AAT which are cost effective may be paid with prior approval from the FMS.
4. Items worn out through normal everyday use (such as keyboards, switches, etc.) may be considered for replacement with prior approval from the FMS. Maintenance costs and repairs due to normal wear and tear are the responsibility of the individual and/or the family.
5. The Children's Waiver will not serve as an alternative to fund AAT that has been denied through a State Plan or waiver request justifiable cause. Items determined to be DME must be pursued through the designated DME process.
6. AAT must be limited for the specific use of the Waiver eligible individual in their POC. General utility items are not considered as AAT eligible.

Service Limitations

All AAT expenditures must be medically necessary and related to an assessed functional need documented in the Children's Waiver participant's Person-Centered Plan of Care (POC). When an assessed functional need for AAT has been determined, consideration must be given to the participant's physical and developmental abilities and whether the item will assist the individual in gaining or maintaining his/her functional status in the home and community.

Once the AAT has been identified, the Health Home Care Manager/C-YES, in cooperation with the individual, family member, and designated representatives as appropriate, must determine whether payment for the AAT is accessible through other sources. Any eligible alternative funding resource must be identified and exhausted prior to the use of Medicaid funding for AAT request. Alternative funding resources include but are not limited to: private insurance, Technology Related Assistance for Individuals with Disabilities (TRAID) programs, public or private funding, or other Local/State/Federal/ agencies. The TRAID Program coordinates statewide activities to increase access to and acquisition of AAT and serves individuals of all ages and disabilities. Information on the 12 Regional TRAID Centers is provided in the following link: https://www.justicecenter.ny.gov/services- supports/assistive-technology-traid/locations.

Children's Waiver funds cannot be used for the purchase of subscriptions, maintenance agreements, service contracts, or additional insurance coverage for the AAT device.

Services and Supports Not Included Under Adaptive and Assistive Technology

FMS will not fund services/items/devices that are not for an assessed need including, but not limited to the following:

- Devices that are considered experimental,
- Animal support and assistance (i.e., service and/or therapy pets) or the costs of training an existing family pet,
- Ongoing care and maintenance of animals for support and assistance (e.g., food, veterinarian services, etc.),
- Entertainment or recreational equipment/technology not specifically addressing and/or adapted for an assessed need in the POC

AAT costs cannot exceed $15,000 soft cap per calendar year without prior approval from the New York State

Department of Health (NYSDOH). Service limits for AAT are soft limits that may be exceeded due to medical necessity. The FMS must contact NYSDOH to obtain this approval.

Providers of Adaptive and Assistive Technology (AAT)

All AAT providers must have a contract or agreement with the FMS. AAT providers must ensure that all devices and supplies meet standards established by Underwriters Laboratory and/or comply with Federal Communications Commission regulations, if applicable. The provider is responsible for training the participant who will be receiving the AAT, their caregiver/parent, and any informal or formal support persons who will be assisting the individual in using the AAT device. FMS and HHCM/C-YES are encouraged to identify providers in advance of service requests to ensure adequate capacity.

Authorizing Adaptive and Assistive Technology

If a child/youth receives HCBS as part of the Children's Waiver, the child is eligible to apply for AAT following the *Procedure for Authorizing Adaptive and Assistive Technology (AAT).*

Procedure for Authorizing Adaptive and Assistive Technology (AAT) for Childrens Waiver Members

1. During a POC meeting through the person-centered planning process, the HHCM/C-YES, waiver participant, family/caregiver, and anyone involved in the development of the POC will determine if any AAT is necessary to assist and enhance the individual in performing ADLs, IADLs, and/or health related tasks and/or will substitute for human assistance (to the extent that expenditures would otherwise be made for human assistance). It is expected that equipment loan programs or trial periods of non-customized equipment, if available, be explored before extensive commitments are made to provide/purchase products.

   The HHCM/CYES will update the current Plan of Care (POC) with the AAT. The family should receive a copy of the Parent Information Sheet for Assistive and Adaptive Technology. The HHCM/C-YES will explain the information and answer any questions the family has for the process.
   The HHCM/CYES will notify FMS of the VMod request within seven (7) business days of adding/updating the POC. The HHCM/C- YES will submit this notification to the FMS Portal at CHHUNY - FMS Waiver.

2. FMS Request Submission Information

   The HHCM/CYES will provide the following information to FMS regarding a request:
   - Child/youth's name
   - Child/youth's CIN #
   - Type of request: AAT, EMod, or VMod
   - Brief summary of the request – what is needed and why the support is needed
   - HHCM agency name or C-YES and HHCM/C-YES contact information
   - Letter of medical necessity for modification or technology support signed and dated by treating MD or DO only.
   - Proof of Medicaid as Payor of Last Resort including FMS Due Diligence template and for participants covered under third party health insurance, a letter of denial of contract coverage for the AAT request

This FMS portal submission by the Care Manager starts the AAT request process by generating an individualized link for the request. All communication regarding the request will be conducted through the portal link. The HHCM/CYES should keep the link provided to submit documentation and receive updates on the request status.

Any time there is an addition or change to the portal information, the HHCM/CYES will receive notification as to the status and next steps for the request via the autogenerated link.

If a submission request is not allowable under the Waiver, the FMS will contact the HHCM/CYES within 5 business days of initial submission to inform them that the request is closed for noncompliance with the Waiver.

3. Letter of Medical Necessity
   Letter of Medical Necessity (LoMN) is provided by a Medical Doctor (MD) or Doctor of Osteopathy (DO) who is currently treating the Waiver participant. Other allied health professionals such as physician's assistants, nurse practitioners, and other therapists and clinicians can't provide a LoMN for EMod, VMod, and AAT requests.

   The LoMN should contain the diagnoses directly linked to the medical need for support, an order by the doctor for the submitted request, and why the request is medically necessary for the Waiver participant. The LoMN must be signed and dated by the Medical Doctor (MD) or Doctor of Osteopathy (DO). The POC must be consistent with the details of the letter of medical necessity.

4. The HHCM/C-YES, on behalf of the individual, will seek a clinical justification from the appropriate clinician (e.g. Occupational Therapist, Speech Language Pathologist, clinician from Article 16 or 28 clinic, Physical Therapist, or other licensed professional) and/or service specialist to assess the individual's need for the requested service or device and must indicate how the intended purpose, special features, and expected use of the AAT meets the needs of the individual in the most cost effective manner. In addition, where the individual has had the opportunity to use the AAT device or item, the clinician should provide any experience the individual has had using the item or device, their success in use for medical need to be supported, and expected benefit of continued use.

   Examples of when a clinical justification are required include, but are not limited to:
   - using the clinical justification as the scope of project for AAT requests or
   - using a clinical justification to justify the cost or provision of a more-costly alternative or specific item or system which supports the needs of the individual more fully than a less expensive alternative or another brand/model of the same item

   If the AAT request requires an environmental modification for its installation and/or use, then the clinical justification must include a pre-project evaluation to determine if there are any obstacles to the use of the AAT in the home. If modifications to the individual's residence are required due to the AAT, the name of the owner/landlord must be included, and a separate Environmental Modification (EMod) Service Request Packet must be completed. The AAT will not be approved until the EMod project has been completed.

   Please note that AAT requests that have no environmental impact for installation or use do not require a pre-project evaluation.

5. AAT project cost includes the costs associated with the acquisition, evaluation of the needs of the individual, implementation, training, medically necessary customization of item, and oversight of the technology. Payment for an assessment completed by the clinician or AAT provider, for helping select a particular device, or for training in the use of a device, must be included in the cost of the AAT if the expertise needed for assessing, selecting, and training is NOT available as part of a Medicaid State Plan service, or through other sources that are already involved with the individual.

6. The HHCM/C-YES and the individual must exhaust any potential payment sources for the identified

AAT, including private health insurance, any public or private funding resources, and other Local/State/Federal programs before a request for payment will be considered. Medicaid funding is only available as the payor of last resort.

7. The HHCM/C-YES will obtain a clinical justification. Prior to engaging a clinician or assessor that requires a fee, the HHCM/C-YES must receive permission from the FMS. Prior to granting permission for a clinical justification, or pre-project evaluation/assessment where indicated, the FMS may request additional documentation/information from the HHCM/C-YES. This documentation may include the child/youth's POC, a letter of medical necessity for the proposed AAT, etc.
8. If a clinical justification or pre-project evaluation is completed, the HHCM/C-YES will submit a ***Pre-Project Evaluation Payment Request Form*** to the FMS within five (5) business days of evaluation completion. The submission should also include a copy of the pre-project evaluation or clinical justification invoice. Additional information on the ***Pre-Project Evaluation Payment Request Form*** can be found here.
    - The CM will review the Description and Cost Projection Form with parents/caregivers to review the scope and sign the necessary forms.
    - The cost of a pre-project evaluation is covered by eMedNY claiming, regardless of project feasibility or completion.

9. The HHCM/C-YES and individual/family should obtain the requested number of bids (at least one bid for AT that costs less than $1,000, or AAT least three bids for AAT of $1,000 or more) and submit them to the FMS. If it is not possible to obtain the three required bids, the FMS may proceed with review of fewer than three bids with sufficient written justification by the HHCM/C-YES of their good faith efforts to secure required number of bids. The HHCM/C-YES should always document attempts to obtain three bids in the child/youth's case file.
10. HHCM/CYES will coordinate Case Meetings with FMS, participant/family, and other parties as needed. FMS Case Meetings are held:1) after the pre-project evaluation is completed to review the project scope and determine if there are any changes needed and 2) after the complete Service Request Packet is submitted and reviewed to review the selected bid and collaborate on the project initiation needs.

    FMS may waive case meetings if they determine a project is not complex and the projected cost is within the annual soft cap for the service. The parent will sign the Parent Agreement with a copy for the Waiver participant and family/caregiver and a copy to be retained in the Waiver participant's record.

11. The HHCM/C-YES must submit a complete **Service Request Packet** to the FMS to initiate the authorization process. The documentation submitted by the HHCM/C-YES must detail the need and intended purpose of the AAT to support therequest. The HHCM/C-YES will put the **Service Request Packet** together to submit everything at the same time – individual items and documents should not be submitted separately to the FMS to initiate the authorization process. The HHCM/C-YES will submit supporting documentation, including:
    - A completed ***Description and Cost Projection Form***, signed by all necessary parties, including documentation of Medicaid as the payor of last resort and any previous EMod/VMod/AAT requests,
    - **Letter of Medical Necessity** for the request,
    - **Clinical justification** for the request
    - The child/youth's most recent ***Plan of Care (POC),***
    - **Any necessary evaluations** for the project/technology*,

- **Three bids** for the project/technology or a written and signed justification as to why three bids could not be obtained

The total cost of the project includes any pre- and post-project evaluations and clinical justifications as well as project bids. Cost for post-evaluations are requested in the funding in the **Service Request Packet**.

All documents must be dated and/or signed within the last **twelve (12) months** to be considered valid for review.

*When accompanied by a ***Pre-Project Evaluation Payment Request Form,*** clinical justification should be submitted at the time of their completion and prior to submission of the **Service Request Packet.**

12. On the date of receipt, the FMS will electronically date stamp the **Service Request Packet**. From the date stamped receipt of the **Service Request Packet**, the FMS will have five (5) business days to review the submitted packet for completeness. A request may be deemed incomplete if it is missing any of the following items:
    - A completed ***Description and Cost Projection Form***, signed by all necessary parties, including documentation of Medicaid as the payor of last resort
    - **Letter of Medical Necessity** for the request
    - ***Clinical justification*** for the request, acting as the scope of project;
    - The child/youth's most recent ***Plan of Care (POC)***
    - ***Any necessary evaluations*** for the project/technology as above
        - ***Three bids*** for the project/technology that is $1,000 or more, at least one bid for a project/technology that is less than $1,000 or a written, dated statement by HHCM/C-YES justifying as to why the required number of bids could not be obtained
13. If the above items are missing, then the FMS **MUST** successfully contact the submitting entity no later than five (5) business days after receiving the **Service Request Packet** to indicate that the submitted request is incomplete and to explain what is needed. The FMS is responsible for evaluating bids and selecting the vendor to provide the AAT based on the lowest reasonable bid that meets the assessed need.

    If all the required documents within the **Service Request Packet** are complete, then the FMS has ten (10) business days from receipt to review the request materials. If the **Service Request Packet** is deemed incomplete or if additional information is needed, the FMS will communicate this information to the HHCM/C-YES within the first five (5) business days of the ten (10) total business days that the FMS is given to complete their review. The FMS will make a determination if it will be:
        - Authorized for the request and bid, **OR**
        - Authorized and submitted to NYSDOH for additional review with the selected bid for annual soft cap override, **OR**
        - Denied. If denied, a Notice of Decision (NOD) will be sent within three (3) business days to the HHCM/C-YES, member/family, and provider (if authorized).
14. If the request exceeds the annual soft cap of $15,000 for the service, the completed, FMS approved

Service Request Packet will be submitted to NYSDOH for review via EModVModAT@health.ny.gov. Within seven (7) business days from receipt of the **Service Request Packet**, NYSDOH will issue a letter to the FMS supporting the project/product or a letter of non-compliance with Waiver regulations. The State may also request more information from the FMS within seven (7) business days of request receipt.

If the project is approved by the FMS and does not exceed the annual soft cap for the service, the project does not require additional review by NYSDOH.

15. The FMS will notify the HHCM/C-YES, the participant/family, and the selected AAT provider of its determination by issuing a Notice of Decision (NOD) within three (3) business days of receipt of decision from NYSDOH if project exceeds the annual soft cap of $15,000 or within ten (10) business days of receipt of the complete Service Request Packet if a project does not exceed the annual soft cap. The FMS will issue a NOD to the individual and the HHCM/C-YES when they authorize or deny a request for AATs.

16. The AAT provider will be responsible for coordination of the project, including the following tasks:
    - provide a detailed description of the product,
    - provide detailed expenditures/receipts,
    - ensure the satisfactory completion of the project in accordance with bid specifications,
    - compliance with ADA requirements, and
    - obtain approval of any changes before proceeding if determined that changes/additional work are necessary that will result in a cost difference from the original projected cost; if approval is not received before proceeding, the AAT provider may risk non-payment for such changes.

17. Within seven (7) business days of AAT project receipt and completion, the HHCM/C-YES must submit a ***Final Cost Form*** to the FMS that includes a description of the completed AAT project, the final cost, and all invoices. If a post-project evaluation is completed, a copy should be submitted to the FMS as part of the ***Final Cost Form*** submission.

18. The FMS will electronically date stamp the ***Final Cost Form*** upon receipt. The FMS will review the ***Final Cost Form,*** all invoices, and associated documentation *within five (5) business days of receipt.*

19. The FMS must maintain the completed ***Final Cost Form and all supporting project documents for audit purposes***. Once the Final Cost Form has been received, the FMS can submit their final claims for any remaining project costs, including any evaluation costs and reimbursement to FMS of any portion of the cost of the AAT up to 50% of the total cost that FMS advanced to acquire the AAT.

20. Payment to the AAT vendor will be made by the FMS within thirty (30) business days of fund receipt from NYS Medicaid.

21. FMS reconciles all project payments, submits a claim for the FMS administrative fee, and closes out the project.