Policy Title: **Home and Community Based Services (HCBS) Plan of Care (POC) Workflow**
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I. Purpose

This workflow defines how a child accesses aligned Children's Home and Community Based Services (HCBS) through the Children's Waiver, which became effective April 1, 2019.[1]

This workflow includes development of a person-centered Plan of Care (POC) that must be compliant with federal requirements 42 CFR §§441.725, 441.720, and 441.730; how referrals are made to HCBS providers, and how HCBS are approved and/or authorized. This document also addresses the roles of the Health Home Care Manager (HHCM), Children and Youth Evaluation Service (C-YES), and Medicaid Managed Care Plans (MMCP).[2]

NYS Person Centered Service Planning Guidelines:
https://www.health.ny.gov/health_care/medicaid/redesign/cfco/docs/2018-12-19_pcsp_guidelines.pdf

I.A. Definitions of Key Terms

Child/Children: Throughout this document, the term "child" or "children" refers to a child/youth under age 21.

Children and Youth Evaluation Service (C-YES): C-YES is the State-designated Independent Entity which conducts HCBS/Level of Care (LOC) eligibility determinations and provides Medicaid application assistance for children who are eligible for HCBS not yet enrolled in Medicaid. C-YES also develops an HCBS POC, refers eligible children for HCBS and monitors access to care for children who opt out of Health Home care management.

Care Team or Multi-disciplinary Team: Are the providers, identified family supports, family members, managed care plan and other individuals or entities that the child/youth or family identified to be involved in the care coordination and service provision development.

[1] The New York State 1915(c) Children's Waiver and *Children's Home and Community Based Services Provider Manual,* which full describes available children's HCBS, are available here: https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/1115_waiver_amend.htm

[2] Mainstream Medicaid Managed Care plans and HIV Special Needs Plans are responsible for the MMCP functions described in this policy for eligible enrolled children upon the inclusion of aligned children's HCBS in the Benefit Package on October 1, 2019.

Duration: Describes how long the service will be delivered to the child and/or family. The duration of the service should correspond to the abilities of the child/family and be reflective of the billing unit identified by service.

Family: Within this document the term "family" is used and defined as the primary caregiving unit inclusive of the wide diversity of primary caregiving units in our society. Family is a birth, foster, adoptive or self-created unit of people residing together, with significant attachment to the individual, consisting of adult(s) and/or child(ren), with adult(s) performing duties of parenthood/caregiving for the child(ren) even if the individual is living outside of the home.

Frequency: Outlines how often the service will be offered to the child and/or family. Services may be delivered on a weekly, biweekly or monthly basis, according to the needs of the child and family.

HCBS/LOC Eligibility Determination: is a tiered assessment where multiple factors must be met for child's HCBS/LOC eligibility to be determined. To access Children's HCBS, a child must meet target population, risk factors, and functional criteria as described in the Children's Waiver. The HCBS/LOC Eligibility Determination is housed within the Uniform Assessment System (UAS).

Health Home: Means New York State designated Health Home Serving Children.

Medicaid managed care plan (MMCP): Means the mainstream Medicaid Managed Care Plan or HIV Special Needs Plan in which the child is enrolled on the date of service, or which the child has selected for enrollment and has provided written consent to share protected health information with prior to enrollment.

Parent, guardian, or legally authorized representative: Are the individuals who have custody/guardianship of the child and who are able to consent to the child's services, when the child is not of age to self-consent or does not have the mental capacity to self-consent to services. (Children who are 18 years or older or under the age of 18 years old who are pregnant, married, or a parent can self-consent for the Health Home, C-YES and HCBS)[3].

Note: When developing the POC, foster parents are encouraged to provide input. The final signature for the POC needs to be signed by the child/parent/guardian/legally authorized representative.

[3] This policy guidance does not change or modify the applicability of any law, regulation, or court order regarding custody, guardianship, right to consent to health care, or right to protected health information.

Scope: The service components and interventions being provided and utilized to address the identified needs of the child.

I.B. Appropriate Candidates for Children's HCBS

Children who are eligible and appropriate for HCBS must have a physical health, developmental disability, or mental health diagnosis with related significant needs that place them at risk of hospitalization, institutionalization, or need to return safely home and to their community from a higher level of care. (Institutionalization refers to children at risk of being admitted to a higher level of care such as out-of-home residential settings, hospitalization, ICF-I/ID, or nursing facility)

I.C. Care Management and Monitoring Access to Care for HCBS

Care Management

Children and youth who are enrolled in the Children's Waiver, are HCBS/LOC eligible, and are receiving Home and Community Based Services are required to receive care management. This requirement may be met in one of the following three ways:

1) **Health Home comprehensive care management:** Children eligible for HCBS are eligible for Health Home services, including comprehensive care management; care coordination and health promotion; comprehensive transitional care; enrollee and family support; and referral to community and social supports. Health Home comprehensive care management ensures a holistic assessment, through the CANS-NY and comprehensive assessments, of the child/youth's behavioral health, medical, community and natural supports; as identified through a person-centered POC by the child/family.
2) **C-YES:** If a child/youth and their family do not want Health Home care management (which is an optional benefit), they can opt-out of Health Home and receive HCBS care management from C-YES. C-YES will develop a HCBS POC using information from the HCBS/LOC Eligibility Determination, and a person-centered discussion that identifies personal goals and how specific HCBS may support the child in achieving those goals. C-YES will maintain the POC for children who opt of Health Home and are not enrolled in an MMCP.
3) **MMCP:** For children/youth who opt-out of Health Home and are enrolled with a MMCP, once C-YES establishes HCBS/LOC eligibility and the HCBS POC, the MMCP updates the POC as needed through a person-centered planning process. C-YES conducts the HCBS/LOC Eligibility Determination annually for children/youth who are managed by the MMCP.

Monitoring Access to Care

The State must ensure children participating in the Children's waiver are able to access and receive HCBS identified in the POC. The MMCP will monitor access to care for all enrolled children in receipt of HCBS. The Health Home will monitor access to care for children in receipt of HCBS who are enrolled in the Health Home and are not enrolled in an MMCP. C-YES will monitor access to care for children in receipt of HCBS who opt out of Health Home and are not enrolled in an MMCP.

Monitoring access to care means that there is contact with the child/youth and family to ensure that they are receiving the HCBS indicated in the POC and contact with the HCBS providers to ensure child/youth and family are attending the appointment and working toward established identified goals.

The contact with the family:
This contact may be by phone or other regular communication methods (unless otherwise outlined) but must occur at least once per quarter for CYES and the MMCP and once per month for Health Home care management. This verification can be combined with a regularly scheduled meeting or care management contact with the child/youth and family. Care Managers should document this contact in a case note. The monitoring access to care requirement does not change the high-medium billable standard for Health Homes. Alternatively, MMCPs can combine monitoring of access to care with the plan's service verification activity.

The contact with HCBS providers:
The contact with providers must occur at minimum once (unless otherwise outlined) during the service duration timeframe to ensure that appointment times and schedule accommodates the family's schedule and ability to attend. Additionally, this contact occurs to verify that the service(s) is meeting the identified need and progressing towards established identified goals. The HCBS provider(s) need to be an active member in the family's care team and person-centered POC development, monitoring and planning.

II. HCBS/LOC Eligibility and Plan of Care

II.A. HCBS/LOC Eligibility

To access Children's HCBS, a child must meet Level of Care criteria using the HCBS/LOC Eligibility Determination which is housed within the Uniform Assessment System (UAS) along with the Child and Adolescent Needs and Strengths – NY (CANS-NY) assessment. Only a HHCM, C-YES, or the OPWDD Developmental Disabilities

Regional Office (DDRO) are given access in the UAS to complete the HCBS/LOC Eligibility Determination.

Upon the signing and finalizing of the HCBS/LOC Eligibility Determination within the UAS, the assessor will be presented with an outcome of either HCBS/LOC eligible or not HCBS/LOC eligible for the identified target population. The HHCM/C-YES will send the child a Notice of Determination, which will memorialize the outcome of the HCBS/LOC Eligibility Determination and provide information on State fair hearing rights.

The HCBS/LOC Eligibility Determination is a twelve (12) month (annual) determination. The annual determination date does not change according to the CANS-NY completed for the Health Home Serving Children program. Once the HCBS/LOC Eligibility Determination outcome is complete within the UAS, it remains active for one year from the date of signature and finalized date, with two exceptions:

1) Change in circumstance - through person-centered care planning and collaboration with providers, child, and family, if knowledge of the child's change in circumstances is found as outlined below, a new HCBS/LOC Eligibility Determination is needed:
   - Significant change in child's functioning (including increase or decrease of symptoms or new diagnosis)
   - Service plan or treatment goals were achieved
   - Child admitted, discharged or transferred from hospital/detox, residential setting/placement, or foster care
   - Child has been seriously injured in a serious accident or has a major medical event
   - Child's (primary or identified) caregiver is different than on the previous HCBS /LOC
   - Significant change in caregiver's capacity/situation
2) In the event that a child that has been determined HCBS/LOC eligible and initially declines HCBS, but later requests HCBS, or if a child has been determined HCBS/LOC eligible, but has been placed on a wait list due to capacity limitations of the Children's Waiver: a new HCBS/LOC Eligibility Determination is required if an approved/active HCBS/LOC Eligibility Determination is not utilized within six (6) months of the date the HCBS/LOC Eligibility Determination outcomes.

If a child/youth is found HCBS/LOC ineligible and there is a change in circumstances, the child/youth can be reassessed at any time, as there is no wait period between assessments.

For more information regarding HCBS requirements for independent assessment, see Section 1915(i)(1)(F) of the Social Security Act.

II.B. Plan of Care (POC) Development

To develop a POC, the HHCM/C-YES must meet with the child/youth and their family and their identified care team to discuss the strengths and needs of the child/youth, using person-centered planning guideline/principles. The POC development is based upon the assessment of needs which is determined through the interaction with the child, their family, and identified supports as well as through the multi-disciplinary team meeting/information, CANS-NY (for HH), Health Home Comprehensive Assessment (for HH), and/or HCBS/LOC Eligibility Determination. The POC is led by the HHCM/C-YES and involves collaboration between family, family-identified supports, providers, other child-serving systems, and the MMCP (if enrolled). The HHCM/C-YES will recommend services that can support the child in reaching their defined goals and addressing identified needs. Each HCBS that the child receives must be listed in their POC with a defined goal.

The POC will change and evolve over time as the child meets their goals or there is a need for new services/supports. The POC is a fluid document that can be developed incrementally and may be updated at any time. At a minimum, the POC must be reviewed annually, during CANS-NY reassessment (for Health Home), or earlier if there is a significant life event as well as during HCBS/LOC Eligibility determination reassessment.

The POC must be signed by the child, if age appropriate (able to understand and contribute to their own POC) and/or the parent, guardian, or legally authorized representative. All involved providers must be given an opportunity to contribute to the POC and, with informed consent of the child/parent/guardian/legally authorized representative, sign the POC when it is developed.

NYS Person-centered planning guidelines:
https://www.health.ny.gov/health_care/medicaid/redesign/cfco/docs/2018-12-19_pcsp_guidelines.pdf

II.C. Development of the POC and Referrals for HCBS

At the time of the initial development of the POC, the POC must identify the need(s) of the child/family, the chosen HCBS, and goal/outcome to be attained. The POC must be reviewed with the child/family, signed by the child/family and copies given to the child/family and, with informed consent, to the involved multi-disciplinary team providers upon request.

When adding identified needs and services to a POC (initial/updated), it is not necessary to immediately identify the specific providers; providers should be specified

once it is assured the HCBS provider identified and chosen has availability to accept the referral. Additionally, forms have been developed, as outlined below, to facilitate updating and sharing the POC. This process will also ensure that the HHCM/C-YES are compliant with the child/family specific Protected Health Information (PHI) requests regarding the sharing of the POC with various providers.

Step 1: Referral to Identified HCBS Providers and Services

Once HCBS and HCBS provider(s) have been identified with the child/family through the person-centered POC process, the HHCM/C-YES will work with the identified HCBS provider(s) to set an initial intake appointment. This can be accomplished by making a phone call with or without the child/family present.

For MMCP enrollees, prior authorization is not required for the first 60 days, 96 units or 24 hours of HCBS,[4] in accordance with the *Children's Home and Community Based Services Provider Manual*.[5]

Regardless of how the initial intake appointment is established/scheduled, the HHCM/C-YES must complete the ***Referral for Home and Community Based Services (HCBS) to HCBS Provider*** form*.* This form needs to be completed and sent to the chosen HCBS provider(s) within four (4) calendar days of the HCBS referral request.

The HHCM/C-YES must ensure that referrals are made to in-network MMCP providers if the child/youth is enrolled in a MMCP. If the HHCM/C-YES is having difficulty finding HCBS provider for MMCP members, then the HHCM/C-YES should contact the MMCP to notify them and obtain assistance.

> *Note: For Non-Medical Transportation, Environmental Modification (E-MODS), Vehicle Modification (V-MODS) and Assistive Technology (AT) needs identified through the person-centered planning process, refer to guidance and policy links below, as the* ***Referral for Home and Community Based Services (HCBS) to HCBS Provider*** *form and related process does not apply for these HCBS.*
>
> Non-Medical Transportation:
> https://www.emedny.org/ProviderManuals/Transportation/index.aspx
>
> EMODS:
> https://www.health.ny.gov/health_care/medicaid/redesign/cfco/emod_guidelines.htm

[4] Prior authorization is not required for Crisis Intervention. Prior authorization is not required for the first 7 calendar days of Planned Respite. Prior authorization is not required for the first 72 hours of Crisis Respite.

[5] https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/hcbs_manual.pd

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VMODS:
https://www.health.ny.gov/health_care/medicaid/redesign/cfco/vmod_guidelines.htm

AT: https://www.health.ny.gov/health_care/medicaid/redesign/cfco/at_guidelines.htm

When Referring Child for HCBS the First Time

Use the ***Referral for Home and Community Based Services (HCBS) to HCBS Provider*** form**:**

- This form must be completed by the HHCM/C-YES for each HCBS provider selected by the child/family. If there are multiple identified HCBS providers, then a separate form needs to be completed for each individual provider. If an HCBS provider will be providing more than one HCBS for the child/family, then only one form needs to be used for that provider.
- Each HCBS must be specified on the form, indicating the title of the HCBS identified and the desired goal or need to be addressed as identified by the child and family.
- The completed form is sent by the HHCM/C-YES to each identified HCBS provider as documentation that a referral for HCBS was made.
- HHCM/C-YES should keep a copy of the form(s) sent and document within the case record when the form(s) were sent.
- HHCM/C-YES will need to establish how the form will be sent with each HCBS provider, i.e. fax, secure email, US mail, etc.

New/additional Referrals for Established Cases

The ***Referral for Home and Community Based Services (HCBS) to HCBS Provider*** form needs to be completed and sent to an HCBS provider when:

- There is a request or need to change the HCBS provider OR
- There is a new service requested OR
- There is a new need identified, or the child/family chooses to now address an identified need. This can occur when updating/reviewing the POC or an occurrence of a significant life event.

If the POC is being maintained by the MMCP, it is required the MMCP use the ***Referral for Home and Community Based Services (HCBS) to HCBS Provider*** form to refer the child/family to a new HCBS provider to ensure information regarding the need and goal related to the HCBS is communicated to the provider.

If the HCBS provider working with a child/family identifies a need for a new service which they are designated to provide, then the HCBS provider documents in the record and the HHCM/C-YES/MMCP, as applicable, are included in the discussion for the

service to ensure all parties are in agreement and that the child/family was presented options of choice of provider(s). The HHCM/C-YES/MMCP, as applicable, updates the POC accordingly and sends an updated ***Referral for Home and Community Based Services (HCBS) to HCBS Provider*** form with the new service to the chosen provider (either the original provider or different provider).

If the HCBS provider is not designated to provide the new identified service, then the HHCM/C-YES/MMCP, as applicable, will be notified so the child's care manager can identify a new HCBS provider by choice of the child/family, complete the ***Referral for Home and Community Based Services (HCBS) to HCBS Provider*** form, and send the referral to the chosen provider.

Step 2: Establishment of First Appointment and Notification to the MMCP *(if the child is not enrolled in a MMCP, skip this step)*

It is the responsibility of the referred HCBS provider(s) to ensure that the first scheduled appointment with the child/family is known by the HHCM/C-YES and the MMCP. The HCBS provider(s) will contact the MMCP to ensure their awareness of the first appointment. Should the first appointment be rescheduled, or the child/family misses their first appointment, the MMCP and HHCM/C-YES will need to be notified.

Notification to the MMCP regarding the HCBS appointment must be made **IMMEDIATELY** upon the first appointment being scheduled. The HCBS provider should not wait until they have exhausted the initial service amount of 60 days, 96 units, or 24 hours. When the HCBS provider is contacting the MMCP, they will need to know the following information:

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

Contact with the MMCP for this purpose can occur by phone, or fax, however established between the MMCP and the HCBS provider.

If the first appointment will be rescheduled, the MMCP must be notified of the rescheduled first appointment **PRIOR** to the appointment, to ensure that the count will begin for the initial coverage of 60 days, 96 units, or 24 hours of any HCBS at the appropriate time. The HHCM/C-YES must be notified of the rescheduled first appointment to work with the child/family to ensure their attendance to the rescheduled first appointment and assist with any barriers of attending the first appointment.

Upon receipt of notification of the first appointment, the MMCP will establish the provider on their claim systems to ensure payment for 60 days, 96 units, or 24 hours.

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

Once the referred HCBS provider has met with the child/family for the first appointment and any subsequent appointments needed to establish if the referred service is appropriate for the identified need/desired goal and how the service will be delivered, then the HCBS provider must request authorization of HCBS needed beyond the initial 60 days, 96 units or 24 hours. Providers should not wait until this initial service amount/period has been exhausted before proceeding with this step. To request continued authorization the HCBS provider will complete the ***Children's HCBS Authorization and Care Manager Notification Form.*** This form must be completed and sent immediately upon the assessed and identified information of Frequency, Scope and Duration (F/S/D) is made, as outlined below.

For the Child/Youth Enrolled in a MMCP:

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

1) HCBS provider completes Section 1 of the ***Children's HCBS Authorization and Care Manager Notification Form*** and sends to MMCP.
2) The MMCP completes service authorization review and issues determination to the HCBS provider and the enrollee.
3) When the authorization process is complete, the HCBS provider completes Section 2 of the ***Children's HCBS Authorization and Care Manager Notification Form*** and sends copy of form AND service authorization determination to HHCM.
4) HHCM updates POC and distributes POC as outlined below in **Development, Updating, and Distribution of the POC** section.

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

1) HCBS provider completes Section 1 of the ***Children's HCBS Authorization and Care Manager Notification Form*** and sends to MMCP.
2) The MMCP completes service authorization review and issues determination to the HCBS provider and the enrollee.
3) MMCP care manager updates POC and distributes the POC.
4) The MMCO will share the POC with C-YES at least quarterly.

- The HCBS Provider and MMCP will need to establish how the form will be sent to the MMCP, i.e. fax, secure email, US mail, etc.
- The HCBS Provider will indicate on the form the title of the HCBS to be provided, the desired goal or need to be addressed by choice of the child and family and if this goal has been updated since previously form sent.
- The HCBS Provider will indicate the Frequency, Scope and Duration of each specific services that the provider was referred to provide and agrees is necessary based upon their intake assessment.

- The HCBS Provider should keep a copy of the form(s) sent and document within the case record when the form(s) were sent.
- The MMCP may request additional information to complete the review.

The MMCP will review the documentation provided and the child's POC, and issue a determination in accordance with the Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract (Model Contract): standard concurrent review is completed within 1 business day of all needed information received but not more than 14 calendar days from the request, unless the review is extended, which may add up to 14 calendar days to the review.[6] The MMCP must inform the HCBS provider and the child/family of the determination outcomes. If the MMCP denies or partially approves the services requested by the HCBS provider, the MMCP must issue an initial adverse determination with applicable appeal rights.

For a child in Health Home, once the HCBS provider has received authorization for Frequency, Scope, and Duration of HCBS, the HCBS provider must notify the HHCM to add these details to the POC, within five (5) calendar days of notification. The HCBS provider will also notify if there is a change or denial by the MMCP to the requested continuance of HCBS and the frequency, scope, and duration. It is the responsibility of the HHCM to work with the HCBS provider, the MMCP and child/family to determine how to move forward with services and update the child's POC.

The HCBS provider completes Section 2 of the ***Children's HCBS Authorization and Care Manager Notification Form*** and forwards the Service Authorization Determination that was issued by the MMCP to the HHCM to communicate this information.

If the child is not enrolled in a Health Home, then the MMCP CM will update the child's HCBS POC to include the approved frequency, scope, and duration.

Ongoing Services

Before the end of the authorization period, if the child/family and HCBS provider believe additional services are needed, the HCBS Provider completes the ***Children's HCBS Authorization and Care Manager Notification Form*** at least 14 calendar days prior to the existing HCBS authorization period ending, following the above process to obtain authorization and ensure the POC is updated. The HCBS provider may also contact the

[6] For the purposes of this policy, concurrent review means a review of a request for authorization of continued, extended, or more services during a period in which the child is receiving services. See concurrent review timeframes as of 4/1/18 here: https://www.health.ny.gov/health_care/managed_care/plans/appeals/2018-2-2_timeframe_comparison.htm

MMCP directly to discuss the continued service, however the ***Children's HCBS Authorization and Care Manager Notification Form*** *will need to be completed for documentation purposes.*

For the Child NOT Enrolled in MMCP:

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

1) HCBS provider completes Section 1 of the ***Children's HCBS Authorization and Care Manager Notification Form*** and sends to HHCM.
2) HHCM updates POC and distributes POC as outlined below in **Development, Updating, and Distribution of the POC** section.

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

1) HCBS provider completes Section 1 of the ***Children's HCBS Authorization and Care Manager Notification Form*** and sends to C-YES care manager.
2) C-YES updates POC and distributes POC as outlined below in **Development, Updating, and Distribution of the POC** section.

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

Once the referred HCBS provider has met with the child/family for the first appointment and any subsequent appointments as needed to establish if the referred service is appropriate for the identified need/desired goal and how the service will be delivered, then the HCBS provider will complete the ***Children's HCBS Authorization and Care Manager Notification Form.*** This form must be completed and sent immediately upon the assessed and identified information of Frequency, Scope and Duration is made, to the HHCM/C-YES as outlined below.

- The HCBS Provider will complete the ***Children's HCBS Authorization and Care Manager Notification Form*** and send to the HHCM/C-YES.
- The HCBS Provider will need to establish how the form will be sent the HHCM/C-YES, i.e. fax, secure email, US mail, etc.
- The HCBS Provider will indicate on the form the title of the HCBS to be provided, the desired goal or need to be addressed by choice of the child and family and if this goal has been updated since previously form sent.
- The HCBS Provider will indicate the Frequency, Scope and Duration of each specific services that the provider was referred to provide and agrees is necessary based upon their intake assessment.
- The HCBS Provider should keep a copy of the form(s) sent and document within the case record when the form(s) were sent.

- The HHCM/C-YES should keep a copy of the received form(s) and document within the case record when the form(s) were received.

Ongoing Services

The HCBS Provider should use the above process to inform the HHCM/C-YES of continued F/S/D updates for the child's services. New service needs should be discussed with the HHCM/C-YES as in Step 1 above.

Step 4: Development, Updating, and Distribution of the POC

The POC is never stagnant and must be flexible to ensure it is meeting the child/family's changing needs, situation, and choice. Therefore, there are points in time in which the POC will need to be sent to the MMCP (if applicable) with the information that is the most up-to-date at the time and the HHCM/C-YES should not hold off sending to the MMCP while awaiting information. Additionally, HHCM/C-YES do not need to have the child/family along with other identified supports and involved professionals re-sign the POC if information is added **to previously identified** needs, goals, and choice of services in the POC. Updates to the POC, as a part of this process, should always be reviewed with the child/family at the next appropriate meeting to ensure agreement and to verify appropriate service delivery. If POC updates are not signed, proper documentation of how their input contributed to the update/revision must be recorded in the case record.

The POC must be signed at minimum during the annual review and if there is a significant change in the POC with newly identified need, goal, service, and/or provider.

Note: At a minimum, the child and/or the parent, guardian, legally authorized representative, and/or child must sign the POC at least once prior to submitting the completed POC to the MMCP.

The Health Home care manager is required to complete a POC with HCBS within thirty (30) days of the **initial** HCBS/LOC Eligibility Determination being conducted. A child/youth can become eligible for HCBS at various times, therefore the type of POC may vary at this 30-day timeframe.

Types of POC within 30-days of HCBS/LOC Eligibility:

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

Both the HCBS and Health Home comprehensive POC must indicate the child's HCBS with Frequency, Scope, and Duration. Additionally, a Health Home comprehensive POC will include, behavioral health services, medical services, community and natural supports, actionable needs identified through the CANS-NY, and comprehensive assessments. The HHCM must facilitate a person-centered conversation with the child, family, and their identified care team to identify their personal goals based on actionable needs and to determine how specific HCBS may support the child in achieving those goals.

- **POC by Health Home Care Managers:**

For children enrolled in an MMCP, within thirty (30) calendar days from the completion and signed (initial) POC, the HHCM must send the POC to the MMCP with whatever information is available at that time.

If the POC that is sent to the MMCP is an HCBS only POC, then when the HHCM develops a comprehensive POC that complies with Health Home Serving Children standards (within 60 days of Health Home enrollment), the POC must be re-sent to the MMCP.

- If the F/S/D has not been reported from each of the providers or services, then the POC must still be updated and sent to the MMCP within the 30-calendar day timeframe.
    - Once the remaining providers and or services have been reported with F/S/D, then the POC will be updated again with the new information within ten (10) business days of being notified by the HCBS provider of the F/S/D on the Children's HCBS Authorization and Care Manager Notification Form and the updated POC is shared with the MMCP.
    - If a new need and or service is identified by the HHCM, child/family, involved providers, etc., then the above outlined steps would be followed and the HHCM sends the updated POC to the MMCP within thirty (30) calendar days of the revision.

Note: If the member is in urgent need of services and/or will go over the initial 60 days/96 units/24 hours prior to the POC being sent to the MMCP, once the MMCP received the ***Children's HCBS Authorization and Care Manager Notification Form*** the MMCP will contact the HHCMA/HHCM to verify the POC.

- **POC by C-YES:**

C-YES must develop an HCBS POC using information from the HCBS/LOC Eligibility Determination, and a person-centered discussion that identifies personal goals and how specific HCBS may support the child in achieving those goals.

- For children who are in fee-for-service Medicaid and not in Health Home: C-YES will develop an HCBS POC with Frequency, Scope, and Duration, updating the HCBS POC using the information provided by the HCBS providers from the ***Children's HCBS Authorization and Care Manager Notification Form***. C-YES will conduct person-centered meetings with the child and family at least quarterly or upon significant change and update the POC as necessary.
- For children who are enrolled in an MMCP and not in Health Home: C-YES must send the HCBS POC to the MMCP within 15 calendars days of its development with whatever information is available at that time. The MMCP is required to update the HCBS POC with the child/family using the information provided by the HCBS providers from the ***Children's HCBS Authorization and Care Manager Notification Form*** and related service authorization determinations. The MMCP will meet with the child and family as needed to maintain the POC with person-centered service planning and care management for children with special needs as per the Model Contract.

C-YES will determine annual HCBS/LOC Eligibility and conduct an annual review and will coordinate with the MMCP to update the HCBS POC, with signatures based upon the HCBS/LOC reassessment.

III. Referrals for HCBS

III.A. Referrals by Health Home Care Managers

The HHCM must follow up on referrals made and work to keep the child/family engaged, ensuring linkage to service. This may include sending reminders for appointments, arranging transportation, and contacting the child, family, and/or providers throughout the referral process. Additionally, the HHCM is responsible for making referrals and ensuring proper connectivity to any other service providers, to meet the comprehensive needs of the child, and must meet all HHSC standards.

III.B. Referrals by the Child-Youth Evaluation Service (C-YES)

For children in fee-for-service Medicaid who are not in Health Home, C-YES will be responsible for making referrals to HCBS providers and will retain responsibility for updating the POC.

For children enrolled in an MMCP who are not in Health Home, C-YES will make first referrals to the HCBS providers and send the MMCP the HCBS POC, the MMCP will assume responsibility for updating the POC, including changes to services, changes in HCBS provider, and changes in frequency, scope, and duration of a service.

III.C. Referrals to HCBS Providers

Prior to making any referral, the HHCM/C-YES must complete the following:

- Provide a choice of HCBS providers in the child's community who can deliver the recommended service. For children in a MMCP, all providers must be In-Network providers[7]. It is the responsibility of the HHCM/C-YES to verify the In-Network status of the HCBS provider.

- Acquire a signed *Freedom of Choice (DOH-5276)* form, documenting the choice of HCBS providers.

- Acquire signed DOH 5201/5055 consent or C-YES consent form to share the child's information before making a referral with HCBS providers, MMCP, LGU/SPOA, and other appropriate identified service providers.

- Record the child's choice of HCBS provider in the child's case record.

Note: The HCBS provider is responsible for verifying the child's MMCP status to validate that the child is in a MMCP that the HCBS provider participates with, prior to accepting the referral.

IV. Updating the Plan of Care

The POC should be discussed with the family/child and all involved providers regularly to ensure active engagement surrounding work towards the POC's goals.

Possible updates to the child's POC must be discussed at the following intervals:

- Following the annual HCBS/LOC Eligibility Redetermination
- Following completion of the CANS-NY for Health Home program
- After a significant change in the child's condition (for example, admitted to a higher level of care or being discharged from a higher level of care)

[7] During the managed care transition period for HCBS children, a child may continue to see their current HCBS provider for a continuous episode of care for up to 24 months from the date the child was enrolled in a MMCP or from the date the HCBS are part of the benefit package, currently scheduled for October 1, 2019, regardless of whether that provider is in-network. Out-of-network providers must enter into single case agreements as needed to be reimbursed for services by MMCP's.

- Whenever the child experiences a significant life event
- Whenever a change that will impact the POC is requested (for example, requests to change service or provider, added HCBS due to a newly identified need)

If the POC needs to be updated, whenever possible, all involved providers, family-identified supports, other child-serving systems, and MMCP, should be involved in a person-centered multidisciplinary team (care team) meeting to discuss the need to revise the POC. If members of this multidisciplinary team are unable to attend, the POC must document how their input and needs drove revisions to the POC. The revised POC must be shared with the MMCP (if applicable) and other involved providers and supports, as appropriate.

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

VI. Individuals who are ineligible for or decline children's HCBS

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

1. Child is found eligible for HCBS, but child/family do not feel HCBS will help them reach their identified goals and therefore decline HCBS.
2. Child is found eligible for HCBS, but child/family choose to remain in a State Plan service already meeting their need(s).
3. Child is found eligible for HCBS and resides in a setting that is not considered home and community based (see NYS "HCBS Final Rule Statewide Transition Plan").

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

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

HHCM/C-YES will send Notice of Determination Form to the family/child indicating the outcome. (see Notice of Decision form for HH:
https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/nod_elig.pdf)

At any time, a child who was previously found ineligible for HCBS, can request and/or be referred for another HCBS/LOC Eligibility Determination by contacting the Health Home care management agency or C-YES who previously conducted the HCBS/LOC

Eligibility Determination. Since circumstances and situations may change, a child could be found eligible at any time.

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Appendix A: Table of Responsibilities

Milestone event	Responsible entity			
	Enrolled in MMCP		FFS Medicaid	
	Enrolled in HH	Opt-out of HH, Served by C-YES	Enrolled in HH	Opt-out of HH, Served by C-YES
HCBS Provider referral	HHCM	C-YES	HHCM	C-YES
Notifies MMCP and HHCM of First Appointment	HCBS Provider	HCBS Provider	N/A	N/A
On-going POC updates	HHCM	MMCP	HHCM	C-YES
Request Authorization for Services	HCBS Provider	HCBS Provider	N/A	N/A
Major life event requiring POC update	HHCM	MMCP	HHCM	C-YES
Monitoring access to care	MMCP	MMCP	HHCM	C-YES
Annual reassessment	HHCM	C-YES	HHCM	C-YES

Appendix B: Definition of Licensed Practitioner of the Healing Arts (LPHA) for Purposes of Documenting HCBS Risk Factors

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

a. Licensed Psychologist is an individual who is currently licensed and currently registered as a psychologist by the New York State Education Department from the New York State Education Department and who possesses a doctoral degree in psychology.

b. Licensed Clinical Social Worker (LCSW) is an individual who is currently licensed and registered as a Clinical Social Worker by the New York State Education Department.

c. Nurse Practitioner is an individual who is currently certified and currently registered as a nurse practitioner by the New York State Education Department.

d. Physician is an individual who is licensed and currently registered as a physician by the New York State Education Department.

e. Physician Assistant is an individual who is currently licensed and registered as a physician assistant by the New York State Education Department.

f. Psychiatrist is an individual who is licensed and currently registered to practice medicine in New York State, who (i) is a diplomat of the American Board of Psychiatry and Neurology or is eligible to be certified by that Board, or (ii) is certified by the American Osteopathic Board of Neurology and Psychiatry or is eligible to be certified by the Board.

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

Appendix C: Forms

1. ***Referral for Home and Community Based Services (HCBS) To HCBS Provider***

2. ***Children's HCBS Authorization and Care Manager Notification Form***