UPDATE

Utilization Management and Other Requirements for 1915(c) Children's Waiver Services

TO: Medicaid Managed Care Plans and HIV Special Needs Plans (MMCPs), Health Homes Serving Children (HHSC), Health Home Care Management Agencies (HH CMAs), Children and Youth Evaluation Services (C-YES) and Children's Home and Community Based Services (HCBS) Providers

RE: Utilization Management and Other Requirements

DATE: March 16, 2023, UPDATED MAY 8, 2023

UPDATE: The purpose of this announcement is to clarify expectations of MMCPs and HCBS providers related to the *Children's HCBS Authorization and Care Management Notification Form.* Updates are highlighted in yellow.

Effective for dates of service on or after April 15, 2023, Medicaid Managed Care Plans (MMCPs) are required to deny claims for payment for Children's Waiver Home and Community Based Services (HCBS) that exceed the initial service period of 60 days, 96 units or 24 hours that have not been authorized by the MMCP via the *Children's HCBS Authorization and Care Management Notification Form.*

No later than **Friday March 31, 2023**, HCBS providers must submit all outstanding *Children's HCBS Authorization and Care Management Notification Form* to MMCPs for current eligible and enrolled children/youth already receiving HCBS beyond the initial service period. Upon receipt of a completed form, Plans must review and make determinations regarding authorization of services requested via the forms within 14 days. This notice does not impact authorizations that are already approved.

Utilization Management

Utilization management is important for assuring access to appropriate levels of care, promoting disease prevention and wellness, ensuring medical necessity of the service(s), and efficiency of services. Utilization management is the MMCP's opportunity to ensure that services are being provided in alignment with the approved *Children's HCBS Authorization and Care Management Notification Form*. Utilization management by MMCPs was not permitted when Children's HCBS were added to the MMCP benefit package effective October 1, 2019, and during the COVID-19 Public Health Emergency (PHE). **Note:** Utilization management will now be required effective for dates of service on or after April 15, 2023.

Children' HCBS Authorization and Care Management Notification Form

The requirement to complete and submit this form to the MMCP was ***not waived*** during the PHE. Upon determination of HCBS eligibility and the HCBS provider's acceptance of a referral, the HCBS provider will schedule a first appointment with the member/family and **MUST** notify the MMCP upon the first appointment being scheduled, but no later than 1 business day after

the first appointment. Upon receipt of notification of the first appointment, the MMCP will establish the provider on their claim systems to authorize payment up to 60 days, 96 units, or 24 hours initial service period.

HCBS providers **must** determine frequency/scope/duration (F/S/D) during the initial service period. The HCBS provider must request authorization of any HCBS needs beyond the initial service period by submitting the *Children's HCBS Authorization and Care Management Notification Form*, no later than 14 days prior to exhausting the initial or approved service period.

The MMCP has 14 days from the date of receipt of the *Children's HCBS Authorization and Care Management Notification Form* to review and issue a determination. Late submission is not an allowable reason for MMCPs to deny authorization of services. If an HCBS provider submits the form late, less than 14 days prior to the initial or approved service period ending, the plans should begin their review starting on the day the form was received and have 14 days to complete their review. Any claims submitted for services provided during a lapse in authorization may be denied by the Plan.

Services can be authorized for up to six months at a time. MMCPs are not permitted to retroactively authorize services. If the MMCP does not have an active and approved authorization on file for services beyond the initial service period, HCBS claims will be denied.

HCBS Plan of Care (POC) Workflow Policy

This policy has been in effect since September 2019 and outlines how referrals are made to HCBS providers and the approval process for frequency, scope, and duration of HCBS. Health Home Care Managers (HHCMs) and C-YES are required to complete a POC with HCBS and obtain the member or parent/guardian/authorized representative signature within 30 calendar days of the HCBS/LOC Eligibility Determination being conducted. HHCMs and C-YES must share this POC with the MMCP within 30 calendar days from the completion of the signed POC.

The initial POC must identify services that are requested on the *Children's HCBS Authorization and Care Management Notification Form*; however, the initial POC is not required to contain the F/S/D or may not match the F/S/D requested on the authorization form. When the MMCP authorization process is complete, the HCBS provider must send a copy of the form and determination to the care manager. The care manager will make the appropriate updates to the POC of F/S/D and distribute it as required by the HCBS POC Workflow policy.

Children's HCBS Service Limits and Medical Necessity Documentation

In April 2022, DOH sent a reminder to MMCPs, HHSCs, HCBS providers, and Children and Youth Evaluation Services (C-YES) about HCBS billing requirements. This included Recipient Restriction/Exemption (RR/E) K-code verification, processes for identifying frequency/scope/ duration of services, and medical necessity documentation requirements. These requirements are still in effect.

The "soft" unit limits outlined in the HCBS Manual may be exceeded only when the requested F/S/D are medically necessary. Factors to consider include other available services, the child/youth's natural supports, individual needs at the time of the request, and any additional assessments. HCBS providers should have ongoing/regular communication with MMCPs for members who have a medical need to exceed the "soft" unit limits. HCBS providers must provide and maintain documentation from a licensed professional or third party involved

professional not affiliated with the HCBS agency or the HHCMA/C-YES, that outlines the need to exceed the "soft" unit limits. The documentation must clearly describe the need for additional units of service and how the services will enable the child/youth to remain at home and in the community and help achieve their goals.

In addition to soft unit limits, a flexibility for rounding of service time was allowed during the PHE but expired in 2021. Therefore, providers/plans should currently be adhering to the guidance provided in the HCBS Manual.

Services Provided During School Hours

There are limitations when HCBS can be provided to school aged children/youth, refer to HCBS vs State Plan Services Delivered During School/Day Time.

Please refer to the Children's Home and Community Based Services Manual for additional guidance.

Any questions can be submitted to BH.Transition@health.ny.gov .