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CHILDREN'S HCBS COLLABORATIVE STAKEHOLDER MEETING

FEBRUARY 10, 2025

PURPOSE

To provide a forum for Children's Home and Community Based Service (HCBS) Providers, Medicaid Managed Care Plans (MMCP), Health Homes (HHs), Care Management Agencies (CMAs), and Children and Youth Evaluation Services (C-YES) 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

- ✓ Children’s HH/MCO Subcommittee Announcement
- ✓ HCBS Eligibility
- ✓ General HCBS Reminders
- ✓ HCBS Authorization
  - ✓ Initial Service Period
  - ✓ HCBS Service Schedule

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CHILDREN'S HH/MCO SUBCOMMITTEE ANNOUNCEMENT

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HH/MCO KIDS SUBCOMMITTEE ANNOUNCEMENT

The HH/MCO Kids Subcommittee will be discontinued.

Instead, the subcommittee will use the ***HCBS Collaborative Stakeholder Meeting*** series, in partnership with the New York State Department of Health (the Department), to highlight topics specific to Health Homes Serving Children (HHSC), Managed Care Organizations (MCO) and the HCBS providers.

The Co-Chairs from the HH/MCO Kids Subcommittee will assist with ***HCBS Collaborative Stakeholder Meeting*** planning moving forward

Alyssa Paulozzo, HHSC Collaborative for Children and Families
Raechel Schwartz, Healthfirst

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HCBS ELIGIBILITY

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HCBS PURPOSE & ELIGIBILITY

To be eligible for HCBS, participants must have a diagnosed 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.

Children's Home and Community Based Services (HCBS) Waiver Enrollment Policy

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

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HCBS ELIGIBILITY DETERMINATION

- **Prior to the care manager conducting the HCBS Eligibility Determination, there must be an indication that the child/youth is high needs/high risk. Such as:**
- A **service history** (beyond HH, school, Person-Centered Planning (PCP)) with the child/youth prior to consideration of HCBS (i.e., other involved providers, services, specialist, hospitalizations, crisis and diversion documented activities, documented activities in accessing State Plan, community, and other services)
- **Other providers and systems** (beyond HH, School, PCP) involved with the child/youth
  - These providers should be consulted if HCBS is **appropriate and needed** (i.e., Interdisciplinary Team meetings and conferences surrounding the appropriate services for the child/youth)
  - These providers would be able to **assist the care manager** with needed eligibility documentation and if found eligible, be able to **assist the HCBS provider** with supporting documentation for Frequency, Scope, Duration
- HCBS should **NEVER** be the only service the child/youth is receiving
- There should be **consistent and ongoing documentation** in the child/youth case record indicating evidence of high needs/high risk

HCBS ELIGIBILITY DETERMINATION

Continuous education and communication with involved providers and the child/youth/family regarding HCBS purpose and what is needed to determine eligibility, should be an **on-going discussion** with documentation in the case record and months prior to the annual re-determination

Diagnosis alone and lack of other community resources **does not meet HCBS eligibility**

Care managers who are concerned if the children/youth services stop would place the child/youth at risk of institution, must have **supporting documentation and demonstrate how this would impact the child/youth's daily functioning**

- This supports why HCBS should **never be the only service**
- HCBS should be **supplement** to other services
- HCBS are **not clinical services**
- If the child/youth's needs can be met by State Plan, community, and other services, then **HCBS should not be pursued**

Specific supporting documentation from other provider outlining how HCBS is supporting the clinical services or other services, documented progress made towards goals, and the additional time needed to reach goal, etc.

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HCBS ELIGIBILITY REVIEW BY MMCP & FFS

MMCP & FFS staff reviewing HCBS Authorization request for approval and payment of services. Many times, the Authorizations lack information and documentation to support the number of units and frequency of the services.

At times, when reviewing the participants history of services, HCBS Eligibility is questioned. This makes it difficult to approve the Authorization and prompts additional request for information from the HCBS providers.

It is the responsibility of the CM to **determine HCBS eligibility** and for the HCBS provider to **verify the service requested can be met** by the service and how the service is provided aligns with the service definition.

The Department requests HCBS providers and MMCPs with concerns about a participant's HCBS Eligibility **report concerns to the lead HH and to the Department to be addressed**.

The Department will follow up with HHs to verify a review of the case and next steps to take.

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HCBS ELIGIBILITY REVIEW

To conduct the HCBS Eligibility Determination within the Uniform Assessment System (UAS) to obtain an electronic determination, the CM must have the **supporting documentation** to start and complete the HCBS Eligibility Determination. Otherwise, the HCBS Eligibility Determination cannot be conducted within the UAS, and the CM must issue a Notice of Determination/Decision (NOD) for Discontinuance to the participant/family utilizing the box below:

This is to advise you that effective _____ this agency _____
Date — Name of Care Management Agency/Health Home

☐ **Discontinued your Home and Community Based Services (HCBS) enrollment in the 1915(c) Children's Waiver**

Your enrollment in the waiver and access to HCBS are being discontinued as of the effective date above due to the following reason(s):

☐ You no longer meet the Level of Care (LOC) criteria of Target, Risk and Functional requirements necessary for enrollment in the waiver based on a completed HCBS Eligibility Determination indicating an Ineligible outcome.

☐ You failed to provide documentation required for eligibility to be determined within the mandated timeframe per 18 NYCRR § 360, and are no longer eligible for HCBS Children's Waiver.

This choice can be utilized during the annual re-assessment or after a case review with a questionable HCBS Eligibility Determination

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HCBS NOTICE OF DETERMINATION

Enrollment or Denial of Enrollment from Children's HCBS – DOH 5287

- Each time an HCBS Eligibility determination is completed, a NOD is issued. ***This NOD is required upon initial and annual re-determination eligibility (regardless of continued eligibility) – *this is a change to previous practice*.**

- Upon signing and finalizing the HCBS Eligibility Determination within the UAS, the HH/C-YES care manager will be presented with an outcome confirming that the member is HCBS eligible or ineligible for the identified Target Population.
  - Unless as noted in the previous slide the HCBS Eligibility Determination could not be completed in the UAS

- The Notice of Decision Enrollment Form (DOH 5287) is sent for both enrollment and denial of enrollment and will document the outcome of the HCBS Eligibility Determination.

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HCBS NOTICE OF DETERMINATION

Discontinuance from the Children's Waiver HCBS – DOH 5288

- If the member no longer meets the HCBS Eligibility Criteria or is found ineligible during the annual HCBS Eligibility Determination, then the HH/C-YES care manager must send a NOD for Discontinuance (DOH 5288) within five (5) calendar days from the ineligibility determination and ten (10) calendar days (based on date mailed) prior to the action of disenrollment from the Children's Waiver.

- If an annual Children's Waiver HCBS Eligibility Determination cannot be completed due to lack of documentation, a DOH 5288 is sent at least ten (10) calendar days prior to the annual reassessment due date.

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AID CONTINUING

When a Notice of Determination/Decision is issued to the participant, they have the **right to determine whether they want to request a Fair Hearing** and whether the **selection of Aid Continuing is right for them**.

If the Department receives notification from the Office of Temporary and Disability Assistance (OTDA) granting the member's request for a Fair Hearing with Aid Continuing, Home and Community Based Services can continue to be provided until the Decision of the Fair Hearing is determined, the Fair Hearing is denied, or the Fair Hearing is withdrawn.

*Children/youth enrolled in the Children's Waiver **must** have care management through the HH or C-YES. Therefore, if a child/youth has a pending **Fair Hearing with Aid Continuing** for the Children's Waiver, HH/C-YES care management cannot be closed until such time a Fair Hearing determination is made, or the Fair Hearing is withdrawn.*

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AID CONTINUING IMPACT ON HCBS

The CM will be notified if the participant/family requested a Fair Hearing with Aid to Continue. If Aid to Continue was granted, the participant will remain HCBS eligible for referrals and authorizations in the HCBS Referral and Authorization Portal in the Incident Reporting and Management System (IRAMS).

The CM should maintain communication with HCBS providers about any HCBS eligibility changes. HCB services can be adjusted and the HCBS provider can determine when an HCBS discharge may be appropriate.

Additional information on the Fair Hearing process can be found in ***Health Home & HCBS Notices and Fair Hearings Policy #HH0004***

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GENERAL HCBS REMINDERS

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GENERAL HCBS REMINDERS

Children's HCBS **cannot be utilized when** services otherwise available to the participant through the Medicaid State Plan Section 110 of the Rehabilitation Act of 1973 (Rehabilitation Act) including, the Individuals with Disabilities Education Act (IDEA), or private insurance/Medicare. Services that are covered under the Medicaid State Plan cannot be provided under and billed as HCBS. These include but are not limited to services such as:

- Early Intervention (EI),
- Applied Behavior Analysis (ABA) therapy,
- Mental health assessment and treatment,
- Physical therapy, occupational therapy, and speech therapy.

This also includes activities with the sole purpose of personal care or Private Duty Nursing (PDN), which are available to all pediatric Medicaid participants for whom the service is **medically necessary** under the Early Periodic Screening Diagnosis and Treatment (EPSDT) benefit

This is the primary responsibility of the Care Manager, however if the HCBS provider or MMCP/FFS believes that the referred HCBS identified goals can be addressed with State Plan services, they should notify the care manager and refuse the referral or deny the authorization with this justification.

GENERAL HCBS REMINDERS

HCBS Limitations/Exclusions

- **HCBS is not billable when provided while another billable Medicaid service is provided such as PDN, EI, ABA therapy, Speech therapy, personal care, etc.**

In certain instances, there may be exceptions to this. If during regular HCBS delivery, a participant receives a specific PDN/personal care service for a portion of time that HCBS takes place that cannot be provided at another time (for example, nurse stops by to change a trach, administer medication, etc.) and the service provided is not duplicative in any way of the HCBS being provided, this is permissible.

It is not permissible for an HCBS participant to receive PDN or other personal care services for the entire or most of the duration of HCBS delivery. HCBS providers should be working with the care manager, family, and other service providers to ensure appropriate scheduling of services.

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GENERAL HCBS REMINDERS

HCBS Limitations & Exclusions

- HCBS cannot be provided during school hours to participants attending school.
- Children's HCBS is not a substitute for parenting, babysitting, childcare, or generalized supervision. HCBS must be provided in a professional capacity with a clearly defined purpose and outcome that exceeds general childcare needs. HCBS does not replace the role of the parent/caregiver in fostering skill development essential to typical child development.
- Children's HCBS cannot duplicate or replace the role of the participant's care manager.
- If a participant receives multiple HCBS, the goals for each service must be distinctly different from goals associated with other HCBS provided.
- If multiple HCBS is received, the Frequency, Scope, and Duration should be taken into account for all the services being proposed including all the HCBS.

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GENERAL HCBS REMINDERS

HCBS Limitations & Exclusions

HCBS may only be provided when the following criteria are met:

- The **need for the service** has been assessed and determined by the care manager (CM), and authorized (by the MMCP or the Department) in **alignment with the service definition** as part of the person-centered planning (PCP) process.
- The service is **identified in the participant's Service Plan**, developed by the HCBS provider, and **Plan of Care (POC)** developed by the CM and is associated with specific attainable **goal(s) and outcome(s)** to enhance the participant's ability to remain in the home/community
- The HCBS provider has **received a referral** from the CM, has evaluated the participant for **appropriateness**, and confirmed the participant's **eligibility**
- The HCBS provider has **maintained documentation** that clearly substantiates the need for services to support the proposed Frequency, Scope, and Duration (F/S/D) and the participant remaining in the home/community

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GENERAL HCBS REMINDERS

The Department is working on several initiatives to assist stakeholders, providers, and families to better understand the purpose and role of HCBS and assist with consistent communication and education about the services.

Additionally, the Department will provide a webinar and training for each individual service.

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HCBS AUTHORIZATION

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HCBS AUTHORIZATION – ROLES BY ENTITY

Care Manager
The CM is expected to educate the participant/family on the specific service they are requesting to receive and develop a detailed referral for the service in IRAMS, including need and specific goal(s) clearly aligning with the service purpose/definition.

HCBS Provider
Once selected to provide the service, the HCBS provider is expected to work with the participant/family to conduct an intake assessment, gather documentation on the service need, determine F/S/D, develop an authorization request, and complete the HCBS Service Plan.

MMCP
Once informed of the first appointment, the MMCP will establish the provider in their claim systems. Upon receipt of an authorization request, the MMCP will issue an authorization determination, either approve, partially approve, or deny.

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INITIAL SERVICE PERIOD

Initial Service Period: The period after a provider accepts a referral, but prior to the submission of an authorization request. The period lasts for **96 units/24 hours or 60-days** (whichever comes first).

The Initial Service Period begins on the **first date of billable service** for the participant and is **service specific**.

The Initial Service Period is used to complete an **intake assessment**, finalize service **goals and objectives**, and determine **F/S/D** for the service.

If the service is needed beyond the initial service period, the **HCBS provider will submit an HCBS authorization request** to the participant's MMCP (for MMCP enrollees) or the Department (for Fee-for-Service (FFS) participants).

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SUBMITTING THE HCBS SERVICE SCHEDULE

As part of the HCBS authorization process, the HCBS provider and CM should collaborate to define the participant's HCBS service schedule, accounting for school, extracurricular activities, and the participant's receipt of other services.

This service schedule should be clear within the authorization request submitted to the MMCP or the Department.

The requested F/S/D must align with the parameters of the established service schedule and take into consideration the participant's other appointments and activities as well as the participant's age, development, and condition.

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HCBS SERVICE SCHEDULE

- MMCPs should be asking for supporting documentation from a HCBS provider requesting service authorization.

- However, asking for a schedule of daily, weekly, monthly services, or specific dates on which services will be provided is not person-centered. F/S/D is the plan between the HCBS provider and the participant/family and needs to be flexible to a degree to accommodate the participant/family schedule.

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AUTHORIZATION EXAMPLES

The following instances constitute inappropriate authorization requests:

Undefined goals and objectives:

An authorization request must demonstrate how delivery of the HCBS will support and achieve goals of participant success in their communities and home environments. The objectives must outline how the service will be delivered.

Incomplete justification for F/S/D:

MMCPs and the Department can only authorize services when F/S/D aligns with the HCBS definition, participant's POC, and Service Plan.

Misalignment of needs and services:

Services must align with the assessed needs of the participant in order to deliver the most accurate, meaningful services available for the specific participant.

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FFS AUTHORIZATION EXAMPLE- RESPITE DENIAL

Inappropriate Authorization Request (FFS Example)

Procedure Code S5150

Scope	Frequency	Modality	Unit Type	Visits	Hours	Units
6 Hours	4 Every Week	Individual	15 Minute	104	624	2496
Total :				**104**	**624**	**2496**

GOALS AND OBJECTIVES

Goal 1
The individual will engage in meal-related tasks (e.g., feeding, preparing simple snacks) independently or with minimal prompting, at least 3 days a week, with a goal of improving both functional and safety awareness during eating activities.The individual will enhance their independence and functional abilities in ADLs by practicing and improving self-care skills, including dressing, grooming, toileting, and feeding, with a target of achieving at least 80% independence in these tasks over the next six months.

Objective 1: **Not Met**
The client currently experiences challenges in completing certain tasks independently and requires prompts to initiate or complete activities. In addition, there are specific areas within Activities of Daily Living (ADLs) where the client is receiving support from the caregiver. These challenges will be addressed through individualized strategies aimed at fostering greater independence and enhancing skill development. By focusing on these targeted areas, the client will have the opportunity to build confidence, improve functional abilities, and work toward greater self-sufficiency in daily routines.

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FFS AUTHORIZATION EXAMPLE- RESPITE DENIAL

In this example, the participant is 5 years old.

This Planned Respite request was denied due to the lack of specific measurable goal and the goal provided does not meet the service definition.

The definition from the HCBS Manual: Planned Respite is to be utilized to provide planned short-term relief for the child/youth or family/primary caregivers to enhance the family/primary caregiver's ability to support the child/youth's functional, developmental, behavioral health, and/or health care needs.

The goal doesn't reflect that the planned respite will provide respite for the family/caregiver. The goal identified is not a deficiency of ADLs as these tasks are developmentally appropriate for the identified age and should be managed typically through parenting and childcare.

This authorization was also denied due to the number of hours that were requested. The request of 24 hours a week was not justified by the objectives and the goals provided.

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FFS AUTHORIZATION EXAMPLE- CFASS DENIAL

Inappropriate Authorization Request (FFS Example)

Procedure Code H2014

Scope	Frequency	Modality	Unit Type	Visits	Hours	Units
4 Hours	5 Every Week	Individual	15 Minute	130	520	2080
Total :				**130**	**520**	**2080**

Procedure Code H2015

Scope	Frequency	Modality	Unit Type	Visits	Hours	Units
4 Hours	5 Every Week	Individual	15 Minute	130	520	2080
Total :				**130**	**520**	**2080**

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FFS AUTHORIZATION EXAMPLE- CFASS DENIAL

GOALS AND OBJECTIVES

Goal 1
Child/youth will decrease occurrences of problematic social behavior

Objective 1: **Not Met**
[redacted] will follow directions 2 out of 4 times

Objective 2: **Not Met**
[redacted] will pick up after herself 2 out of 4 occurrences

Objective 3: **Not Met**
[redacted] will engage in age appropriate social interactions 3 out of 5 times, weekly

Goal 3
[redacted] will develop daily living skills

Objective 1: **Not Met**
[redacted] will develop 3 independent living skills.

Objective 2: **Not Met**
[redacted] will utilize independent living skills 3 out of 5 opportunities.

Questions that should be answered through the goals and objectives:

How is the service being provided regarding the specific objectives?

What is the HCBS staff doing with the participant regarding the objectives to support the requested number of units?

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FFS AUTHORIZATION EXAMPLE- CFASS DENIAL

The participant in this example is 12 years old.

This CFASS was denied due to the lack of specific measurable goal and the goal provided does not meet the service definition.

Per the HCBS Manual definition: Caregiver/Family Advocacy and Support Services are to be used enhance the child/youth's ability, regardless of disability, to function as part of a caregiver/family unit and enhance the caregiver/family's ability to care for the child/youth in the home and/or community as well as, provides the child/youth, family, caregivers, and collateral contacts with techniques and information not generally available so that they can better respond to the needs of the participant.

These goals are not aligned with CFASS but do appear to possibly align with the definition of Community Habilitation. It was also denied due to the number of hours that was requested. The request of 40 hours a week is not justified by the objectives and the goals provided, along with the child's schedule schooling and extracurricular activities.

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FFS AUTHORIZATION- CFASS PARTIAL APPROVAL

Procedure Code H2015

Scope	Frequency	Modality	Unit Type	Visits	Hours	Units
3 Hours	6 Every Week	Individual	15 Minute	156	468	1872
Total :				**156**	**468**	**1872**

GOALS AND OBJECTIVES

Goal 1
Over the next six months, [redacted] and his family will work together to enhance his time management and organizational skills, fostering personal growth, self-discipline, and a greater sense of responsibility in daily life.

Objective 1: **Not Met**
[redacted] will keep his room neat and all his clothes & possessions where they belong 95% of the time.

Objective 2: **Not Met**
[redacted] will keep his school supplies organized in his desk/drawer/briefcase both at home & at school so he can find what he needs when he needs it 100% of the time.

Objective 3: **Not Met**
[redacted] will complete his morning routine independently & in a timely manner so that he is ready for school on time 95% of the time.

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FFS AUTHORIZATION- CFASS PARTIAL APPROVAL

Goal 2
Over the next 6 months, [redacted] family will work together with him to improve his social skills so that he can develop and maintain friendships.

Objective 1: **Not Met**
[redacted] will initiate positive interactions with his siblings 8x a day.

Objective 2: **Not Met**
[redacted] will initiate positive interactions with familiar peers 8x a day.

Objective 3: **Not Met**
[redacted] will initiate positive interactions with unfamiliar peers and adults 8x a day.

Goal 3
Over the next 6 months, [redacted] family will work together with him to improve his emotional regulation.

Objective 1: **Not Met**
[redacted] will identify and verbally describe his negative emotions, to prevent them from escalating out of control 10x a day.

Objective 2: **Not Met**
[redacted] will count to 60 slowly & out loud or take 6 deep breaths whenever he feels himself becoming agitated, 8x a day.

Objective 3: **Not Met**
[redacted] will use a mirror to gain visual feedback on the emotions he is feeling and will describe his facial expressions & how others view them, to help regulate his emotions 8x a day.

Questions that should be answered through the goals and objectives:

How is the service being provided regarding the specific objectives?

What is the HCBS staff doing with the participant regarding the objectives to support the requested number of units?

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MMCP & FFS AUTHORIZATION

- The MMCPs and FFS are attempting to allow services when a need is clearly identified, however it is difficult when goals and objectives are not aligned with the service definition, unclear what the HCBS staff will be doing with the participant for the number of requested units, and when taking into consideration the other services being provided and participant's schedule.

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FFS AUTHORIZATION- CFASS PARTIAL APPROVAL

The participant in this example is 13 years old and has been diagnosed with ADHD, Generalized Anxiety Disorder (GAD), and Persistent Depressive Disorder (PDD).

This CFASS request was partially approved for a total of 312 hours as the goals did not support the number hours requested. The request for 18 hours per week was not justified by the goals and objectives provided.

The DOH determined that 12 hours a week was a more appropriate duration to align with the goals and objectives provided.

It is also important to acknowledge that this participant is also receiving 10 hours a week of Prevocational services in addition to CFASS services.

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MMCP AUTHORIZATION EXAMPLE- CFASS

Inappropriate Authorization Request (MMCP Example)

Scope	Frequency	Modality	Unit Type	Visits	Hours	Units
6 Hours	2 Every Week	Individual	15 Minute	52	312	1248
Total :				**52**	**312**	**1248**

Goal 1

[redacted] will participate in CFASS-H2015 services for 6 Months with a behavioral health specialist.

Objective 1: **Not Met**

[redacted] BHS will regularly assess her progress toward objectives, adjusting strategies as needed to ensure effectiveness.

Objective 2: **Not Met**

[redacted] will involve her family in the therapeutic process, providing education on her diagnoses and ways to support her at home.

Objective 3: **Not Met**

[redacted] will regularly assess her progress toward objectives, adjusting strategies as needed to ensure effectiveness.

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MMCP AUTHORIZATION EXAMPLE- CFASS

The participant is a 16-year-old diagnosed with Post Traumatic Stress Disorder (PTSD). The goals provided were not measurable or specific, and it was therefore difficult to decipher how the goals and objectives were related to the service requested.

The child did however have a hospitalization that MMCP identified within two months of the service request and had recently discharged from a Partial Hospitalization Program. The justification provided did not align with the requested number of hours (12 per week). This CFASS request was partially approved for a total of 624 hours.

It is also important to note that this member is also receiving 6 hours of Respite per week in addition to CFASS.

The total requested services combined were for 30 hours of respite and 12 hours of CFASS, a total of 42 hours of HCBS per week.

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HCBS AUTHORIZATION GUIDANCE

For more guidance on the development of F/S/D, Specific, Measurable, Achievable, Relevant, and Time-bound (SMART) goals, and objectives, please reference the *HCBS Authorization and Care Manager Notification Form Instructional Guide*.

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STAKEHOLDER FEEDBACK & CONTACT INFORMATION

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ARE THE COLLABORATIVE MEETINGS HELPFUL TO STAKEHOLDERS?

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FUTURE TOPICS, FEEDBACK, AND QUESTIONS

The Department would like to discuss topics of interest to all stakeholders and hear suggestions and ideas for improvement.

Pending topics:

- **Referral and Authorization Portal Updates**
- **K-Code reminders**
- **Continuity of Care updates**
- **CHPlus**

Please submit your feedback, questions, and meeting topics 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 questions regarding **CHPlus**, email *chplus@health.ny.gov*.

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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