NEW YORK STATE | Department of Health | Office of Mental Health | Office of Addiction Services and Supports | Office of Children and Family Services | Office for People With Developmental Disabilities

Medicaid and the Children's Waiver

For HCBS Providers &
Health Homes Care Managers (HHCM)/C-YES

January 27, 2021

Agenda

- ✓ Medicaid and the HCBS Children's Waiver
- ✓ Medicaid and Eligibility Check
- ✓ Children's Waiver Enrollment
- ✓ Children's Waiver and Medicaid
- ✓ Situations that might Impact Medicaid/Waiver
- ✓ Medicaid Prior to Waiver
- ✓ Stepping up and Stepping Down Services
- ✓ Appendix

HCBS Children's Waiver Training Overview

HCBS Overview	LOC/ Eligibility Determination	Waiver Enrollment	POC Development	Referral	Maintaining Waiver Enrollment / Service Delivery	Transfer / Disenroll
Children's Medicaid System Overview / Children's Waiver Overview	CANS-NY/ Eligibility Assessment	Capacity Management	Plan of Care/Person-Centered Planning Requirements	HCBS POC Workflow and MMCP Authorization	Care Management Requirements	Waiver Disenrollment
Health Home Care Management	NODs and Fair Hearing	Participant Rights and Protections / Conflict Free Care Management	Service Delivery		Service Delivery Requirements	Transferring to Adult Services or OPWDD waiver
HCBS Provider Requirements	Children and Youth Evaluation Services (C-YES) – the Role of the Independent Entity	Conflict Free Care Management				
Medicaid Overview / Medicaid and the Children's Waiver						
Service Definitions						

Required for only Health Home Care Managers
Required for only HCBS Providers
Required for Both
Optional for Both

Medicaid and the HCBS Children's Waiver

January 2021

Medicaid and the Children's Waiver

- All children/youth enrolled in the Children's Waiver are required to receive care coordination services
- Health Home (HH) comprehensive care management provides the care coordination service required under the Children's Waiver
  - If a child/youth is eligible for the Children's Waiver first, they automatically receive HH care management, and a separate HH eligibility determination is ***not*** needed
- As HH is an optional benefit, a child/family can opt-out of HH services
  - For a child/youth who opts-out of HH services:
    - If enrolled in Fee for Service (FFS) Medicaid, their care coordination will be provided by the independent entity of C-YES (Children and Youth Evaluation Services)
    - If enrolled in a Medicaid Managed Care Plan (MMCP), their care coordination will be provided by the MMCP care manager
- A child/youth who needs HCBS, but is not enrolled in Medicaid, will be referred to C-YES who will determine HCBS/LOC Eligibility and assist with establishing Medicaid eligibility

Person-Centered Practice: *The child/youth/family has a choice regarding who provides care coordination and services.* Once the child/youth is HCBS and Medicaid eligible, the child/family can choose who they would like to provide care coordination, either HH or C-YES.

Children's Waiver and Care Management

Who can be in the Children's Waiver:

- Children who are eligible for HCBS are automatically eligible for Health Home
- Children who are Health Home eligible are **NOT** automatically eligible for HCBS
- Children who are no longer eligible for HCBS will also lose HH care management unless they are separately found to be HH eligible and appropriate

Medicaid and Eligibility Check

Health Home Eligibility Check

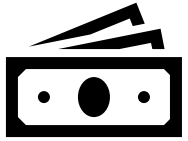
- Children/adolescents who are already enrolled in Medicaid who are believed to be HCBS eligible and or in need of HCBS will be referred to HH
  - Those not enrolled in Medicaid will be referred to C-YES
- HHCM's are required to verify HH and Medicaid eligibility upon initial referral for HH services and monthly thereafter
- HHCM's should regularly check EPACES or eMedNY to verify continuous Medicaid eligibility and ensure there are no other Restriction Exception (RE) Codes that conflict with the child/youth receiving HH services due to enrollment in another program that provides care management services
- Children/youth enrolled in the Children's Waiver must have a RE: K-code on their file
- To reference which Restriction Exception Codes are compatible with HH enrollment, refer to the link below:
  - https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/restriction_exception_codes.pdf

Applying for Medicaid

Where can members get additional information on applying for Medicaid?

- Option 1: Families apply at NY State of Health or call 855-355-5777
- Option 2: Household of one applications are filed at the LDSS, a directory can be found here

Medicaid Budgeting



Community Budgeting

Community budgeting is when the LDSS counts family income (and resources if the child/youth is certified disabled) in the budget. The household's income (and resources if certified disabled) is then compared to the appropriate levels to determine financial eligibility for Medicaid.

Institutional (Family of One) Budgeting

Institutional budgeting or **"Family of One"** budgeting is when the LDSS counts only the child/youth's income (and resources if certified disabled) in the budget. The child/youth's own income and resources, if applicable, are then compared to the appropriate levels to determine financial eligibility for Medicaid.

Institutional or Family of One Budgeting

What is Family of One?

- In general, certified disabled children/youth who are expected to be out of the household for at least 30 days **or are participating in a waiver** are eligible to have Medicaid eligibility determined under the SSI-related budgeting methodology as a family of one without counting parental income and resources.
- For the purposes of the Children's Waiver, non-disabled children/youth eligible for Children's Waiver services may have their Medicaid eligibility determined under ADC-Related budgeting as a family of one without counting parental income (resources are not considered under this budgeting methodology for anyone).
- This means that if a child/youth is not found Medicaid eligible under community budgeting and meets HCBS LOC, etc., criteria, Medicaid eligibility can be determined under Institutional or Family of One budgeting.

Under Family of One Medicaid, the HHCM or C-YES will only have to gather/document the child/youth's income/resource data, not the parent(s)

Children's Waiver Enrollment

The HCBS Children's Waiver

What are HCBS?

- Services to help keep children and youth with complex health or mental health needs in their home and community
- Services to safely return a child/youth from a higher level of care/out-of-home placement, back to the community with services to maintain them at home and/or in the community
- HCBS can be provided where children/youth and families/caregivers are most comfortable, at home or in the community
- Not all children/youth on Medicaid or enrolled in Health Home will need HCBS

The HCBS Children's Waiver

HCBS Eligibility

- To be determined eligible for the HCBS Children's Waiver, children/youth must meet Level of Care
  - **Level of Care (LOC):** children/youth that meet institutional placement

- LOC determinations require the completion of the HCBS/LOC Eligibility Determination tool within the Uniform Assessment System (UAS)

LOC Groups

- Serious Emotional Disturbance (SED)
- Medically Fragile Children (MFC)
- Developmental Disability (DD) and Medically Fragile
- Developmental Disability (DD) and Foster Care

The HCBS Children's Waiver

HCBS Level of Care Determination

- The HCBS LOC Eligibility Determination is valid for 1 year (365 days)
- An annual (365 days) ***active*** HCBS LOC Eligibility re-determination is required to be completed for the child/youth to remain in the Children's Waiver and continue receiving waiver services
- The HHCM or C-YES staff is required to complete this eligibility determination prior to its annual expiration
- The annual re-determination should begin two (2) months prior to the expiration of the current HCBS/LOC determination

It is the HHCM or C-YES staff's responsibility to know and understand the requirements and necessary paperwork needed to complete an HCBS/LOC eligibility determination

The HCBS Children's Waiver
Necessary Monthly Waiver Service

Monthly HCBS Requirements:

- If a child/youth has been determined eligible for HCBS and the child/family consents to receive HCBS, then *at least* ***one*** HCBS must be received monthly to maintain eligibility for the Children's Waiver
- The child/youth must begin receiving HCBS within 45 days of the POC being finalized
- Referrals for HCBS are made by the HHCM/C-YES to HCBS providers who will review the needs/goals of the child/youth and determine the Frequency, Scope, and Duration (F/S/D) for the service they will provide.
- HCBS providers needs to share the F/S/D with the HHCM/C-YES to add into the Plan of Care and the Medicaid Managed Care Plan (MMCP) for potential authorization or continued authorization of services

The HCBS Children's Waiver

Monthly Waiver Service by Health Home

Monthly HCBS Requirements:

- For children/youth eligible for the Children's Waiver who have Family of One Medicaid budgeting and do not need/want an HCBS, the Health Home care management may count as their monthly HCBS
- C-YES care coordination does not meet this requirement, the child/youth would need to be transferred to HH
- The Health Home care manager would need to determine Frequency, Scope, and Duration (F/S/D) for their care management services based upon the child/youth needs and Waiver eligibility and enrollment.
- The F/S/D would need to be documented within the Plan of Care and shared with the MMCP, if the child/youth was enrolled in a MMCP
- Should the child/youth's Family of One Medicaid status change, then the HHCM would need to ensure a referral to an HCBS provider for a monthly HCBS
- Family of One HCBS eligible children/youth receiving HH service as an HCBS, **MUST** be continuously enrolled in HCBS with an annual HCBS/LOC Eligibility Determination. **Without continuous HCBS/LOC eligibility:**
  - the child/youth may lose their Family of One Medicaid
  - the child/youth cannot be only enrolled in HH (HH is not a criteria to obtain Family of One Medicaid)

The HCBS Children's Waiver
Barriers to Service

Monthly HCBS Requirements:

- It is the responsibility of the HHCM, C-YES, HCBS providers, and Manage Care Plans to collectively work together to ensure access to HCBS for children/youth enrolled and eligible for HCBS Children's Waiver
- HCBS providers needs to share If the child/youth is not connected to an HCBS upon eligibility being determined or misses monthly HCBS, then the HHCM, C-YES, or MMCP, as applicable, must document efforts made to ensure access in the case record
- If there is a concern regarding the child/family's interest in continuing HCBS and issues occur regularly, then the HH, C-YES, or MMCP, as applicable, should review HCBS quarterly (three months) with the child/family and care team to determine if HCBS should be continued, terminated, or changed and/or if a referral to a different provider/service is needed
- Children/youth who are eligible for Children's Waiver services through Community Medicaid (as opposed to Family of One Medicaid) and whose needs are met through State Plan Services of Children and Family Treatment Support Services (CFTSS) should be considered for disenrollment from the Children's Waiver.

Children's Waiver And Medicaid

Previous Guidance Documents

Guidance for Care Managers

HCBS Waiver Eligibility Service Requirements

- Intended to clarify eligibility determination requirements
- Describes process for when a child/youth in waiver experiences a significant life event
- Outlines scenarios when a child/youth in waiver is hospitalized or placed in an HCBS restricted setting
- Clarifies monthly HCBS requirement, accessibility, and matching services to need

Medicaid Status Impact on HCBS Eligible Children

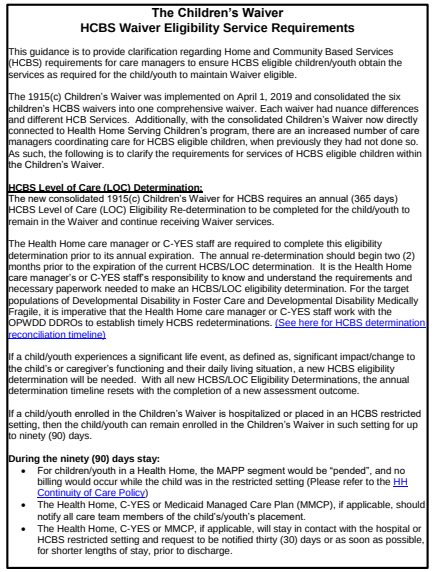
- Intended to clarify Medicaid eligibility as it relates to the approved 1115 waiver
- Explains how receipt of services is related to waiver and Medicaid eligibility for Family of One children
- Demonstrates when HHCM or HCBS are required to obtain waiver eligibility
- Showcases process flows of matching services to need and how this might impact Medicaid eligibility

Children's Waiver Care Management (cont.)

Click on the images below for a link to the documents

Both guidance documents can also be found in the Children's HCBS Manual Appendix J

HCBS Waiver Eligibility Service Requirements



The Children's Waiver
HCBS Waiver Eligibility Service Requirements

This guidance is to provide clarification regarding Home and Community Based Services (HCBS) requirements for care managers to ensure HCBS eligible children/youth obtain the services as required for the child/youth to maintain Waiver eligible.

The 1915(c) Children's Waiver was implemented on April 1, 2019 and consolidated the six children's HCBS waivers into one comprehensive waiver. Each waiver had nuance differences and different HCB Services. Additionally, with the consolidated Children's Waiver now directly connected to Health Home Serving Children's program, there are an increased number of care managers coordinating care for HCBS eligible children, when previously they had not done so. As such, the following is to clarify the requirements for services of HCBS eligible children within the Children's Waiver.

HCBS Level of Care (LOC) Determination:
The new consolidated 1915(c) Children's Waiver for HCBS requires an annual (365 days) HCBS Level of Care (LOC) Eligibility Re-determination to be completed for the child/youth to remain in the Waiver and continue receiving Waiver services.

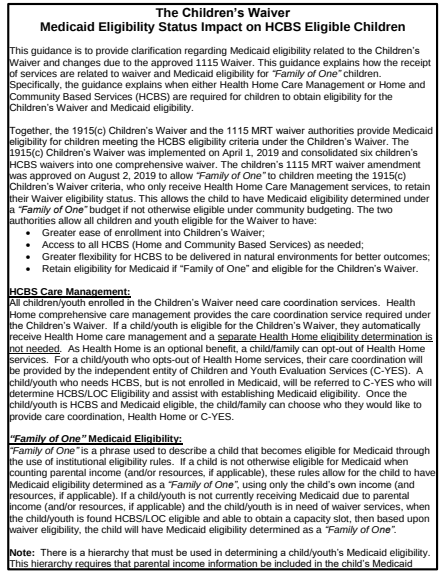
The Health Home care manager or C-YES staff are required to complete this eligibility determination prior to its annual expiration. The annual re-determination should begin two (2) months prior to the expiration of the current HCBS/LOC determination. It is the Health Home care manager's or C-YES staff's responsibility to know and understand the requirements and necessary paperwork needed to make an HCBS/LOC eligibility determination. For the target populations of Developmental Disability in Foster Care and Developmental Disability Medically Fragile, it is imperative that the Health Home care manager or C-YES staff work with the OPWDD DDROs to establish timely HCBS redeterminations. (See here for HCBS determination reconciliation timeline)

If a child/youth experiences a significant life event, as defined as, significant impact/change to the child's or caregiver's functioning and their daily living situation, a new HCBS eligibility determination will be needed. With all new HCBS/LOC Eligibility Determinations, the annual determination timeline resets with the completion of a new assessment outcome.

If a child/youth enrolled in the Children's Waiver is hospitalized or placed in an HCBS restricted setting, then the child/youth can remain enrolled in the Children's Waiver in such setting for up to ninety (90) days.

During the ninety (90) days stay:
- For children/youth in a Health Home, the MAPP segment would be "pended", and no billing would occur while the child was in the restricted setting (Please refer to the HH Continuity of Care Policy)
- The Health Home, C-YES or Medicaid Managed Care Plan (MMCP), if applicable, should notify all care team members of the child's/youth's placement.
- The Health Home, C-YES or MMCP, if applicable, will stay in contact with the hospital or HCBS restricted setting and request to be notified thirty (30) days or as soon as possible, for shorter lengths of stay, prior to discharge.

Medicaid Status Impact on HCBS Eligible Children



The Children's Waiver
Medicaid Eligibility Status Impact on HCBS Eligible Children

This guidance is to provide clarification regarding Medicaid eligibility related to the Children's Waiver and changes due to the approved 1115 Waiver. This guidance explains how the receipt of services are related to waiver and Medicaid eligibility for *"Family of One"* children. Specifically, the guidance explains when either Health Home Care Management or Home and Community Based Services (HCBS) are required for children to obtain eligibility for the Children's Waiver and Medicaid eligibility.

Together, the 1915(c) Children's Waiver and the 1115 MRT waiver authorities provide Medicaid eligibility for children meeting the HCBS eligibility criteria under the Children's Waiver. The 1915(c) Children's Waiver was implemented on April 1, 2019 and consolidated six children's HCBS waivers into one comprehensive waiver. The children's 1115 MRT waiver amendment was approved on August 2, 2019 to allow *"Family of One"* to children meeting the 1915(c) Children's Waiver criteria, who only receive Health Home Care Management services, to retain their Waiver eligibility status. This allows the child to have Medicaid eligibility determined under a *"Family of One"* budget if not otherwise eligible under community budgeting. The two authorities allow all children and youth eligible for the Waiver to have:
- Greater ease of enrollment into Children's Waiver;
- Access to all HCBS (Home and Community Based Services) as needed;
- Greater flexibility for HCBS to be delivered in natural environments for better outcomes;
- Retain eligibility for Medicaid if "Family of One" and eligible for the Children's Waiver.

HCBS Care Management:
All children/youth enrolled in the Children's Waiver need care coordination services. Health Home comprehensive care management provides the care coordination service required under the Children's Waiver. If a child/youth is eligible for the Children's Waiver, they automatically receive Health Home care management and a separate Health Home eligibility determination is not needed. As Health Home is an optional benefit, a child/family can opt-out of Health Home services. For a child/youth who opts-out of Health Home services, their care coordination will be provided by the independent entity of Children and Youth Evaluation Services (C-YES). A child/youth who needs HCBS, but is not enrolled in Medicaid, will be referred to C-YES who will determine HCBS/LOC Eligibility and assist with establishing Medicaid eligibility. Once the child/youth is HCBS and Medicaid eligible, the child/family can choose who they would like to provide care coordination, Health Home or C-YES.

***"Family of One"* Medicaid Eligibility:**
"Family of One" is a phrase used to describe a child that becomes eligible for Medicaid through the use of institutional eligibility rules. If a child is not otherwise eligible for Medicaid when counting parental income (and/or resources, if applicable), these rules allow for the child to have Medicaid eligibility determined as a *"Family of One"*, using only the child's own income (and resources, if applicable). If a child/youth is not currently receiving Medicaid due to parental income (and/or resources, if applicable) and the child/youth is in need of waiver services, when the child/youth is found HCBS/LOC eligible and able to obtain a capacity slot, then based upon waiver eligibility, the child will have Medicaid eligibility determined as a *"Family of One"*.

Note: There is a hierarchy that must be used in determining a child/youth's Medicaid eligibility. This hierarchy requires that parental income information be included in the child's Medicaid

Medicaid Eligibility Status Impact on HCBS

Family of One Medicaid Eligibility

The Local Departments of Social Services (LDSS) determines Medicaid eligibility.

- Community Medicaid budgeting needs to be completed first and the family found ineligible for the "*Family of One"* Medicaid budgeting to be determined
- If a child is not otherwise eligible for Medicaid when counting parental income (and/or resources, if applicable), these rules allow for the child to have Medicaid eligibility determined as a *"Family of One"*, using only the child's own income (and resources, if applicable)

- Family of One: describes a child that becomes eligible for Medicaid through the use of institutional eligibility rules **due to HCBS eligibility and enrollment**
- If a child/youth is not currently receiving Medicaid due to parental income (and/or resources, if applicable) and the child/youth is in need of waiver services, **when** the child/youth is found HCBS/LOC eligible and able to obtain a capacity slot, then based upon waiver eligibility, the child will have Medicaid eligibility determined as a *"Family of One"*

Medicaid Eligibility Status Impact on HCBS

- *"Family of One" children/youth Waiver eligible and enrolled will have a KK code on their Emedy / EPaces file*
- Any *"Family of One"* child/youth can also receive other Medicaid services (i.e. State Plan services) such as Private Duty Nursing, Children and Family Treatment and Support Services (CFTSS)
- Once a child/youth with *"Family of One"* Medicaid is no longer eligible for the Children's Waiver and/or doesn't receive HCBS or Health Home care management, they may lose their Medicaid eligibility altogether or they may have to meet a large spenddown each month in order to access Medicaid services*
- A child/youth who is disenrolled from the Children's Waiver who has Family of One Medicaid budgeting cannot remain in Health Home only.
  - *There is no need for the Health Homes, CYES, or MMCP care managers to send anything to the Local Department of Social Services (LDSS) during annual HCBS re-certification as was done in previous waivers. See Administrative Directive to the LDSS*

Once a child/youth obtains Medicaid under "*Family of One*" they must be continually enrolled in the Waiver and receiving HCBS or Health Home care management services to continue their "*Family of One*" eligibility for the Medicaid.

Medicaid and the Children's Waiver

Medicaid and the Children's Waiver

- Medicaid is a prerequisite to being in the Children's Waiver or Health Home (HH) Care Management

What to do if a member loses Medicaid

- Find out why and when the member lost Medicaid
- Work with the member and family to re-establish Medicaid, so they will not lose HH and Waiver services or experience a disruption in treatment from providers

What happens to their Home and Community Based Services (HCBS)

- If a member loses Medicaid, they will keep their HCBS waiver slot for 90 days while the Health Home Care Manager (HHCM) tries to re-establish Medicaid
- If the HHCM is not able to re-establish Medicaid after 90 days, the member needs to be disenrolled from HH Care Management services
- The HHCM should notify the Capacity Management Team if a member has lost Medicaid

Situations That Might Impact Medicaid/Waiver

The HCBS Children's Waiver

HCBS Restricted Settings

When an HCBS eligible child/youth who is receiving HCBS Waiver services enters a hospital or HCBS Restricted Setting:

The child/youth can REMAIN enrolled in the Children's Waiver while in a restricted setting for up to 90 days

During the ninety (90) days stay:

1. For children/youth in a HH, the Medicaid Analytics Performance Portal (MAPP) segment would be "pended", and HH care management could bill based upon the HH Continuity of Care Policy
2. For all children/youth, **NO** HCBS billing would occur while the child was in the restricted setting
3. The HH, C-YES, or MMCP, as applicable, should notify all care team members of the child's/youth's placement
4. The HH, C-YES, or MMCP, as applicable, will stay in contact with the hospital or HCBS restricted setting and request to be notified thirty (30) days (or as soon as possible, for shorter lengths of stay) prior to discharge, to be part of discharge planning

The HCBS Children's Waiver

HCBS Restricted Settings - Length of Stay

Length of Stay – 90 days or shorter:

- The HH, C-YES, or MMCP, as applicable, will be requested to be notified when the child/youth will be discharged
- Whenever possible, the HH or C-YES staff will conduct a new HCBS/LOC Eligibility Determination prior to discharge to ensure continuous waiver eligibility, will update the Pan of Care (POC) as needed, and link the child/youth to service upon discharge

Length of Stay – longer than 90 days:

- Child/youth will be discharged from the Children's Waiver. Proper notification to the child/family with the Notice of Decision (NOD) will be followed as well as notifying DOH Capacity Management. *(Those with "Family of One" Medicaid based upon waiver eligibility and enrollment may lose their Medicaid)*
- The HH or C-YES staff will ask the hospital or HCBS restricted setting to notify them when the child/youth is being discharged, if the child/youth will need and want HCBS upon discharge

If a child/youth leaves the Children's Waiver, a new HCBS/LOC Eligibility Determination can be conducted to determine if the child/youth can be re-enrolled in the Children's Waiver

Children's Waiver Enrollment
Change in Family Circumstances

Community Medicaid

- Families must report to the LDSS when there is a change in their circumstances
  - New Income
  - New Job
  - New Insurance
- Based on new circumstance the family may no longer be Medicaid eligible under Community Budgeting.
- If this occurs, the RE: K-code on the child/youth's file indicates to the LDSS that child is Waiver eligible and enrolled.
- The LDSS should then conduct the Family of One budgeting for the child/youth to keep the child enrolled in Medicaid and put the RE: KK-code on the file
- HHCM/C-YES can also print from the UAS the HCBS/LOC Eligibility Determination if there is an issue to verify HCBS enrollment. HHCM/C-YES should contact NYSDOH if there are any concerns

Excess Income Program

- Some people have too much income to qualify for Medicaid. The Excess Income Program is a way for certain individuals to receive Medicaid coverage even though their income is over the Medicaid level.
- The amount the individual's income is over the Medicaid level is referred to as excess income. It is also sometimes referred to as surplus income or spenddown.
- It is like a deductible.
- If the individual is Medicaid eligible except for having excess income and can show medically necessary paid or unpaid medical bills to their Local Department of Social Services (LDSS) when at least equal to their excess income liability in a particular month, Medicaid will pay additional medical bills beyond that for the rest of the month.
- Individuals without medical bills can also pay their excess income to the Local Department of Social Services to receive coverage.

Excess Income & Medicaid Coverage

- If an individual has not met their excess income liability, provisional coverage (no coverage) will be authorized.
  - If an individual has provisional coverage but has not met his/ her spenddown, the individual can remain enrolled in the Health Home if they are otherwise eligible, but the Health Home cannot bill for services unless the individual has met the spenddown for that particular month.
- If an individual has met a one-month excess income liability, outpatient coverage will be authorized for that month. Outpatient coverage includes but is not limited to doctor and dental visits, laboratory and X-ray services, prescription drugs, outpatient hospital services.

- If an individual has met a six-month excess income liability, outpatient and inpatient coverage will be authorized for six months.
- HHCM/C-YES need to talk with members and families regarding the type of Medicaid they have and what is required. Contact with the LDSS to help support the member and family to ensure no gap in coverage

Children's Medicaid Spend-down Coverage Guidance

Medicaid Prior to Children's Waiver

Children's Waiver Enrollment

What is NYSoH

- Children/youth/families/individuals can enroll in Medicaid through the New York State of Health exchange (NYSoH)
  - Online service for Medicaid application, renewal, etc.
- Children/youth enrolled in the Children's Waiver cannot be managed through NYSoH
- Children/youth enrolled in the Children's Waiver are enrolled in Medicaid through the Local Department of Social Services (LDSS).
- If a child/youth is enrolled in Medicaid via NYSoH (New York State of Health exchange), then their Medicaid will need to be transferred to their LDSS once enrolled in the Children's Waiver
- Care managers should be prepared to explain the process to families and answer their questions, or refer them to the LDSS

Children's Waiver Enrollment

Process for Transitioning Medicaid Coverage from NYSoH to the LDSS

- Waiver Services start when NYS DOH Capacity Management assigns a waiver slot.
- DOH Capacity Management sends the Children's Waiver cover letter to DOH support staff.
- DOH support staff enter the appropriate Waiver RE: K-coding, end dates coverage on NYSoH and a closing notice is generated to the individual informing that, "You **no longer qualify** for Medicaid through NY State of Health as of ……."
  - The letter explains that they are being disenrolled from NYSoH, which can be confusing. But their Medicaid is not ending
- DOH support staff refer the case to the Local Department of Social Services (LDSS).
  - Upstate districts authorize coverage for four months and issues the welcome letter/renewal, which must be completed and returned to the LDSS by the deadline.
  - Downstate authorizes coverage for five months and issues the welcome letter. The renewal is issued to the individual in the following month; it must be completed and returned to the LDSS by the deadline.

Stepping Up or Down Services

Stepping Up or Down Services

When an enrolled member may need to transition from HH Care Management to Children's Waiver services ("Step Up"):

- Increasing difficulty managing chronic or mental health conditions and the effects are interfering with regular daily activities
- Whether CFTSS have been utilized
- Attending school, attending doctor appointments when scheduled
- Repeat ED/ Hospital visits, or an increase in the utilization of medical services
- Increased use of Crisis Services
- Recent discharge from long term hospitalization or RTF placement

When an enrolled member may need to transition from Children's Waiver services to only HH Care Management ("Step Down)":

- The child/youth is able manage their health and mental health without the intensive support of the Children's Waiver
- The child/youth has met their goals
- A discharge plan has been discussed with the family and they are in agreement with the transition from the Children's Waiver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A

Appendix

RR/E Codes: K Codes

Members enrolled in the HCBS Children's Waiver will have new Recipient Restriction/Exemption (RR/E) codes, identified as "K codes" to indicate which children are enrolled in waiver services and their specific population category

RR/E Code	RE Code Description
K1	HCBS LOC
K2	HCBS LON (will not be in use < 2021
K3	HCBS Serious Emotional Disturbance (SED)
K4	HCBS Medically Fragile (MF)
K5	HCBS Developmentally Disabled (DD)
K6	HCBS Developmentally Disabled and Medically Fragile (DD & MF)
K7	HCBS Complex Trauma (will not be in use <2021 with LON)
K8	Voluntary Foster Care Agency
K9	Foster Care
KK	Family of One

Reference Page

Health Home Continuity of Care Policy

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/docs/hh0006_continuity_of_care_policy.pdf

HCBS Waiver Eligibility Service Requirements

https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/children_hcbs_waiver_elig_srv_req.pdf

Medicaid Eligibility Status Impact on HCBS Eligible Children

https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/ma_elig_impact_hcbs_elig_children.pdf

Guide To Restriction Exception (RE) Codes And Health Home Services

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/restriction_exception_codes.pdf

Resources and Questions

- HHCMs and HH CMAs should first talk with their Lead HH regarding questions and issues they may have
- Questions, comments or feedback on HHSC to: hhsc@health.ny.gov or contact the HH Program at DOH at 518.473.5569
- Specific Questions/Comments regarding Transition services BH.Transition@health.ny.gov
- Subscribe to the HH Listserv http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/listserv.htm

Additional Information and Support

MAPP Customer Care Center
Email: MAPP-customercarecenter@cma.com
Phone: 518-649-4335

CANS-NY Training
Email: support@CANSTraining.com
Or
www.canstraining.com and click on contact us

Commerce Accounts Management Unit (CAMU)
Phone: 866-529-1890

Uniform Assessment System Support Desk (UAS-NY)
Email: uasny@health.ny.gov
Or
Phone: 518-408-1021 – option 1
Monday – Friday
8:30 AM – 12:00 PM
1:00 PM – 4:00 PM

Department of Health Complaints

- Enrollees and providers may file a complaint regarding managed care plans to DOH
  - 1-800-206-8125
  - managedcarecomplaint@health.ny.gov
- When filing:
  - Identify plan and enrollee
  - Provide all documents from/to plan
  - Medical record not necessary

- Issues not within DOH jurisdiction may be referred

- DOH is unable to arbitrate or resolve contractual disputes in the absence of a specific governing law

- File Prompt Pay complaints with Department of Financial Services: https://www.dfs.ny.gov/insurance/provlhow.htm

Children and Youth Evaluation Service
Your Connection to Home and Community-Based Services

Referral Form Instructions

- The Children and Youth Evaluation Service (C-YES) accepts referrals from individuals and providers including a parent, wider family member, doctor, therapist, school guidance counselor, CBOs and others:

- Individuals and families should call C-YES so that we can send you a Referral Form and a pre-paid return envelope in the mail right away! You can mail back the form in the envelope at no cost to you. Call C-YES at 1-833-333-CYES (1-833-333-2937). TTY: 1-888-329-1541

- Providers and Organizations with secure email protocols can download the Referral Form below. Return the form to: CYESREFERRAL@MAXIMUS.COM. Be sure to include the child/youth's name and contact information.

- C-YES Referral Form

Questions? Call 1-833-333-CYES (1-833-333-2937). TTY: 1-888-329-1541