New York State Children's Health and Behavioral Health (BH) Services – Children's Medicaid System Transformation Guidance for the Transitional Period January 1, 2019 – January 1, 2020

Updated 4/3/2019 to reflect changes in Children's Managed Care Transition Timeline

Introduction

The New York State Department of Health (DOH), Office of Mental Health (OMH), Office of Alcohol and Substance Abuse Services (OASAS), Office of Children and Family Services (OCFS), and Office for People with Developmental Disabilities (OPWDD) are initiating a Children's Health and Behavioral Health System Transformation. The implementation of the new services beginning on January 1, 2019. The Children's Transformation is subject to Centers for Medicare and Medicaid (CMS) approvals and State approvals, and the timing of these approvals. Thus, the effective dates referred to in this document may be updated accordingly.

For information about how the Children's Health and Behavioral Health System Transformation transition will be implemented, please reference the *Transition Plan for the Children's Medicaid System Transformation*.

Purpose

This guidance is a supplement to the *New York State Health and Behavioral Health (BH) Services – Children's Medicaid System Transformation Billing and Coding Manual*, for the period of January 1, 2019 until January 1, 2020, and outlines the requirements necessary to ensure proper claim submission for services only during the time period specified. This guidance addresses:

- The billing for care coordination service now provided under each of the six existing children's 1915(c) waivers that will transition to Health Home beginning January 1, 2019.
- The billing transition for services moving from one of the six 1915c waivers to the Medicaid State Plan authority for Children and Family Treatment and Support Services, starting on January 1, 2019. These services are:
    - Other Licensed Practitioner (OLP)
    - Community Psychiatric Supports & Treatment (CPST)
    - Psychosocial Rehabilitation (PSR)
- Services delivered to children between January 1, 2019 and the date the service is expanded as a State Plan Service. These services are:
    - Family Peer Support Services (FPSS) - transition date to State Plan Authority 7/1/2019
    - Youth Peer Support and Training (YPST) – transition date to State Plan Authority 1/1/2020
    - Crisis Intervention (CI) – transition date to State Plan Authority 1/1/2020
- The billing transition for the existing State Plan Behavioral Health Services moving into Medicaid Managed Care on July 1, 2019.

- The billing transition for children in and discharged from foster care; including the impact of the removal of the exclusion from managed care enrollment for children in the care of Voluntary Foster Care Agencies (VFCAs) and removal of the exemption of foster care children in receipt of HCBS. This transition will occur on October 1, 2019.

This guidance is intended for use by Medicaid Managed Care Plans (MMCPs), including Special Needs Plans (SNPs), and behavioral health service providers.

This guidance is only applicable to information related to billing and claiming. It does not address applicable regulatory requirements or procedures for admission to a program, record keeping, service documentation, initial and on-going treatment planning and reviews, etc.

Transition Timeline:

Children's Proposed Medicaid Redesign Timeline ***Subject to the Availability of Global Cap Resources in excess of Budget Restoration*** ***Subject to timely CMS and other State Approvals***	**Anticipated Start**
• Care coordination service now provided under each of the six children's 1915(c) waivers will transition to Health Home beginning January 1, 2019 • Implement three of six new State Plan services, herein referred to as Children and Family Treatment and Support Services, statewide (Other Licensed Practitioner, Psychosocial Rehabilitation, Community Psychiatric Treatment and Supports) in Fee-for-Service and Managed Care	1/1/2019
• Children's 1915(c) waiver authority for new array of HCBS and the remaining three Children and Family Treatment and Support Services (Family Peer Support Services, Youth Peer Support and Training, and Crisis Intervention) until such time they transition to the Medicaid State Plan Authority and are added to the Medicaid Managed Care Benefit Package	4/1/2019
• Three-year phase-in of expansions of Level of Care (LOC) eligibility for HCBS begins (within limits of Global Spending Cap) • Family Peer Support Services (one of the six new Children and Family Treatment and Support Services) as a new State Plan service added to Medicaid Managed Care Benefit Package • Existing State Plan behavioral health benefits for children under 21 added to Medicaid Managed Care Benefit Package	7/1/2019
• Remove exclusion from mandatory managed care enrollment for children in the care of Voluntary Foster Care Agencies • Remove exemption from mandatory managed care enrollment for children in receipt of HCBS who are also placed in foster care • End exemption from mandatory managed care enrollment for children who formerly received care under each of the six children's 1915(c) waivers • HCBS in the consolidated Children's 1915(c) Waiver are included in the Medicaid managed care benefit package	10/1/2019
• Youth Peer Support and Training and Crisis Intervention (two of the six new Children and Family Treatment and Support Services) as new State Plan services added to the Medicaid Managed Care Benefit Package	1/1/2020
• Level of Need (LON) eligibility for HCBS begins	After full phase in of LOC eligibility

Health Home Care Management

Children eligible for HCBS are required to have some type of care coordination. For the new Children's Waiver beginning April 1, 2019 care coordination will be provided by Health Homes. The care coordination service now provided under each of the six children's 1915(c) waivers and the waiver children they serve will transition to Health Home between January 1, 2019 and March 31, 2019.

Health Home care manager will conduct HCBS eligibility determination and develop a person-centered comprehensive Plan of Care. Health Home is an optional benefit; therefore, children may opt out of Health Home care management and receive HCBS case management through the State-designated Independent Entity. The State-designated Independent Entity will conduct HCBS eligibility determinations and develop a Plan of Care for HCBS only, for those that opt out of Health Home. For children who opt out of Health Home and are enrolled in Medicaid Managed Care, the MMCP will monitor the Plan of Care. For children who opt out of Health Home and are not enrolled in Medicaid Managed Care the Independent Entity will monitor the Plan of Care.

Billing for Children Transitioning from each of the six children's 1915(c) Waiver Care Management to Health Home Care Management

During the January 1, 2019 to March 31, 2019 period, children enrolled in one of the six 1915(c) waivers will transition to Health Home care management. Upon signing a Health Home consents, the member must be enrolled in a Health Home through the MAPP HHTS. Health Home care management services are billed on a per member per month (PMPM) basis and therefore the care manager, with proper agreements in place with Health Homes, will bill the appropriate Health Home rate code (1864 – 1866), beginning in the month the consent is signed based upon the CANS-NY acuity of low, medium and high. Beginning at that time, all Health Home billing rules apply. Health Home rate codes and the six existing children's 1915(c) care management waiver rate codes may not be simultaneously billed for the same month of service.

To assist providers in successfully transitioning from OCFS B2H Health Care Integration (HCI) and OMH SED Individualized Care Coordination (ICC) **only** to Health Home Care Management, a developed Health Home Transitional Rate may be billed in addition to the Health Home CANS-NY acuity rate codes, within the parameters outlined.

Starting January 2019, these Transitional Rates can begin to be billed within the month a 1915c Waiver child is transitioned from OCFS B2H HCI or OMH SED ICC to Health Home Care Management. The Health Home Transitional Rate Codes must be used only for children who are receiving Health Home Care Management services and for

whom the Health Home core requirements have been met, for a Health Home claim to be submitted within the same month.

Health Home CANS-NY acuity billing is completed through the Lead Health Home and their IT billing platform in which the child was enrolled. The Health Home Transitional Rate Codes may be billed ***only*** when the Health Home core requirements have been met. Once a monthly Health Home claim has been submitted due to meeting the Health Home core requirements, the care manager organization will also submit a supplemental claim directly to Medicaid Fee-for-Service (FFS) for the transitional rate code that coincides with the Health Home CANS-NY acuity rate code.

Health Homes billing uses the first day of the month as the date of service (for service provided during that month). For example, if the care manager provides services during January, the date of service on the claim will be January 1 which will be billed by the Lead Health Home the child is enrolled in. The transitional rates will be billed by the care management organization using the Health Home billing rules. So, when Health Home services are provided in January, the care management agency will bill the transitional rate with a January 1 date of service.

OCFS B2H HCI or OMH SED ICC providers will be told the number of allotted transitional rates allowed to be billed each month through a transitional rate allocation letter. Providers that provide both OMH SED ICC and OCFS B2H HCI services will receive a separate letter containing the allotted number of Transitional Rates given for each waiver as the transitional rate amounts for B2H HCI and SED ICC are different. The rule in which the Transitional Rates are applied are still required.

Transitional rate codes are always billed Medicaid Fee-for-Service (FFS), even if the child has Medicaid Managed Care. OMH SED ICC waiver providers will use the transition rate codes 7924-7926, for acuity scores high through low respectively. OCFS B2H HCI waiver providers will use rate codes 8000-8002, for acuity scores high through low respectively. Providers will use procedure code T2022 (Case Management, per month) on claims. Each care manager organization will be able to bill up-to the number of allotted Health Home Transitional Rates each month, as long as there are at least that number of Health Home enrolled 1915c Waiver children who meet the Health Home core requirements.

The number of allotted Health Home Transitional Rates are *not* attached to a specific child; the provider organization may determine which children to attach the Transitional Rate Codes to each month and it does not have to be the same children each month. The intent of the Transitional Rate allocation is to assist providers during this transition period, continuity of care for waiver children within the OCFS B2H and OMH SED waiver during the transition and to ensure those providers with knowledge and expertise in serving the waiver population continue to serve waiver children within the Health Home program.

The Health Home Transitional Rates are effective over a two years period of 1/1/2019 – 12/31/2020, gradually decreasing to eventually align to the Health Home CANS-NY acuity rates. Beginning 1/1/2021, *only* the Health Home CANS-NY acuity rate codes will be billed, and the Health Home Transitional Rate Codes will be set to zero. Health Home Transitional Rates step-down gradually to the Health Home rates using four phases. This gradual decrease will assist providers with maintaining fiscal viability during the transition period.

During the transition month to Health Home care management of January 2019 through March 31, 2019, the CANS-NY should be completed within the same month in which the waiver child transitioned to Health Home care management and begin billing for the CANS-NY acuity. After April 1, 2019 accordingly to Health Home standards and requirements, the CANS-NY should be completed within 30 days of Health Home enrollment. If the CANS-NY is not completed within 30-days the low acuity rate will be billed.

Continuity of Care for State Plan Services Carved into Medicaid Managed Care

Generally, MMCPs are not permitted to apply utilization review for 90 days following the implementation of State Plan services included in the Children's Medicaid Health and Behavioral Health System Transformation moving into the MMCP Benefit package.

Certain continuity of care provisions will continue for 24 months from the date the benefits are included in Medicaid managed care (e.g.; October 1, 2019 through September 30, 2021):

1. For enrollees transitioning from FFS, Medicaid Managed Care Plans are required to authorize HCBS and LTSS in accordance with the existing plan of care (including access to the same provider) for 180 days, or until a new plan of care is in place, whichever is later, unless the beneficiary requests a change in the services provided.

2. Medicaid Managed Care Plans must allow children enrolling in the MMCP from FFS to continue with their current provider for a current behavioral health episode of care for up to 24 months from the benefit inclusion date, regardless of that provider's participation with the MMCP.

Continuity of Care for 1915(c) Transitioning Children

In addition to standard continuity of care provisions for all beneficiaries, the State has ensured that no 1915(c) Transitioning Children will lose access to services due to the transition to the new concurrent waiver authority.

1. Level of Care (LOC) forms must be completed as currently required under existing waivers for any transitioning child who is due for annual recertification between January 2019 through March 31,2019, even if the child has already transitioned to Health Home during this period. For any transitioning waiver child whose annual recertification is on or after April 1, 2019, based on the recertification date under the former waiver, the new HCBS/LOC Eligibility Determination will be completed within the month of the due annual recertification or at any time the participant experiences a significant change of condition (Ex – 90 day's post continued hospitalization). The reassessment for HCBS Eligibility Determination, will include verifying target population, risk factors and functional criteria. Depending upon the target population, the functional criteria will be determined by an HCBS algorithm that is applied to a subset of CANS-NY questions or by the Developmental Disabilities Regional Office (DDRO) to determine developmental disability. Reassessed 1915(c) Transitioning Children meeting HCBS LOC Eligibility Determination will continue to be eligible for HCBS. Children who are no longer eligible for HCBS may continue to be enrolled in Health Home provided they meet Health Home eligibility and appropriateness criteria.

2. Children will not be required to change their Care Management Agency due to this transition.

3. For 1915(c) Transitioning Children, the Health Home comprehensive plan of care, or independent entity HCBS plan of care, will preserve access to 1915(c) HCBS by cross-walking their services to the new State Plan or aligned children's HCBS.

4. For all 1915(c) Transitioning Children, Medicaid Managed Care Plans are required to authorize covered HCBS and LTSS in accordance with the existing plan of care (including access to the same provider) for 180 days from the date the services are carved into managed care, or from the date the child transitions to managed care, or until a new plan of care is in place, whichever is later, unless the beneficiary requests a change in the services provided.

5. For all 1915(c) Transitioning Children, Medicaid Managed Care Plans will not conduct utilization review or require service authorization for new Children and Family Treatment and Support Services or aligned children's HCBS added to plans of care for 180 days from the date the services are carved into managed care, or from the date the child transitions to managed care.

6. Medicaid Managed Care Plans must allow 1915(c) Transitioning Children to continue with their current provider for a current episode of care for up to 24 months, regardless of that provider's participation with the plan.

7. Aligned children's HCBS and new Children and Family Treatment and Support Services are comparable to or enhanced from the HCBS currently provided under the 1915(c) authorities.

Children's Medicaid System Transformation Continuity of Care Requirements		
Child's HCBS Status	**Timeframe**	**Requirement**
All children enrolled in MMCP	90 days from the date the service is carved into MMC	MMCP may not apply Utilization Management (UM) criteria from the implementation date for all services newly carved into Managed Care for individuals under age 21.
1915(c) Transitioning Child	180 days from the date the services are carved into managed care, or from the date the child transitions to managed care	During the first 180 days of the transition period[1] and in accordance with the most recent POC, MMCP will not apply UR criteria to HCBS or LTSS included in the POC.
1915(c) Transitioning Child	180 days from the date the services are carved into managed care	During the first 180 days of the transition period if the POC is modified to include additional children's specialty services[2], such services may not be subject to utilization review or prior approval by the MMCP.
1915(c) Transitioning Child	24 months from the date the services are carved into managed care	During the transition period, the MMCP must allow children to continue with their care providers, including medical, BH and HCBS providers, for a continuous Episode of Care. This applies only to Episodes of Care that were ongoing during the transition of the service from FFS to managed care including those originating children's 1915(c) services that will move into the concurrent waiver authority until they transition to the Medicaid State Plan.
FFS Child in Receipt of HCBS	180 days from enrollment in MMCP between 04/01/19 and 04/01/21	During the first 180 days of enrollment and in accordance with the most recent POC, MMCP will not apply UR criteria to HCBS or LTSS that is included in the POC.

[1] "Transition period" is defined as 24 months from each implementation date.

[2] Children's specialty services are the Children and Family Treatment and Support Services and Aligned HCBS Waiver services.

MMCPs may apply utilization review criteria, as permitted in the Medicaid Managed Care Model Contract, and in compliance with parity laws, for those services which were included in the managed care benefit package for children prior to this transition.

Services in the benefit package are:

- Inpatient psychiatric services
- Licensed mental health outpatient clinic services[3]
- OASAS inpatient rehabilitation services
- Medically managed detoxification (hospital based)
- Medically supervised inpatient detoxification
- Medically supervised outpatient withdrawal

The following 1115 demonstration services:

- Residential Addiction Services
- OASAS Community Based Outpatient Addiction Services

Some services are subject to annual or daily limits. Service utilization in excess of the annual claim limits and daily unit limits listed throughout each service description, and on the accompanying crosswalks, will be subject to medical necessity and possible post-payment review. Documentation of the medical necessity for extended durations must be kept on file in the consumer's record for the applicable period of time as defined by NYS Medicaid regulations.

Transition of Children and Family Treatment and Support Services

Three Children and Family Treatment and Support Services were implemented statewide as State Plan services on **January 1, 2019**. These services are:

- Community Psychiatric Support and Treatment (CPST)
- Other Licensed Practitioner (OLP)
- Psychosocial Rehabilitation (PSR)

For children enrolled in a Medicaid Managed Care Plan when the service is delivered, CPST, OLP and PSR should be billed directly to the MMCP. Please refer to the *New York State Children's Health and Behavioral Health (BH) Services – Children's Medicaid*

[3] SSI Children and Children with SED diagnoses enrolled in SED designated clinics were not included in the MMCP benefit package

System Transformation Billing and Coding Manual for more information about these services.

From **January 1, 2019 to March 31, 2019**, OMH SED waiver and OCFS B2H waiver providers who are designated to provide the Children and Family Treatment and Support Services listed above should bill the Children and Family Treatment and Support Service for crisis activities that correspond to the Crisis Response or Immediate Crisis Response crisis activities from the waivers, as outlined in the grid below and in compliance with the provider qualifications in the *Medicaid State Plan Children and Family Treatment and Support Services Provider Manual*.

For children enrolled in Medicaid managed care, providers must have entered into a provider contract or entered into a single case agreement with the child's MMCP. Claims for OLP, CPST, or PSR for dates of service January 1, 2019 and thereafter should be submitted to the child's MMCP, except for enrolled children who have federal Social Security Insurance disability status or have been determined Social Security Insurance-Related by New York State (SSI Children). SSI Children will receive these services through Medicaid beginning July 1, 2019.

If the provider has not been designated to provide the new Children and Family Treatment and Support Services OR the crisis activity(ies) provided does not align with the Children and Family Treatment and Support Services, the provider should bill the existing service rate code for Crisis Response or Immediate Crisis Response through March 31, 2019 or prior if they receive designation.

Providers who are not designated to provide CFTSS should begin to review the designated provider list within the county of the families' they serve to develop a transition plan to transfer the family to a designated provider that can provide CFTSS, as only CFTSS designated providers can provide such services as outlined in the CFTSS Manual and designation process. If the child is enrolled in a MMCP, the designated provider must be participating with the child's plan or arrange for a single case agreement.

Former Authority/ Service	Cross walks to	New Authority	Service	Rate Code(s)	Allowable Activities During Crisis Event
OMH Waiver Crisis Response	→	SPA Effective 1/1/2019	CPST	**7911** – CPST Service Professional **7921** – Off-Site CPST	Can provide face-to-face rehabilitative supports and intensive interventions during crisis and crisis avoidance pre-crisis and intermediate crisis response post crisis for a child on their caseload
	→	Until 3/31/2019	OMH Waiver Crisis Response	**4652** – Intensive In-Home Extended, 90 minutes **4657** – Brief, 30 minutes **4658** – Full, minimum of 60 minutes	Activities or staff that cannot be billed under rehabilitative supports Note: through 3/31/2019 24/7 crisis response is required through waiver. If the practitioner meets CPST qualifications and provides an activity meeting those requirements, then the agency should bill the State Plan otherwise the agency should bill waiver.
OCFS Waiver Immediate Crisis Response	→	SPA Effective 1/1/2019	CPST	**7911** – CPST Service Professional **7921** – Off-Site CPST	Can provide face-to-face supports and interventions during a crisis, pre-crisis avoidance and post crisis intermediate response for child on their caseload
	→	Until 3/31/2019	OCFS Waiver Immediate Crisis Response	**1322** - Intensive in Home Supports and Services **1349** - Intensive In Home Supports and Services **1376** - Intensive In Home Supports and Services **1319** - Crisis Avoidance & Management Training-Individual **1346** - Crisis Avoidance & Management Training-Individual **1373** - Crisis	Note: through 3/31/2019 24/7 crisis response is required through waiver. If the practitioner meets CPST qualifications and provides an activity meeting those requirements, then the agency should bill the State Plan otherwise the agency should bill waiver.

				Avoidance & Management Training-Individual	
N/A	**NEW** **Service Option**	SPA	OLP	**7900** – OLP Licensed Evaluation **7901** – OLP Counseling **7902** – OLP Crisis Offsite In-person **7903** – OLP Crisis Triage by Phone **7904** – OLP Crisis Complex Care	Can serve any Medicaid child. Provide Licensed Evaluation (Assessment) including Treatment Planning; Psychotherapy (Counseling); Crisis Intervention Activities: Crisis Triage (By telephone), Crisis Off-Site (In-person), Crisis Complex Care (Follow up), up to 3 visits prior to a treatment plan development.
N/A	**NEW** **Service Option**	Consolidated 1915(c) From 4/1/19 through 12/31/19 SPA (1/1/2020)	Crisis Intervention	**7906**- CI 1 Licensed Practitioner **7907** – CI 1 Licensed Practitioner & 1 Peer Support **7908** – CI Licensed Practitioners **7909** – CI 90-180 minute & 2 clinicians, 1 licensed **7910** – CI Per Diem 3 hours, 2 clinicians, 1 licensed	Payment occurs only for face-to-face response but includes telephone triage. 24/7 coverage with 1 hour response time (acknowledge that there will be ramp up as the new service is implemented statewide). DOH/OMH should develop plans for communities to develop this access.
(See Provider Manuals for more detail on service requirements and staff qualifications)					

Three additional Children and Family Treatment and Support Services will be implemented as State Plan services on the dates below. These services are:

- Family Peer Support Services (FPSS)- effective in the Medicaid State Plan July 1, 2019
- Youth Peer Support and Training (YPST) – effective in the Medicaid State Plan January 1, 2020
- Crisis Intervention - effective in the Medicaid State Plan January 1, 2020

Understanding the Transition

Authority for these Children and Family Treatment and Support Services and Aligned HCBS Waiver services will transition from the originating six children's 1915(c) waiver to a new concurrent waiver authority on April 1, 2019. This means:

- On or after the date of the implementation of the CFTSS through the Medicaid State Plan Authority, any child covered by Medicaid may receive the service if they meet medical necessity criteria. No HCBS eligibility is necessary to receive CFTSS.
    - Those children receiving Waiver services prior to the transition to the concurrent waiver authority will continue to receive these services after the transition to concurrent waiver authority. However, some Waiver services will transition to Medicaid State Plan services and HCBS eligibility will not be necessary to access these services. The crosswalk of original six children's 1915(c) waiver services to Children and Family Treatment and Support Services and concurrent waiver authority services is displayed in the following table:

Existing CAH I/II Waiver Services	Existing OCFS B2H Waiver Services	Existing OMH SED Waiver Services	Existing OPWDD CAH Waiver Services	New Children and Family Treatment and Support Services	Newly Aligned HCBS Benefits
	Immediate Crisis Response Services	Crisis Response Services		Crisis Intervention Community Psychiatric Supports and Treatment – Crisis Component OLP – Crisis Component	
	Crisis Avoidance, Management & Training AND Intensive In-Home Services	Intensive In-Home Services		Community Psychiatric Supports & Treatment	
		Family Peer Support Services		Family Peer Support Services	
		Youth Peer Advocacy and Training		Youth Peer Advocacy and Training	
				Other Licensed Practitioner	

Existing CAH I/II Waiver Services	Existing OCFS B2H Waiver Services	Existing OMH SED Waiver Services	Existing OPWDD CAH Waiver Services	New Children and Family Treatment and Support Services	Newly Aligned HCBS Benefits
	Skill Building	Skill Building		Psychosocial Rehabilitation Services	
Case Management	Health Care Integration	Individualized Care Coordination	Case Management		HH Care Management
	Crisis & Planned Respite	Respite Services	Respite		Respite
	Prevocational Services	Prevocational Services			Prevocational Services
	Family/Caregiver Support Services				Caregiver/ Family Support & Services
	Supported Employment	Supported Employment			Supported Employment
	Special Needs Community Advocacy and Support (SNCAS)				Community Self-Advocacy Training and Support
	Day Habilitation				Day Habilitation
					Community Habilitation
	Adaptive and Assistive Equipment		Assistive Technology – Adaptive Devices		Adaptive and Assistive Equipment
Home and Vehicle Modifications	Accessibility Modifications		Environmental Modifications (Home Accessibility)		Accessibility Modifications
Palliative Care (Family Education, Bereavement Service, Massage Therapy, Expressive Therapy)					Palliative Care Pain & Symptom Management
					Palliative Care Bereavement
					Palliative Care Massage Therapy
					Palliative Care Expressive Therapy
					Non-Medical Transportation
					Customized Goods & Services

- Children eligible for HCBS after April 1, 2019, may receive aligned HCBS, subject to available capacity. HCBS eligibility must be determined by a Health Home Care Manager or the Independent Entity. More information can be found in the Transition Plan for the Children's Medicaid System Transformation.
- Beginning January 1, 2019, designated Children and Family Treatment and Support Service providers will begin billing new rate codes for OLP, CPST and PSR if they have revised the service names in the Plan of Care for the eligible child to reflect the newly cross-walked services CPST and/or PSR as outlined in the *New York State Children's Health and Behavioral Health (BH) Services – Children's Medicaid System Transformation Billing and Coding Manual* Providers will have until January 31, 2019 to bill existing waiver codes that correspond to OLP, CPST, and PSR services while they revise the service names in the Plan of Care for the new services that crosswalk from historical waiver services and secure an LPHA recommendation.
- Beginning April 1, 2019, all designated HCBS providers will begin billing the new rates, rate codes and procedure codes for all new services as outlined in the *New York State Children's Health and Behavioral Health (BH) Services – Children's Medicaid System Transformation Billing and Coding Manual, with the exception of managed care billing for HCBS, which will not begin until the services are carved-in to managed care*. **All** HCBS will be billed fee-for-service through eMedNY from April 1, 2019 until such time the services are carved into managed care.
- As of the transition, providers will be delivering Children and Family Treatment and Support Services in compliance with the service description listed in the *Medicaid State Plan Provider Manual for Children's BH Early and Periodic Screening and Diagnostic Treatment (EPSDT) Services*, including Family Peer Support Services, Youth Peer Support and Training, and Crisis Intervention which will be implemented according to the timeline on pages 2-3.
- From April 1, 2019 through the effective date of the service in the Medicaid State Plan, Family Peer Support Services, Youth Peer Support and Training, and Crisis Intervention will be available only to waiver eligible children. As noted above, these services will be billed and provided in compliance with the new requirements.
- For those children enrolled in MMCP, Children and Family Treatment and Support Services will be billed directly to the MMCP beginning January 1, 2019, with the exception of SSI children as noted above on page 12.
    - The MMCP capitation will include OLP, CPST and PSR services beginning January 1, 2019.
- For those children enrolled in MMCP, aligned HCBS will be billed directly to the MMCP at the time the services are carved into managed care.

    - The MMCP capitation will not include any Children's Aligned HCBS for at least 24 months from the implementation of these services in MMC.
- For those children not enrolled in MMCP, Children and Family Treatment and Support Services and Aligned HCBS will be billed to FFS.

Transition of Existing State Plan BH Services to Managed Care

Existing Mental Health and Substance Use Disorder Treatment services delivered prior to July 1, 2019, will continue to be billed fee-for-service for children under 21 through eMedNY. These services are listed below. Effective July 1, 2019, the services below will be part of the MMCP benefit package and claiming will follow billing procedures defined in *New York State Health and Recovery Plan (HARP) / Mainstream Behavioral Health Billing and Coding Manual Billing and Coding Manual:*

- Assertive Community Treatment (ACT) (minimum age is 18 for medical necessity for this adult oriented service)
- Comprehensive Psychiatric Emergency Program (CPEP) (including Extended Observation Bed)
- Continuing Day Treatment (CDT) (minimum age is 18 for medical necessity for this adult oriented service)
- OASAS Outpatient and Opioid Treatment Program (OTP) services (hospital based)
- OASAS outpatient rehabilitation services (hospital based)
- Partial hospitalization
- Personalized Recovery Oriented Services (PROS) (minimum age is 18 for medical necessity for this adult oriented service)

Additionally, the following existing BH services that were previously part of the MMCP benefit package for children without SSI will be part of the MMCP for all children effective July 1, 2019, and these services will be billed to the MMCP for children enrolled in MMC.

- Inpatient psychiatric services
- OMH Licensed[4]

[4] This includes OMH SED designated clinics, which were previously carved out of MMC for children with SED diagnoses.

Transition of Children in the Care of Voluntary Foster Care Agencies and Children in Receipt of HCBS Placed in Foster Care into Medicaid Managed Care

The exclusion from enrollment in Medicaid Managed Care for children in the care of a VFCA and the exemption of mandatory Medicaid Managed Care enrollment for children in receipt of HCBS who are also placed in foster care will remain in effect until October 1, 2019

The chart below summarizes the transition of HCBS for and enrollment of children placed in foster care into Medicaid Managed Care.

Population	HCBS Benefit Transitions to Aligned Children's HCBS under the concurrent waiver authority; provided through FFS	Aligned Children's HCBS Benefit Transitions to MMC	Population enrolled in MMC**
Current and new children placed in foster care in direct care of the LDSS without HCBS	N/A	N/A	4/1/2013
Current children placed in foster care in the direct care of the LDSS and receiving HCBS	4/1/2019	10/1/2019	10/1/2019
New children placed in foster care in the direct care of the LDSS and in need of HCBS	4/1/2019*	10/1/2019	10/1/2019
Current and new children in the care VFCA without HCBS	N/A	N/A	10/1/2019
Current children in the care of VFCA receiving HCBS	4/1/2019	10/1/2019	10/1/2019
New children placed in care of VFCA and in need of HCBS	4/1/2019*	10/1/2019	10/1/2019
Current children discharged from foster care and receiving HCBS	N/A	10/1/2019	1/1/2019
New children discharged from foster care and in need of HCBS	N/A	10/1/2019	1/1/2019

*subject to the State's capacity
**required to enroll unless the individual is otherwise exempt or excluded from Medicaid Managed Care.

Claims Testing

To facilitate a smooth transition to Medicaid Managed Care billing, the MMCPs will reach out and offer billing/claim submission training to newly contracted providers. This will include testing claims submission and processing, and issuance of MMCP contact and support information to assist programs in claim submission.

MMCP contact information can be found at https://matrix.ctacny.org/.

Providers are expected to claims test with MMCPs prior to the service implementation date and upon executing a new contract. This should begin 90 days prior to the implementation date. MMCPs must keep their claims testing systems open throughout the transition.