



# Department of Health

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**TRANSMITTAL:** 19 OHIP/ADM-02

**TO:** Commissioners of Social Services

**DIVISION:** Office of Health Insurance Programs

**DATE:** May 10, 2019

**SUBJECT:** Consolidated Children's Waiver and Medicaid Case Processing Requirements

<b>SUGGESTED DISTRIBUTION:</b>	Medicaid Staff Fair Hearing Staff Legal Staff Staff Development Coordinators Third-Party Liability Staff
<b>CONTACT PERSON:</b>	Local District Liaison: Upstate - (518) 474-8887 New York City - (212) 417-4500
<b>ATTACHMENTS:</b>	Attachment – OHIP-0125, "Children's Waiver Eligibility" Letter

### FILING REFERENCES

Previous Ref. ADMs/INFs	Releases Cancelled	Dept. Regs. Law	Soc. Serv. & Other	Manual Ref.	Misc.
None	None		SSL 366 SSA 1915(c)	None	MRT 1458 MRT 8401 GIS 14 MA/27

## I. PURPOSE

The Medicaid Home and Community-Based Services waiver program is authorized under Section 1915(c) of the Social Security Act. The purpose of this Office of Health Insurance Programs Administrative Directive (OHIP ADM) is to advise Local Departments of Social Services (LDSS) of the consolidation of the State's six (6) children's 1915(c) waivers for Home and Community-Based Services (HCBS) to one (1) 1915(c) Children's Waiver.

The directive describes the actions local districts are required to take regarding Medicaid eligibility for children determined to be eligible for participation in the Children's Waiver. The required actions include the following areas:

- Medicaid eligibility determinations;
- Identification of children eligible for Medicaid as a family-of-one; and
- Data entry of Recipient Restriction and Exception (RR/E) "K" codes for children eligible to enroll in the Children's Waiver.

## II. BACKGROUND

Effective April 1, 2019, the following six (6) 1915(c) HCBS waivers are consolidated into a single 1915(c) Children's Waiver under Department of Health (DOH) Waiver Number NY.4125:

- Office of Mental Health (OMH) Serious Emotional Disturbance (SED) Waiver Number NY.0296;
- DOH Care at Home (CAH) I/II Waiver Number NY.4125;
- Office for People with Developmental Disabilities (OPWDD) Care at Home (CAH) Waiver Number NY.40176 (formerly known as IV);
- Office of Children and Families Services (OCFS) Bridges to Health (B2H) for children with Serious Emotional Disturbances (SED) Waiver Number NY.0469;
- OCFS Bridges to Health (B2H) Medically Fragile Waiver Number NY.0471; and
- OCFS Bridges to Health (B2H) Developmental Disability (DD) Waiver Number NY.0470.

**Note:** The OPWDD Comprehensive Home and Community-Based Services 1915(c) waiver is not impacted by these changes. It is not part of the Children's Waiver consolidation and the provisions contained in this directive do not apply.

To access services under the Children's Waiver, all three of the following criteria must be met:

- The child must be under the age of 21 and be assessed at institutional Level of Care (LOC) using the HCBS/LOC eligibility determination within the CANS-NY tool on the UAS platform (Intermediate Care Facilities (ICF) for Individuals with Intellectual Disabilities (IID) LOC determinations will continue to be made by the OPWDD Developmental Disabilities Regional Office utilizing the ICF-IID Level of Care Eligibility Determination tool);
- NYS DOH has determined that there is capacity to serve the child in the Children's Waiver; and
- The child is enrolled in Medicaid.

**Note:** Children with third-party health insurance coverage and/or a spenddown requirement are qualified to participate in the Children's Waiver provided they meet HCBS/LOC criteria for participation.

The consolidated Children's Waiver (#NY.4125) provides a single HCBS benefit package to children meeting institutional level of care. For their case management services, enrollees may elect to enroll in a Health Home for comprehensive care management or opt out and receive HCBS care coordination, plan of care development and annual re-assessment from the State's designated independent entity, currently Children and Youth Evaluation Service (C-YES).

### III. **PROGRAM IMPLICATIONS**

#### A. **HCBS/LOC Eligibility Determination**

Effective April 1, 2019, HCBS/LOC eligibility determinations will be conducted by either a Health Home or C-YES. If a request for participation in the Children's Waiver is received by the LDSS, the local district will:

- Direct children who are enrolled in a Health Home to their Health Home; and
- Direct children without Medicaid and children who are not enrolled in a Health Home to C-YES.

**Note:** Contact telephone number for C-YES is (833) 333-2937.

No documentation is required to direct a family/child to a Health Home or to C-YES. Agencies and organizations that are assisting families in applying for the Children's Waiver should contact C-YES or the child's Health Home directly. Referrals for the Children's Waiver are not required to go through the LDSS.

#### 1. **Health Home**

Effective April 1, 2019, Health Homes are responsible for conducting HCBS/LOC eligibility determinations for Medicaid-enrolled children who are seeking enrollment in the Children's Waiver. If the child opts out of enrollment in a Health Home, the child must receive an HCBS/LOC eligibility determination from C-YES. A child can opt-out of Health Home at any time.

A list of the 16 Health Homes designated to serve children, the areas they serve, and their contact information for each can be found at:

[https://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_health\\_homes/hh\\_map/index.htm](https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_map/index.htm).

#### 2. **C-YES**

Effective April 1, 2019, C-YES is responsible for conducting HCBS/LOC eligibility determinations for children without Medicaid who are seeking enrollment in the Children's Waiver. For children with Medicaid who are not enrolled in a Health Home, C-YES will assist the individual in choosing a Health Home and refer the individual to the Health Home. If the child opts out of enrollment in a Health Home, C-YES will conduct the HCBS/LOC eligibility determination for the child.

C-YES has nurse assessors across the State who will meet the child in their home or another location of their choosing to conduct the HCBS/LOC eligibility determination.

## **B. Waiver Capacity**

When a child has been determined to meet Level of Care based on the HCBS/LOC eligibility determination, the Health Home or C-YES will be contacted by the DOH Capacity Management group, who will indicate whether capacity is available for the child to enroll in the Children's Waiver. If there is no capacity for a child to participate in the Children's Waiver, the child will be placed on a waitlist until capacity becomes available.

If a child enrolled in the Children's Waiver loses Medicaid coverage, the DOH Capacity Management group will not release that child's slot to a new child for a period of 90 days. If the child regains Medicaid coverage within the 90 days, the child can resume participation in the Children's Waiver immediately.

## **C. Certification of Disability**

Certification of disability means a child has been determined to meet the standards used to determine disability by either the Social Security Administration, the State Medicaid Disability Review Team or the local Medicaid Disability Review Team. Certification of disability is not required for children to meet the Level of Care requirements for participation in the Children's Waiver.

For purposes of determining Medicaid eligibility for children who have been found eligible under the HCBS/LOC eligibility determination, a review of certified disability status will be required when the following three conditions are met:

- The child is in a Medically Fragile diagnostic group (Medically Fragile group or Developmentally Disabled and Medically Fragile group);
- The child is not Medicaid eligible under a Modified Adjusted Gross Income (MAGI) budget; and
- The child is over the income level based on an Aid to Families with Dependent Children (ADC)-related budget that includes parental income.

The State Medicaid Disability Review Team will perform the disability determination for a child who meets all of the above-listed conditions. If the child is certified as disabled, Medicaid eligibility will be determined under the Supplemental Security Income (SSI)-related category of assistance, first by including parental income and resources and then, if ineligible under this budget, Medicaid eligibility for the child will be determined as a family-of-one. To expedite the authorization of Medicaid coverage and receipt of services for the child, Medicaid eligibility will be determined under an ADC-related family-of-one budget, pending the results of the disability determination. Once certification of disability is approved for the child, the local district will change the eligibility budget calculation for the child to an SSI-related budget and the category code to a disabled category.

Children with Serious Emotional Disturbance and children who do not meet the standards for certification of disability are entitled to have their Medicaid eligibility determined as a family-of-one under the ADC-related category of assistance, if the child is not otherwise eligible when parental income is included in the budget calculation (MAGI or ADC-related community budget with parental income).

#### **IV. REQUIRED ACTION**

##### **A. Children who are not Enrolled in Medicaid when HCBS/LOC Eligibility is Determined**

For a child without Medicaid coverage who is approved for enrollment in the Children's Waiver, Medicaid eligibility must be determined by the LDSS and coverage, if otherwise eligible, established on the Welfare Management System (WMS).

Effective April 1, 2019, the LDSS will begin to receive Children's Waiver Eligibility letters (OHIP-0125, see Attachment) from C-YES indicating:

- That a child applied for services under the Children's Waiver and has met Level of Care based on the HCBS/LOC eligibility determination;
- Whether capacity is available for the child to participate in the Children's Waiver; and
- The appropriate RR/E codes to identify the child's enrollment by a diagnostic group.

**Note:** The Children's Waiver Eligibility letter is verification of the child's HCBS waiver eligibility. A copy must be stored in the Medicaid case record or online repository.

Maximus Field Customer Service Representatives will work with families to complete a Medicaid application and gather required documents. For those counties that do not have a Field Customer Service Representative in their office, the local district should call the C-YES number for information about how to make a referral to C-YES for Medicaid application assistance.

Medicaid applications from C-YES will include:

- The Children's Waiver Eligibility letter, indicating whether capacity is available for participation in the Children's Waiver and the appropriate RR/E codes to use if the child is determined Medicaid eligible;
- A complete Medicaid application (and Supplement A for a certified disabled child or a child in a Medically Fragile diagnostic group), including supporting documentation; and
- Completed disability forms for a child in a Medically Fragile diagnostic group.

If the Medicaid application includes other applying family members who are in the Modified Adjusted Gross Income (MAGI) category of assistance, the application must also be referred to NY State of Health for the other family members following existing procedures. If a certification of disability is required, the LDSS will forward the request and completed disability forms to the State Disability Review Team for a determination of disability.

For child-only applications, parents may attest to income. Documentation of parental income is not required to be submitted with the initial application. If the child is subsequently determined to be Medicaid eligible under a budget including parental income, documentation of parental income will be required. Documentation of the child's own income is always required. In addition, documentation of any third-party health insurance that covers the child must be provided.

If Medicaid coverage/reimbursement is requested for medical bills incurred in the three-month retroactive period, documentation of parental income will be required.

If a child is certified disabled or in a Medically Fragile diagnostic group, parents may attest to their income and resources. Documentation of parental income and resources will not be required with the initial application unless the child is subsequently determined to be eligible under an SSI-related budget that includes deeming of parental income and resources. Documentation of the child's own income and resources must be provided.

## **B. Medicaid Budgeting for Children Meeting Level of Care under the HCBS/LOC Eligibility Determination**

**Note:** Children in a Medically Fragile diagnostic group who are not Medicaid eligible under a MAGI-like budget or an ADC-related family budget, must pursue a certification of disability. Pending the disability determination, the child may be determined eligible for Medicaid under an ADC-related family-of-one budget. For all children, the child must first be determined to be ineligible under a family community budget before Medicaid eligibility can be determined for the child as a family-of-one (household of one). Copies of the ineligible family community budget(s) must be retained in the child's case record when a family-of-one budget is used to authorize Medicaid coverage.

To determine Medicaid eligibility for children eligible to participate in the Children's Waiver, the district is required to use the following budgeting methodologies, in the following order:

- First, a MAGI-like budget should be calculated, including all legally responsible household members and their income;
- If the child is over income under the MAGI-like budget, an ADC-related budget is calculated, including all legally responsible household members and their income; and
- If the child is over income under the ADC-related family budget, an ADC-related budget is calculated including only the child in the household and the child's income, disregarding the rest of the household members and their income. Children in a Medically Fragile diagnostic group (Medically Fragile and Developmentally Disabled and Medically Fragile) must also be referred to the State Medicaid Disability Review Team for a disability determination.

**Note:** The categorical code used for the child must be based on the financial budget under which the child is determined to be Medicaid eligible. If a certification of disability is later received for a child who was otherwise eligible under an ADC-related budget, the Medicaid budget and categorical code should be changed to an SSI-related budget and disabled category code (Budget Type 04/categorical code 12).

- If an applying child is certified disabled, a MAGI-like budget should be calculated, including all legally responsible household members and their income;
- If the child is over income under the MAGI-like budget, an SSI-related budget is calculated using parental income and resources for deeming to the disabled child (income of any siblings in the household under 18 years of age must be included in the budget calculation for purposes of allocation); and
- If the child is not eligible or over income under the SSI-related budget with parental income and resources, an SSI-related budget is calculated including only the certified disabled child and the child's own income and resources.

**Note:** Deeming of parental income and resources stops at age 18 for a certified disabled child.

### **1. Child Eligible with Family Income**

If a child is found Medicaid eligible under a community budget with family income (income at or below the income level and parental resources for an SSI-related child at or below the resource level), documentation of the income (and parental resources for an SSI-related child), must be requested to complete the Medicaid eligibility determination. If the required documentation is not provided within the required time frame, Medicaid eligibility cannot be authorized and the application for the child must be denied due to the failure to provide the required documentation. If a parent of a certified disabled child (who is eligible under a

community SSI-related budget with family income and resources) fails to provide required resource documentation, the child's application should not be denied due to the failure to provide the parental resource documentation unless the child is over income under an ADC-related family budget. If the certified disabled child's family income is at or below the ADC-related income level, documentation of the family income can be provided for purposes of completing the eligibility determination under the ADC-related family budget.

For children who are determined to be Medicaid eligible and capacity is available for the child to participate in the Children's Waiver, the appropriate RR/E codes must be entered into eMedNY by the LDSS as instructed on the Children's Waiver Eligibility letter (see Systems Implications Section). For Medicaid applicants, the start dates for the RR/E codes are the first day of the month in which the Medicaid eligibility determination is completed. For example, if an application was filed with the district on April 17, 2019 and the Medicaid eligibility determination was completed on May 8, 2019, the RR/E codes would be effective May 1, 2019.

## **2. Child Eligible under Family-of-One Budget**

When a child is determined Medicaid eligible under a family-of-one budget, the district must enter an RR/E code of "KK" in eMedNY to identify the child. The RR/E code of "KK" must be entered whether the family-of-one budget is an SSI-related budget or an ADC-related budget. The effective date for the RR/E code of "KK" is the first day of the month in which the Medicaid eligibility determination is completed and capacity is available in the Children's Waiver as indicated on the Children's Waiver Eligibility letter.

**Note:** For a certified disabled child, the "KK" RR/E code should be end dated the first day of the month in which the child turns 18 years of age.

If the child is eligible for Medicaid with a spenddown requirement (based on a community budget with family income) for months prior to the effective date of the family-of-one budget, provisional coverage should be authorized for this time period.

If there are unpaid medical bills in the three-month period prior to the date of application and/or in months prior to the effective date of Medicaid coverage under a family-of-one budget, eligibility for purposes of meeting a spenddown must be determined based on regular Medicaid budgeting rules. Documentation of parental income is required. A family-of-one budget cannot be used to determine eligibility for the three-month retroactive period or for months prior to an eligibility determination being completed under a family-of-one budget. Districts are reminded that Medicaid eligibility under a family-of-one budget cannot be authorized unless Waiver capacity has been approved.

## **3. Children with Third-Party Health Insurance**

When a child is determined eligible for Medicaid and has health insurance coverage through a parent, the LDSS must determine if the health insurance is cost effective. Cost effectiveness is determined by comparing the cost of the premiums to the Medicaid managed care rate for the child. If the policy is cost effective, the district must reimburse the cost of the entire premium, even if the policy covers other non-applying or non-Medicaid eligible family members. If the cost of the entire premium is not cost effective, a pro-rated amount of the premium cost, required for the child, should be used to re-compare against the child's Medicaid managed care rate. If the pro-rated cost of the policy is cost effective, the district must reimburse that amount of the premium.

### **C. Medicaid Budgeting when Waiver Capacity is not Available**

If a child is not enrolled in Medicaid, and has met Level of Care for HCBS, but there is no Waiver capacity, the LDSS must still conduct a Medicaid eligibility determination using community budgeting rules. If the child is determined to be Medicaid eligible with a spenddown requirement, the LDSS must open the case with provisional coverage (Medicaid coverage code 06 - Provisional Coverage). If the child presents medical bills to meet a spenddown, income documentation must be provided before Medicaid coverage can be authorized as discussed in Section IV.B.2 of this directive. When notified by DOH that there is Waiver capacity, the LDSS must re-determine Medicaid eligibility for the child as a family-of-one using ADC-related budgeting or an SSI-related budget, whichever is applicable. The effective date of Medicaid coverage under the family-of-one budget is the first day of the month in which Medicaid eligibility is re-determined.

Example:

- Medicaid application date April 15, 2019 and Waiver capacity is not available.
- May 8, 2019, the child is determined Medicaid eligible with a spenddown (community budget with parental income). Provisional coverage authorized beginning April 1, 2019.
- June 24, 2019, the LDSS receives notification that Waiver capacity is available and Medicaid eligibility is re-determined under a family-of-one budget on July 3, 2019.
- The Medicaid coverage start date under the family-of-one budget is July 1, 2019.
- The appropriate RR/E codes are effective July 1, 2019 (KK, K1 plus "K" code based on diagnostic group).

For Medicaid applicants, once Medicaid eligibility has been determined, the LDSS is responsible for data entry of the appropriate RR/E codes on the member's record in eMedNY (see Section V. Systems Implications of this directive).

If the processing time for an initial Medicaid eligibility determination for a child exceeds 30 days, or 90 days for a disability determination, C-YES may contact the LDSS for an update on the application. It is expected the LDSS will communicate with C-YES, providing information on the status of the application.

### **D. Children who are Enrolled in Medicaid when Level of Care for HCBS/LOC is Determined Met**

When a child with Medicaid coverage is determined to meet Level of Care for purposes of participation in the Children's Waiver, the following actions will occur depending on which district is currently administering the child's Medicaid case.

#### **1. Case Administered by the Local District**

If a child has Medicaid coverage through the local district at the time the child is determined to meet Level of Care based on the HCBS/LOC eligibility determination, the Health Home or C-YES will be contacted by the DOH Capacity Management group, who will indicate whether there is Waiver capacity. If there is capacity, the DOH Capacity Management group will submit the Children's Waiver Eligibility letter to the [hxexcept@health.ny.gov](mailto:hxexcept@health.ny.gov) mailbox. The responsible DOH unit will enter the appropriate RR/E coding and forward the Children's Waiver Eligibility letter to the appropriate local district to be retained in the child's Medicaid case record. The effective date for the RR/E coding will be based on the available participation date in the Waiver as indicated by the DOH Capacity Management group and noted on the Children's Waiver Eligibility letter.



## 2. Cases Active through NY State of Health

If a child has Medicaid coverage through NY State of Health at the time the child is determined to meet Level of Care based on the HCBS/LOC eligibility determination, the Health Home or C-YES will be contacted by the DOH Capacity Management group, who will indicate whether there is Waiver capacity. If there is capacity, the DOH Capacity Management group will send the HCBS waiver approval letter to the [hxexcept@health.ny.gov](mailto:hxexcept@health.ny.gov) mailbox. The responsible DOH unit will enter the appropriate RR/E coding and notify the [hxfacility@health.ny.gov](mailto:hxfacility@health.ny.gov) mailbox to have the child's Medicaid coverage transitioned to the local district. DOH will forward the HCBS waiver approval letter to the local district. The case will be transitioned to the local district as advised in GIS 14 MA/027 "Medicaid Applications for Individuals Seeking HCBS Services."

## 3. Children Placed in Foster Care

Children enrolled in foster care are categorically eligible for Medicaid and no separate Medicaid eligibility determination is required. If a child in foster care is determined to meet Level of Care based on the HCBS/LOC eligibility determination, the child will be identified to the DOH Capacity Management group to determine if there is Waiver capacity. If there is capacity, the DOH Capacity Management group will submit the Children's Waiver Eligibility letter to the [hxexcept@health.ny.gov](mailto:hxexcept@health.ny.gov) mailbox for entry of the appropriate RR/E coding. An RR/E "K" code identifying the diagnostic group of the child and RR/E code K9 (Foster Care) will be entered for the child. The Children's Waiver Eligibility letter will be forwarded to the appropriate local district to be retained in the child's case record.

**Note:** Interim manual procedures will be used to identify New York City children who are enrolled in the Children's Waiver, who subsequently enter or leave foster care, to ensure the appropriate RR/E codes are associated with the correct Client Identification Number (CIN) for the child.

Children's Waiver Eligibility letters for children placed in foster care will be sent to the Medicaid Director at the local department of social services. If the child is placed in foster care, the Medicaid Director is requested to forward the approval letter to the appropriate unit for entry in the child's case record.

## E. Annual HCBS/LOC Redetermination and Medicaid Renewal Process

The HCBS/LOC eligibility determination must be conducted annually by the Health Home or C-YES. The HCBS/LOC re-determination results will not be communicated to the district unless there is a change to an RR/E "K" code identifying the waiver participation of the child or the child is no longer eligible for or participating in the Children's Waiver. If there are changes in Waiver status, the district will be notified through the Children's Waiver Eligibility letter and is responsible for making any eligibility re-determinations that may be appropriate. For a child who has been determined eligible under a MAGI category of assistance, the child is eligible for the remainder of the continuous coverage period if determined to be ineligible for on-going Medicaid. Non-MAGI categories of assistance are not eligible for continuous coverage and any re-determination of Medicaid eligibility is effective following 10-day notice. The DOH will be responsible for updating RR/E codes and effective dates or end dating an RR/E code if the child is no longer participating or eligible for the waiver. This includes RR/E code "KK" in instances where a child is no participating in or eligible for the Children's Waiver.

The Medicaid eligibility renewal process for children enrolled in the Children's Waiver will not change. Unless otherwise notified, the district will continue to re-determine Medicaid eligibility for the child as an enrollee in the Waiver.

## V. SYSTEMS IMPLICATIONS

For the new consolidated 1915(c) Children's Waiver, DOH has created new RR/E "K" codes to identify participants in the waiver. If a child is enrolled in a managed care plan, the managed care plan will receive any RR/E "K" code associated with the child's enrollment. For Medicaid coverage months starting April 1, 2019, the following RR/E codes are no longer applicable:

- R/RE 23: OMH HCBS Children's Waiver
- R/RE 62: Care at Home I
- R/RE 63: Care at Home II
- R/RE 65: Care at Home IV
- R/RE 72: Bridges to Health/SED
- R/RE 73: Bridges to Health/DD
- R/RE 74: Bridges to Health/Medically Fragile

Children who were participating in any of the 1915 (c) waivers prior to April 1, 2019 were transitioned to the new consolidated Children's Waiver. The former RR/E codes for these active children were systemically ended with an end date of April 2, 2019, and the new R/RE "K" codes were entered. The former RR/E codes are no longer available for selection in the RR/E code dropdown menu. If a district needs to enter one of these RR/E codes for months prior to April 1, 2019 (for example, RR/E 62 for 3/28/19-4/1/19), the district will need to contact the managed care mailbox at: [mcsys@health.ny.gov](mailto:mcsys@health.ny.gov).

The new RR/E "K" codes created for the consolidated Children's Waiver that will be used for identification purposes are as follows:

- R/RE KK: Child is Eligible for Medicaid as a Family of One
- R/RE K1: HCBS At Level of Care Acuity
- R/RE K3: HCBS Diagnostic Group – Serious Emotional Disturbance
- R/RE K4: HCBS Diagnostic Group – Medically Fragile
- R/RE K5: HCBS Diagnostic Group – Developmentally Disabled and in Foster Care
- R/RE K6: HCBS Diagnostic Group – Developmentally Disabled and Medically Fragile
- RR/E K9: Foster Care

Effective April 1, 2019, the LDSS will be primarily responsible for the data entry of the RR/E codes for new Medicaid applicants who are approved for participation in the new Children's Waiver. The LDSS should enter the appropriate diagnostic group-related RR/E codes based on information in the Children's Waiver Eligibility letter. The district will be responsible for identifying children who are Medicaid eligible under a family-of-one budget (RR/E KK). The new RR/E codes are to be entered with no provider ID number. The "From" date is the first day the month in which Medicaid eligibility is approved. The "Thru" date will be system generated with a "12319999" date, which will be interpreted as "continuing until modified." Districts are responsible for ending RR/E code "KK" the first day of the month in which a certified disabled child turns age 18.

**Note:** Program policy implications and directions related to R/RE code K8: Voluntary Foster Care Agency will be forthcoming in a separate release.

**VI. EFFECTIVE DATE**

The provisions in this Administrative Directive are effective April 1, 2019.

*Donna Frescatore*

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