Children’s Special Services

- ✓ **Home and Community Based Services (HCBS) Training**

September 2023

MetroPlusHealth

CHILDREN'S SPECIAL SERVICES (CSS) PROGRAM

- MetroPlus' **CSS team** is comprised of a Foster Care Liaison, a Medically Fragile Liaison, a Care Management Associate, nurses, social workers, and licensed behavioral analysts who:
  - Provide a hybrid model of care coordination including oversight of utilization and case management to ensure individual needs are identified
  - Identify and anticipate complex needs early by outreaching members to assess if the services that have been captured on the Plan of Care (POC) are in place and whether they are meeting their needs
  - Follow-up on issues raised by member/families and collaborate with Health Homes (HH), Care Management Agencies (CMA), Primary Care Providers (PCPs), specialty providers, homecare agencies, Durable Medical Equipment (DME) providers, pharmacy, and any other collateral contacts to support the member's needs

- The CSS team takes a multi-generational approach to care management which is in line with the state's intention for the program. Supporting the caregivers' needs helps to ensure that the child/youth will continue to receive support to remain in the community and engage in their care. Many of the new services in this program are designed to support the member and family to promote better outcomes.

  ➢ CSS Department can be reached by calling MetroPlus at 1-800-303-9626

IMPROVING CARE FOR CHILDREN

New York State has been focused on improving health outcomes, managing costs, and providing care management services for Medicaid children and youth under 21 years with complex medical, behavioral, and/or developmental issues. Since January 2019, more services have become available to Metro Plus members:

- **All members 0-21 who have Medicaid or SNP have access to:**
  - 6 new behavioral health services have transitioned from FFS Medicaid to managed care starting in January 2019 through January 2020. They are called:
    - **Child and Family Treatment Supports and Services (CFTSS)**
- **For children with complex medical, behavioral, and/or developmental health issues who have been determined eligible for waiver services:**
    - **Home and Community Based Services (HCBS)** transitioned in October 2019
- **Crisis Residence**
  - transitioned to managed Care on December 1, 2020
- **Children in the care of Voluntary Foster Care Agencies (VFCA)**
  - transitioned on July 1, 2021

IDENTIFYING AND REFERRING MEMBERS TO CSS

- **All members 0-21 who have Medicaid, SNP, or CHP coverage** can be referred for CFTSS services. Members can self-refer, be referred by their PCP or BH provider, or by their case managers
  - No authorization is required for CFTSS services
  - Goal to coordinate Trauma-Informed services: these services are based on an understanding of the vulnerabilities or triggers experienced by trauma survivors that may be exacerbated through traditional service delivery approaches so that these services and programs can be modified to be more supportive and avoid re-traumatization.
  - The CSS team engages all individuals with the assumption that trauma has occurred within their lives.
- **Children 0-21 with Medicaid or SNP with complex issues**:
  - To be eligible for Children's HCBS (waiver) services, children must have a physical health, developmental disability, or mental health diagnosis with related significant needs that place them at risk of hospitalization, institutionalization*, or need to return safely home and to their community from a higher level of care.
- Members who may be eligible for HCBS but do not have Medicaid or SNP can be referred to C-YES (Child and Youth Evaluation Services) through Maximus to be evaluated for LOC eligibility and Medicaid Family of One coverage. Providers and organizations can download the referral form: https://nymedicaidchoice.com/connecting-children-home-and-community-based-services

*Institutionalization refers to children at risk of being admitted to a higher level of care such as out-of-home residential settings, hospitalization, ICF-I/ID, or nursing facility

CHILD AND FAMILY TREATMENT SUPPORTS AND SERVICES (CFTSS)

- All children and youth aged 0-21 with Medicaid, SNP, or CHP coverage who have mental health and/or substance abuse issues can access these services in their home or in the community. These services can help:
  - Identify mental health and/or substance use problems early
  - Avoid the need for emergency room visits, hospital admissions, or out of home placements.
- CFTSS are therapeutic and rehabilitative services that help families
  - Learn to improve their health, well-being, and quality of life
  - Make informed decisions about their care
  - Advocate for the child's and family's needs
- CFTSS services are part of the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services that include appropriate preventive, dental, health, behavioral health, developmental and specialty services for all Medicaid children.
  - EPSDT services can assist medically fragile children in reaching their maximum functional capacity, considering the appropriate functional capacities of children of the same age.
  - Additional information is available here: NEW YORK STATE DEPARTMENT OF HEALTH (emedny.org)

CHILD & FAMILY TREATMENT SUPPORTS & SERVICES (CFTSS)

OLP (Other Licensed Practitioner)

Individual, group, or family therapy where you are most comfortable

CPST (Community Psychiatric Supports and Treatment)

Helps you stay in your home and communicate better with family, friends and others; intensive in-home services; crisis avoidance management and training

PSR (Psychosocial Rehabilitation)

helps you learn/ relearn self-care skills to help you in your community; skill building.

FPSS (Family Peer Supports and Services)

Help from credentialed family peer advocates with lived experience for families dealing with mental health or substance use challenges; support making informed decisions; locating resources to meet youth/family's needs

CI (Crisis Intervention)

Professional help for children/youth in distress; support with using crisis plans to de-escalate crisis and prevent or reduce future crises

YPST (Youth Peer Supports and Treatment)

Help from credentialed youth peer advocates to develop skills to manage challenges, support independence, make empowered decisions, link to resources, and transition to adulthood.

ELIGIBILITY FOR CHILDREN'S HEALTH HOMES AND HCBS SERVICES

To be eligible for **Children's Health Home services**, the individual must be enrolled in Medicaid and must have:

- Two or more chronic conditions (e.g., Substance Use Disorder, Asthma, Diabetes*) OR
- One single qualifying chronic condition:
  - HIV/AIDS or
  - Serious Mental Illness (SMI) (Adults) or
  - Sickle Cell Disease (both Adults and Children) or
  - Serious Emotional Disturbance (SED) or Complex Trauma (Children)

Network providers or managed care organizations may refer members aged 0-21 years with complex who are covered by Medicaid to Health Homes where they can be evaluated for additional services like CFTSS and HCBS services.

Members who do not wish to be enrolled with a Health Home may be referred to the NYS Independent Entity (IE) called Child and Youth Evaluation Service (C-YES) to be evaluated for HCBS eligibility. If found eligible, C-YES will work with the family, the MCO, and complete the initial Plan of Care.

For additional information on documentation requirements regarding

- Disability Determination for the **Medically Fragile (MF)** Target Population for Children's: guide_re_mfdd_req.pdf (ny.gov)
- S**erious Emotional Disturbance (SED)** Target Population for Children's HCBS Eligibility Determination: clarif_guide.pdf (ny.gov)

Once a child is found eligible for HCBS services, the Health Home Care Management Agency (HH/CMA) is responsible for creating the Plan of Care, coordinating services, and sharing it with the member and the managed care organization. The HH/CMA is also responsible for the annual reassessment for HCBS eligibility. For addition guidance:

- Health Home Plan of Care Policy: Health Home Plan of Care Policy (ny.gov)
- Plan of Care Development: Community First Choice Option (CFCO) (ny.gov)

HOME AND COMMUNITY BASED SERVICES (HCBS)

Members with the following conditions are identified and referred to Health Homes for care management and evaluation for HCBS eligibility:

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

Goals of referring members to HCBS services is to:

- Enable children to remain at home, and/or in the community, therefore avoiding institutional placement
- Safely return a child from a higher level of care back to the community with support services provided where they are most comfortable
- Support children and adolescents as they grow and work toward their goals
- Offer person-centered flexible services to meet the medical, mental health, substance use treatment and/or developmental needs of children/youth

HOME AND COMMUNITY BASED SERVICES (HCBS)

When a child meets criteria for HCBS, they are eligible for the full range of services that may include:

- Caregiver/Family Advocacy and Support Services
- Community Habilitation
- Day Habilitation
- Prevocational Services
- Supported Employment
- Palliative Care
- Planned Respite
- Crisis Respite
- Accessibility Modifications
  - Environmental Modifications
  - Vehicle Modifications
- Adaptive and Assistive Equipment
- Non-Medical transportation (FFS)

HCBS SERVICES

- **Caregiver/Family Advocacy and Support Services**
  - Caregivers and families can receive training and support to make informed and empowered choices for children with complex medical, behavioral, developmental, and/or substance use needs
  - Children and their families can learn to understand their complex needs and receive self-advocacy training
- **Community Habilitation**
  - Learning social, daily living, and health related tasks/skills to promote more effective communication, independence, and make informed choices.
- **Day Habilitation**
  - Learning social and daily living skills in an agency setting to promote engagement in the community, gain independence, and make informed choices

HCBS SERVICES- CONTINUED

- **Prevocational Services**
  - Youth 14 years and older can learn skills to prepare for paid or volunteer work that matches their interests. Skills can include communicating with supervisors, coworkers, and customers, problem-solving, and workplace safety.
- **Supported Employment**
  - Support for youth 14 and older to search for or maintain a steady job. Services includes job coaching, benefits support, and career advancement.
- **Accessibility Modifications**
  - Home or vehicle modifications to help with health needs
- **Adaptive and Assistive Equipment**
  - Technology aids or devices to support child's/youth's health, welfare, and safety

HCBS Services- continued

- **Palliative Care**
  - Children/youth with chronic or life-threatening illnesses can receive:
    - Massage therapy
    - Expressive therapy- art, music, play therapy to better understand and express emotions
    - Pain and symptom management to relieve or control suffering
    - Bereavement counseling to help children/youth and their families to cope with grief related to end-of life experiences
- **Planned Respite -** can be provided at home, in the community, or other allowable location
  - Short term relief for families/caregivers to support the child's/youth's goals
- **Crisis Respite -** can be provided at home, in the community, or other allowable location
  - Short term relief from mental health, substance use, or health crisis to avoid a higher level of care
- **Non-Medical transportation (covered by Fee-for-Service Medicaid)**
  - Transportation to services that support the child's/youth's goals

COLLABORATION BETWEEN MANAGED CARE AND COMMUNITY PROVIDERS

- Currently all our children/youth eligible for Home and Community Based Services (HCBS) services are enrolled with **Children's** Health Homes (HH) to coordinate care and promote health outcomes
  - ➢ Health Homes provide care management to help members/families connect to the services that meet their needs

➢ Per NYS requirements to support HH care management efforts:
  - ➢ Members eligible for HCBS services are assigned to MetroPlus CSS care managers for review and approval of the Plan of Care (POC) and collaboration with the HH/CMA to support linkage to services, improve quality outcomes, and meet Gaps in Care
  - ➢ All members who are eligible for HCBS services should be linked to HCBS services
  - ➢ MetroPlus CMs share our member summary to ensure current concerns are addressed
    - ➢ CSS CMs notify HH/CMAs, and VFCAs about hospital admissions, Emergency Department (ED) visits, open Gaps in Care and assist with coordinating care as needed
    - ➢ CSS CMs request updated POCs after qualifying events to ensure more comprehensive community treatment is coordinated for members who need **more or different** support to remain safe and stable in the community.

- Children in foster care may receive care coordination and support from MetroPlus, Voluntary Foster Care Agencies, HH/CMS, and providers in the community
  - If eligible, children in foster care may be eligible for HCBS services and care coordination

➢ The additional services and information available through managed care allows MetroPlus and providers to work together to support children's goals and development as they transition to adulthood

DOCUMENTATION EXPECTATIONS FOR THE POC

- POCs must be submitted for each HCBS eligible member annually, or sooner if there is a qualifying event like a hospitalization, Emergency Department (ED) visit, or other significant change to the family/community supports
- POCs should include and reflect an integrated approach to care coordination and include medical, behavioral, HCBS, and CFTSS services
  - Information should include, but is not limited to coordination with primary care providers, Gaps in Care, school issues, housing issues, vocation issues, crisis plans, needs related to Transition Aged Youth (TAY), etc
- Initial POCS and updated POCs may include services that are in the process of being coordinated
  - e.g. referrals for new services have been made and appointment times, frequency, scope, and duration are pending response from the HCBS provider
  - Once this information is available, the POC should be updated and resubmitted to MetroPlus
- The expectation is that the POC is updated on an ongoing basis and meets the changing needs of youth as they move through their development into adulthood.

COLLABORATION EXPECTATIONS BETWEEN METROPLUS AND HH/CMA'S

- MetroPlus CMs will notify CMAs about medical and behavioral admissions, ED visits, new Gaps in Care, and will review ongoing issues that require follow-up:
  - The goal is to **ensure appropriate coordination of care is in place to support the member's evolving needs**. Some examples include:
    - If the member is hospitalized, coordination with the inpatient staff and outpatient providers is needed to ensure the aftercare plan is enhanced to **better** support the member's needs upon discharge
      - Additional referrals may be needed to meet the member's and family's needs for support
      - Coordination with schools may be needed to advocate for additional supports
    - If the member presents to the ED, the crisis plan would be expected to be reviewed and updated as needed to support the family to recognize the early signs of escalation and ideally avoid future urgent or emergent events
      - Activities may include review of precipitating factors, available services, compliance with current treatment and medications, and/or linkage to additional supports
  - **The evolving needs of Transitioning Aged Youth (TAY)**
    - For members 16-21, focus on education, vocation, and the development of skills to support growth and development to adulthood and independence
    - POCs should reflect efforts to support members as they age out of Children's Services and transition to Adult Serving systems
      - This may include referrals to adult Health Homes or other community supports

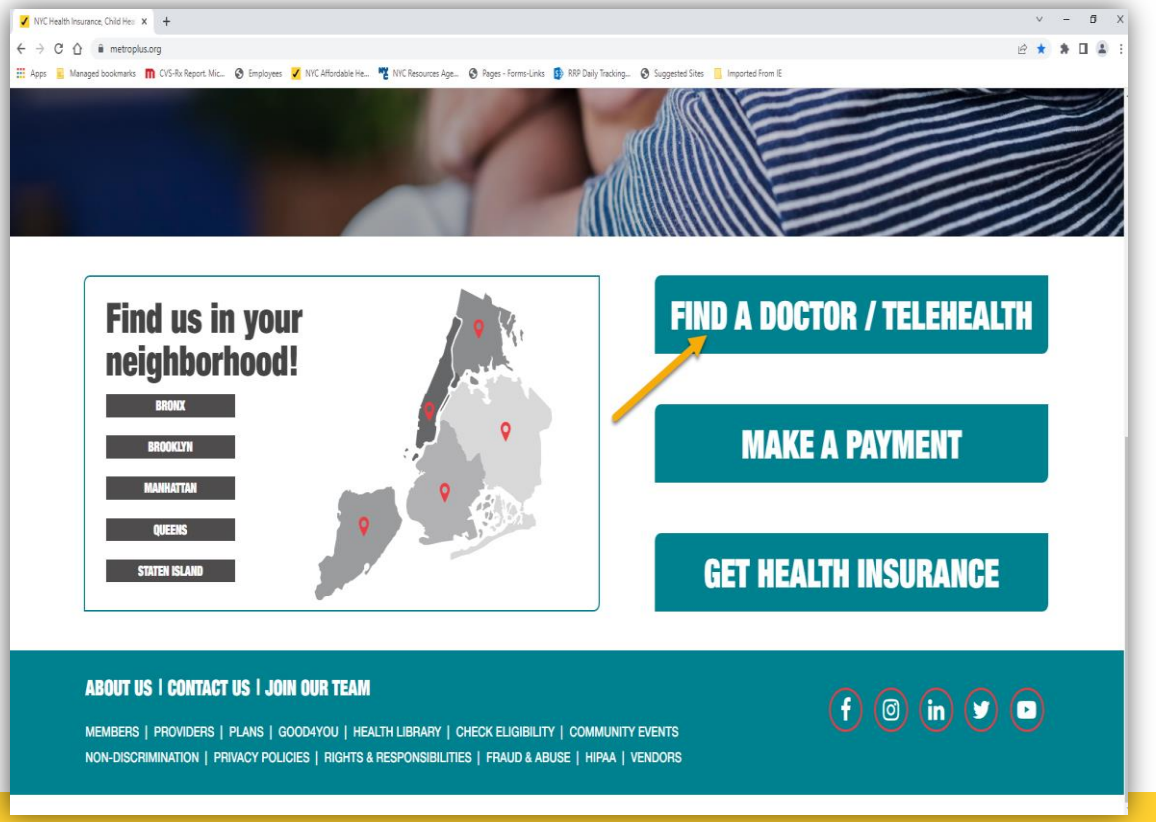
HCBS IDENTIFICATION OF PROVIDERS

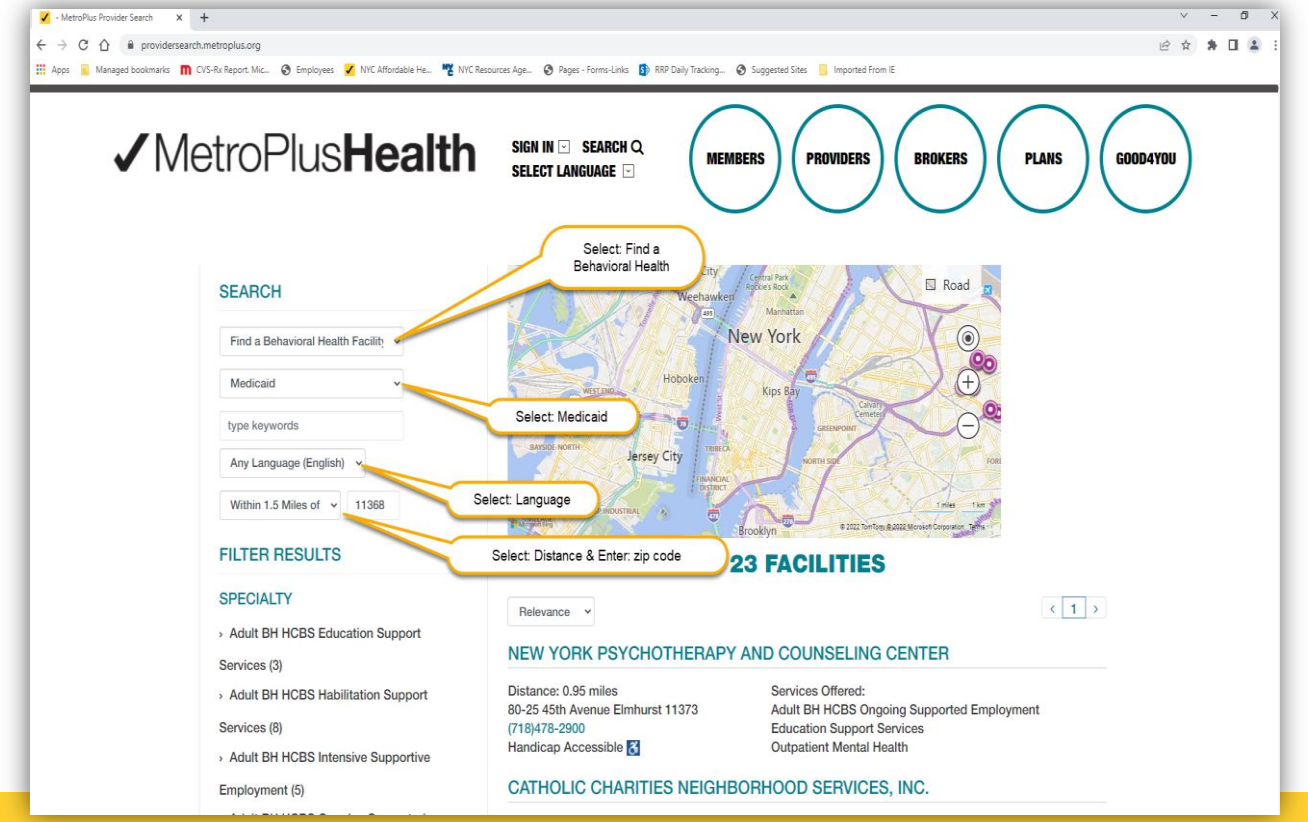
Searching for Providers

- Search the MetroPlus website

  https://www.metroplus.org/find-doctor

  https://providersearch.metroplus.org/





HCBS AUTHORIZATION REQUEST PROCESS

- Per NYS guidelines, MetroPlusHealth Expects:
  - CMA will collaborate with members and families to identify the need for a referral(s) to HCBS services
  - With the member's/family's consent, identify participating providers, submit referrals, and follow-through on member engagement
  - Referral must be documented on the POC
  - Upon confirmation of linkage to a provider, the POC should be updated and resubmitted to MetroPlusHealth
  - The HCBS services must be listed on the POC for managed care to provide authorization
- The medical necessity criteria to evaluate authorization requests is defined by **Children's Health and Behavioral Health Medicaid System Transformation: Children's Home and Community Based Services Manual March 2023**: https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/hcbs_manual.pdf
- The link to the HCBS authorization request form: https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/childrens_hcbs_authorization_cm_notification_form_fillable.pdf

ADDITIONAL INITIATIVES

Follow up after Emergency Department visits and/or Hospitalization

- CSS care managers conduct outreach to members to assist with coordinating care after acute psychiatric or medical hospitalization and emergency room visits to avoid readmission and escalation of issues.
- Assessing members identified as high risk to provide linkage to services or referrals to Health Homes as indicated

Psychotropic Pharmacy Initiative

- Medicaid children taking 3 or more psychotropic medications may receive telephonic outreach by the CSS team to assess needs, review gaps in care, and assist with community linkages including treatment, housing, food insecurity, health coverage for caregivers, technology/educational issues especially relevant during remote learning

Medically Fragile

- Members diagnosed with Sickle Cell Disease or those taking Blood Clotting Factor medications
- CSS Medically Fragile Liaison oversees the care management needs of these complex members and assigns members to nurse care managers to assess needs provide support to avoid the needs for admission or readmission

Children diagnosed with autism or Developmental Issues

- The CSS team assesses the complex needs of children and may coordinate referrals for Applied Behavioral Analysis (ABA), referrals to Office for People with Developmental Disabilities (OPWDD).

Supporting the coordination of care for the mandated initial health assessments for children placed in foster care:

- Prior authorization is not required for the mandated initial health assessments. Additional information is available here: https://www.health.ny.gov/health_care/medicaid/publications/docs/adm/21adm03.pdf

HELPFUL LINKS TO ACCESS CHILDREN'S SERVICES

MetroPlusHealth:

Call **1-800-303-9626** or follow this link:

NYC Health Insurance, Child Health Plus, Managed Care & Medicare | MetroPlus Health Plan

Submit POCs or HCBS Auth requests to:

- Childrensspecialservice@metroplus.org
- Fax: 212-908-3018

Link to Children's HCBS Authorization Form from MetroPlusHealth website:

- childrens_hcbs_authorization_cm_notification_form_fillable.pdf (metroplus.org)

PROVIDER RESPONSIBILITIES

- ✓ Provide trauma informed care to children placed in foster care
- ✓ Provide initial health assessments within mandated timeframes as required by the *New York Medicaid Program 29-I Health Facility Billing Manual* and the *Transition of Children Placed in Foster Care and NYS Public Health Law Article 29-I Health Facility Services into Medicaid Managed Care* guidance documents located at: https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/vol_foster_trans.htm.
- ✓ Provide Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services that include appropriate preventive, dental, health, behavioral health, developmental and specialty services for all Medicaid children.
- ✓ Provide EPSDT services that assist medically fragile children in reaching their maximum functional capacity, considering the appropriate functional capacities of children of the same age. EPSDT services Additional information is available here: NEW YORK STATE DEPARTMENT OF HEALTH (emedny.org)
- ✓ Medically fragile children have chronic debilitating condition or conditions, who may or may not be hospitalized or institutionalized, and meets one or more of the following criteria:
  - Is technologically dependent for life or health sustaining functions, requires complex medication regimen or medical interventions to maintain or to improve their health status; and/or needs ongoing assessment or intervention to prevent serious deterioration of their health status or medical complications that place their life, health or development at risk.
- ✓ Chronic Debilitating Conditions: include, but are not limited to bronchopulmonary dysplasia, cerebral palsy, congenital heart disease, microcephaly, pulmonary hypertension, and muscular dystrophy.

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