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

RE: Reminder Regarding Children's HCBS Billing and Claiming Requirements

DATE: April 4, 2022

This notice is to remind MMCPs, including Mainstream MMCPs and HIV Special Needs Plans (HIV SNPs), Children and Youth Evaluation Services (C-YES), Health Homes Serving Children (HHSC), and Children's HCBS Providers of HCBS Billing requirements.

Effective for dates of service on or after April 4, 2022, if an MMCP receives an HCBS claim for a child whose enrollment in the Children's Waiver cannot be verified by confirming a K1 Recipient Restriction/Exemption (RR/E) code on the child's record, and if the MMCP has not received an *Authorization and Care Manager Notification Form*, the MMCP should deny the claim for lack of verification of Children's Waiver eligibility, enrollment, and approved service. The MMCP may also deny the claim if the units billed are not supported by the frequency, scope and duration documented on the *Authorization and Care Manager Notification Form*.

Children's Waiver RR/E K-Code Verification Requirements

All children/youth who are found eligible and enrolled in the HCBS Children's Waiver must have Recipient Restriction/Exemption (RR/E) K1 code on their Medicaid record. It is the responsibility of Children's HCBS providers to verify a child/youth is eligible and enrolled in the 1915(c) Children's Waiver on the date of service, by verifying through eMedNY or ePACES that the member has an active RR/E K1 code on their record. Eligibility determinations using RR/E K-codes must be made prior to submitting claims for Children's HCBS to either Medicaid Fee-For-Service (FFS) or MMCPs as outlined in the guidance found at this link: Process for Renewing and Establishing Medicaid for Children's Waiver Participants (ny.gov). If the child does not have a K1 code, the HCBS provider must contact the Health Home Care Manager (HHCM) or C-YES to verify the child's eligibility for HCBS and request that the K code be added. The HHCM or C-YES is responsible for ensuring proper Children's Waiver K-codes and will communicate any K-code issues to the NYS DOH Capacity Management.

It is the responsibility of MMCPs to verify that members have the appropriate RR/E K-codes prior to approving claims for payment. Appropriate K-codes are identified below:

- RR/E KK: Child is Eligible for Medicaid as a "Family of One"
- RR/E K1: HCBS Level of Care Acuity
- RR/E K3: HCBS Diagnostic Group – Serious Emotional Disturbance (SED)
- RR/E K4: HCBS Diagnostic Group – Medically Fragile (MF)

- RR/E K5: HCBS Diagnostic Group – Developmentally Disabled and in Foster Care (DD/FC)
- RR/E K6: HCBS Diagnostic Group – Developmentally Disabled and Medically Fragile (DD/MF)

Identifying Frequency, Scope, and Duration

The HCBS provider determines the focus of the service(s) and must identify and document the frequency, scope, and duration for each service that will be provided.

- Frequency: Outlines how often the service will be offered to the child/youth and/or family. Services may be delivered on a weekly, biweekly or monthly basis, according to the needs of the child/youth and family.
- Scope: The service components and interventions being provided and utilized to address the identified needs of the child/youth.
- Duration: Describes how long the service will be delivered to the child/youth and/or family. The duration of the service should correspond to the abilities of the child/youth/family and be reflective of the billing unit identified by service. *(Maximum time period, is not more than 6 months, enough time to evaluate if the service is meeting the need and not too long for re-evaluation.)*

The frequency and duration of service delivery should be tailored to the availability and needs of the child/youth and should consider other appointments or commitments the child/youth may have. Once the HCBS Provider assesses and identifies the frequency, scope, and duration for the needed services, they must complete *Children's HCBS Authorization and Care Manager Notification Form.*

HCBS Authorization and Care Manager Notification Form Submission

As of October 1, 2019, HCBS providers were required to utilize the *Children's HCBS Authorization and Care Manager Notification Form* to notify MMCPs of a child/youth's enrollment in HCBS for children/youth participating in the Children's Waiver and enrolled in a MMCP.

The requirement to submit this form was ***not*** waived because of the Public Health Emergency. Children's HCBS providers must submit the *Children's HCBS Authorization and Care Manager Notification Form* to MMCPs immediately after the HCBS provider has identified need/desired goal and how the service will be delivered. The MMCP will review the authorization form and issue a determination. The MMCP must inform the HCBS provider and the child/youth/family of the determination outcomes and include language related to appeal rights with any partial or total denial of services. The HCBS provider must request authorization of HCBS needed beyond the initial 60 days, 96 units or 24 hours and for ongoing authorization at least 14 calendar days prior to the existing HCBS authorization period ending.

Providers should be proactive and request authorization of continued HCBS prior to exhaustion of authorized services. **If the MMCP does not have an active Children's HCBS Authorization and Care Manager Notification Form for a child/youth, the MMCP can deny HCBS claims**. HCBS providers and MMCPs are encouraged to collaborate to ensure all documentation requirements are met to ensure effective processing of HCBS claims.

Additional information related to the Children's HCBS Authorization and Care Manager Notification Form can be found in the Children's Home and Community Based Services (HCBS) Plan of Care (POC) Workflow Policy.

Medical Necessity Requirements

Service utilization in excess of the unit (i.e., annual, daily, dollar amount) limits as outline in the HCBS manual, must be based on medical necessity. Documentation of the medical necessity for extended durations should be submitted to the MMCP as the payer of services. Additionally, all medical necessity documentation must be kept on file in the child/youth's record.

For additional information and resources, please reference:

- Children's HCBS Waiver Enrollment Policy
- Process for Renewing and Establishing Medicaid for Children's Waiver Participants (ny.gov)
- Children's Home and Community Based Services (HCBS) Plan of Care (POC) Workflow Policy
- Children's HCBS Authorization and Care Manager Notification Form
- Children's Home and Community Based Services (HCBS) Manual (ny.gov)

Please send any questions relating to these requirements to: bh.transition@health.ny.gov.