Children's Waiver Home and Community Based Services (HCBS)
Medicaid Managed Care Plan (MMCP) Transfer Continuity of Care Requirements

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: Authorization for HCBS during a transfer from Fee-for-Service (FFS) Medicaid to Medicaid Managed Care Plan (MMCP) enrollment **AND** during transfers from one MMCP to another MMCP

Date: September 5, 2023

This guidance outlines continuity of care service delivery requirements when HCBS providers are serving Children's Waiver members who transfer from FFS Medicaid to a MMCP, or from one MMCP to another MMCP. For the purposes of this document, these scenarios are referred to as Plan transfers.

Plan transfers must be communicated in a timely manner to ensure that approved authorizations are in place and that the delivery of HCBS is not interrupted, as it can take about two weeks for a member's MMCP enrollment status to be updated in ePACES. HCBS providers are expected to verify Waiver and Plan enrollment in ePACES at least once per month.

Designated HCBS Providers, Care Managers, and MMCPs must follow the Children's Waiver HCBS Plan of Care Workflow Policy, in which the HCBS provider notifies the member's MMCP of the first service date and submits the Children's HCBS Authorization and Care Manager Notification Form, when appropriate.

Plan Transfer – FFS to MMCP:

- The HCBS provider will continue to provide services according to the Frequency/Scope/Duration (F/S/D) submitted to the care manager on the Children's HCBS Authorization and Care Manager Notification Form for up to 90-days from the date of enrollment in the MMCP or until the end of the existing F/S/D period, whichever comes first.

- The HCBS provider must notify the new MMCP and submit a copy of the previous Children's HCBS Authorization and Care Manager Notification Form outlining F/S/D that was sent to the care manager and noted on the member's Plan of Care (POC) as well as service period begin and end date within 5 business days of becoming aware of the enrollment change, prior to submitting a claim, and no later than 14 business days from the end of the 90-day transition period.

- If there is a continued need for HCBS beyond the existing service period/90-day transition period, the HCBS provider must submit a new Children's HCBS Authorization and Care Manager Notification Form to the MMCP at least 14 days prior to the expiration of the existing F/S/D period or at least 14 days prior to the end of the 90 day transition period, whichever comes first.

Plan Transfer – MMCP to MMCP:

- For a member who has a current active and approved Children's HCBS Authorization and Care Manager Notification Form, the HCBS provider will continue to provide services according to the F/S/D approved by the previous MMCP up to 60-days from the date of enrollment in the new MMCP or until the end of the existing F/S/D period, whichever comes first.

- The HCBS provider must notify the new MMCP and submit a copy of the previous MMCP's approved Children's HCBS Authorization and Care Manager Notification Form, and a copy of the MMCP's Authorization letter that includes the authorization time period and approved F/S/D within 5 business days of becoming aware of the enrollment change and prior to submitting a claim, and no later than 14 business days from the end of the 60-day transition period.

- The new MMCP must honor the existing Children's HCBS Authorization and Care Manager Notification Form approval for 60-days from the date of enrollment in the new Plan or until the end of the existing authorization period, whichever comes first.

- If there is a continued need for HCBS beyond the existing authorization period/60-day transition period, the HCBS provider must submit a new Children's HCBS Authorization and Care Manager Notification Form 14 days prior to the expiration of the 60-day transition period or 14 days prior to the end of the existing Authorization period, whichever comes first.

For a member who does not have an approved *Children's HCBS Authorization and Care Manager Notification Form* in place at the time of Plan transfer, the HCBS provider must contact the MMCP within 5 business days of becoming aware of the enrollment change of MMCP and prior to submitting a claim, to share the current status of the member, the initial service appointment if it occurred, and the date by which the Children's HCBS Authorization and Care Manager Notification form will be submitted. All other standard Authorization and Care Manager Notification processes as outlined in the HCBS Plan of Care Workflow policy must be followed.

If the MMCP is notified as outlined above, the MMCP cannot deny claims for HCBS provided during the 60/90-day transition period or end date of the current authorization for reasons related to authorization. If HCBS providers receive denials for claims due to the member no longer being enrolled in a MMCP, they must notify the new MMCP prior to submitting claims. This will assist in the correct payment for services. Delivery of HCBS must not be delayed or halted in any way as the result of a Plan transfer. Plans are prohibited from authorizing services retroactively outside the transition period and as outlined in the March 2023 Update regarding

Utilization Management, unless to correct an agreed upon error in which a new claim submission is needed.

When a Plan transfer of a member who has an active authorization in place for HCBS occurs, the requirement to notify the MMCP of a first appointment date is waived. However, HCBS cannot be provided if an authorization has lapsed. After the 60/90-day transition period, any changes that take place (e.g., a new HCBS is needed, change in F/S/D), standard notification requirements as outlined in the HCBS Plan of Care Workflow Policy must be followed.

In addition to this guidance, the MMCP must also follow continuity of care requirements outlined in the Medicaid Managed Care /Family Health Plus/ HIV Special Needs Plan/ Health and Recovery Plan Model Contract related to services rendered by out of network providers.

Any questions on this guidance can be directed to BH.Transition@health.ny.gov