Adirondack Health Institute

Lead Empower Innovate

POLICY AND PROCEDURE

Title: Children's Waiver and HCBS Policy

Department: Health Home

Intended Population: Health Home Serving Children

Effective Date: 7/1/2020

Date Revised: 1/1/2021;11/1/2022; 2/1/2023; 9/1/2023

DOH Policy Number: CW0002

Purpose of Policy

This Policy defines how a child accesses the aligned Children's Home and Community Based Services (HCBS) through the Children's Waiver, which became effective April 1, 2019. This Policy includes development of a person-centered Plan of Care (POC) that must be compliant with federal requirements; how referrals are made to HCBS providers, and how HCBS are approved and/or authorized.

Scope

1. This policy must be distributed to all AHI Health Home Program staff and all subcontracting Health Home Service Providers.
2. All recipients of this policy must acknowledge their receipt and understanding of the policy by referring any questions, problems, or compliance issues with the policy within ten days of the issue date to the AHI's Health Home Assistant Director.
3. All questions regarding this policy or its implementation may be directed to the AHI Health Home Assistant Director.

Statement of Policy

AHI shall develop, disseminate, and review at least annually, a Children's Waiver and HCBS Policy that addresses purpose, scope, roles and responsibilities, management commitment, coordination among organization entities, and compliance. AHI shall formalize documented procedures to facilitate the implementation of the Children's Waiver and HCBS Policy.

Definitions

AHI HH: AHI Health Home, a designated lead Health Home by the New York State Department of Health

Child: A person age 21 or younger who is not on AOT (Assisted Outpatient Treatment).

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Health Home Network Partners: The group of medical, behavioral, social services, and other community-based organizations by which a Health Home Participant receives services to address needs identified in the comprehensive care management plan developed by the Health Home Participant's AHI Health Home Services Provider.

Health Home Participant: A Health Home Candidate who is participating in the AHI Health Home and is assigned to an AHI Health Home Services Provider for care management.

Health Home Service Provider: An organization that has a fully executed contract (the "Health Home Services Provider Agreement") with the Adirondack Health Institute to provide health home outreach and/or care management services.

Care Management Record System: A structured information system, maintained by the Adirondack Health Institute Health Home (AHIHH), and made available for Health Home Service Providers and Health Home Network Partners to utilize, as applicable and appropriate to their role in the Health Home.

Core Health Home Services: The list of five (5) approved categories of services for which a Health Home Care Management Agency can be paid, as defined by the New York State Department of Health:

- Comprehensive Care Management
- Care Coordination & Health Promotion
- Comprehensive Transitional Care
- Member & Family Support
- Referral and Community & Social Support Services

Note: the sixth category of Core Health Home Services, "The use of HIT [Health Information Technology] to link services, as feasible and appropriate," is NOT considered a billable activity.

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: 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.

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.

Home and Community Based Services (HCBS)/Level of Care (LOC) Eligibility Determination: 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).

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

Workforce member: Employees, board members, volunteers, interns, independent contractors, vendors, and other persons whose conduct, in the performance of work for a covered entity, is under the direct control of such entity, whether or not they are paid by the covered entity. This includes full and part time employees, affiliates, associates, volunteers, and staff from third party entities who provide service to the covered entity.

Background

The Children's Waiver and HCBS Policy Program Policy at AHI is intended to facilitate the effective implementation of the processes necessary to meet the Health Home Program standards and requirements as stipulated by the NYS DOH, federal regulations, and best practices. This policy directs that AHI meet these requirements.

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All children and youth enrolled in Health Home may be eligible for Home and Community Based Services. Each Health Home Care Manager (HHCM) will need to be familiar with the services and how to identify youth that may benefit from HCBS. Health Home Care Managers and Care Management Agencies (CMA) are encouraged to discuss HCBS when a child or youth are at risk of a higher level of care. Each CMA and HHCM should utilize the Brochures or parent tip sheets provided by DOH when discussing services options. Health Home Care Managers are responsible for conducting HCBS Level of Care (LOC) Eligibility

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Determinations necessary for participation in the Children's Waiver. HHCMs will complete different steps, depending on if:

- The child/youth is newly referred to HCBS,
- The children/youth are actively enrolled in Medicaid,
- The child/youth is already enrolled in Health Homes Serving Children (HHSC), or
- The child/youth is being reassessed for HCBS eligibility.

The HHCM assigned to the member must be the individual that conducts the LOC Eligibility Determination and must maintain regular contact with the child/youth/family throughout the HCBS LOC Eligibility Determination process.

(Staffing contracts or subcontracting the HCBS LOC Eligibility Determination is not prohibited)

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:

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, as well as their medical, community, and natural supports as identified through a person-centered POC by the child/family.

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.

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.

Home and Community Based Services:

- Community Habilitation
- Day Habilitation
- Caregiver/Family Advocacy and Support Services

- Respite
- Prevocational Services
- Supported Employment
- Non-medical Transportation
- Adaptive and Assistive Equipment
- Vehicle Modifications
- Environmental Modifications
- Palliative Care- Expressive Therapy
- Palliative Care- Massage Therapy
- Palliative Care- Counseling and Support Services
- Palliative Care Pain and Symptom Management

Monitoring Access to Care

Monitoring access to care means that there is monthly contact with the child/youth and family to ensure that they are receiving the HCBS indicated in the Plan of Care (POC) and monthly contact with the HCBS providers to ensure child/youth and family are attending the appointments and working toward established, identified goals.

This contact may be by phone or other regular communication methods but must occur at least once per month for Health Home care management.

If the member has been placed on a waitlist the HHCM should have monthly contact with the provider agency and/or monitoring the waitlist.

Home and Community Based Services (HCBS)/Level of Care (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 Health Home Care Manager (HHCM), Children Youth Evaluation Services (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 HHCM will be presented with an outcome of either HCBS/LOC eligible or HCBS/LOC ineligible for the identified target population. The HHCM will send the child a Notice of Determination (DOH-5287), 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. 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 exceptions:

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Change in Circumstance

- 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

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.

Target Populations

Target Population Criteria must be met to begin the HCBS/LOC process. Each Target Population has specific risk factors and functional criteria.

Target Populations:
A. Serious Emotional Disturbance (SED)
B. Medically Fragile Children (MFC)
C. Developmental Disability (DD) and Medically Fragile
D. Development Disability (DD) and in Foster Care

HHCMs must document in the chart (by uploading supporting documentation) how the target population criteria were verified. A diagnosis alone is not enough, as the target population must be determined and documented by a licensed professional.

Requirements by target population for risk factors and functional criteria are listed below and must follow the three (3) step process when completing the HCBS/LOC Eligibility Determination in UAS.

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Serious Emotional Disturbance (SED)

Target Population- SED:

• SED target population definition (Diagnosis + Functional Limitations)
• The HHCM must acquire documentation from a Licensed Practitioner and the practitioner attests to diagnosis and functional impairment. The HHCM must collect the SED attestation and upload it into the record. This is an annual attestation that will need to be completed prior to the annual LOC as well.
• The proof of SED target population must be uploaded into Netsmart

Risk Factors (SED):
Once the target population information has been obtained and documented, the risk factors must be noted with supporting documentation through placement/hospital records and/or provider information in Netsmart. The child/youth must be under the age of 21. Child/youth has been diagnosed with a designated mental illness according to the most recent Diagnostic and Statistical Manual of Mental Disorders (DSM) (a comprehensive list of the designated mental illnesses is included on the LPHA Attestation form).

The child meets one of the factors:

1. The child is currently in an out-of-home placement, including psychiatric hospital, or
2. The child has been in an out-of-home placement, including psychiatric hospital within the past six months, or
3. The child has applied for an out-of-home placement, including placement in psychiatric hospital within the past six (6) months, or
4. The child currently is multi-system involved (i.e., two or more systems) and needs complex services/supports to remain successful in the community.

Out-of-home placement in LOC Risk Factor #1-4 includes: Residential Rehabilitation Services for Youth (RRSY), Residential Treatment Facility (RTF), Residential Treatment Center (RTC), or other congregate care setting such as SUD residential treatment facilities, group residences, institutions in the OCFS system or hospitalization. Multisystem involved means two or more child systems including: child welfare, juvenile justice, OASAS clinics or residential treatment facilities or institutions, OMH clinics or residential facilities or institutions, OPWDD services or residential facilities or institutions, or having an established IEP through the school district.

Documentation of these Risk Factors must be uploaded into Netsmart; these Risk Factors must be present for the initial LOC and annually thereafter.

A Licensed Practitioner of the Healing Arts determination and attestation, in addition to meeting one of the four risk factors above, is also required. The LPHA will be determining that the child/youth, in the absence of HCBS, is at risk of institutionalization. The DOH 5275-LPHA Attestation is required to be

completed and signed by the LPHA and uploaded to Netsmart. The LPHA signature date will be required when completing the HCBS/LOC Eligibility Determination. The HHCM will provide the LPHA with the form and any required documentation the LPHA may need to complete the form.

Child/youth must have experienced functional limitations due to emotional disturbance over the past 12 months on a continuous or intermittent basis, as determined by a Licensed Mental Health Professional; the functional limitations must be moderate in at least two of the following areas or severe in at least one of the following areas:

- Ability to care for self (e.g., personal hygiene; obtaining/eating food; dressing; avoiding injuries); or
- Family life (e.g., capacity to live in a family or family-like environment; relationships with parent or substitute parents, siblings, and other relatives; behavior in family setting); or
- Social relationships (e.g., establishing and maintaining friendships; interpersonal interactions with peers, neighbors, and other adults; social skills; compliance with social norms; play and appropriate use of leisure time); or
- Self-direction/self-control (e.g., ability to sustain focused attention for a long enough period of time to permit completion of age-appropriate tasks; behavioral self-control; appropriate judgment and value systems; decision-making ability); or
- Ability to learn (e.g., school achievement and attendance; receptive and expressive language; relationships with teachers; behavior in school)

For HCBS/LOC purposes, for all target populations, LPHA is defined as an individual professional who is a Licensed Psychoanalyst, Licensed Psychologist, Licensed Clinical Social Worker, Nurse Practitioner, Physician, Physician Assistant or Psychiatrist and practicing within the scope of their State license.

Functional Criteria (SED):

Once the target population and risk factors have been obtained and documented, then the Functional Criteria must be established to finalize the HCBS/LOC Eligibility Determination. It is the responsibility of the HHCM to obtain the documentation that supports the answers to the subset of the CANS-NY to meet the HCBS/LOC Functional Criteria and upload proof into Netsmart. Functional criteria is a subset of questions from the CANS-NY tool completed by the HHCM in the HCBS/LOC Eligibility Determination assessment.

If a child is already enrolled in HH with an active CANS-NY, when the child is assessed for HCBS Eligibility, the assessor can save time and effort by linking to a recently completed CANS-NY assessment within the UAS. To determine if a CANS-NY assessment is eligible to be linked to a HCBS/LOC Eligibility Determination, the CANS-NY assessment must:

- be the most recently signed and finalized assessment for the child,
- have a finalization date less than 6 months old, Children's Waiver & HCBS

- be for the same age range as the HCBS/LOC Eligibility Determination, and
- have the Target Population Selection in HCBS/LOC Eligibility Determination answered

Medically Fragile

Target Population (MF):

Medically Fragile children are children who have a chronic debilitating condition(s), who may or may not be hospitalized or institutionalized, and meet one or more of the following criteria: is technologically dependent for life or health sustaining functions; or requires complex medication regimen or medical interventions to maintain or to improve their health status; or is in need of ongoing assessment or intervention to prevent serious deterioration of their health status; or medical complications that place their life, health or development at-risk.

For the Medically Fragile Target Population the child/youth must be under 21 and only one of the three options need to be identified and documented to meet the Target Population. For the annual HCBS/LOC Eligibility Determination, current / updated documentation is needed for the eligibility each time the HCBS/LOC is conducted.

1. **Current SSI Certification** – as determined by New York State Office of Temporary and Disability Assistance (OTDA), NYS Supplemental Program (SSP) for either Supplemental Security Income (SSI) or Social Security

Disability (SSD) https://otda.ny.gov/programs/ssp/

For a child under the age of 18 it is every 3 years if the diagnosis may improve. For adults, it is every 3 years for a diagnosis that may improve, and every 7 years for a long-term diagnosis.

2. **DOH 5144 disability certificate** – https://health.ny.gov/forms/doh-5144.pdf
    a) The length of disability coverage varies from case to case. For example, the minimum is usually 12 months, and the maximum can be as long as 10 years.

3. Forms DOH 5151, 5152 and 5153
    b) DOH 5151 – "Childhood Medical Report" completed by physician
    c) DOH 5152 – "Questionnaire of School Performance" completed by teacher (if applicable)
    d) DOH 5153 – "Description of Child's Activities Report" completed by parent/guardian

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- All forms must be completed by appropriate professionals and caregivers to be reviewed and approved by a Licensed Professional of the Healing Arts (LPHA)
- These forms would accompany the LPHA Attestation that needs to be completed for the Medically Fragile Risk Factors to be reviewed by the LPHA
- These three forms can only be used for the initial LOC; annually the HHCM will need to have either a Current SSI certification or a disability certificate.

After HCBS eligibility is determined, it is REQUIRED that disability is established for the child/youth to remain in the Children's Waiver. These three forms above are never to be utilized for re assessment.

All proper documentation should be in the members record to support the Target Population criteria chosen and has been obtained and documented, the risk factors must be noted with the supporting documentation obtained. After the Target Population has been determined, the functional limitation must be determined by answering a subset of CANS-NY questions within the UAS. Supporting documentation must be in the case record to support the ratings within the CANS-NY

There are No required Risk Factors for this target population

Functional Criteria (MF)

Once the target population has been obtained and documented, then the Functional Criteria must be established to finalize the HCBS/LOC Eligibility Determination. It is the responsibility of the HHCM to obtain the documentation that supports the answers to the subset of the CANS-NY to meet the HCBS/LOC Functional Criteria and upload proof into Netsmart. Functional criteria are a subset of questions from the CANS-NY tool completed by the HHCM in the HCBS/LOC Eligibility Determination assessment.

If a child is already enrolled in HH with an active CANS-NY when the child is assessed for HCBS Eligibility, the assessor can save time by linking to a recently completed CANS-NY assessment within the UAS. To determine if a CANS-NY assessment is eligible to be linked to a HCBS/LOC Eligibility Determination, the CANS-NY assessment must:

- be the most recently signed and finalized assessment for the child,
- have a finalization date less than 6 months old, Children's Waiver & HCBS
- be for the same age range as the HCBS/LOC Eligibility Determination, and
- have the Target Population Selection in HCBS/LOC Eligibility Determination answered

- If the child is *not* found eligible for the Children's Waiver MF HCBS/LOC but is also believed or is diagnosed with a DD condition, then the child should be referred to OPWDD for the potential determination of DD eligibility and ICF IDD LOC for the OPWDD Comprehensive Waiver.
- If the child *is* found eligible for the Children's Waiver MFC HCBS/LOC, then to ensure the child has access to adult HCBS services provided under the OPWDD Comprehensive HCBS Waiver and other

State plan clinic services, the child should also subsequently seek OPWDD determination of DD eligibility and ICF IDD LOC.

Developmental Disability and Medically Fragile (DD/MF)

Target Population (DD/MF)

To meet DD/MF target population the child must be determined Medically Fragile and have a Developmental Disability as defined by the Office for People with Developmental Disabilities (OPWDD) which would include meeting at least one (1) of the criteria a-c, as well as all criteria in d, e, and f.

a) is attributable to intellectual disability, cerebral palsy, epilepsy, neurological impairment, familial dysautonomia, Prader-Willi syndrome or autism; or
b) is attributable to any other condition of a child found to be closely related to intellectual disability because such condition results in similar impairment of general intellectual functioning or adaptive behavior of a child with intellectual disability or requires treatment and services similar to those required for such children; or
c) is attributable to dyslexia resulting from a disability described above; and
d) originates before such child attains age 22; and
e) has continued or can be expected to continue indefinitely; and
f) constitutes a substantial handicap to such child's ability to function normally in society

*** For Children who are Medically Fragile and suspected to have a Developmental Disability (not yet determined by OPWDD), the HHCM will conduct the HCBS/LOC following the Medically Fragile target population requirements for risk factors and functional criteria. ***

Annual LOC Process

To be eligible for the Children's Waiver HCBS/LOC Eligibility Determination under the Target Population of DD/MF, the OPWDD DDROs must complete the ICF-IDD Level of Care Eligibility Determination (LCED). When the HHCM has the ICF-IDD LCED from OPWDD for the Children's Waiver annual HCBS/LOC Eligibility Determination, then the HHCM will complete the HCBS/LOC Eligibility Determination within the UAS.

The annual HCBS/LOC Eligibility Determination and the ICF-IDD LCED may not be due at the same time. *If OPWDD has determined ICF-IDD LCED for a child/youth, the HHCM/C-YES should continue to work with OPWDD DDROs annually to continue eligibility for the DD/MF Target Population so the LCED is maintained annually with OPWDD. Should the child/youth need to transfer to OPWDD's services or the OPWDD Comprehensive Waiver, the child/youth can do so without difficulty. The annual OPWDD LCED maintenance is less difficult/time consuming when there has not been a lapse in eligibility. If the child/youth's OPWDD LCED has lapsed and they need OPWDD services, the child/youth must start all over to obtain OPWDD ICF-IDD LCED. Additionally, it absolutely necessary that children/youth at the age of 14 years old and above annually maintain their OPWDD LCED eligibility to ensure proper access to adult HCBS*

services (at age 21) provided under the OPWDD Comprehensive HCBS Waiver and other State Plan clinic services.

If the child/youth is not found HCBS/LOC eligible for the Children's Waiver under the MF Target Population, but may have a DD condition, then the child/youth should be referred to OPWDD for the ICF-IDD LCED for determination of DD eligibility and possible enrollment in the OPWDD Comprehensive Waiver

HCBS/LOC Outcomes:

- If the child is *not* found eligible for the Children's Waiver MF HCBS/LOC but is also believed or is diagnosed with a DD condition, then the child should be referred to OPWDD for the potential determination of DD eligibility and ICF IDD LOC for the OPWDD Comprehensive Waiver
- If the child *is* found eligible for the Children's Waiver MF HCBS/LOC, then to ensure the child has access to adult HCBS services provided under the OPWDD Comprehensive HCBS Waiver and other State plan clinic services, the child should also subsequently seek OPWDD determination of DD eligibility and ICF IDD LOC
- As part of providing care management and planning transition care, HHCMs must ensure this referral and determination is made for its MF DD children well before the child's 21st birthday.

OPWDD and ICF-I/ID LOC Process

Once the child is found to be MF HCBS/LOC eligible, has a POC in place and is accessing HCBS, the HHCM will also begin the OPWDD determination process if applicable. The HHCM will submit the Children's Waiver Transmittal Form with the documents listed below to OPWDD's Children's Liaison:

- General medical report completed within the past 365 days
- Copy of child's Plan of Care (POC), social/developmental history, psychosocial report or other report that provides information on developmental history/psychosocial status within the past 365 days.
- Current Psychological Report that includes assessment of intellectual and adaptive functioning (most recently available psychological report may be used as long as it accurately reflects the child's current status). An Early Intervention Multidisciplinary Core Evaluation may be acceptable provided it includes standardized test scores relevant to cognitive, language and communicative, adaptive, social, and motor functioning and includes the participation of a school psychologist or licensed psychologist.
- For conditions other than intellectual disability, a medical or specialty report that includes health status and diagnostic findings to support the developmental disability diagnosis.

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Developmentally Disabled (DD) and Foster Care

Target Population (DD/Foster Care)

To meet DD/FC target population, the child must have a developmental disability as defined by OPWDD which would include meeting at least one (1) of the criteria a-c, as well as all criteria in d, e, and f.

a) is attributable to intellectual disability, cerebral palsy, epilepsy, neurological impairment, familial dysautonomia, Prader-Willi syndrome or autism; or
b) is attributable to any other condition of a child found to be closely related to intellectual disability because such condition results in similar impairment of general intellectual functioning or adaptive behavior of a child with intellectual disability or requires treatment and services similar to those required for such children; or
c) is attributable to dyslexia resulting from a disability described above; and
d) originates before such child attains age 22; and
e) has continued or can be expected to continue indefinitely; and
f) constitutes a substantial handicap to such child's ability to function normally in society

The child must also meet one of the criteria below:

- Current Foster Care (FC) child in the care and custody of Local Departments of Social Services (counties and New York City) (LDSS) or a child in the custody of OCFS Division of Juvenile Justice and Opportunities for Youth (DJJOY) or
- A FC child who enrolled in HCBS originally while in the care and custody (LDSS) or (DJJOY). Once enrolled, eligibility can continue after the child is discharged from LDSS and OCFS DJJOY custody so long as the child continues to meet targeting, risk and functional criteria (no break in coverage permitted*). This risk factor continues Maintenance of Effort for children up through, but not including, their 21st birthday.

DD/FC HCBS/LOC Process

OPWDD Developmental Disability Regional Office (DDRO) will complete the HCBS/LOC Eligibility Determination for all children that would meet DD Foster Care for initial determinations and annual re-determinations, which includes the ICF-I/ID Level of Care Eligibility Determination (LCED). The HHCM will work with the family and other involved providers to gather the necessary documentation needed to refer the child to the DDRO. The HHCM will then make a referral and provide the required information and work with the DDRO to determine that the child meets the DD ICD-I/ID LCED.

The following documentation will need to be completed/submitted through Health Commerce System (HCS) Secure File Transfer when referring a child/youth to the OPWDDDDRO* for HCBS/LOC determination:

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- The Children's Waiver Transmittal Form
- General medical report completed within the past 365 days
- Copy of child's Plan of Care (POC), social/developmental history, psychosocial report or other report that provides information on developmental history/psychosocial status within the past 365 days.
- Current Psychological Report that includes assessment of intellectual and adaptive functioning (most recently available psychological report may be used as long as it accurately reflects the child's current status). An Early Intervention Multidisciplinary Core Evaluation may be acceptable provided it includes standardized test scores relevant to cognitive, language and communicative, adaptive, social, and motor functioning and includes the participation of a school psychologist or licensed psychologist.
- For conditions other than intellectual disability, a medical or specialty report that includes health status and diagnostic findings to support the developmental disability diagnosis.

The DDRO will monitor the eligibility determination and once a determination is made, an Eligibility Letter will be sent by the DDRO.

If the child is determined to be OPWDD eligible, the DDRO completes the initial ICFI/ID LCED. If the child is determined OPWDD ineligible, DDRO notifies the HHCM and VFCA (if applicable) for alternative services. DDRO will send the eligibility letter to the individual.

Once the child is found ICF-I/ID eligible:

- The OPWDD Children's Liaison works with the HHCM/C-YES to secure physician signature.
- The OPWDD Children's Liaison signs the ICF-I/ID LCED and e-mails through the HCS secure file transfer HHCM/C-YES securely with scanned copy.
- The DDRO will enter the UAS HCBS Eligibility Determination and complete the HCBS/LOC documentation.
- DDRO communicates the HCBS/LOC results to the HHCM.
- HHCM contacts Capacity Management to confirm there is capacity in the Children's Waiver.
- HHCM will communicate the outcomes of these determinations to the child/youth and family throughout the process.

To be eligible for the Children's Waiver HCBS/LOC Eligibility Determination under the Target Population of DD/Foster Care, the OPWDD DDROs must complete the ICF-IDD Level of Care Eligibility Determination (LCED). The UAS identifies if the OPWDD ICFIDD LCED is up to date and current, if so, then the HHCM/C-YES can complete the HCBS/LOC Eligibility Determination within the UAS. Otherwise, the DDROs will complete the HCBS/LOC Eligibility Determination within the UAS after the ICF-IDD LCED is determined, which the HHCM/C-YES will confirm for enrollment/continuous enrollment in the Children's Waivers.

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Risk Factors for DD AND Foster Care:
Request documentation of foster care placement or previously in foster care when enrolled in HCBS, without a break in HCBS

HCBS/LOC Outcomes

Upon completion of the HCBS/LOC determination the UAS will display the outcomes immediately. The member will be found Eligible or Ineligible for HCBS.

Ineligible

If a Child/Youth is found ineligible for HCBS, the HHCM needs to complete the DOH-5287 (Notice of Decision for Denial of Enrollment) and upload a copy into the chart. If at any point, there is a change in circumstance or at the request of the family or a provider the HCBS/LOC determination can be done again by the HHCM; there is no waiting period. If the member is deemed ineligible this must be recorded in the member's Health Home Plan of Care.

Notice of Decision:

If the child/youth is not found to be HCBS eligible, the HHCM will send the NOD form to the child/family and will work with the child/family to connect to other needed services, as appropriate. The same form – Notice of Decision (NOD) Enrollment (DOH5287) – is sent for both enrollment and denial of enrollment. The Notice of Decision (NOD) will document the outcome of the HCBS/LOC Eligibility Determination and provide information on State Fair Hearing rights available to the child/family if they do not agree with the HCBS/LOC Eligibility Determination.

Eligible

If the member is found eligible the member will be able to begin HCBS once the DOH capacity management team has assigned the member a slot. DOH will check the UAS daily for finalized HCBS/LOC determinations. The capacity management team will contact the HHCM via the Secure File Transfer located in the Heath Commerce System (HCS) within 24 hours of a finalized HCBS/LOC determination. If the member is assigned a slot the family will need to be issued the DOH-5276 Freedom of Choice form and a copy uploaded into the chart. The Children's Rights and Responsibilities Flyer will also need to be reviewed with the family and the conversation will need to be documented in the member's record. The family will also need to be issued the DOH-5287 Notice of Decision for Enrollment into the HCBS Waiver; if waitlisted the member will also need the DOH-5287.

Notice of Decision:

Upon signing and finalizing the HCBS/LOC Eligibility Determination within the UAS, the HHCM will be presented with an outcome confirming that the child/youth is HCBS/LOC eligible or ineligible for the identified Target Population. HHCMs must notify the child/youth of the HCBS/LOC eligibility determination within 3 – 5 business days of determining the eligibility outcome.

POLICY AND PROCEDURE

If the child/youth is determined eligible and there is a Children's Waiver slot available per Capacity Management, the HHCM will send the child/youth a Notice of Decision Enrollment (DOH5287) form. The Notice of Decision (NOD) will document the outcome of the HCBS/LOC Eligibility Determination.

Waitlist

DOH Capacity Management Team may place a member on a waitlist if there is no slot available. If the member is on the waitlist longer than six months, the HCBS/LOC Eligibility Determination will need to be re-completed in full at the time a slot becomes available. At this time the family will be issued the DOH-5276. If a member is on the waitlist for over a year the HHCM would need to have a discussion with the family about remaining on the waitlist. If the family chooses to remove themselves from the waitlist at this time, the HHCM must contact the DOH Capacity Management Team.

If the child/youth is determined HCBS/LOC eligible but no slot is available per Capacity Management, the child/family will still receive a NOD from the HHCM. Once a slot becomes available, DOH Capacity Management will notify the HHCM/C-YES and the HHCM/CYES will issue an updated letter to the child/family, indicating a slot is available.

Crisis Designation

If a member is placed on the waitlist but the HHCM feels that the child would be appropriate for a crisis slot, then the HHCM can complete the Crisis Designation Form. A HHCM can consider a Crisis Designation Slot if:

- HCBS would help prevent a long-term hospitalization (over 30 days).
- A member was recently discharged (within 30 days) or has an upcoming discharge form a hospital, nursing home, residential or psychiatric facility and HCBS would help the member safely return home.
- HCBS would help the member remain safely in the home if the child is having chronic disruptions (hospital and/or ER visits).

HCBS/LOC Eligible – But the family Declines

If the family/member decide they would no longer like to pursue HCBS then they would indicate that on the DOH-5276. The HHCM must contact the Capacity Management Team within 5 business days to let DOH know that the family/member has declined to participate.

If they initially declined but later decide to peruse HCBS (within 6 months) the HHCM can contact the capacity management team to see if there is a slot available. If there is no slot available, they will be placed on the waitlist. If the member/family declines HCBS, the HHCM must record this in the member's Plan of Care.

If they initially decline but later decide to peruse HCBS (after 6 months) then the HCBS/LOC Determination will need to be re-completed in full at that time, or when a slot becomes available. The HHCM will need to communicate with the Capacity Management Team about slot capacity.

Once a member has a slot and is enrolled in the HCBS Waiver K Codes will be assigned:

RR/E code	R/RE Code Description
K1	HCBS LOC
K3	HCBS Serious Emotional Disturbance (SED)
K4	HCBS Medically Fragile (MF)
K5	HCBS Developmentally Disabled and Foster Care (DD & FC)
K6	HCBS Developmentally Disabled and Medically Fragile (DD & MF)
K9	Foster Care
KK	Family of One
A1	Children's Health Home: indicates the member is in outreach or enrolled with a Care Management Agency (CMA)
A2	Children's Health Home: indicates the member is in outreach or enrolled with a Health Home (HH)

Annual HCBS/LOC Determination

HCBS/LOC Determination is an annual redetermination process for all target populations unless there is a significant life event.

Significant Changes Include:

- Service Plan or Treatment goals have been achieved
- The member was admitted, discharged, or transferred from hospital/detox, residential setting/placement, or foster care.
- The member's primary caregiver is different than the previous HCBS/LOC
- Significant change in the Caregivers capacity/situation

Each time an annual HCBS/LOC Determination is conducted, updated documentation supporting Target population, Risk Factors (for SED), and Functional Criteria are required. If the member is deemed eligible the Capacity Management Team will not contact the HHCM, but an updated DOH-5276 and DOH-5287 will need to be issued. The Health Home Care Manager will need to collect an annual DOH -5275 LPHA attestation for the SED population only prior to completing the annual HCBS/LOC Determination in the UAS unless there is a break in service.

Development of the Plan of Care

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.

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. If the initial POC with the identified HCBS does not contain Frequency, Scope, and Duration (F/S/D) then the HHCM will need to send an updated POC to the MMCP within 10 days of receiving F/S/D from the HCBS Provider. This process will be followed if there are changes in services.

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 Health Home Comprehensive POC must be re-sent to the MMCP.

Referrals to Identified HCBS Providers and Services

Prior to making referrals to HCBS providers, the HHCM must provide a choice of HCBS providers in the member's community who can deliver the service(s). If the member is enrolled in a MMCP then the provider must be In-Network. Parent/Legal Guardian will note their Freedom of Choice in the DOH-5276. The HHCM will need to ensure that the 5201/5055 contains the providers information in order to send the HCBS referral.

Once HCBS and HCBS provider(s) have been identified with the child/family through the person-centered POC process, the HHCM 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 Managed Care enrollees, prior authorization is not required for the first 60 days, 96 units or 24 hours of HCBS. HHCM 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 must ensure that referrals are made to in-network MMCP providers if the child/youth is enrolled in a MMCP.

HCBS Referral Form

This form must be completed by the HHCM for each HCBS provider selected. If there are multiple HCBS providers, then a separate form will need to be completed for each one. If one provider has been chosen to provide more than one service only one HCBS referral to that provider is needed listing the multiple HCBS service requests. Each HCBS must be specified on the form, indicating the time of the HCBS and the desired goal or need.

POLICY AND PROCEDURE

The completed HCBS referral is sent by the HHCM to each identified provider. HHCM should keep a copy of the form(s) in the member's chart. A new referral will need to be sent when there is a request to add a service, request to change a provider.

Once you have sent the HCBS referral form to the providers the HHCM will need to complete the HCBS referral assessment. In this tool you will select what services the family/member have chosen to receive and the status of that service. Each time the status of a service changes the HHCM must go into Netsmart and update the tool.

Authorization and Care Manager Notification Form

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.

<u>The member is enrolled in a Managed Care Plan</u>:

- HCBS Provider will complete the HCBS Authorization and Care Manager Notification Form and send to the MMCP.
- The plan will complete service authorization review and issue a determination to the HCBS provider and the member.
- When the authorization process is complete, the HCBS provider will complete Section 2 of the authorization form and send a copy to the HHCM within 5 business days.
- The HHCM will update the Plan of Care with Frequency, Scope, and Duration.

<u>The Member is Not enrolled in a Managed Care Plan:</u>

- HCBS Provider will complete Section 1 of the HCBS Authorization form and send it to the HHCM.
- The HHCM will update the Plan of Care with Frequency, Scope, and Duration.

POLICY AND PROCEDURE

Discontinuing HCBS

Members can discontinue HCBS for various reasons.

1. The member is admitted to an Excluded Setting.
    a) HCBS cannot be provided to a member who is in an excluded setting.
    b) If a member is placed in an excluded setting and receiving HCBS, the HHCM will pend the member's Health Home segment and notify the HCBS provider. If the member is in an excluded setting longer than 90 days, the member will need to be disenrolled from the HCBS Waiver.
    c) The member will need to discontinue HCBS after 90 days in an excluded setting. The HHCM will need to complete the DOH-5288 Notice of Decision for Discontinuance in the NYS 1915c Children's Waiver form, 10 days before the member will lose HCBS. A copy will also need to be placed in the member's chart.
2. The member no longer qualifies for HCBS – Annual HCBS/LOC Determination
    e) The HHCM will need to complete the DOH-5288 and upload to the member's chart.
    f) The HHCM will need to complete the DOH-5287 and upload to the member's chart.
    g) HHCM will need to notify the HCBS provider(s).
    h) The member can stay in Health Home and receive Health Home Care Management services; except for Family of One. Family of One members will lose their Medicaid status and will need to be Disenrolled (Please see the Health Home Disenrollment Policy).
3. The Member and/or Family request Disenrollment from HCBS
    a) The Member and/or family will be able to stay enrolled in the Health Home and receive Health Home Care Management if they would like to. If they chose to disenroll from Health Home, please follow the Health Home Disenrollment Policy.
    b) The HHCM will complete the DOH-5288 and upload a copy to the member's chart.

*** Any time a member is no longer in receipt of HCBS and will be issued the DOH-5288 the HHCM must contact the DOH Capacity Management Team and notify them of the member's disenrollment of the HCBS Waiver***

POLICY AND PROCEDURE

C-YES and Family of One

C-YES is the Independent Entity that is contracted with the Department of Health to provide Care Management services to those members who peruse HCBS but decline Health Home services. If your CMA is working with a member who wishes to disenroll from Health Home Care Management but maintain their HCBS, then the HHCM must make a referral to C-YES.

If you are working with non-Medicaid members and the HHCM believes that they can benefit from HCBS, the Care Manager can make a referral to C-YES to apply for Family of One status.

Guidance for E-Mod, V-Mod, and AT Request

The HHCM will identify a specific need for the member and identify the need on the Health Home Plan of Care. The HHCM will ensure that the family is issued/reviewed the Caregiver Information Sheet for the correlating request. The HHCM will secure a Physicians order or statement that supports the members need and justification for the requested service. This can be done on the DOH-4359 or on Physician's Letter Head.

The HHCM will notify NYSDOH of the identified need and the anticipated request for an AT, EMod, and/or VMod within seven (7) business days of adding/updating the POC with the needed AT, EMod, and/or VMod and starting the application process for both Fee for Service (FFS) and Medicaid Managed Care Plan (MMCP)enrolled children/youth. The HHCM will send this notification by email to EModVModAT@health.ny.gov with the following information and CC the Health Home:

1. Child's/youth's name
2. Child's/youth's CIN #
3. Type of request: AT, EMod, or VMod
4. The County LDSS/MMCP to which the request will be submitted
5. Brief summary of the request
6. HHCM agency name and HHCM contact information for HHCMs, the Lead HH should be cc'd on the email

The HHCM will work with the family to secure clinical justification (Physical therapist, Behavioral health Specialist, licensed profession, etc.). The justification should define the scope and appropriateness and ensure that the request would not be covered under private insurance, community programs or other local/state/federal programs. Bids will need to be collected from three qualified Vendors/Contractors. The HHCM, family, and LDSS/MOC will work collaboratively on this process. The HHCM will then send the Request for Service Packet to the LDSS/MCO:

Request for Service Packet must include:

1. The Member's Plan of Care that identifies the assessed need.
2. Physicians' order supporting medical necessity (signed and dated).

3. Professional assessment/clinical justifiable identifying the scope of the project and documentation detailing the project/product specification including scope, estimated material, and labor costs, and other requires expenditures.
4. Bids: if the AT, E-Mod or V-mod costs $1,000 or more, 3 bids or justification for why 3 bids could not be secured, is required.
5. Any required documentation that is needed for the modification/service/adaption/device such as landlord's permission if the home is leased, or proof that the vehicle is less than 5 years old/less than 50,000 miles for a V-Mod (all requirements in the HCBS Provider Manual).
6. Completed ***Clinical Justification*** with the description/scope of work and ***Cost Projection Form***.

Non-Medical Transportation

Non-Medical Transportation services are offered in addition to any medical transportation. Non-Medical Transportation services are available for individuals to access authorized HCBS and destinations that are related to a goal included on the child/youth's POC.

Examples where this service may be requested include transportation to: HCBS that a child/youth was determined eligible to receive, a job interview, college fair, a wellness seminar, a GED preparatory class, etc. This service will be provided to meet the child/youth's needs as determined by an assessment performed in accordance with the State's requirements and as outlined in the child/youth's POC (Plan of Care). The care manager must document a need for transportation to support an individual's identified goals. The Health Home Care Manager will include justification for this service within the Person-Centered POC.

Health Home Care Managers are responsible for conducting and developing the Person-Centered POC. If the care manager determines there is a need for transportation to support an individual's identified goals, the Health Home Care Manager will include justification for this service within the Person-Centered POC. The Health Home Care Manager will complete the NYS DOH Plan of Care Grid for Non-Medical Transportation for Children's Home and Community Based Services (HCBS) with all known information. It is possible that the complete trip destination details may not be known (e.g., exact appointment time and date). This information can be provided by the enrollee to the Transportation Manager upon request of transportation.

** Please see the EMOD, VOMOD, and AT specific AHI Policy for more information**

For More information on E-Mod, V-Mod, AT, and Non-Medical Transportation please visit:
https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/1115_waiver_amend.htm

POLICY AND PROCEDURE

HCBS LOC Supervisor Checklist and Health Home Sign Off Form

Children and Youth who are being considered for HCBS Waiver and/or enrolled in HCBS require an increased level of oversight from the Health Home Care Management Supervisors to ensure success for this population. A checklist/sign off form has been developed to ensure that Supervisors are included in the initial LOC and annual LOC process. This form is required to be completed by the HHCM and to have the supervisor sign off attesting that the required documentation is present and correct in the record PRIOR to the LOC completion. A case conference with the Health Home can be requested at any time to review the documentation as well. Once the supervisor has signed off on the form it MUST be submitted to the Health Home for review. The Health Home will then review the documentation collected for the LOC process and make the determination as to whether the HHCM can proceed with the completion of the LOC, OR determine that the documentation completed is incorrect or insufficient, and immediate follow up by the HHCM is needed in order to move forward with the LOC. The HHCM is responsible for knowing the date that the annual LOC is due; it is a 12-month redetermination and needs to be completed 365 days from the last Level of Care. HHCM's and Supervisors should start working on the redetermination 30-60 days prior to the current Level of Care's expiration. In some cases when the member is referred from CYES to Health Home and they come with a completed LOC, the Health Home will reach out to the CMA and complete a case conference to review the transfer and next steps. This will be done in addition to the warm handoff meeting conducted by CYES.

POLICY AND PROCEDURE

Quality and Performance Improvement

AHI Health Home will review a selection of cases from each HHSP's member attributions that have had a member with a K Code in e-paces. Each case will be assessed for completeness and adherence to the Health Home Policy. Any record found to not have adequate documentation in the member's Electronic Care Management Record is expected to review this policy with their direct supervisor to ensure future adherence. CMA's, HHCM's, and supervisors may be subject to required additional training if this policy is not followed. HCBS cases will be audited twice per year and the scores on the HCBS audit portion will be factored into the comprehensive chart reviews. If a CMA is not in compliance with this policy, they may be placed in corrective action.

Training

This policy will be disseminated for review and questions before policy training is given. If more time is needed outside of the initial policy training, future in-depth training will be developed and/or identified for Health Home Care Managers to gain an understanding of the Children's HCBS and Waiver workflow.

Contact Person: Assistant Director, Care Management and Health Home

Responsible Person: Health Home Service Provider

Reviewed By: Director, Care Management and Health Home

Approved By: Chief Operating and Compliance Officer