The information in this presentation is current as of the published date noted below and is subject to change.

Children's Home and Community Based Services (CHCBS)

April 2025

Topics Discussed in this Presentation

- Program Description
- Member Eligibility
- Services within CHCBS
- Program Requirements
- Authorization/Prior Notification Requirements
- Billing Guidance
- CHCBS for Child Health Plus Members
- Resources

Program Description

CHCBS History

- Select population of children receiving HCBS Waiver Services, known as 1915(c) Waiver Services
- As part of children's system transformation, now called Children's HCBS was created, to align multiple waiver services by consolidating into a single set
- These services are available to all HCBS eligible children ensuring consistency across systems regardless of primary diagnosis
- HCBS billed to Medicaid Fee for Service from April 1 until September 30, 2019
- Children's HCBS transitioned into Medicaid Managed Care

CHCBS Description

Children's Home and Community Based Services (CHCBS) are designed to allow children and youth to:

- Participate in developmentally and Culturally appropriate services,
- Access care in the least restrictive environment possible, and
- Provide services and supports to children and families at home and in the community

CHCBS Vision & Goals

HCBS are designed to offer support and services to children/youth in non-institutionalized settings that enable them to remain at home and in the community or for children/youth being discharged from an institutional setting who require these services to safely return to their home and community.

HCBS provides a family-driven, youth-guided, culturally and linguistically appropriate system of care that accounts for the strengths, preferences, and needs of the individual, as well as the desired outcome.

Services are individualized to meet the physical health, developmental, and behavioral health needs of each child/youth.

Participants have independent choice among an array of service options and Providers. These services are provided in a flexible, complimentary package that evolves over time to meet the changing needs of the child/youth.

Program Focus

Person centered care

Individualized care

Available to member/family in home/community settings

Member Eligibility

Who is eligible for CHCBS?

- Child or youth who under the age of 21
- Enrolled in Managed Medicaid coverage
- Meet institutional placement criteria based upon Level of Care (LOC)
- HHCM/C-YES determine HCBS/LOC eligibility and MVP must be notified of the first appointment (see Prior Authorization requirements)

Components of Eligibility	Subgroups Within the LOC Group	Medical Necessity
1) Target criteria 2) Risk factors 3) Functional criteria	1) Serious Emotional Disturbance (SED) 2) Medically Fragile Children (MFC) 3) Developmental Disability (DD) and Medically Fragile 4) Developmental Disability (DD) and Foster Care	Have a physical health, developmental disability, and/or mental health diagnosis with related significant needs that place child/youth at risk of hospitalization or institutionalization, or HCBS is needed for the child/youth to return safely home and to his/her community from a higher level of care

Eligibility Determinations

- HCBS Level of Care (LOC) Eligibility assessments are completed at least annually by either the HHCM or C-YES.

Exceptions- If any of the following exception criteria is met, the child/youth's eligibility assessment may be done more frequently:

- **Significant life event:** if extenuating circumstances created a new need for CHCBS services, a new eligibility determination can be made
- **Initial decline/waitlist:** if a child/youth is determined eligible and initially declines or is placed on a waitlist due to capacity limitations a new determination can be made
- **Placement in a restrictive setting:** if a child/youth spends 90-days or longer in a restrictive setting, they are automatically disenrolled from the CHCBS program and would need another eligibility assessment to reenroll as part of discharge/step-down planning

Care Management and Monitoring Access to Care

- HCBS Level of Care (LOC) Eligibility Determination must be made based upon target population, risk factors, functional criteria, and Medicaid eligibility by a HHCM or C-YES
- Care Management is required for all CHCBS participants; three options for Members:
    1. Health Home Care Manager (HHCM) or,
    2. State's Independent Entity of Children and Youth Evaluation Services (C-YES) or,
    3. State's Independent Entity of Children and Youth Evaluation Services (C-YES) with MVP Case Management.
- HCBS cannot duplicate or replace existing care management services, and HCBS Providers must coordinate through HHCM or C-YES

Communication & Child-Serving Systems

- **Child and Adolescent Needs and Strengths New York (CANS-NY)** is a comprehensive multisystem assessment for children and youth, and a guide that informs planning for children/youth under 21 with behavioral needs, medical needs, developmental disabilities, and juvenile justice involvement.

- HHCM or C-YES utilize CANS-NY to complete the eligibility determination and inform care planning by identifying areas of impaired/impacted functioning

- CANS-NY Background:
  - Customized for the Health Home model in NYS and upgraded in 2023 based upon data findings
  - Used as a planning tool with decision support models based upon data from the children's Health Home population
  - Data from 2016 – 2022 showed overall improvement within the population over time with 37% of the population rating high acuity
  - Updated tool rates children ages 0 – 5 as low, early development or complex and children/youth 6 – under 21 as standard, intensive or complex to inform the Plan of Care and care management to be received

- For more information on CANS-NY see reference guides listed in the **Resources** section or view this video: https://youtu.be/_2Af1goyRUg

Utilization Management for CHCBS

- MVP determines if the services are medically necessary for the child based on NYS guidelines separate from the eligibility determination completed by the HHCM/C-YES
- As part of concurrent review, MVP determines if each proposed HCBS is appropriate for the child and likely to achieve the goals on the POC
- MVP cannot conduct UM for first 180 days for continuity of care cases
- Initial authorization free period is 96 units within 60 days

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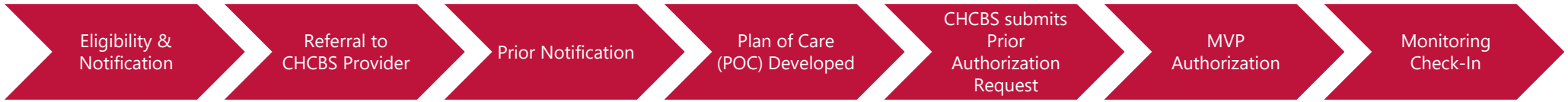
Medical Necessity Guidelines for CHCBS

Admissions	Continued Stay	Discharge
All criteria must be met	**All criteria must be met**	**Criteria 1, 2, 3, 4, 5 or 6 are required for discharge and criteria 7 is recommended, but optional**
The child/youth must meet Level of Care (LOC) Eligibility Determination criteria to be eligible for HCBS.	Child/youth continues to meet admission criteria and an alternative service would not better serve the child/youth.	Child/youth no longer meets admission criteria and/or meets criteria for another, more appropriate service, either more or less intensive.
The child/youth must meet risk and functional criteria as evidenced by the completion and affirmative outcome of the HCBS Eligibility Determination tool or the ICF-IDD Level of Care determination.	A POC has been developed, informed and signed by the child/youth, Health Home care manager or Independent Entity, and others responsible for implementation.	Child/youth or parent/guardian withdraws consent for treatment
The HCBS supports the child/youth's efforts to maintain the child in the home, community, and school and is reflected in the Plan of Care (POC).	Interventions are timely, need based and consistent with evidence based/best practice and provided by a designated HCBS Provider.	Child/youth is not participating in the POC development and/or utilizing referred services
The child/youth must be willing to receive HCBS.	Child/youth is making measurable progress towards a set of clearly defined goals Or There is evidence that the POC and/or Provider treatment plan are modified to address the barriers in treatment progression Or Continuation of services is necessary to maintain progress already achieved and/or prevent deterioration.	Child/youth's needs have change and current services are not meeting these needs
There is no alternative level of care or cooccurring service that would better address the child/youth's clinical and functional needs.		Child/youth's goals would be better served with an alternate service and/or service level
The child/youth must live in an appropriate setting in accordance with Federal and State guidance.	Family/guardian/caregiver is participating in treatment, where appropriate.	Child/youth's POC goals have been met
		Child/youth's support system is in agreement with the aftercare service plan

CHCBS Provider Approval Workflow

This is a high-level workflow of key approvals and milestones to ensure high quality and consistent care that can be billed for CHCBS services. Eligibility is determined on an annual basis. The POC can be updated at anytime. Changes to one process flow step require the completion of the subsequent steps each time.



Eligibility & Notification	Referral to CHCBS Provider	Prior Notification	Plan of Care (POC) Developed	CHCBS submits Prior Authorization Request	MVP Authorization	Monitoring Check-In
Completed by HHCMA or C-YES and submitted to the Uniform Assessment System (UAS) and HHCMA/C-YES notifies the child/youth of the determination and provides information on State Fair Hearing rights.	HHCMA/C-YES assists the child/youth with identifying a CHCBS Provider to provide the services identified and establishes the first appointment.	CHCBS Provider must notify MVP of the first scheduled CHCBS appointment with the child/family/youth via the "Children's Home and Community Based Services Notification form" (found on MVP website)	Developed by the HHCMA/C-Yes with the CHCBS Provider which include the goals of these services. The POC which includes the frequency, scope and duration of the services should be sent to the MVP during this phase.	Prior to the expiration of the initial notification period, the CHCBS Provider is required to submit the CHCBS Authorization Continuation Form to update MVP on ongoing care and implementation of the POC.	MVP reviews authorization request to ensure that it meets medically necessity criteria and review for duplication of services per NYS guidelines. MVP notifies the Provider, HHCMA/C-YES and member of the determination.	HHCMA/C-YES to communicate updates to the POC, to MVP as needed.

Child/Family Enrollment Experience

The enrollment process follows the CHCBS Provider Approval Workflow from the perspective of the child/family

Choice of Designated Agencies

- HHCM/C-YES provides the child/family with a choice of HCBS designated agencies that provide the services that they are interested in
- Choice is recorded on POC
- MVP is responsible to ensure choice was given
- HHCM/C-YES must ensure HCBS Providers are in network with MVP

Provider Referrals

- Child/family decides and consents to receive services
- HHCM/C-YES makes referrals to those HCBS Providers
- Chosen Providers are documented in POC once the HHCM/C-YES ensures the Provider has availability to accept the referral

HCBS Provider Notification

- Child/family makes appointments with referred Providers for services
- HCBS Provider contacts MVP to make them aware of the date of the 1st appointment
- If 1st appointment is cancelled or rescheduled, HCBS Provider must let MVP know

Child Receives Services

- Service provision begins
- Child's HCBS Provider(s) determine the Frequency, Scope, and Duration of services in communication with the child/family
- Provider communicates these details to the HHCM who includes them in the POC (if not enrolled in HH, MVP updates the POC)
- HCBS Provider submits the Children's HCBS Authorization and Care Manager Notification Form to obtain authorization for additional services beyond the initial time period

Enrollment in CHCBS

- If a child is determined eligible for HCBS they can receive any/all services in the HCBS array, but should only receive those appropriate for their needs and goals as noted in the POC.
- HHCM/C-YES must notify family within 3-5 business days of determining outcome of eligibility assessment with a “Notice of Determination Enrollment” (NOD). Services can begin immediately if slots are available.
- If a child is found eligible, there must be a slot available for them in order for them to receive HCBS. If no slot is available, a “Notice of Decision” is given to the family and the child is placed on a waitlist.
- Slot capacity is managed by NYS DOH Capacity Management, who will notify the HHCM/C-YES when slots become available. HHCM/C-YES will then notify family by an updated “Notice of Determination” (NOD).
- Specific to C-YES, if found eligible, C-YES will assist families in completion of the Medicaid application and submission before referring to appropriate care management.
- If determined ineligible, child/family can appeal the decision by following the Fair Hearing Process with DOH. Child/youth can be reassessed at any time, as there is no wait period between assessments if there is a change in circumstances.

Disenrollment

The HHCM/C-YES and HCBS Providers maintain a responsibility for carrying out the discharge planning for the child/youth being disenrolled from the Children's Waiver and/or discharged from HCBS. The situations under which children/youth may be disenrolled include:

- Child/youth no longer meets admission criteria and/or meets criteria for another, more appropriate service, either more or less intensive.
- Child/youth or parent guardian withdraws consent for treatment.
- Child/youth is not participating in the POC development and/or utilizing referred services.
- Child/youth needs have changed, and current services are not meeting those needs.
- Child/youth's goals would be better served with an alternate service and/or service level.
- Child/youth's POC goals have been met.
- Child/youth's support system is in agreement with the aftercare service plan.

Services within CHCBS

Types of CHCBS Services

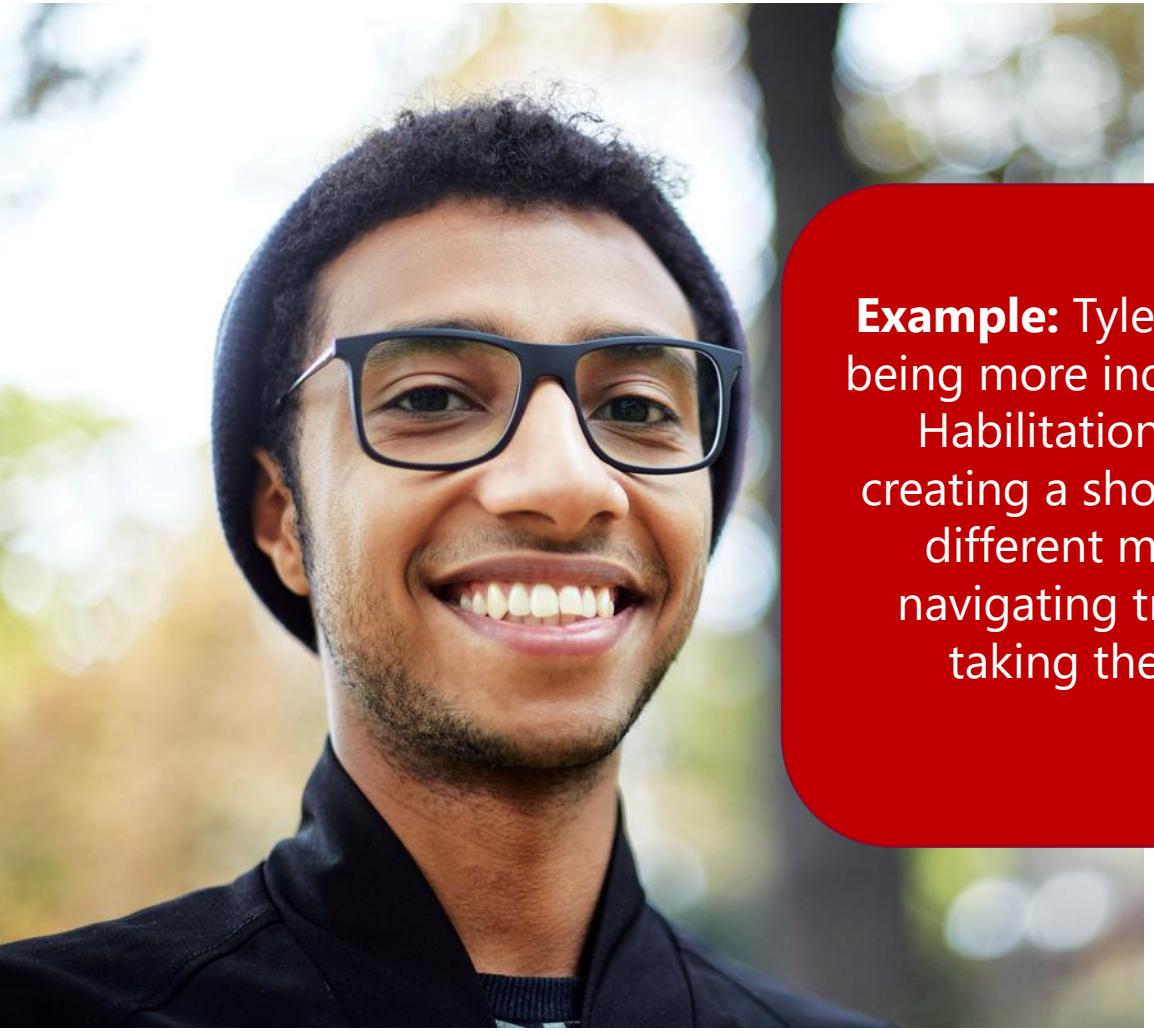
Habilitation	Community Habilitation & Day Habilitation
Caregiver/Family Advocacy and Support Services	
Respite	Planned & Crisis
Employment Services	Pre-Vocational & Supported Employment
Palliative Care	Expressive Therapy, Massage Therapy, Counseling and Support Services, Pain and Symptom Management
EMod, VMod & AT	Services Carved Out of Medicaid Managed Care Effective 7/1/24

Community Habilitation

Covers in-person services and supports related to the child/youth's acquisition, maintenance, and enhancement of skills necessary to perform Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), and/or Health-Related Tasks delivered in the community (non-certified) settings.

- **Acquisition** is described as the service available to a child/youth who is seeking greater independence by learning to perform the task for him/herself
- **Maintenance** is described as the service available to prevent or slow regression in the child/youth's skill level and to prevent loss of skills necessary to accomplish the identified task
- **Enhancement** activities are provided to the child through training and demonstration to promote growth and independence with an already acquired skill level and to support the child/youth's goal outside of the training environment

Community Habilitation



Example: Tyler, age 19, is on the Autism Spectrum. He is interested in being more independent from his caregivers. Tyler and his Community Habilitation Provider work on skills around meal prep, including creating a shopping list, visiting the grocery store, and cooking a few different meals at home. They also work to enhance Tyler's skill navigating transportation in order to transfer the skills he learned taking the bus to school to using public transportation in his community.

Day Habilitation

Assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills including communication and travel that regularly takes place in a non-residential setting, separate from the person's private residence or other residential arrangement. Foster the acquisition of:

- Daily Living Skills
- Appropriate behavior
- Greater independence
- Community inclusion
- Relationship building
- Self-advocacy
- Informed choice

Day Habilitation

Example: Juan, who is a child in Foster Care and has a developmental disability, receives Day Habilitation at an OPWDD certified agency. Juan and his Day Habilitation Provider work on his communication skills, including introductions, small talk, appropriate topics of conversation, etc. in pursuit of Juan's goal to make more friends and feel more comfortable around people he doesn't know well.

Caregiver/Family Advocacy and Support Services

Enhance the child/youth to function as part of the caregiver/family unit and enhance the caregiver/family's ability to care for the child/youth in the home and/or community as well as, provides the child/youth, family, caregivers, and collateral contacts (family members, caregivers, and other stakeholders identified on the child/youth's POC) with techniques and information not generally available so that they can better respond to the needs of the participant.

- Educational, advocacy, and support services
- Self-sufficiency
- Address needs and issues
- Training

Caregiver/Family Advocacy and Support Services

Example: Jamil is 7 years old and struggling with significant impulse control issues impacting school performance and peer relationships. His father is concerned about him maintaining his school placement and feels helpless. The Caregiver/Family Support Provider helps Jamil's father connect with available resources, provides education about Jamil's diagnosis, and helps Jamil's father understand the issues Jamil is experiencing in school and actively take part in school meetings.

Respite Definitions

Respite is short-term assistance provided to children/youth, regardless of disability, because of the absence of or need for relief of the child/youth or the child/youth's family caregiver. Respite workers supervise and engage the child/youth in activities that support his/her and/or primary caregiver/family's constructive interests and abilities. Services are offered with a level of expertise in understanding and implementing behavioral/developmental interventions required to support optimal functioning for children/youth.

Types	Definition
Planned	Planned short-term relief for the child/youth or family/primary caregivers to enhance the family/primary caregiver's ability to support the child/youth's functional, developmental, behavioral health, and/or health care needs.
Crisis	Short-term care and intervention strategy for children/youth and their families that helps to alleviate the risk for an escalation of symptoms, a loss of functioning, and/or a disruption in a stable living environment.

Respite Care Parameters

	Planned	Crisis
Allowed Period	No more than 7 days per calendar year and may occur in short-term increments of time or on an overnight or longer-term basis	No more than 72 hour stay
Service Provision	Direct care for the child/youth by individuals trained to support the child/youth's' needs	Required services to assure collaboration and continuity in managing the crisis situation and identifying subsequent support and service needs
Key Elements	Includes providing supervision and activities that match the child/youth's developmental stage	• Crisis residence • Monitoring for high-risk behavior • Health and healthcare Providers
Follow-Up Care	Continues to maintain the child/youth health and safety	At the end of the Crisis Respite period, all involved parties, make a determination for: • Continuation of necessary care • Make recommendations for modification as to the continuation of necessary care • Make recommendations for modifications to the child/youth's POC

Respite Limitations

- Respite is not a substitute for childcare
- This service should only be used in instances to enhance the family/primary caregiver's ability to support the child/youth's functional, developmental, behavioral health, and/or health care needs.
- The needs of the child/youth should be driving this service and not the availability of the family/primary caregiver to supervise the child/youth.
- For example:
  - Acceptable Respite (billable): accompanying a child/youth to a community activity at a local park from 5 PM – 7 PM if aligned with the child/youth's POC and in alignment with the f/s/d outlined in the HCBS Service Plan
  - Unacceptable Respite (not billable): Provider staying in the home from 8 PM – 10 PM to provide supervision after bedtime

Prevocational Services

Prevocational Services are individually designed to prepare a youth (age 14 or older) to engage in paid work, volunteer, or career exploration.

- Reflected in the youth's POC
- Directed at teaching skills rather than explicit employment objectives
- Facilitating development of appropriate work habits, acceptable job behaviors, and learning job production requirements

Prevocational Services

Example: Susie is 17 years old and her Prevocational Employment Provider engages her in exploring opportunities for college including considering a technical school and completing a college application. The Prevocational Employment Provider also helps Susie create a resume and explore opportunities for a part-time job to help finance her college pursuits. In preparation for getting a part time job, Susie's Prevocational Provider works with her to develop punctuality and understand what is and is not appropriate workplace behavior.

Supported Employment

Supported Employment services are individually designed to prepare youth with disabilities (age 14 or older) to engage in paid work.

- Provide assistance to participants with disabilities as they perform in a work setting
- Includes services and supports that assist the participant in achieving self-employment through the operation of a business including home-based self-employment
- The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals

Supported Employment

Example: Susie has a developmental disability. She just obtained a part time job working in a department store. The Supported Employment Provider meets with Susie's supervisor to discuss her specific workplace needs based upon her health care needs.

Palliative Care

- Palliative Care is specialized medical care focused on providing relief from the symptoms and stress of a chronic medical, physical, or developmental condition or life-threatening illness
- The HHCM or C-YES will assist the family with obtaining a doctor's written order and justification for all palliative therapies from a Physician, PA, NP, OT, PT or Psychiatrist. This written order is to be included with the child/youth's POC and made available to the MMCP as needed
- NYS is seeking more designated Palliative Care Providers, see **Resources** for more information
- The different components of Palliative Care services can be found on the next slide

Components of Palliative Care

Expressive	• Art, music, and play, helps children/youth better understand and express their reactions through creative kinesthetic treatment.
Massage	• To improve muscle tone, circulation, range of motion, and address physical symptoms related to illness as well as provide physical and emotional comfort, pain management, and restore the idea of healthy touch for children/youth who are dealing with treatments that may involve painful interventions and ongoing and/or past trauma.
Counseling & Support	• Requires an initial review by the Provider and be incorporated into the Service Plan that outlines the frequency, scope, and duration of counseling and incorporated into the HCBS care management POC. Families can receive six (6) months of services and one (1) month of HHCM after the passing of their child/youth if included in the POC prior to the participant's passing.
Pain and Symptom Management	• Provide relief and/or control of the child/youth's suffering related to their chronic medical, physical, or developmental condition.

Transition of EMod, VMod, AT Services to Financial Management Services (FMS)

Effective July 1, 2024, any new cases for Adaptive and Assistive Technology (AAT), Vehicle Modifications (VMods), and Environmental Modifications (EMods) are transitioning out of Medicaid Managed Care and being paid through Fee-for-Service.

Adaptive and Assistive Technology (AT) provides technology aids and devices identified within the child/youth's POC which enable the accomplishment of daily living tasks that are necessary to support the health, welfare, and safety of the child/youth.

Vehicle Modifications (VMods) provide physical adaptations to the primary vehicle of the enrolled child/youth which, per the child/youth's POC, are identified as necessary to support the health, welfare, and safety of the child/youth or that enable the child/youth to function with greater independence.

Environmental Modifications (EMods) provide internal and external physical adaptations to the primary residence of the enrolled child/youth which, per the child/youth's POC are identified as necessary to support the health, welfare, and safety of the child/youth or that enable the child/youth to function with greater independence in the home and without which the child/youth would require an institutional and/or more restrictive living setting.

The review, payment, and approval of all new Children's Waiver Emod, Vmod, and AT for children and youth enrolled in a Medicaid Managed Care Plan (MMCP) will be managed by the Children's Health Home of Upstate NY (CHHUNY) who will serve as the designated FMS Provider in conjunction with the NYS DOH.

Non-Medical Transportation

- Medicaid Transportation is a service managed and administered by the Department of Health to ensure Medicaid/HARP members have access to transportation to access Medicaid-covered services
- **Non-Medical Transportation (NMT)** services are available for individuals to access authorized CHCBS services and destinations that are related to a goal included on the child/youth's POC.
- NMT is not available for routine events
- NMT can be used to help a Member develop life-skills with routine events if tied to the POC goal to be very specific and the goal is time limited
- For more information visit the Medicaid Transportation (ny.gov) site

Eligibility

- Enrolled in Medicaid
- Determined eligible for CHCBS

Goals

- Transportation must be tied to a goal in the person-centered BH CHCBS Plan of Care

Verification of Abilities

- NYS-2015 completed by Member's practitioner and sent to MAS directly
- A single form needed for all trips to identify wheelchair or high modes of transportation needs

Prior Authorization

- NYS Grid Form completed by HHCM or C-Yes and sent to MAS directly
- Requests must be 72 hours in advance

Program Requirements

CHCBS Program Requirements

- Care Management is required for all participants receiving HCBS through HHCM, C-YES, or MMCP
  - The HCBS referred and provided cannot duplicate or replace existing and required care management services New York State (NYS) must ensure children/youth participating in the Children's Waiver are able to access and receive HCBS identified in the Plan of Care (POC)
- The entity providing Care Management for the child/youth must monitor access to care:
  - Contact with the child/youth/family to ensure that they are receiving the HCBS indicated within 45 days of the POC being signed
  - Ensure all are attending appointments and working toward established service goals
- The POC is the central element of HCBS care delivery
  - All care management and monitoring is oriented around POC
  - POC is based upon the needs and goals of the child/youth and family

CHCBS Program Requirements (Continued)

- The POC must at the time of the initial development:
  - Identify the need(s) of the child/family, the chosen HCBS, and goal/outcome to be attained
  - Be reviewed with the child/family
  - Signed by the child/family
  - Be provided to the child/family and, with informed consent, to the involved multi-disciplinary team Providers
- Once an HCBS Provider receives a referral from a Care Manager:
  - The Provider will meet with the child/youth and family/caregiver to identify how the referred services will help to address identified needs
  - The HCBS Provider is responsible for documenting the approach for service provision on an HCBS Service Plan for the services they expect to provide

The POC is a fluid document that changes and evolves over time as the child/youth meets their goals or new services/supports are needed.

Plan of Care (POC)

- A POC is created by the Health Home (HH) for each enrolled child
  - If a child is new to HH/referred to HH because of HCBS may first create an HCBS only POC, which will include HCBS services, and the goals of these services. Frequency, scope and duration may not be included yet if HH members have not been connected to an HCBS Provider.
  - If a child was in HH prior to HCBS, HHS should already have created a Comprehensive POC that HCBS will now be added on to
  - Within 30 days from completion/signature, HHCM sends POC to the MVP
    - POC may be incomplete, but all information available must be sent
    - If Frequency, Scope and Duration are not yet included, HHCM must resend once that has been added (after next meeting with the child/family)
  - If the POC sent to the MVP is HCBS only, the HH must send the Comprehensive POC once it is completed
  - Whenever the POC is revised, HHCM must send it to MVP within 30 days of revision
- A POC is created by the C-YES (when the child/family opt out of HH)
  - C-YES creates an HCBS POC, which includes HCBS services and the goals of these services (included are F/S/D)
  - Within 15 days of development, C-YES must send POC to MVP
  - MVP will meet with child/family on an ongoing basis once case management has begun as needed, to engage the person-centered planning and will update the POC as needed and every 6 months.
  - C-YES will conduct the child's annual HCBS Eligibility Determination and review/update of HCBS POC

MMCP Plan Transfer Authorization

New York State (NYS) provided guidance on plan transfers for CHCBS from either

1. Fee-For-Service (FFS) Medicaid to Medicaid Managed Care Plans (MMCP)
2. One MMCP to another MMCP

In both scenarios, it is imperative that CHCBS Providers,

- Communicate in a timely manner
- Ensure authorizations are in place
- Avoid care delivery interruptions

Please note: *It may take up to two (2) weeks for Member enrollment status to update in ePACES to MVP.*

The next two slides provide more detail on the two transfer scenarios indicated above.

Transitioning from FFS Medicaid to MVP

Care Continues

- CHCBS Providers will continue to provide services according to frequency/scope/duration (F/S/D) in the Children's HCBS Authorization and Care Manager Form
- Care lasts for up to 90-days or the end of the existing approved period under FFS Medicaid, whichever comes first

Notify MVP

- CHCBS Providers must notify the MVP by submitting a copy of the Children's HCBS Authorization and Care Manager Form
- Form must outline F/S/D noted in the POC, and service period start/end dates within five (5) business days of becoming aware of the enrollment change
- Update should occur prior to submitting a claim and no later than 14 business days from the end of the 90-day transition period

New Request for Care

If services are still required after the existing service period/90-day transition period, CHCBS Providers much submit a new Notification form to MVP at least 14 days prior to the end of the 90-day transition period

Transitioning from One MMCP to Another

Care Continues

For a Member with current, active and approved Notification Form, CHCBS Provider will continue to provide services according to F/S/D approved by the previous MMCP up to 60-days from the date of enrollment in the new MMCP or the end of the F/S/D period, whichever comes first.

Notify MMCP

The CHCBS Provider must notify the new MMCP and submit a copy of previous MMCP approval and copy of the authorization letter that includes the time period and approved F/S/D within five (5) business days of becoming aware of the enrollment change.

Update should occur prior to submitting a claim and no later than 14 business days from the end of the 60-day transition period.

MMCP must honor existing notification form approval for 60-days from date of enrollment in the new plan or until the end of the existing authorization period, whichever comes first.

New Request for Care

If there is a need for CHCBS beyond the existing authorization period/60-day transition period, a new Notification Form must be submitted 14 days prior to the expiration of the 60-day transition period or 14 days prior to the end of the existing authorization.

New CHCBS Services During Transition

If a Member does not have an approved CHCBS Notification form in place at the time of Plan transfer:

- **CHCBS Provider responsibilities:**
  - Must contact MMCP within 5 business days of becoming aware of the enrollment change of MMCP and prior to submitting a claim to share current status, initial service appointment, and the date by which the notification will be submitted
  - If CHCBS Providers receive denials for claims due to member no longer being enrolled in an MMCP, they must notify new MMCP prior to submitting claims
  - CHCBS cannot be provided if an authorization has lapsed

When a plan transfer of a Member who has an active authorization in place occurs the requirement to notify of 1st appointment is waived. After 60-90-day transition period, any changes would follow the HCBS Plan of Care Workflow.

Authorization/Prior Notification Requirements

Prior Notification/ Authorization Requirements

- MVP requires Prior Authorization for CHCBS services. Reference the CHCBS Approval Workflow in the Member Eligibility section of this presentation for more process details.

- The CHCBS Provider must notify MVP of the first scheduled CHCBS appointment with the child/family/youth once eligibility has been determined by the HHCMA/C-YES.
  - Initial notification must be made immediately when an appointment is scheduled and included on form
  - The new HCBS Authorization Requests must be created and managed within the **HCBS Referral and Authorization Portal**
  - Only authorizations generated by the Portal can be submitted for authorization and claim payment
  - Approval of this form authorizes 60 days and 96 units of care to develop the POC and initiate services
  - Start date of the initial appointment for authorized services must be included in the submitted form
- MVP requires the CHCBS Provider use the HCBS Referral and Authorization Portal to authorize ongoing care and implementation of the POC.
  - Authorizations are required for both MMCP and FFS participants
  - Concurrent review after initial units/time period is required
  - If a service will exceed unit limits of authorization, the CHCBS Provider must get approval for additional services
  - Requests must be made at least 14 calendar days prior to the end of the existing authorization in order to prevent disruption of services

- Additional details can be found in the **Provider Policies (Behavioral Health)** on the MVP website and on the **Resources** slide

Authorization Review

MVP reviews authorization requests to ensure quality and compliance with NYS guidelines and clinical best practice. The Member and CHCBS Provider are notified of each determination. CHCBS Provider notifies HHCMA.

Each request is reviewed for:

- Medical necessity
- Frequency/scope/duration of services
- Duplication of services
- Compliance with NYS requirements and regulations
- HHCMA/C-YES determination and eligibility determination

NYS DOH launched the HCBS Referral & Authorization Portal within the Incident Reporting and Management System (IRAMS) on June 17, 2024 (see **Resources** for more information) to:

- Streamline the HCBS referral and authorization process,
- Provide up to date information, status of referrals, and services,
- Track service delivery, and
- Track potential waitlist

Authorization & Referral Portal Implementation

1. New referrals for HCBS Members – June 17, 2024

Children/youth who are not currently receiving services, even if they have been previously referred to HCBS providers, must be referred through the Referral Portal with a new referral.

2. Connections for children/youth currently receiving services – July 24, 2024

Current members receiving HCBS must be entered into the Referral & Authorization Portal. Care managers and HCBS providers will work together to confirm children/youth already enrolled and receiving services. The Department has ended the Short Form Connection process access as of mid-November 2024.

3. Authorization Process – October 21, 2024

The authorization form was integrated into the Referral & Authorization Portal. CHCBS providers must create and manage their CHCBS Authorization Request within the portal and then enter the MMCP response. The NYS DOH moderates Fee-For-Service Authorizations. Only authorizations generated by the Portal can be submitted for authorization and claim payment. Use of the previous HCBS Authorization and Care Manager Notification Form is no longer permitted.

4. MMCP Access to the Referral & Authorization Portal – November 15, 2024

MMCPs obtained access to the Portal to view members' complete referral, authorization, and waitlist information.

Authorization & Active K-Code Requirements

- Authorizations can only be created if the child/youth has an active K-code, active Medicaid, an active service (full referral or short form connection) or has a pending Fair Hearing and Aid to Continue
- Only Authorizations generated in the Referral & Authorization Portal will be allowable for MMCP and FFS authorization after the launch of the Authorization portion of the Portal
- MMCPs and FFS personnel will be instructed to deny all other forms of authorization
- Submitting Authorizations for review and authorization by the MMCP will be conducted outside the Portal at this time, current submission processes remain in effect

Respite Authorization Requests

- Annual units for Planned and Crisis Respite are limited to 14 days (full per diems) during the calendar year or 1,344 15-minute units annually
- In submitting Authorization Requests for Planned and Crisis Respite, be mindful of the volume of per diem utilization of the service to appropriately submit your request

Concurrent Service Authorization

- If service will exceed unit limits of authorization or an extension beyond the approved authorization period is needed, CHCBS Provider must submit for additional approval
- This should be requested at least 14 calendar days prior to end of existing authorization to prevent disruption of services
    - MVP performs concurrent review post initial units/time period when an extension of those initial units is requested
    - MVP must determine additional authorization within timelines outlined
- Reviews occur on upon request of additional units

Billing Guidance

Billing Guidance

- Providers who are designated by NYS to provide CHCBS services are required to bill for these services in accordance with the guidelines in the NYS Children's Home and Community Based Services (CHCBS) Provider Manual that includes both program guidance and billing requirements.
- The most current NYS Children's HCBS Provider Manual can be found here
- Claims for CHCBS must be billed on an institutional claim form (837I or UB-04) with the applicable rate code, revenue code, CPT/HCPCS/Modifier combinations for the service being rendered and applicable Federal Information Processing Standards (FIPS)/County Locator Coding
- Claims must be submitted within MVP's Timely Filing guidelines to be eligible for reimbursement

FIPS Code Billing Requirements

- Effective for dates of service beginning December 1, 2023, claims for CHCBS must be billed with the applicable **Federal Information Processing Standards (FIPS)/County Locator Code** to be reimbursable

Electronic claims must include Value Code 24 and the Rate Code for the CHCBS service into the 39A field; Value Code 85 with the applicable Federal Information Processing Standard (FIPS) code are to be entered into field 40A.

Paper claims must include Value Code 24 and the Rate Code for the CHCBS service in the 39A field; Value Code 61 with the applicable Proxy Locator Code are to be entered into 40A.

- For services rendered via telehealth, the FIPS/County Locator Code should represent the county where the staff member was during service delivery. If the staff member was located outside of an office location (telecommuting), the county of the agency's administrative office should be used as the location on the claim
- These requirements apply to MVP's New York State Government Program plans, including Managed Medicaid Members
- The next few slides provide an illustration of the NYS FIPS/County locator Code crosswalk.

Additional information can be found at:
health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/2023/docs/cftss-hcbs_kids_fips.pdf
and
health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/changes_faqs.htm

FIPS & Proxy Codes

FIPS Code	County	Proxy Locator	Rate Region
36001	Albany	901	Upstate
36003	Allegany	902	Upstate
36005	Bronx	958	Downstate
36007	Broome	903	Upstate
36009	Cattaraugus	904	Upstate
36011	Cayuga	905	Upstate
36013	Chautauqua	906	Upstate
36015	Chemung	907	Upstate
36017	Chenango	908	Upstate
36019	Clinton	909	Upstate
36021	Columbia	910	Upstate
36023	Cortland	911	Upstate
36025	Delaware	912	Upstate
36027	Dutchess	913	Downstate
36029	Erie	914	Upstate
36031	Essex	915	Upstate
36033	Franklin	916	Upstate
36035	Fulton	917	Upstate
36037	Genesee	918	Upstate
36039	Greene	919	Upstate

FIPS Code	County	Proxy Locator	Rate Region
36041	Hamilton	920	Upstate
36043	Herkimer	921	Upstate
36045	Jefferson	922	Upstate
36047	Kings (Brooklyn)	959	Downstate
36049	Lewis	923	Upstate
36051	Livingston	924	Upstate
36053	Madison	925	Upstate
36055	Monroe	926	Upstate
36057	Montgomery	927	Upstate
36059	Nassau	928	Downstate
36061	New York (Manhattan)	960	Downstate
36063	Niagara	929	Upstate
36065	Oneida	930	Upstate
36067	Onondaga	931	Upstate
36069	Ontario	932	Upstate
36071	Orange	933	Downstate
36073	Orleans	934	Upstate
36075	Oswego	935	Upstate
36077	Otsego	936	Upstate
36079	Putnam	937	Downstate

FIPS & Proxy Codes (Continued)

FIPS Code	County	Proxy Locator	Rate Region
360081	Queens	961	Downstate
36083	Rensselaer	938	Upstate
36085	Richmond (Staten Island)	962	Downstate
36087	Rockland	939	Downstate
36091	Saratoga	941	Upstate
36093	Schenectady	942	Upstate
36095	Schoharie	943	Upstate
36097	Schuyler	944	Upstate
36099	Seneca	945	Upstate
36089	St. Lawrence	940	Upstate
36101	Steuben	946	Upstate
36103	Suffolk	947	Downstate
36105	Sullivan	948	Downstate
36107	Tioga	949	Upstate
36109	Tompkins	950	Upstate
36111	Ulster	951	Downstate
36113	Warren	952	Upstate
36115	Washington	953	Upstate
36117	Wayne	954	Upstate
36119	Westchester	955	Downstate

FIPS Code	County	Proxy Locator	Rate Region
36121	Wyoming	952	Upstate
36123	Yates	957	Upstate

Respite Billing Reminder

Sessions lasting 6-12 hours or 12-24 hours have designated Rate Codes and bill a per diem volume of units. This should be accounted for in billing and planning to achieve the POC goals related to this service.

See CHCBS Provider Manual for additional details:
https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/manuals.htm

Up to 6 hours

- Rate Code: 8028
- Billed in 15-minute units
- Billed when service is provided less than 6 hours

6-12 hours

- Rate Code: 8029
- Bill as per diem
- Billed when services is provided for exactly 6 hours, for more than 6 hours, but less than 12 hours

12-24 hours

- Rate Code: 8030
- Billed as per diem
- Billed when service is provided for exactly 12 hours, for more than 12 hours, or up to 24 hours

CHCBS For Child Health Plus Members

CHP Eligibility

- Child or youth who under the age of 21
- Enrolled in Child Health Plus (CHP) coverage
- Meet institutional placement criteria based upon Level of Care (LOC)
- CHCBS/LOC eligibility determination by HH Entity/C-YES
- MVP must receive all required documentation prior to the first CHCBS Provider appointment

Components of Eligibility	Subgroups Within the LOC Group	Medical Necessity
1) Target criteria 2) Risk factors 3) Functional criteria	1) Serious Emotional Disturbance (SED) 2) Medically Fragile Children (MFC)	Have a physical health, developmental disability, and/or mental health diagnosis with related significant needs that place child/youth at risk of hospitalization or institutionalization, or HCBS is needed for the child/youth to return safely home and to his/her community from a higher level of care

CHPlus Forms to Request an Eligibility Assessment

- **Submit** the *Licensed Practitioner of the Healing Arts (LPHA) form* to request an Eligibility Assessment to MVP by email to communityservices@mvphealthcare.com or by fax to 1-855-853-4850

- Find this form at **mvphealthcare.com/providers/forms** Under the NYS Child Health Plus (CHP) Program Forms section

CHP CHCBS Participation Workflow

CHP Members became eligible for CHCBS services on January 1, 2025.

Request	Eligibility Assessment	Enrollment Forms Completed	Referral to CHCBS Provider	Prior Notification	Plan of Care (POC) Developed	CHCBS submits Prior Authorization Request	MVP Authorization	Monitoring Check-In
Submit the "LPHA form" to MVP to request an Eligibility Assessment and MVP will connect the Member to an HH Entity or C-YES.	HH Entity or C-YES completes the eligibility determination and notifies the child/youth of the determination.	HH Entity/C-YES submits all documentation to MVP, including but not limited to: • Medical Disability Report • Questionnaire of School Performance • Description of School Performance .	HH Entity/C-YES assists the child/youth with identifying a CHCBS Provider to provide the services identified and establishes the first appointment.	CHCBS Provider must notify MVP of the first scheduled CHCBS appointment with the child/family/youth via the "Children's Home and Community Based Services Notification form"	Developed by the HH Entity/C-Yes with the CHCBS Provider which include the goals of these services. The POC which includes the frequency, scope and duration of the services should be sent to the MVP during this phase.	Prior to the expiration of the initial notification period, the CHCBS Provider is required to submit the "CHCBS Authorization Continuation Form" to update MVP on ongoing care and implementation of the POC.	MVP reviews authorization request to ensure that it meets medically necessity criteria and review for duplication of services per NYS guidelines. MVP notifies the Provider, HH Entity/C-YES and member of the determination.	HH Entity/C-YES to communicate updates to the POC, to MVP as needed.

Submissions to MVP: communityservices@mvphealthcare.com or 1-855-853-4850 (fax)

Find required documents on **mvphealthcare.com/providers/forms** under the NYS Child Health Plus (CHPlus) Program Forms section

CHP Standards & Expectations

- The "NYS Children's HCBS Referral and Authorization Portal" that is required for CHCBS referrals and authorizations for Managed Medicaid members **is not utilized** for CHCBS services for CHP members
  - MVP will maintain all information for the CHP Member related to CHCBS services
- Level of Care (LOC) supporting documentation will be collected and maintained by the HH Entity/C-YES as part of the Eligibility Assessment
- HH Entity or C-YES will complete the paper referral process with HCBS providers to schedule services for enrolled members
- Provision of care management services for CHP Members should meet the standard and expectations of Medicaid Members, including frequency, modality, and documentation
- MVP will notify HH Entity or C-YES three months prior to the annual eligibility renewal requirement
  - If a CHP member is found to no longer be eligible, the HH Entity/C-YES must provide a letter to MVP and all active Providers including the end date of services

Prior Notification by CHCBS Provider

- **Notify MVP that the first appointment** was scheduled with the *Children's Home and Community Based Services Notification Form*
- **Submit** this form to request an Eligibility Assessment to MVP by email to communityservices@mvphealthcare.com or by fax to 1-855-853-4850
- Find this form at **mvphealthcare.com/providers/forms** Under the Behavioral Health section

Concurrent Service Authorization

- Prior authorizations must be obtained before the expiration of the initial notification period by submitting the *Children's Home and Community Based Services Authorization & Continuation Form*: **mvphealthcare.com/providers/forms** and selecting the Behavioral Health form dropdown.
- Submit by email to **communityservices@mvphealthcare.com** or by fax to **1-855-853-4850**
- This should be requested at least 14 calendar days prior to end of existing authorization to prevent disruption of services
- The authorization form and documentation must clearly define the frequency, scope, and duration of the specific CHCBS services being requested and align with specific service goals.

CHP Billing Guidance

- CHCBS for CHP members must be billed in accordance with the Children's HCBS Provider Manual billing guidance.
- Claims are required to be submitted on an institutional claim form (837I or UB-04) with the applicable rate code, revenue code, CPT/HCPCS/Modifier combinations for the CHCBS service being rendered
- Federal Information Processing Standards (FIPS)/County Locator Coding is required on the claim.
- See previous Billing Guidance section for additional details

Resources

Resources

Children's HCBS Waiver Provider Information (ny.gov)

HCBS Provider Manuals and Rates (ny.gov)

Children's HCBS Billing Guidance (ny.gov)

MVP CHCBS Notification Form (Used for Prior Authorization)

MVP CHCBS Authorization Continuation Form (Used for services beyond the initial period)

Changes to Billing Requirements for Children's HCBS and CFTSS FAQ (ny.gov)

Child Adolescent Needs and Strengths NY (CANS-NY) Provider Information (ny.gov)

Becoming a Designated Children's HCBS Provider (Palliative Care Providers needed)

NMT_GRID_Form_Childrens_HCBS.pdf (emedny.org) (NMT Requirement)

Children's HCBS Referral and Authorization Portal: Authorization Features Frequently Asked Questions (PDF Version)

Children's Home and Community Based Services (HCBS) Referral and Authorization Portal User Guide (PDF)

HCBS Referral & Authorization Portal User Guide, Guide to Edits (PDF)

Critical Incident, Staff Compliance Tracker, and HCBS Referral and Authorization Portal

Thank you for being part of MVP

Contact your Behavioral Health Professional Relations Representative with questions. Visit the MVP Website to identify your representative and contact information by county.

Contact: Provider Relations Territory Listing Behavioral Health

MVP HEALTH CARE