UnitedHealthcare Community Plan

UnitedHealthcare Community Plan Children Under 21

New York Medicaid Behavioral Health Manual



OPTUM

United Behavioral Health and United Behavioral Health of New York, I.P.A., Inc. operating under the brand Optum

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Introduction

Welcome.

We are pleased to have you working with us to serve the children and under 21 years of age individuals covered under Medicaid. We are focused on creating and maintaining a structure that helps people live their lives to the fullest. At a time of great need and change within the health care system, we are energized and prepared to meet and exceed the expectations of consumers, customers and partners like you. Our relationship with you is foundational to the recovery and well-being of the individuals and families we serve. We are driven by a compassion that we know you share. As we work together, you will find that we seek and pursue opportunities to collaborate with you to set the standard for industry innovation and performance.

We encourage you to make use of our industry-leading website, PROVIDEREXPRESS.COM where you can get news, access resources and, in a secure environment, make demographic changes at the time and pace you most prefer. We continuously expand our online functionality to better support your day-to-day operations. Visit us often. MANAGED CARE TECHNICAL ASSISTANCE CENTER (MCTAC) has created a "GLOSSARY OF TERMS". Refer to this resource for more information about terms you are unfamiliar with.

Important Notice

Optum provides this manual as a more focused resource for providers serving the UnitedHealthcare Community Plan Children's Medicaid membership. This manual does not replace the primary NATIONAL NETWORK MANUAL. Rather, this manual supplements the Network Manual by focusing on the core service array, roles and responsibilities as well as process and procedures specific to the State of New York Children's Medicaid program. Topics or requirements that are specific to the Children's Medicaid program as offered through UnitedHealthcare Community Plan are detailed here. In addition, some sections of the primary Network Manual are repeated for convenience. There is a link on the Optum provider website, PROVIDER EXPRESS, to the Optum National Network Manual.

Questions?

GO TO: QUICK LINKS > GUIDELINES /POLICIES & MANUALS > NETWORK MANUAL > NATIONAL NETWORK MANUAL.

Governing Law

This manual shall be governed by, and construed in accordance with, applicable federal, state and local laws. To the extent that the provisions of this manual conflict with the terms and conditions outlined in your Agreement, the subject matter shall first read together to the extent possible; otherwise and to the extent permitted by, in

accordance with, and subject to applicable law, statutes or regulations, the Agreement shall govern.

Overview and Model of Care

Our goal is to create an environment where service providers, care managers, family peers, youth peers, child serving systems of care (e.g. education, child welfare, juvenile justice, developmental disabilities), and local government agencies work together with us to support the physical, social and emotional development of children and youth while increasing health and wellness outcomes during childhood and into adulthood. This partnership will be based on the following values:

Integrated

Success for children requires both integrated and effective treatment. Initial and on-going collaboration between providers and natural supports is fundamental to enhancing resiliency, meeting the imperatives of developmental stages, and promoting wellness for each child and their family.

Recovery Oriented Services

Services should be provided based on the principle that individuals have the capacity to recover from mental illness and/or substance use disorders. Specifically, services should support the acquisition of living, vocational, and social skills and be offered in home and community-based settings that promote hope and encourage each person to establish an individual path towards recovery.

Person-Centered Care

Services should reflect a child and family's goals and emphasize shared decision-making approaches that empower families, provide choice, and minimize stigma. Services should be designed to optimally treat illness, improve clinical and psychosocial outcomes, and emphasize wellness and attention to the family's overall well-being and the child's full community inclusion.

Evidenced-Based Practice

The INSTITUTE OF MEDICINE (IOM) defines "evidence-based practice" as a combination of the following three factors: (1) best research evidence, (2) best clinical experience, and (3) consistent with patient values (INSTITUTE OF MEDICINE, 2001. CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY. Washington, DC: National Academy Press). These factors are also relevant for child welfare. New York State has adopted the INSTITUTE OF MEDICINE'S definition for evidence-based practice with a slight variation that incorporates child welfare language: Best Research Evidence, Best Clinical Experience, and Consistent with Family/Client Values. This definition

builds on a foundation of scientific research while honoring the clinical experience of child welfare practitioners and being fully cognizant of the values of the families served.

Trauma-Informed

Trauma-informed 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. All programs should engage all individuals with the assumption that trauma has occurred within their lives (SAMHSA, 2014).

Data-Driven

Outcomes, monitor performance and promote health and well-being. Performance metrics should reflect a broad range of health and recovery indicators beyond those related to acute care and also document medical necessity.

Participant Information

UnitedHealthcare Community Plan of New York has been qualified to manage the expanded Medicaid-covered services for all Medicaid enrolled children and individuals under the age of 21. Optum works in close collaboration with UnitedHealthcare Community Plan to administer the behavioral health benefits for these beneficiaries.

Children in Medicaid and Additional Populations

Membership encompasses all Medicaid eligible and enrolled children under 21 years of age. This manual applies to Members enrolled with UnitedHealthcare Community Plan of New York.

Confidentiality and Consent for Children

All providers are required to maintain policies and procedures that assure confidentiality of behavioral health and substance use related information. The policies should include but are not limited to the following information:

- Initial and annual in-service education of staff, contractors
- Identification of staff allowed access to information and limits of that access
- Procedure to limit access to trained staff (including contractors)
- Protocol for secure storage (including electronic storage)

- Procedures for handling requests for behavioral health and substance use information and protocols to protect persons with behavioral health and/or substance use disorder from discrimination

There are specialized consent rules for Children under the age of 18. Refer to the following educational resource developed by the NY STATE DEPARTMENT OF HEALTH at the following link.

HEALTH.NY.GOV/HEALTH_CARE/MEDICAID/PROGRAM/MEDICAID_HEALTH_HOMES/WEBINARS/DOCS/2018/6.6.18_CONSENTS_REVISION.PDF

Quality Assurance

Quality Assurance reviews may occur for a variety of reasons:

- Quality Assurance reviews and claims audits will be conducted by Optum, New York state or its designee, including Local Government Units, to ensure providers comply with the rules, regulations, and standards of the program, and may be conducted without prior notice
- Optum Quality Assurance reviews resulting from Quality of Care, Quality of Service, regulatory concerns as well as best practice reviews
- The Quality Assurance reviews will focus on program aspects, but may include technical requirements such as billing, claims, and other Medicaid program requirements. Managed care plans may also be developing protocols to oversee the provision of these services in their provider networks

Sentinel events may result in quality reviews. Sentinel events are defined as a serious, unexpected occurrence involving a Member that is believed to represent a possible quality of care issue on the part of the Practitioner/Facility providing services, which has, or may have, deleterious effects on the Member, including death or serious disability, that occurs during the course of a Member receiving behavioral health treatment.

We have established processes and procedures to investigate and address sentinel events. This includes a centralized review committee, chaired by medical directors within UnitedHealthcare Community Plan, and incorporates appropriate representation from the various behavioral health disciplines. As a network provider, you are required to cooperate with sentinel event investigations.

Sentinel Event Reporting

- If you are aware of a sentinel event involving a member, you must notify UnitedHealthcare Community Plan within one business day of the occurrence
- Standardized reporting forms should be sent directly to the Quality Department through secure fax or email, below:

Fax: 1-844-342-7704
Attn: Quality Department

Email: NYBH_QIDEPT@UHC.COM

The Sentinel Event reporting form is located on PROVIDEREXPRESS.COM. To locate the form from the home page of Provider Express, go to: PROVIDEREXPRESS.COM > UNITED STATES > OUR NETWORK >STATE-SPECIFIC PROVIDER INFORMATION NEW YORK > WELCOME TO THE NETWORK>QUALITY IMPROVEMENT > SENTINEL EVENT REPORTING FORM

Refer to APPENDIX A for a more detailed description of Sentinel Events that must be reported to Optum according to these guidelines.

Quality Oversight Committee (QOC)

QOC is the decision-making body responsible for the implementation, coordination and integration of all Quality Improvement (QI) activities. Responsibilities of the QOC are:

- Provide program direction and continuous oversight of QI activities as related to the unique needs of the Members and providers in the areas of clinical care, service, patient safety, administrative processes, compliance and network credentialing and recredentialing
- Develop Quality Improvement Program Description (QIPD), QI Work Plan and QI Annual Evaluation and review the Work Plan at least quarterly
- Evaluate, at least annually, the impact and effectiveness of Medicaid specific Performance Improvement Projects (PIPs) and recommend changes as necessary
- Report annually or more frequently as needed, on health plan quality activities to the Governing Body
- Review and accept decisions of the National Quality Oversight Committee (NQOC), offering feedback as appropriate
- Review reports and recommendations from other national and health plan QI subcommittees, act upon recommendations as appropriate and provide feedback, follow-up and direction to the committees
- Monitor compliance with regulatory requirements and accrediting organizations
- Provide local delegation and oversight as specified by State regulatory requirements
- Recommend appropriate resources in support of prioritized activities
- Oversees the Provider Advisory Committee (PAC), Healthcare Quality Utilization Management Committee (HQUM), Service Quality Improvement Subcommittee, Children's Behavioral Health Advisory (BHAS-Child), Behavioral Health Quality Management Subcommittee (BHQM).

Provider Advisory Committee (PAC)

The Provider Advisory Committee (PAC) performs peer review activities, review credentialing/recredentialing, and review disposition of concerns about quality of clinical care provided to Members as requested by UnitedHealthcare Community Plan's Chief Medical Officer. In addition, the committee is responsible for evaluating and monitoring the quality, continuity, accessibility, availability, utilization, and cost of the medical care rendered within the network. The responsibilities of the PAC are to:

- HEDIS, state metrics, PIP's, and continuity and coordination of medical and BH care conduct/review barrier analysis and recommend monitor performance on clinical indicators (e.g. actions, as appropriate.
- Review and accept nationally endorsed Clinical Practice Guidelines (CPGs), providing input as appropriate.
- Review summary data regarding quality of care complaints, appeals, and grievances; identify trends, conduct barrier analysis and recommend corrective actions as needed.
- Review reports on mortality and inpatient quality issues, and recommend actions as indicated.
- Review and accept the National Credentialing Plan and regulatory requirements as applicable.
- Perform peer review and provide oversight of final decisions by the Credentialing Committee for the credentialing and recredentialing process. Monitor process for compliance with regulatory and accreditation compliance.
- Review, track, identify opportunities for improvement and make recommendations relating to medical record issues, and potential quality of care concerns.
- Review provider satisfaction survey results and make recommendations for improvement.

Children's Behavioral Health Advisory Subcommittee (BHAS-Child)

The Behavioral Health Advisory Subcommittee's (BHAS-Child) mission is to advise and assist the plan in identifying and resolving issues related to the management of children's health and behavioral health benefits and is reflective of UnitedHealthcare Community Plan's entire New York geographic service area and reports to the Quality Management Committee (QOC) . The QOC reports to the UnitedHealthcare Governing Body. Participants include:

- Behavioral Health Executive Director (Chair)
- Health Plan President or Designee
- Behavioral Health Medical Director-Children
- Health Plan Quality Director
- Behavioral Health Quality Director

- Children's BH Medical Director
- Medical Director, General Medicine
- Plan Quality Manager
- Recovery & Resiliency Manager
- Behavioral Health Clinical Services Director
- Children's Clinical Services Director
- Peer Specialist(s)
- Regional Planning Consortium representative(s)
- NYC DOHMH Representative(s)
- Provider Representative(s)
- Youth and Family Members who have been served in the child welfare and behavioral health system
- Youth and Family Members who have been served in the child welfare and behavioral health system
- Trained Peers with lived experience
- Children's Service Providers, Voluntary Foster Care Agencies (VFCAs)
- Foster/Adoptive Family Members
- Other stakeholders as appropriate

Representatives shall have expertise in children's services and familiarity with children eligible for aligned HCBS, medically fragile children (including those with developmental disabilities), children with serious emotional disturbance, and children with diagnoses across multiple HCBS categories. Issues related to children identified with specific diagnosis groups.

Healthcare Quality and Utilization Management (HQUM) Committee

The Healthcare Quality and Utilization Management (HQUM) Committee monitors clinical QI and utilization management activities within the UnitedHealthcare Community Plan. The responsibilities of the HQUM are to:

- Review and accept the UM Program Description and UM Program Evaluation, at least annually
- Review and approve Care Management and Disease Condition Management Programs including HEALTHY FIRST STEPS.
- Oversee implementation of the UnitedHealthcare Community Plan for Children and Youth Under 21 Utilization Management Program
- Review and approve UM performance measures from all clinical areas, including behavioral health services
- Monitor progress on clinical performance improvement programs
- Review reports on inpatient mortality and other clinical quality issues and advise improvement actions as indicated

- Evaluate the consistency of the UM decision making process through inter-rater reliability reports
- Identify over- and under-utilization issues and recommend corrective actions as indicated
- Monitor continuity and coordination of care
- Recommend improvement actions as indicated
- Ensure intervention strategies have measurable outcomes and are recorded in the UM/clinical management committee meeting minutes.
- Analyses shall be conducted separately for individuals under 21 years of age
- Examination of service utilization and outcomes for children and medically fragile children
- The Behavioral Health Utilization Management Subcommittee reports to the HQUM

Physical and Behavioral Health Integration for Children

When a Member is receiving services by more than one professional, it is critical that the service providers collaborate and coordinate effectively in order to ensure that care is comprehensive, safe and effective. Providers are expected to make a "good faith" effort at coordinating care with other behavioral health clinicians or facilities and medical care professionals who are treating the Member.

To coordinate and manage care between behavioral health and medical professionals, it is expected that providers will coordinate the Member's consent to exchange appropriate treatment information with medical care professionals (e.g., primary physicians, medical specialists) and/or other behavioral health clinicians (e.g., psychiatrists, therapists).

Coordination and communication should take place:

- At the time of intake
- During treatment
- At the time of discharge or termination of care
- At the point of transition between levels of care, and
- At any other point in treatment that may be appropriate

Coordination of services may improve the quality of care to Members in a number of ways:

- Allows behavioral health and medical providers to create a comprehensive care plan
- Allows a primary care physician to know that his or her patient followed through on a behavioral health referral
- Minimizes potential adverse medication interactions for Members who are being treated with psychotropic and non-psychotropic medication

- Allows for better management of treatment and follow-up for Members with coexisting
- Communication with primary physicians and other health care professionals
- Promotes a safe and effective transition from one level of care to another
- Reduces the risk of relapse

The following guidelines are intended to facilitate effective communication among all behavioral health and medical professionals as appropriate to a Member's care:

- During the diagnostic assessment session, request the Member's written consent to exchange information with all appropriate behavioral health and medical professionals who are providing treatment
- After the initial assessment, provide other behavioral health and medical professionals with the following information within two weeks:

  - ✓ Summary of Member's Evaluation
  - ✓ Diagnosis
  - ✓ Treatment Plan Summary (including any medications prescribed)
  - ✓ Primary Clinician Treating the Member
  - ✓ Update other behavioral health and medical professionals when there is a change in the Member's condition or medication(s)
  - ✓ Update other behavioral health and medical professionals when serious medical conditions warrant closer coordination
  - ✓ At the completion of treatment, send a copy of the discharge summary to the other behavioral health and medical professionals
  - ✓ Attempt to obtain all relevant clinical information that behavioral health and medical professionals may have pertaining to the Member's mental health or substance use conditions

It is understood that some Members may refuse to consent to release information to other behavioral health and medical professionals. Optum encourages its providers to discuss the benefits of sharing information and the potential risks of not sharing information, and to document the discussion in the Member's clinical record.

UnitedHealthcare Community Plan and Optum ensure the integration of medical and behavioral health services through a variety of activities including:

- Regular medical leadership meetings that provide direction to clinical staff
- Board Certified Child Psychiatrist on staff to lead the clinical delivery of services
- Multidisciplinary team of licensed clinicians and community health workers are available to address membership needs
- Specific training and educational programs are available to Members at MYUHC.COM

Network Participation Requirements

Referral and linkage to community providers

Providers must meet the Network Requirements as outlined in the Optum National Network Manual. Credentialing is done at the group level when a behavioral health provider is OMH Licensed, OMH or DOH operated, or OASAS certified. Individual employees, subcontractors and agents of such providers do not require separate credentialing.

Optum is required to collect program integrity related information (the Disclosure of Ownership and Control Interest Statement). Optum also requires that providers not employ or contract with any employee, subcontractor or agency that has been debarred or suspended by the federal or state government, or otherwise excluded from participation in the Medicare or Medicaid programs.

Providers of services to children under age 21 will be required to receive Criminal History Record Checks (CHRC), Statewide Central Register (SCR) Checks and Staff Exclusion List (SEL) checks. They will also be required to be Mandated Reporters.

Network Requirements

Network providers are required to maintain availability to Members as outlined in the UHC Access to Care Standards. A Network provider's physical site(s) must be accessible to all Members as defined by the Americans with Disabilities Act (ADA). Network providers are required to support Members in ways that are culturally and linguistically appropriate, and to advocate for the Member as needed.

Network Providers must provide or arrange for the provision of assistance to Members in emergency situations 24 hours a day, 7 days a week. Network Providers must notify Members about their hours of operation and how to reach you after hours in case of an emergency. In addition, any after-hours message or answering service must provide instructions to the Member regarding what to do in an emergency situation. When you are not available, coverage for emergencies should be arranged with another participating clinician.

Network providers are required to notify us at Providerexpress.Com within ten (10) calendar days whenever you make changes to your practice including office location, weekend or evening availability, billing address, phone number, Tax ID number, entity name, or active status (e.g., close your business or retire). If your hours of operation change, you can contact Network Management at:

Email: NYNETWORKMANAGEMENT@OPTUM.COM

Phone Number: Behavioral Health Provider Services
1-877-614-0484

Providers are prohibited from balance billing any Member for any reason for covered services.

Providers are expected to follow-up with Members who miss their aftercare appointment and document and track their outreach in those cases.

Providers that are licensed by OASAS will not require an on-site audit as part of the credentialing and recredentialing process.

Network Training Requirements

Providers are required to participate in a comprehensive provider training and support program to gain appropriate knowledge, skills, and expertise to comply with state requirements. A schedule of trainings will be available on the NEW YORK "HOME" PAGE of Provider Express which will be updated as needed.

A robust training plan had been built around our current provider education curriculum to offer trainings that cover the expanded children's benefits and populations, and promote the values set forth by the transformation of the children's system. Training will be offered to a full range of service providers. When possible, Optum will work through the REGIONAL PLANNING CONSORTIUMS (RPC) to deliver provider education opportunities.

Providers are expected to review and be familiar with the LEVEL OF CARE GUIDELINES and BEST PRACTICE GUIDELINES posted on Provider Express.

Go to Provider Express "Home" page > Quick Links > Guidelines/Policies & Manual > Best Practice Guidelines or Level of Care Guidelines.

The annual training program will address the following areas:

- Orientation to Optum:
  - ✓ Credentialing and Recredentialing
  - ✓ Provider Website Orientation
  - ✓ Member Eligibility Verification
  - ✓ Utilization Management
  - ✓ Quality Improvement
- Clinical Model:
  - ✓ Cultural Competency
  - ✓ Clinical Vision
  - ✓ Complex and High Need Population
  - ✓ HCBS Requirements
  - ✓ Use of Evidence Based Practices
  - ✓ Transitions
  - ✓ Supplementary Supports
  - ✓ Trauma Informed Care

- Claims, Billing Guidelines, and Coding
- Understanding Home and Community Based Services
- Primary Care Provider (PCP) Training
- Provider Directory and Online Resources

Data Analysis and Reporting

Optum will collect and review data from a variety of sources including but not limited to claims, authorizations, appeals, complaints, and clinical audits. The data will be used to identify potential training needs and opportunities for improvement. Information will be shared with providers on a regular basis. When there are updates from the State, we will communicate those to provider.

HCBS Eligibility and Enrollment

To HCBS under Medicaid, a child or youth must be determined eligible based on meeting target population, risk factors, and functional criteria measured by the HCBS Eligibility Determination. Children receiving HCBS through enrollment in a 1915(c) Medicaid waiver will have continued access to HCBS for as long as the child continues to meet the eligibility criteria for the 1915(c) Medicaid waiver.

Children and youth must be under 21 years old and eligible for Medicaid to receive HCBS. HCBS eligibility is comprised of three components: 1) target criteria, 2) risk factors, and 3) functional criteria.

There are two HCBS eligibility groups:

1. Level of Care (LOC): children that meet institutional placement criteria. There are four subgroups within the LOC group:
    a. Children with Serious Emotional Disturbance (SED) with or without co-occurring Substance Use Disorders (SUD)
    b. Children with a Developmental Disability in Foster Care
    c. Children who are Medically Fragile
    d. Children who are Medically Fragile with a Developmental Disability
2. Level of Need (LON): children who are at risk of institutional placement. There are two subgroups within the LON group:
    a. Children with Serious Emotional Disturbance (SED) with or without co-occurring Substance Use Disorders (SUD)
    b. Abuse, Neglect and Maltreatment or Health Home Complex Trauma

The services described in this document are accessible to the child once a Plan of Care (POC) is in place.

Both LOC and LON determinations require the completion of the HCBS Eligibility Determination tool within the Uniform Assessment System (UAS).

The target criteria, risk factors, and functional limits must be documented in the UAS. Children seeking HCBS who are not otherwise eligible for Medicaid (e.g. income and resources are above Medicaid eligibility allowances) must meet a needs-based criterion for Medicaid eligibility determination via the following process:

- The Independent Entity must complete the HCBS Eligibility Determination
- The Independent Entity will assist families in completion of the Medicaid application and submission to the Local District of Social Services (LDSS) or New York City (NYC) Human Resources Administration (HRA) to determine Medicaid Eligibility
- Once Medicaid is established, referral to appropriate care management will be completed
- Whether a child meets the LOC or the LON criteria, eligible children, youth, and their families will have access to all HCBS services

Level of Care (LOC) Guidelines

Optum maintains a national library of LEVEL OF CARE (LOC) GUIDELINES along with state-specific guidelines. LOC GUIDELINES are objective and evidence-based behavioral health guidelines used to standardize coverage determinations, promote evidence-based practices, and support the Members' recovery, resiliency, and wellbeing. New York State has reviewed and approved the LOC GUIDELINES used for Medicaid services.

LOC GUIDELINES are derived from generally accepted standards of behavioral practice, including guidelines and consensus statements produced by professional specialty societies and guidance from government sources such as CMS NATIONAL COVERAGE DETERMINATIONS (NCDS) and LOCAL COVERAGE DETERMINATIONS (LCDS).

Each LEVEL OF CARE GUIDELINE includes these elements:

- A Definition of the Level of Care
- Admission Criteria
- Continued Service Criteria
- Discharge Criteria
- Clinical Best Practices
- References (information sources for the document)
- The LEVEL OF CARE FOR ALCOHOL & DRUG TREATMENT REFERRAL (LOCADTR) tool is used to make level of care determinations for all OASAS services. Information about LOCADTR may be found on the OASAS WEBSITE

For more information on Children's Utilization Management Guidelines, Medical Necessity Criteria or Level of Care or Level of Need criteria, refer to the home page for Children's Behavioral Health on the New York State Department of Health website.

Benefit Plan, Authorization and Access to Care

Continuity of Care Requirements

UnitedHealthcare Community Plan will allow children to continue with their care providers for a continuous Episode of Care.

- This requirement will be in place for the first 24 months of the transition.
- It applies only to episodes of care that were ongoing during the transition period from Fee for Service to Managed Care.
- Providers are expected to notify UnitedHealthcare Community Plan of a Member's current episode of treatment at time of transition to managed care to secure Single Case Agreements (SCAs) for timely payment of claims and coordinate transition of care benefits.
- Providers can contact Member Services on behalf of the Member at 1-866-362-3368 for more information.

  To ensure continuity of care and no service disruptions, 1915(c) Transitioning Children will not be reassessed for HCBS eligibility until one year after the date of their completed initial CANS-NY assessment or, for children who opt out of Health Home, the date the Independent Entity opens their case record.

Benefits in Medicaid

As of July 1, 2019, the new Health Plan benefits for all Medicaid Managed Care Populations under 21 years of age, included in the Children's System Transformation are identified below.

Department of Health Services

- Health Home Care Management

Office of Mental Health Services

- Assertive Community Treatment (ACT) (minimum age 18)
- Children and Family Treatment and Supports including:
- Community Psychiatric Supports and Treatment (CPST)
- Family Peer Support Services (FPSS)
- Other Licensed Practitioner (OLP)
- Psychosocial Rehabilitation (PSR)

- Comprehensive Psychiatric Emergency Program (CPEP) (minimum age 18)
- Continuing Day Treatment (CDT) (minimum age 18)
- Inpatient Psychiatric Services
- Outpatient Clinic* Services
- Personalized Recovery Oriented Services (PROS) (minimum age 18)

OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES

- PART 816.6 MEDICALLY MANAGED INPATIENT DETOXIFICATION (Article 28/32 Providers)
- PART 816.7 MEDICALLY SUPERVISED INPATIENT WITHDRAWAL AND STABILIZATION (Article 28/32 and Article 32 Providers)
- PART 816.8 MEDICALLY SUPERVISED OUTPATIENT WITHDRAWAL AND STABILIZATION (Article 28/32 and Article 32)
- PART 818 CHEMICAL DEPENDENCE INPATIENT REHABILITATIVE SERVICES (Article 28/32 and Article 32 Providers)
- PART 820.10 AND 820.11 RESIDENTIAL STABILIZATION AND REHABILITATION SERVICES (Article 32 Only)
- PART 822 OUTPATIENT CLINIC (Article 28/32 and Article 32 Providers)
- PART 822.15 OUTPATIENT REHABILITATION (Article 28/32 and Article 32 Providers)
- PART 822.16 OPIOID TREATMENT PROGRAM (OTP) (Article 28/32 and Article 32 Providers)

* This includes OMH SED designated clinics and Children with SSI who were previously carved out of Medicaid Managed Care

Authorization Requirements

UTILIZATION MANAGEMENT GUIDELINES for the Children's state plan and demonstration services for the Medicaid managed care plans are located on the New York State DEPARTMENT OF HEALTH website:

HEALTH.NY.GOV/HEALTH_CARE/MEDICAID/REDESIGN/BEHAVIORAL_HEALTH/CHILDREN/2017-10_UTILIZE_MGMT_GUIDE.HTM

The Children and Family Treatment and Support Services (CFTSS), including: OLP, CPST, PSR, and FPSS, do not require authorization and concurrent review. Members can self-refer for most behavioral health services.

Exceptions include ACT, Inpatient Psychiatric Hospitalization, Partial Hospitalization and HCBS. Members may self-refer for services that have unlimited assessments.

Authorizations and notifications can be obtained:

Toll-free line: 1-866-362-3368
Fax: 1-877-339-8399

Notification and Authorization forms are located on Provider Express:

providerexpress.com/content/ope-provexpr/us/en/ournetwork/welcomentwk/wny.htlm

A Care Advocate will contact the providers for additional information. Providers must be registered users to submit authorization and notification requests.

Children must meet institutional and functional eligibility criteria for the Level of Care (LOC) either using the CANS-NY or the Office for People with Developmental Disabilities (OPWDD) Level of Care/Medical Care Screen eligibility tool for children with developmental disabilities who may be medically frail or in foster care.

Health Homes must submit the Member's Plans of Care (POC) for review and approval. The approved POC is reassessed at least annually and more frequently when warranted by a significant change in the Member's medical and/or behavioral health condition.

For more information on Coordination of Care Guidelines, refer to the following link:

providerexpress.com/content/dam/ope-provexpr/us/pdfs/clinResourcesMain/cqiTools/cqiCoordOfCare.pdf

Authorizations

Prior Authorization Request

A Prior Authorization Request is a service authorization request by a provider on the Member's behalf, for coverage of a new service, whether for a new authorization period or within an existing authorization period, made before such service is provided to the Member. Prior authorization should always be obtained prior to services being rendered or as soon as the Member is stabilized to ensure both proper care of the Member and coverage of services following initial stabilization.

Concurrent Review Request

A Concurrent Review Request is a service authorization request by a Member, or a provider on Member's behalf for continued, extended or more of an authorized service than what is currently authorized by the Provider within an existing authorization period.

Prior Notification

Out of Network Providers (OON) are responsible for providing UnitedHealthcare with advance notification of anticipated services for Members. Notification should be submitted as far in advance as possible, but must be at least five business days before the planned service date, unless otherwise specified.

Additional Information

A medically necessary admission following stabilization in an emergency room may require authorization or notification prior to the admission to a facility. Facilities should notify Optum immediately. All staff members who make Service Authorization Determinations must have received comprehensive training, which includes information about OMH Clinic Standards of Care and OASAS Clinical Guidance. Service Authorization Determinations are made based on reviewing clinical information submitted by the provider against the Level of Care Guidelines.

Refer to the "Authorization Grid for Children's Service" in Appendix C for more information, or go to the New York State Website and review the Utilization Guide

Notification and Authorization forms are also located on Provider Express:

Providerexpress.com/Content/Ope-Provexpr/Us/En/Our-Network/Welcomentwk/wny.htmlh

Children and Family Treatment Supports Services Continuing Authorization

The Plan may request concurrent review before the fourth CFTSS visit. The CFTSS provider can complete a Continuing Authorization form. If the services are deemed appropriate, then a minimum of 30 visits can be authorized. Concurrent review will be completed as applicable after the first concurrent authorization.

A telephonic request can be completed if necessary. **NOTE:** No prior authorization is required for CFTSS.

Health Home Care Management

Concurrent with the managed care carve-in on April 1, 2019, children eligible for HCBS can receive Health Home Care Management. The Care Management service is provided under each of the six children's 1915(c) waivers transitioned to Health Home Care Management on January 1, 2019.

Health Home Care Management is a service model for individuals enrolled in Medicaid with complex chronic medical and/or behavioral health needs. Health Home care managers provide person-centered, integrated physical health and behavioral health care management, transitional care management, and community and social supports to improve health outcomes of high-cost, high need Medicaid Members with chronic conditions

Since Health Home participation is an optional benefit, children may opt out of Health Home Care Management. If the child and family opt out of the Health Home and would still like HCBS Services, the State Designated Entity, Children and Youth Evaluation Service (C-YES) is available to conduct HCBS Eligibility Determinations and develop a

Plan of Care for the child. For children who opt out of Health Home and are enrolled in Medicaid Managed Care, the Medicaid Managed Care Plan will monitor the child's Plan of Care.

For children who opt out of Health Home and are not enrolled in Medicaid Managed Care, C-YES will monitor the Plan of Care. C-YES will conduct HCBS Eligibility Determinations at the point of referral for HCBS Eligibility Determination.

For further guidance, please refer to the New York State Department of Health HEALTH HOME SERVING CHILDREN:

HEALTH.NY.GOV/HEALTH_CARE/MEDICAID/PROGRAM/MEDICAID_HEALTH_HOMES/HH_CHILDREN

Home and Community Based Services

Home and Community Based Services (HCBS)

Home and Community Based Services (HCBS) are designed to allow children and youth to participate in developmentally and culturally appropriate services through Medicaid. New York State (NYS) is committed to serving individuals in the least restrictive environment possible by providing services and supports to children and their families at home and in the community. HCBS are designed for people who, but for these services, would require the level of care provided in a more restrictive environment such as a long-term care facility or psychiatric inpatient care and for those at risk of elevating to that level of care.

The Children's Medicaid System Transformation for individuals under the age of 21 includes the alignment of the following NY children's waivers previously accessible under the authority of the 1915(c) amendment of the Federal Social Security Act: Office of Children and Family Services (OCFS) Bridges to Health (B2H) Serious Emotional Disturbance (SED), B2H Developmental Disabilities (DD), B2H Medically Fragile (MedF), the Office of Mental Health (OMH) SED Waiver, Office for People With Developmental Disabilities (OPWDD) Care at Home (CAH) IV Waiver, and the Department of Health (DOH) operated Care at Home (CAH) I/II Waiver.

The Office of Alcoholism and Substance Abuse Services (OASAS), OCFS, OMH, OPWDD and DOH have collaborated to create a newly aligned service array of HCBS benefits for children meeting specific diagnostic and functional criteria. The new 1915(c) Children's Waiver and 1115 Children's Demonstration, with approval from the Centers for Medicare and Medicaid Services (CMS), provides NYS the authority for these HCBS benefits. The waiver includes person-centered planning requirements and specifies transitional coverage requirements for children enrolled in any of the aforementioned 1915(c) waivers at the time of transition.

HCBS eligibility includes Medicaid eligibility and:

1) Target criteria
2) Risk factors
3) Functional criteria

Level of Care (LOC) has been expanded to include a new needs based criteria category referred to as Level of Need (LON), allowing more children to access HCBS benefits. This addresses gaps in service for children who may benefit from HCBS but do not meet the LOC criteria, or for children who require continued services to avoid regressing to a higher level of care.

New York State will use the HCBS Eligibility Determination within the Uniform Assessment System (UAS) to confirm HCBS eligibility. In addition, Health Home Care Managers will continue to use the comprehensive Child and Adolescent Needs and Strengths New York (CANS-NY) assessment tool to support person-centered service planning for HCBS eligible children/youth.

This manual defines the specific composition of each service while outlining provider roles and responsibilities. All HCBS benefits are applicable in any home or community setting meeting federal HCBS settings requirements inclusive of the child or family environment, with some exceptions noted in this manual.

Community Habilitation

Definition Community Habilitation covers face-to-face services and supports related to the child'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 who is seeking greater independence by learning to perform the task for him or herself. There should be a reasonable expectation that the individual will acquire the skills necessary to perform that task within the authorization period.

Maintenance is described as the service available to prevent or slow regression in the child'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's goal outside of the training environment.

ADL, IADL, skill acquisition, maintenance, and enhancement are face-to-face services that are determined by the person-centered planning process and must be identified in the child's Plan of Care (POC) on an individual or group basis. These identified services will be used to maximize personal independence and integration in the community, preserve functioning, and prevent the likelihood of future institutional placement. Skill acquisition, maintenance, and enhancement services are appropriate for children who have the capacity to learn to live in the community, with or without support. Community Habilitation may be delivered in individual or group modality.

Service Components ADL, IADL skill acquisition, maintenance, and enhancement is related to assistance with functional skills and may help a child who has difficulties with these types of skills accomplish tasks related to, but not limited to:

- Self-care
- Life safety
- Medication and health management
- Communication skills
- Mobility
- Community transportation skills
- Community integration
- Appropriate social behaviors
- Problem solving
- Money management

For additional information related to:

- Provider and Condition Requirements
- Modalities
- Settings
- Limitations/Exclusions
- Certification/Provider Qualifications
- Training Requirements

Refer to the CHILDREN'S HOME AND COMMUNITY BASED SERVICES PROVIDER MANUAL at the following link:

HEALTH.NY.GOV/HEALTH_CARE/MEDICAID/REDESIGN/BEHAVIORAL_HEALTH/CHILDREN/DOCS/HCBS_MANUAL.PDF

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 nonresidential setting, separate from the person's private residence or other residential arrangement. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, community inclusion, relationship building, self-advocacy, and informed choice. Day Habilitation (DH) services may be provided to a child at a NYS certified (e.g., OPWDD certified) setting typically between the daytime hours of 9 a.m. and 3 p.m. However, service delivery may include outings to community (non-certified) settings.

Individual Day Habilitation (a one-to-one, individual-to-worker provided service with an hourly unit of service) and Group Day Habilitation services are furnished four or more hours per day on a regularly scheduled basis for one or more days per week or less frequently as specified in the participant's POC. Meals provided as part of these services shall not constitute a "full nutritional regimen" (three meals per day).
A supplemental version of Individual and Group Day Habilitation is available for children who do not reside in a certified setting. The supplemental Day Habilitation is provided

outside the 9 a.m. to 3 p.m. weekday time period and includes later afternoon, evenings, and weekends. Day Habilitation and Supplemental Day Habilitation services cannot be delivered at the same time.

All Day Habilitation services (Group and Individual) have the same service description and focus on enabling the participant to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies in the POC. In addition, Day Habilitation services may serve to reinforce skills, behaviors, or lessons taught in other settings. Provider agencies of Day Habilitation must develop a Day Habilitation service plan to document the child's goal(s)/outcomes(s), health/safety needs required during the delivery of the service, and the necessary staff actions to assist the child in reaching his/her Day Habilitation goal(s)/outcomes(s), and health/safety needs.

For additional information related to:

- Provider and Condition Requirements
- Modalities
- Settings
- Limitations/Exclusions
- Certification/Provider Qualifications
- Training Requirements

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Caregiver/Family Supports and Services

Caregiver/Family Supports and Services enhance the child/youth's ability, regardless of disability (developmental, physical, and/or behavioral), to function as part of a caregiver/family unit and enhance the caregiver/family's ability to care for the child/youth in the home and/or community. Family is broadly defined, and can include families created through birth, foster care, adoption, or a self-created unit.

NOTE: this service is not the State Plan service of Family Peer Support Services which must be delivered by a certified/credentialed Family Peer with lived experience. Based upon the Caregiver/Family Supports and Services plan developed by the child/youth and caregiver/family team, this service provides opportunities to:

- Interact and engage with family/caregivers and children/youth to offer educational, advocacy, and support resources to develop family/caregivers
- ability to independently access community services and activities
- Maintain and encourage the caregivers'/families' self-sufficiency in caring for
- The child/youth in the home and community
- Address needs and issues of relevance to the caregiver/family unit as the child/youth is supported in the home and community

- Educate and train the caregiver/family unit on available resources so that they
- might better support and advocate for the needs of the child and appropriately
- access needed services
- Provide guidance in the principles of children's chronic condition or
- Life threatening illness

For additional information related to:

- Provider and Condition Requirements
- Modalities
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Respite

This service focuses on short-term assistance provided to children/youth, regardless of disability (developmental, physical and/or behavioral), because of the absence of or need for relief of the child or the child's family caregiver. Such services can be provided in a planned mode or delivered in a crisis situation. Respite workers supervise the child/youth and engage the child/youth in activities that support his/her and/ or primary caregiver/family's constructive interests and abilities.

Respite providers offer services with a level of expertise in understanding and implementing behavioral/developmental interventions required to support optimal functioning for children/youth. Respite providers regularly communicate the details of the child/youth's intervention plan so that there is a carryover of skill from the respite source to the caregivers and treatment providers.

Planned Respite

Planned Respite services provide planned short-term relief for the child 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. The service is direct care for the child/youth by individuals trained to support the child/youth's needs. This support may occur in short-term increments of time (usually during the day) or on an overnight or longer-term increment. Planned Respite activities support the POC goals and include providing supervision and activities that match the child/youth's developmental stage and continue to maintain the child/youth health and safety.

Crisis Respite

Crisis Respite is a 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. It may be used when challenging behavioral or situational crises occur that the child/youth and/or family/caregiver is unable to manage without intensive assistance and support. Crisis Respite can also be used for crisis intervention or from visiting the emergency room. Crisis Respite should be included on the POC to the extent that it is an element of the crisis plan or risk mitigation strategy.

Crisis Respite services may be delivered in a home or residence by qualified practitioners, out-of-home/residence by staff in community-based sites, or in allowable facilities. Services offered may include site-based crisis residence, monitoring for high risk behavior, health and wellness skill building, wellness activities, family/caregiver support, conflict resolution, and other services as needed.

Ongoing communication between child/youth or the family/primary caregiver receiving crisis respite for their child, the crisis respite staff, and the child/youth's established behavioral health and health care providers is required to assure collaboration and continuity in managing the crisis situations and identifying subsequent support and service needs.

At the conclusion of a Crisis Respite period, crisis respite staff, together with the child/youth and family/primary caregiver, and his or her established behavioral health or health care providers when needed, will make a determination as to the continuation of necessary care and make recommendations for modifications to the child's POC.

Children are encouraged to receive Crisis Respite in the most integrated and cost effective settings appropriate to meet their respite needs. Out-of-home Crisis Respite is not intended as a substitute for permanent housing arrangements.

For additional information related to:

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- Training Requirements

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Prevocational Services

Prevocational Services are individually designed to prepare a youth (age 14 or older) to engage in paid work, volunteer work, or career exploration. Prevocational Services are not job-specific, but rather are geared toward facilitating success in any work environment for youth whose disabilities do not permit them access to other prevocational services. The service will be reflected in youth's POC and must be directed to teaching skills rather than explicit employment objectives. In addition, Prevocational Services assist with facilitating appropriate work habits, acceptable job behaviors, and learning job production requirements.

Prevocational Services may include volunteer work, such as learning and training activities that prepare a person for entry into the paid workforce. Prevocational Services should enable each participant to attain the highest level of work in the most integrated setting and with the job matched to the participant's interests, strengths, priorities, abilities, and capabilities, while following applicable federal wage guidelines from the U.S. Department of Labor. Services are intended to develop and teach general skills.

Examples include, but are not limited to:

- Ability to communicate effectively with supervisors, co-workers, and customers
- Generally accepted community workplace conduct and dress
- Ability to follow directions
- Ability to attend to and complete tasks
- Punctuality and attendance
- Appropriate behaviors in and outside the workplace
- Workplace problem solving skills and strategies
- Mobility training
- Career planning
- Proper use of job-related equipment and general workplace safety

Prevocational Services include activities that are not primarily directed at teaching skills to perform a particular job, but at underlying habilitative goals (e.g., attention span, motor skills, interpersonal relations with co-workers and supervisors) that are associated with building skills necessary to perform work and optimally to perform competitive, integrated employment.

- Resume writing, interview techniques, role play, and job application completion
- Exploring career options, facilitating appropriate work habits, acceptable job behaviors, and learning job production requirements
- Assisting in identifying community service opportunities that could lead to paid employment
- Helping the youth to connect their educational plans to future career/vocational goals
- Helping youth to complete college, technical school, or other applications to continue formal education/training
- Helping youth to apply for financial aid or scholarship opportunities
- Documentation is maintained that the service is not available under a program

funded under Section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.)

For additional information related to:

- Provider and Condition Requirements
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Supported Employment

Supported Employment services are individually designed to prepare youth with disabilities (age 14 or older) to engage in paid work. Supported Employment services provide assistance to participants with disabilities as they perform in a work setting.

Supported Employment provides ongoing supports to participants who, because of their disabilities, need intensive on-going support to obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. 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 services are individualized and may include any combination of the following services: vocational/job-related discovery or assessment, person-centered employment planning, job placement, job development, negotiation with prospective employers, job analysis, job carving, training and systematic instruction, job coaching, benefits support, training and planning, transportation, career advancement services, and other workplace support services including services not specifically related to job skill training that enable the participant to successfully integrate into the job setting. Supported Employment services may also include services and supports that assist the participant in achieving self-employment through the operation of a business including home-based self-employment. However, Medicaid funds are not used to defray the expenses associated with starting up or operating a business.
In addition to the need for an appropriate job match that meets the individual's skills and interests, individuals may also need long term employment support to successfully maintain a job due to the ongoing nature of the HCBS participant's support needs, changes in life situations, or evolving and changing job responsibilities.

Service Components

Supported employment services may be provided in a variety of settings, particularly work sites. Supported employment services include the following:

- Supervision and training that are not job-related
- Intensive ongoing support
- Transportation to and from the job site
- Interface with employers regarding the individual's disability(ies) and needs related to his/her healthcare issue(s)
- Other activities needed to sustain paid work (e.g., employment assessment, job placement, and/or adaptive/assistive equipment necessary for employment)
- Job finding and development training in work behaviors
- Assessing the interest and fit of an individual for particular job opportunities, staff work with employers and job sites preparing them to be able to make necessary and reasonable accommodations
- On-site support for the individual as they learn specific job tasks
- Monitoring through on-site observation and through communication with job supervisors and employers

For additional information related to:

- Provider and Condition Requirements
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Community Self-Advocacy Training and Supports (CSTS)

Community Self-Advocacy Training and Support provides family, caregivers, and collateral contacts with techniques and information not generally available so that they can better respond to the needs of the participant. Community Self-Advocacy Training and Support is intended to assist the child/youth, family/caregiver, and collateral contacts in understanding and addressing the participant's needs related to their disability(ies). The use of this service may appropriately be provided to prevent problems in community settings as well as when the child/youth is experiencing difficulty. The POC objectives must clearly state how the service can prevent as well as ameliorate existing problems and to what degree. This service cannot be used to develop an Individualized Education Program (IEP), the plan for students with disabilities who meet the federal and state requirements for special education, or to provide special education services to the child/youth. Participating in community events

and integrated interests/occupations are important activities for all children/youth, including those with disabilities (developmental, physical, and/or behavioral health in origin). Success in these activities is dependent not only on the child/youth, but on the people who interact with and support the child/youth in these endeavors.

Community Self-Advocacy Training and Support improves the child/youth's ability to gain from the community experience and enables the child/youth's environment to respond appropriately to the child/youth's disability and/or health care issues and may include the following:

- Training (one-on-one or group) for the child/youth and/or the family/caregiver regarding methods and behaviors to enable success in the community. Each group must not exceed 12 participants (enrollees and collaterals).
- Direct self-advocacy training in the community with collateral contacts regarding the child/youth's disability(ies) and needs related to his or her health care issues.
- Self-advocacy training for the child/youth and/or family/caregiver, including during community transitions.

For additional information related to:

- Provider and Condition Requirements
- Modalities
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Non-Medical Transportation

Non-Medical Transportation services are offered, in addition to any medical transportation furnished under the 42 CFR 440.17(a) in the State Plan. Non-Medical Transportation services are available for individuals to access authorized HCBS and destinations that are related to a goal included on the child/youth's POC.

Examples where this service may be requested include transportation to: HCBS that a child/youth was determined eligible to receive, a job interview, college fair, a wellness seminar, a GED preparatory class, etc. This service will be provided to meet the child/youth's needs as determined by an assessment performed in accordance with the State's requirements and as outlined in the child/youth's POC.

The care manager must document a need for transportation to support an individual's identified goals. The Health Home Care Manager will include justification for this service

within the Person-Centered POC. For individuals not enrolled in a Health Home, the Independent Entity or MCO Care Manager will be responsible for completing documentation of which goals in an individual's POC to which the trips will be tied. For each participant utilizing Non-Medical Transportation, the Transportation Manager will provide a monthly report of authorized trips to the State.

For additional information related to:

- Provider and Condition Requirements
- Modalities
- Settings
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- Training Requirements

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Adaptive and Assistive Equipment

This service provides technological aids and devices identified within the child's Plan of Care (POC) which enable him/her to accomplish daily living tasks that are necessary to support the health, welfare, and safety of the child.

Adaptive and Assistive Equipment includes but not limited to: direct selection communicators, alphanumeric communicators, scanning communicators, encoding communicators, speech amplifiers, electronic speech aids/devices; voice activated, light activated, motion activated, and electronic devices; standing boards/frames and therapeutic equipment for the purpose of maintaining or improving the participant's strength, mobility, or flexibility to perform activities of daily living; adaptive switches/devices, meal preparation and eating aids/devices/appliances, specially adapted locks, motorized wheelchairs; guide dogs, hearing dogs, service dogs (as defined in New York Civil Rights Law Article 47-b(4)), and simian aides (capuchin monkeys or other trained simians that perform tasks for persons with limited mobility); electronic, wireless, solar-powered, or other energy powered devices that demonstrate to the satisfaction of the commissioner, or designee, that the device(s) will significantly enable the participant to live, work, or meaningfully participate in the community with less reliance on paid staff supervision or assistance. Such devices may include computers, observation cameras, sensors, telecommunication screens, and/or telephones and/or other, telecare support services/systems that enable the participant to interact with remote staff to ensure health and safety. Such devices cannot be used for surveillance, but to support the person to live with greater independence including devices to assist with medication administration, including tele-care devices that prompt, teach, or otherwise assist the participant to independently self-administer medication routinely, portable generators necessary to support equipment, or devices needed for

the health or safety of the person including stretcher stations.

Adaptive and Assistive Equipment Services include:

- Evaluation of the assistive technology needs of a participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant
- Services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for the participants
- Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices
- Training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant
- Training or technical assistance for professionals or other individuals who
- Provide services to, employ, or are otherwise substantially involved in the major
- Life functions of participants

Vehicle Modifications

Under this benefit, Vehicle Modifications are allowable (formerly called Home and Vehicle Modifications). This service provides physical adaptations to the primary vehicle of the enrolled child which, per the child's plan of care (POC), are identified as necessary to support the health, welfare, and safety of the child or that enable the child to function with greater independence.
Modifications include but are not limited to:

- Portable electric/hydraulic and manual lifts,
- Ramps
- Foot controls
- Wheelchair lock downs
- Deep dish steering wheel
- Spinner knobs
- Hand controls
- Parking break extension
- Replacement of roof with fiberglass top
- Floor cut outs
- Extension of steering wheel column
- Raised door
- Repositioning of seats
- Wheelchair floor
- Dashboard adaptations
- Other ancillary equipment or modifications necessary to guarantee full access to, and safety in, a motor vehicle

The LDSS (for FFS enrollees) or MCO (for managed care enrollees) secures a local contractor and/or evaluator qualified to complete the required work. In the case of

vehicle modifications, the evaluators and modifiers are approved by the NYS Education Department's Adult Career and Continuing Education Services Rehabilitation (ACCES-VR).

Activities include and are not limited to:

- Determining the need for the service, the safety of the proposed modification
- Expected benefit to the child
- The most cost effective approach to fulfill the child's need

In FFS, the LDSS is the provider of record for Vehicle Modifications for billing purposes. The work is done by a contractor who is selected by the LDSS in conjunction with NYSDOH (for FFS) through a standard bid process, following the rules established by the Office of the State Comptroller. Standard provisions of the NYS Finance Law and procurement policies must be followed to ensure that contractors are qualified and that State required bidding procedures have been followed. In managed care, the plan is the payer and may contract with an approved network provider for the service. Services are only billed to Medicaid or the MCO once the contract work is verified as complete and the amount billed is equal to the contract value. Vehicle Modifications are limited to the primary vehicle of the recipient..
NOTE: This service does not duplicate other services available through the New York Medicaid State Plan. All services require prior authorization by the MCO or the LDSS in conjunction with NYSDOH.

For additional information related to:

- Provider and Condition Requirements
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Environmental Modifications

Environmental Modifications provides internal and external physical adaptations to the home or other eligible residences of the enrolled child which, per the child's plan of care (POC), are identified as necessary to support the health, welfare, and safety of the child or that enable the child to function with greater independence in the home and without which the child would require and institutional and/or more restrictive living setting.

Modifications include but are not limited to:

- Installation of ramps, hand rails, and grab bars
- Widening of doorways (but not hallways)
- Modifications of bathroom facilities
- Installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies needed for the welfare of the
- recipient
- Lifts and related equipment
- Elevators when no feasible alternative is available
- Automatic or manual door openers/bells
- Modifications of the kitchen necessary for the participant to function more independently in his/her home
- Medically necessary air conditioning
- Braille identification systems
- Tactile orientation systems
- Bed shaker alarm devices
- Strobe light smoke detection and alarm devices;
- Small area drive-way paving for wheel-chair entrance/egress from van to home
- Safe environment modifications for behaviorally challenged participants require the prior review of a behavioral specialist
- Window protections, reinforcement of walls and durable wall finishes
- Open-door signal devices, fencing, video monitoring systems, and shatter-proof shower doors

Environmental Modification may also include future technology devices that allow the participant to live more safely and independently to avoid possible institutional placement or placement in a more restrictive living environment, which are available at a reasonable cost in comparison to living in a more restrictive residential setting. The scope of environmental modifications will also include necessary assessments to determine the types of modifications needed.

NOTE: This service does not duplicate other services available through the New York Medicaid State Plan. All services require prior authorization by the LDSS in conjunction with NYSDOH if exceeding established limits or MCO.

For additional information related to:

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Palliative Care

Palliative care is specialized medical care focused on providing relief from the symptoms and stress of a chronic condition or life-threatening illness. The goal is to improve quality of life for both the child and the family. Palliative care is provided by a specially-trained team of doctors, nurses, social workers, and other specialists who work together with a child's doctors to provide an extra layer of support. It is appropriate at any stage of a chronic condition or life-threatening illness and can be provided along with curative treatment.

Children must meet LOC functional criteria and suffer from the symptoms and stress of chronic medical conditions OR illnesses that put individuals at risk for death before age 21.

The Health Home Care manager or C-YES will assist the family with obtaining a Doctor's written order including justification for Massage Therapy from a Physician, Physician Assistant, Nurse Practitioner, Occupational Therapist, Physical Therapist or Psychiatrist, be included with the child/youth's POC and made available to the managed care plan as needed.

For additional information related to:

- Provider and Condition Requirements
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- Training Requirements

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Expressive Therapy

Expressive Therapy (art, music, and play) helps children better understand and express their reactions through creative and kinesthetic treatment.

Expressive therapy helps children to feel empowered in their own creativity, control, and aid in their communication of their feelings when their life and body may be rapidly changing during the stressful time of undergoing a chronic condition and/or life-threatening illness and the trauma that often comes with its treatment. Whether through music, art, and/or play therapy, the child may find an outlet that allows them to express their emotions safely and have a medium where they have complete control to play and explore with abandon. The family can participate as well, whether in the form of memories shared together or by tangible objects made by their child they can hold onto

- scrapbooks, paintings, or sculpture - mementos that tell their child's life from their perspective and aid in their family's own journey of grief and loss.

Massage Therapy

Massage Therapy is intended 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 and youth who are dealing with treatments that may involve painful interventions and ongoing and/or past trauma.

Massage Therapy – To improve muscle tone, circulation, range of motion and address physical symptoms related to their illness.

Bereavement Service

Bereavement Service help for participants and their families to cope with grief related to the participant's end-of-life experience. Bereavement counseling services are inclusive for those participants in receipt of hospice care through a hospice provider. Children and youth with chronic conditions and life-threatening illnesses and their families deal with grief and loss in a variety of ways and may need various kinds of support over time including counseling and support groups and other services. Bereavement counseling services are inclusive for those participants who are receiving services with a hospice care provider.

Pain and Symptom Management

Pain and Symptom Management: Relief and/or control of the child's suffering related to their illness or condition.

Pain and symptom management is an important part of aiding in providing relief from pain and symptoms and/or controlling pain, symptoms, and side effects related to chronic conditions or life-threatening illness a child is enduring. This management is not only an important part of humanely caring for the child's pain and suffering but helping the child and family cope and preserve their quality of life at a difficult time.

Youth Peer Supports and Training (YPST)

Youth Peer Support and Training (YPST) services are formal and informal services and supports provided to youth, who are experiencing social, medical, emotional, developmental, substance use, and/or behavioral challenges in their home, school, placement, and/or community centered services. These services provide the training and support necessary to ensure engagement and active participation of the youth in the POC process and with the ongoing implementation and reinforcement of skills. Services are delivered in a trauma informed, culturally and linguistically competent manner.

The need for YPST must be determined by a licensed practitioner and included within a POC. Youth Peer Support and Training activities must be intended to develop and

achieve the identified goals and/or objectives as set forth in the youth's individualized POC.

The structured, scheduled activities provided by this service emphasize the opportunity for the youth to expand the skills and strategies necessary to move forward in meeting their personal, individualized life goals, develop self-advocacy skills, and to support their transition into adulthood.

NOTE: YPST will be authorized under the 1915c array of services upon CMS approvals until authority for this service is covered under the State Plan with an expected implementation date of January 1,2020 and CMS approvals. Children who meet Level of Care for HCBS will be able to access YPST based on need and appropriateness.

Youth Peer Supports and Training may include the following service components:

- Skill Building:
  - ✓ Developing skills for coping with and managing psychiatric symptoms, trauma, and substance use disorders
  - ✓ Developing skills for wellness, resiliency, and recovery support
  - ✓ Developing skills to independently navigate the service system
  - ✓ Developing goal-setting skills
  - ✓ Building community living skills
- Coaching: Enhancing resiliency/recovery oriented attitudes, (i.e., hope confidence, and self-efficacy)
  - ✓ Promoting wellness through modeling
  - ✓ Providing mutual support, hope, reassurance, and advocacy that include sharing one's own "personal recovery/resiliency story" as the Youth Peer Advocating (YPA) deems appropriate as beneficial to both the youth and themselves
  - ✓ YPA's may also share their recovery with parents to engage parents and help them "see" youth possibilities for future in a new light
- Engagement, Bridging, and Transition Support:
  - ✓ Acting as a peer partner in transitioning to different levels of care and into adulthood; helping youth understand what to expect and how and why they should be active in developing their POC and natural supports.
- Self-Advocacy, Self-Efficacy, and Empowerment:
  - ✓ Developing, linking, and facilitating the use of formal and informal services, including connection to peer support groups in the community
  - ✓ Serving as an advocate, mentor, or facilitator for resolution of issues.
  - ✓ Assisting in navigating the service system including assisting with engagement and bridging during transitions in care.

- ✓ Helping youth develop self-advocacy skills (e.g., may attend a Committee on Preschool or Special Education meeting with the youth and parent, coaching the youth to articulate his educational goals)
- ✓ Assisting youth with gaining and regaining the ability to make independent choices and assist youth in playing a proactive role in their own treatment (assisting/mentoring them in discussing questions or concerns about medications, diagnoses or treatment approaches with their treating clinician).
- ✓ The YPA guides the youth to effectively communicate their individual perspective to providers and families.
- ✓ Assisting youth in developing skills to advocate for needed services and benefits and seeking to effectively resolve unmet needs.
- ✓ Assisting youth in understanding their POC and help to ensure the plan is person/family centered

- Community Connections and Natural Supports:

  - ✓ Connecting youth to community resources and services. The YPA may accompany youth to appointments and meetings for the purpose of mentoring and support but not for the sole purpose of providing transportation for the youth.
  - ✓ Helping youth develop a network for information and support from others who have been through similar experiences, including locating similar interest programs, peer-run programs, and support groups.
  - ✓ Facilitating or arranging youth peer resiliency/recovery support groups.

For additional information related to:

- Provider and Condition Requirements
- Modalities
- Settings
- Limitations/Exclusions
- Certification/Provider Qualifications
- Training Requirements

Refer to the Children's Home and Community Based Services Provider Manual at the following link:

HEALTH.NY.GOV/HEALTH_CARE/MEDICAID/REDESIGN/BEHAVIORAL_HEALTH/CHILDREN/DOCS/HCBS_MANUAL.PDF

Crisis Intervention (CI)

Crisis Intervention (CI) services are mobile services provided to children/youth under age 21 who are identified as experiencing an acute psychological/emotional change which results in a marked increase in personal distress and which exceeds the abilities and the resources of those involved (e.g. family, provider, community member) to effectively resolve it.

CI services are designed to interrupt or ameliorate the crisis experience and result in immediate crisis resolution. The goals of CI are engagement, symptom reduction, stabilization, and restoring child/youth to a previous level of functioning, or promoting coping mechanisms within the family unit to minimize or prevent crises in the future. CI is a face-to-face intervention that can occur in a variety of settings, including community locations where the child/youth lives, attends school, engages in services (e.g., office settings), socializes, and/or works. CI services are delivered in a person centered, family-focused, trauma-informed, culturally and linguistically responsive manner.

CI includes engagement with the child/youth, family/caregiver and other collateral sources (e.g., school personnel) as needed, to determine level of safety, risk, and plan for the next level of services. All activities must be delivered within the context of a potential or actual behavioral health crisis with a desired outcome of diverting an emergency room visit and/or inpatient admission, when appropriate.

CI services are provided through a multi-disciplinary team to enhance engagement and meet the unique needs of the child/youth and family. Teams are encouraged to include a range of service providers as defined below (see: Individual Qualifications) to promote the multi-disciplinary approach, such as, the inclusion of a Credentialed Family Peer Advocate or CASAC.

The team should be comprised of at least two professionals for safety purposes. One member of a two-person crisis intervention team must be a licensed behavioral health professional and have experience with crisis intervention service delivery including:

- Psychiatrist
- Physician
- Licensed Psychoanalyst
- Licensed Clinical Social Worker
- Licensed Master Social Worker
- Licensed Mental Health Counselor
- Licensed Psychologist
- Licensed Marriage and Family Therapist, or Nurse Practitioner with experience/background in treatment of mental health and/or substance use disorders

The team may also be comprised of non-licensed behavioral health professionals to include:

- Certified Alcoholism and Substance Abuse Counselor
- Credentialed Family Peer Advocate with lived experience as a family member
- Certified Recovery Peer Advocate-Family
- Certified Rehabilitation Counselor
- Registered Professional Nurse

If one member of the team is a Peer Advocate, the Peer Advocate must have a credential/certification as either an OMH established Family Peer Advocate Credential or an OASAS established Certified Recovery Peer Advocate-Family.

If determined through triage only one team member is needed to respond to a psychiatric crisis, that team member must be a behavioral health professional and have experience with crisis intervention. If determined through triage only one team member is needed to respond to a substance use disorder (SUD) crisis, the team member may be a Credentialed Alcoholism and Substance Abuse Counselor (CASAC) and a licensed behavioral health professional must be available via phone. A Peer Support specialist may not respond alone.

Substance use should be recognized and addressed in an integrated way as it elevates risk and impacts both the crisis intervention being delivered and the planning for ongoing care, further demonstrating the necessity of a multi-faceted team approach. As such, crisis services cannot be denied based upon substance use and crisis team members should be trained on screening for substance use disorders.

Referrals for CI service may be made through a number of sources such as: family members, school social worker, provider agencies, primary care doctors, law enforcement, etc.

Upon receiving a call/request for crisis services, a preliminary assessment of risk and mental status is conducted. The preliminary assessment will determine if crisis services are necessary to further evaluate, resolve, and/or stabilize the crisis.

This determination can be made by the following practitioners of the healing arts, operating within their scope of practice, who may or may not be part of the crisis team:

- Psychiatrist
- Physician
- Licensed Psychoanalyst
- Registered Professional Nurse
- Nurse Practitioner
- Clinical Nurse Specialist
- Licensed Clinical Social Worker
- Licensed Married Family Therapist
- Licensed Mental Health Counselor,
- Licensed Psychologist

CI must provide 24/7/365 availability and respond within one (1) hour of the completion of the initial call to the crisis provider and upon the determination an in-person contact is required. A crisis intervention episode begins with the provider's initial face to face contact with the child.

The CI team uses methods and techniques to engage and promote symptom reduction and stabilization to restore the child/ youth to a previous level of functioning. Relevant information is gathered from the child, family, and/or other collateral supports to assess

the risk of harm to self or others and to develop a crisis plan to address safety/mitigate risk. The crisis plan is developed in collaboration with the child/family and should follow to the extent possible, any established crisis plan already developed for the child/youth if it is known to the team.

Care coordination is provided and must include, at a minimum, a follow up contact either by phone or in person, to assure the child's continued safety and confirm that linkage to needed services has taken place. Follow up may, however, include further assessment of mental status and needs, continued supportive intervention (face to face or by phone, as clinically indicated), coordination with collateral providers, linkage to services or other collateral contacts.

The end of the CI episode will be defined by the resolution of the crisis and alleviation of the child/youth's acute symptoms, and/or upon transfer to the recommended level of care. The crisis intervention and follow up should not exceed 72 hours. If exceeding 72 hours, it shall be considered a new CI episode and should be transferred to longer-term rehabilitative supports and services.

CI services must be documented in the individual's case record in accordance with Medicaid regulations. The child/youth's case record must reflect resolution of the crisis which marks the end of the episode. Warm handoff to follow up services (such as CPST, or other identified supports) with a developed plan should be clearly identified in the case record.

Mobile Crisis

The mobile crisis component of the crisis intervention benefit includes the following services and corresponding activities. Each service is eligible for reimbursement separately when delivered in accordance with this guidance, including:

- Telephonic triage and crisis response
- Mobile crisis response
- Telephonic crisis follow-up
- Mobile crisis follow-up

The goals of these services are engagement, symptom reduction, and stabilization. These services can be provided to an adult or child who appears to be experiencing, or is at imminent risk of experiencing, a behavioral health (psychiatric and/or substance use) crisis.

These services are designed to interrupt and/or ameliorate a crisis by:

- Providing services in the community where the individual is experiencing a crisis
- Assessing the immediate crisis and facilitating resolution and de-escalation
- Assisting the individual to use community and family/support systems with the intent of preventing the reoccurrence of similar events in the future
- Engaging the individual to identify follow-up services and assist the individual to access these services that are necessary to manage and/or prevent further behavioral health crisis experiences

- Engaging with the individuals' caretaker and /or family members when appropriate.

NOTE: Crisis intervention will be authorized under the 1915c array of services upon CMS approvals until authority for this service is covered under the State Plan with an expected implementation date of January 1, 2020 and CMS approvals.
For additional information related to:

- Provider and Condition Requirements
- Modalities
- Settings
- Limitations/Exclusions
- Certification/Provider Qualifications
- Training Requirements

Refer to the Children's Home and Community Based Services Provider Manual at the following link:

HEALTH.NY.GOV/HEALTH_CARE/MEDICAID/REDESIGN/BEHAVIORAL_HEALTH/CHILDREN/DOCS/HCBS_MANUAL.PDF

Mental Health Services

For detailed information of all programs listed below, refer to the appropriate Part of TITLE 14 OF NEW YORK CODES, RULES AND REGULATIONS at this link: GOVT.WESTLAW.COM/SITELIST

Licensed Outpatient Programs

Assertive Community Treatment (ACT)

Assertive Community Treatment (ACT) is a comprehensive and integrated set of psychiatric, psychosocial rehabilitation, case management and support services. These services are provided by a mobile multi-disciplinary mental health treatment program mainly in the client's residence or other community.

The minimum age to meet medical necessity is 18 for these adult oriented services. Young adults may receive this service as a benefit covered under the Children's Community Plan until their 21st birthday. For more information refer to the NY OMH ACT Program Guidelines at the following link:

OMH.NY.GOV/OMHWEB/ACT/PROGRAM_GUIDELINES.HTML, or PART 508 OF TITLE 14 NYCRR.

Clinic Services*

A program for adults, adolescents, and/or children which provides an array of treatment services for assessment and/or symptom reduction or management. Services include but are not limited to individual and group therapies. The purpose of such services is to

enhance the person's continuing functioning in the community. The intensity of services and number/duration of visits may vary. For more information refer to: PART 599 OF TITLE 14 NYCRR or OMH.NY.GOV/OMHWEB/CLINIC_RESTRUCTURING/PART599/PART-599.PDF

*This includes OMH SED designated clinics which were previously carved out of MMC for children with SED diagnosis. Psychiatric and psychological services for SSI and Non-SSI children are also included

Continuing Day Treatment (CDT)

A Continuing Day Treatment (CDT) program provides active treatment designed to maintain or enhance current levels of functioning and skills, to maintain community living, and to develop self-awareness and self-esteem through the exploration and development of strengths and interests. The program is designed for seriously mentally ill adults ages 18 and older. It supports them in the development of a more independent level of functioning. Participants often attend several days per week with visits lasting an hour or more. A CDT program shall offer each of the following services, to be provided consistent with recipients' conditions and needs:

(1) Medication therapy
(2) Medication education
(3) Case management
(4) Health referral
(5) Rehabilitation readiness development
(6) Psychiatric rehabilitation readiness determination and referral
(7) Symptom management

A CDT program may also provide the following additional services:

(1) Supportive skills training
(2) Activity therapy
(3) Verbal therapy
(4) Crisis intervention services
(5) Clinical support services

For more information refer to: 14 CRR-NY PART 587.10 and 14 NYCRR PART 588.7.

Partial Hospitalization

A Partial Hospitalization program is a program for adults or adolescents which provides active treatment designed to stabilize or ameliorate acute symptoms in a person who would otherwise need hospitalization, to serve as an alternative to inpatient hospitalization, or to reduce the length of a hospital stay within a medically supervised program. Eligibility for admission to a Partial Hospitalization program shall be based on a designated mental illness diagnosis which has resulted in dysfunction due to acute symptomatology which requires medically supervised intervention to achieve stabilization and which, but for the availability of a partial hospitalization program, would necessitate admission to or continued stay in an inpatient hospital.

For more information refer to: 14 NYCRR PART 587.12 and 14 NYCRR PART 588.

Licensed Behavioral Health Practitioner Waiver Services

Effective October 1, 2015 in New York City and July 1, 2016 in the rest of New York State, Medicaid Managed Care Organizations (MMCOs) including Mainstream Medicaid Managed Care Plans, Health and Recovery Plans, and HIV-Special Needs Plans, are able to reimburse OMH-Licensed Clinic Treatment Programs for provision of services at locations other than the clinic's main site or satellite locations. This benefit is called LICENSED BEHAVIORAL HEALTH PRACTITIONER (LBHP) services.

The LBHP benefit is intended to enable clinics to support person-centered clinical goals, including transitions between Levels of Care (e.g., after a COMPREHENSIVE PSYCHIATRIC EMERGENCY PROGRAM (CPEP)/ Emergency Room visit or inpatient discharge), improved engagement in care and provision of services to individuals who are unable to take advantage of clinic-based services due to clinical or medical factors. LBHP services are intended to be provided to individuals who are receiving clinic treatment. However, clients not enrolled in clinic can receive LBHP services. Per PART 599, OMH allows for three preadmission procedures for children/families to determine whether he or she is appropriate for admission to the clinic.

Integrated Clinics licensed by OMH under PART 598 may also provide LBHP services and should adhere to requirements outlined in this guidance. Integrated clinics certified by OASAS under PART 825 should consult the relevant OASAS guidance for off -site services. Refer to the following for more information:

OASAS.NY.GOV/REGS/INDEX.CFM

A LBHP is an individual who is licensed in the State of New York to prescribe, diagnose and/or treat individuals with mental illness or substance abuse operating within the scope of practice defined in State law and in any setting permissible under State practice law. A LBHP includes individuals licensed as a:

- Licensed Psychiatrist or Advanced Nurse Practitioner
- Licensed Psychologist
- Licensed Psychoanalyst
- Licensed Social Worker (LMSW or LCSW)
- Licensed Marriage & Family Therapist
- Licensed Mental Health Counselor

Refer to the LBHP Guidance Document for more information:

OMH.NY.GOV/OMHWEB/BHO/DOCS/GUIDANCE-ON-LICENSED-BEHAVIORAL-HEALTH-PRACTITIONER-BENEFIT.PDF

Integrated Outpatient Services

Effective January 1, 2015, New York State established the licensure category "Integrated Outpatient Services", appearing identically within regulations for the Office of Mental Health licensed providers (14 NYCRR PART 598), Office of Alcoholism and Substance Abuse Services licensed providers (14 NYCRR PART 825), and Department

of Health licensed providers (10 NYCRR PART 404), The section defines an "INTEGRATED SERVICES PROVIDER" as a provider holding multiple operating certificates or licenses to provide outpatient services, which has also been authorized by a Commissioner of a state licensing agency to deliver identified integrated care services at a specific site in accordance with the provisions of the regulations. This section describes three (3) models for host programs:

- Primary Care Host Model with compliance monitoring by DOH
- Mental Health Behavioral Care Host Model with compliance monitoring by OMH
- Substance Use Disorder Behavioral Care Host Model with compliance monitoring by OASAS

These regulations were designed to allow providers to comply with the requirements of Medicaid managed care plans. The provisions within 14 NYCRR 825.7(C)(2), 14 NYCRR 598.7(C)(2) and 10 NYCRR 404.7(C)(2) are intended to avoid any potential conflict between the treatment planning requirements of these regulations and those of Medicaid managed care companies. An integrated service provider shall have written policies, procedures, and methods governing the provision of services to patients, including a description of each service provided. The regulations outline the minimum content that should be addressed. Providers that are adding primary care services should be aware that policies and procedures for investigating, controlling and preventing infections must be developed and utilized. See 14 NYCRR 598.8(M) and 14 NYCRR 825.8(M) for specific requirements. See the following link for additional guidance:

OMH.NY.GOV/OMHWEB/CLINIC_RESTRUCTURING/DOCS/CLINIC-IOP-GUIDANCE.PDF

The requirement that providers be licensed or certified by more than one agency is intended to allow the respective state agencies to expedite approval and streamline oversight at the site where additional services are to be added. The multiple license requirement means that the provider must possess a license or certification from DOH, OMH and/or OASAS for the clinic site seeking to integrate services, and be licensed or certified within the organization for the services the provider now wishes to add to that particular clinic site.

Psychiatric Inpatient Units of General Hospitals and Hospitals for Persons with Mental Illness

Inpatient Treatment Program

An Inpatient Treatment Program is a 24 hours per day hospital based program which includes psychiatric, medical, nursing, and social services which are required for the assessment and or treatment of a person with a primary diagnosis of mental illness that cannot be adequately served in the community. Such programs may be offered to adults, adolescents, and/ or children by general hospitals, private hospitals for the mentally ill, and state operated psychiatric centers. Information about RESIDENTIAL TREATMENT FACILITIES (RTF'S), which are a specialized type of inpatient treatment program for children and adolescents, can be found on the NY OMH website.

General Hospital Inpatient Programs

A GENERAL HOSPITAL INPATIENT PROGRAM is a 24 hours per day inpatient treatment programs that are jointly licensed by the New York State Office of Mental Health and the New York State Department of Health and operated in medical hospitals

Hospital for Mentally Ill Persons Inpatient Programs

A Hospital for Mentally Ill Persons Inpatient program are 24 hours per day inpatient treatment programs that are licensed by the New York State Office of Mental Health and operate in private hospitals that provide behavioral health services exclusively.

State Psychiatric Center Inpatient Programs

Please go to OMH Facility Directory for a list of state operated psychiatric center: OMH.NY.GOV/OMHHWEB/ABOUTOMH/OMH_FACILITY.HTML

Personalized Recovery Oriented Services

Personalized Recovery Oriented Services (PROS)

A PERSONALIZED RECOVERY ORIENTED SERVICES program is a hospital based program which offers/provides access to crisis outreach, intervention, and residential services; and/or provides beds for the extended observation (up to 72 hours) to adults who need emergency mental health services. The minimum age to meet medical necessity is 18 for this adult oriented service.

Crisis Services

Comprehensive Psychiatric Emergency Program (CPEP)

A COMPREHENSIVE PSYCHIATRIC EMERGENCY PROGRAM (CPEP) is a hospital based program which offers/provides access to crisis outreach, intervention, and residential services; and/or provides beds for the extended observation (up to 72 hours) to adults who need emergency mental health services. CPEP includes EXTENDED OBSERVATION BEDS (EOB).

Early and Periodic Screening, Diagnosis, and Treatment Services For Children (EPSDT)

Children and Family Support Services (CFTSS)

These services are an outgrowth of NYS' Medicaid Redesign efforts and the valuable direction of the NYS Children's Medicaid Redesign Subcommittee. In collaboration with the Subcommittee, the Office of Mental Health (OMH), Office of Alcoholism and

Substance Abuse Services (OASAS), OFFICE OF CHILDREN AND FAMILY SERVICES (OCFS), and the Department of Health (DOH) worked to identify six services to benefit New York State's children from birth up to 21 years of age.

These CHILDREN AND FAMILY TREATMENT AND SUPPORT SERVICES are authorized under the EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT benefits (EPSDT). EPSDT is an array of Medicaid benefits for children under 21 years of age, which historically have been focused primarily on children's preventive medical care (e.g., well baby visits, vaccinations, and screenings at designed ages). This set of Medicaid State Plan services will enable a greater focus on prevention and early intervention by providing a greater array of available services and the capacity to intervene earlier in a child/youth's life.

The addition of these new services offers opportunities to better meet the behavioral health needs at earlier junctures in a child/youth's life to prevent the onset or the progression of behavioral health conditions. This expansion of access to and range of these services will also help to prevent the need for more restrictive and higher intensity services for children and youth. All CFTSS services are delivered in a trauma informed, culturally and linguistically competent manner. The following CFTSS services will be available to any child eligible for Medicaid who meets relevant medical necessity criteria.

Community Psychiatric Support and Treatment (CPST)

Definition

CPST services are goal-directed supports and solution-focused interventions intended to address challenges associated with a behavioral health need and to achieve identified goals or objectives as set forth in the child's treatment plan. CPST services:

- Must be part of the treatment plan, which includes the activities necessary to correct or ameliorate conditions discovered during the initial assessment visits
- CPST is a face -to-face intervention with the child/youth, family/caregiver or other collateral supports
- It is a multi-component service that consists of therapeutic interventions such as counseling, as well as functional supports

Activities provided under CPST are intended to assist the child/youth and family/caregivers to achieve stability and functional improvement in:

- Daily living
- Personal recovery and/or resilience
- Family and interpersonal relationships in school and community integration

The family /caregiver, is expected to have an integral role in the support and treatment of the child/youth's behavioral health need. CPST is designed to provide community-based services to children and families who may have difficulty engaging in formal office settings, but can benefit from home and/or community based rehabilitative services.

CPST allows for delivery of services within a variety of permissible settings including, but not limited to:

- Community locations
- Location where the child youth:
- Lives
- Works
- Attends school
- Engages in services
- Socializes

CPST is also a service which is easily complimented by the integration of additional SPA services, such as PSYCHOSOCIAL REHABILITATION (PSR). For example, PSR can support CPST by providing the more targeted skill building activities needed for the child/youth to further objectives related to functioning within the community. CPST can also be provided in coordination with clinical treatment services, such as those within OLP, to address identified rehabilitative needs within a comprehensive treatment plan.

Service Components

Non counseling Core Services:

- Strengths Based Service Planning
- Rehabilitative Supports
- Rehabilitative Psychoeducation

Counseling Services:

- Intensive Interventions
- Crisis Avoidance
- Intermediate Term Crisis Management

Modality

- Individual face to face intervention
- Group face to face may be delivered under Rehabilitative Supports and Psychoeducation
- Group Limits refer to the number of children/youth participants, regardless of payer.
- Groups cannot exceed 8 children/youth.
- Consideration should be given to smaller limit of Members if participants are younger than 8 years of age.
- Consideration should be given to group size when collaterals are included
- Consideration for group limits or the inclusion of an additional group clinician/facilitator, should be based on, but not limited to the purpose/nature of the group, the clinical characteristics of the participants, age of participants, developmental level and severity of needs of the participants, inclusion of collaterals in group; as well as the experience and skill of the group clinician/facilitator

- CPST service delivery may also include collateral contact , as long as the contact is identified directly related to the child/ youth's foals in the treatment plan

Additional Information

Refer to the Updated CHILDREN AND FAMILY TREATMENT AND SUPPORT SERVICES (CFTSS) MANUAL for more information about:

- Service Components
- Settings
- Limitations/Exclusions
- Certification/Provider Qualifications
- Training Requirements

Refer to the following link for more information:

HEALTH.NY.GOV/HEALTH_CARE/MEDICAID/REDESIGN/BEHAVIORAL_HEALTH/CHILDREN/DOCS/UPDATED_SPA_MANUAL.PDF

Other Licensed Practitioner (OLP)

Definition

OTHER LICENSED PRACTITIONER (OLP) is a term that refers to Non-Physician Licensed Behavioral Health Practitioners (NP-LBPHP). A NP-LBPHP is authorized under OLP and includes the following:

- Licensed Psychoanalysts
- Licensed Clinical Social Workers
- Licensed Marriage and Family Therapists
- Licensed Mental Health Counselors
- Licensed Masters Social Workers when under the supervision of licensed clinical social workers (LCSWs), licensed psychologists, or psychiatrists

NP-LBPHPs are licensed clinicians able to practice independently for which reimbursement is authorized under OLP within the Medicaid State Plan. This OLP "billing authority" allows services provided by NP-LBHP's to be reimbursable when delivered in nontraditional settings, including the home and/or community, or other site-based settings when appropriate, as permissible under State Practice Law. Services must be within the practitioner's scope of practice, as defined in NY STATE LAW. The delivery of services by NP-LBHP's in these natural settings:

- Expands the range of treatment options for families/caregivers by
- Allows greater flexibility and choice based on the needs of the child or youth
- Is also expected to more effectively engage those children, youth and families/caregivers who may have difficulty engaging in traditional clinic based settings

The clinical services provided under OLP are intended to:

- Help prevent the progression of behavioral health needs through early identification and intervention,
- Provided to children/youth in need of assessment for which behavioral health conditions have not yet been diagnosed, including but not limited to children ages 0-5.
- Provide treatment for children/youth with an existing diagnosis for which flexible community based treatment is needed to correct or ameliorate conditions identified during an assessment process, such as problems in functioning or capacity for healthy relationships.
- Provide an assessment of needs may, which may result in the recommendation of further medically necessary services, such as rehabilitative services.

Children may be referred to any agency designated to provide clinical services under OLP. Referrals may come from a variety of routine sources such as schools, pediatricians, etc., or may be a result of self-identification by a parent/caregiver or the child/youth. Under OLP, the NP-LBHP may conduct a comprehensive clinical assessment to diagnose, and/or determine medical necessity to develop a treatment plan with the child/family to restore functioning and/or ameliorate behavioral health symptoms. In many instances, the treatment plan may also include service needs beyond those provided by NP-LBHP's, and incorporate medically necessary rehabilitative STATE PLAN SERVICES (such as those described below in this manual) to effectively address the needs of the child/family. By recommending and including rehabilitative services, the treatment plan serves as the mechanism to develop a comprehensive rehabilitative service package and to support a child and family whose needs may be complex and/or require flexible nontraditional approaches.

Service Components

OLP has four core service components:

- Psychotherapy
- Crisis Intervention
- Licensed Evaluation/Assessment
- Treatment Planning

Modality

- Modalities include individual or group services
- Group limit refers to number of participants, regardless of payer
- Groups cannot exceed 8 individuals
- Consideration may be given to smaller limit of Members if participants are younger than 8 years of age
- Consideration should be given to group size when collaterals are included
- Consideration for group limits, or, the inclusion of an additional group clinician/facilitator, should be based on, but not limited to: the purpose/nature of the group, the clinical characteristics of the participants, age of participants, developmental level and severity of needs of the participants, as well as the experience and skill of the group clinician/facilitator

Additional Information

Refer to the Updated CHILDREN AND FAMILY TREATMENT AND SUPPORT SERVICES (CFTSS) MANUAL for more information about:

- Service Components
- Settings
- Limitations/Exclusions
- Certification/Provider Qualifications
- Training Requirements

HEALTH.NY.GOV/HEALTH_CARE/MEDICAID/REDESIGN/BEHAVIORAL_HEALTH/CHILDREN/DOCS/UPDATED_SPA_MANUAL.PDF

Psychosocial Rehabilitation (PSR)

Definition

PSYCHOSOCIAL REHABILITATION (PSR) services are designed to restore, rehabilitate, and support a child/youth's developmentally appropriate functioning as necessary for the integration of the child/youth as an active and productive member of their family and community with the goal of achieving minimal on-going professional intervention. Services assist with implementing interventions on a treatment plan to compensate for, or eliminate, functional deficits and interpersonal and/or behavioral health barriers associated with a child/youth's behavioral health needs. Activities are "hands on" and task oriented, intended to achieve the identified goals or objectives as set forth in the child/youth's individualized treatment plan. These services must include assisting the child/youth to develop and apply skills in natural settings. PSR is intended to foster and promote the development of needed skills identified in assessment or through the ongoing treatment of a licensed practitioner. PSR services are to be recommended by a licensed practitioner and a part of a treatment plan. PSR activities are focused on addressing the rehabilitative needs of the child/youth as part of a treatment plan and can be provided in coordination with treatment interventions by a licensed practitioner (e.g. OLP) or provider of CPST.

Service Components

PSR has four core service components:

- Social and Interpersonal Skills
- Daily Living Skills
- Community Integration
- Personal and Community Competence

Modality

- Individual, or Group
- Group limits refers to number of child/youth participants, regardless of payer. Groups cannot exceed 8 children/youth.

- Consideration for group limits, or the inclusion of an additional group clinician/facilitator, should be based on, but not limited to: the purpose/nature of the group, the clinical characteristics of the participants, age of participants, developmental level and severity of needs of participants, inclusion of collaterals in group; as well as the experience of skill of the group clinician/facilitator
- PSR may include collateral contact, as long as the contact is directly related to the child/youth's goals and treatment plan

Additional Information:

Refer to the Updated CHILDREN AND FAMILY TREATMENT AND SUPPORT SERVICES (CFTSS) MANUAL for more information about:

- Service Components
- Settings
- Limitations/Exclusions
- Certification/Provider Qualifications
- Training Requirements

Family Peer Support Services (FPSS)

Description

FAMILY PEER SUPPORT SERVICES (FPSS) are an array of formal and informal activities and supports provided to families caring for/raising a child who is experiencing social, emotional, medical, developmental, substance use, and/or behavioral challenges in their home, school, placement, and/or community. FPSS provides a structured, strength-based relationship between a FAMILY PEER ADVOCATE (FPA) and the parent/family member/caregiver for the benefit of the child/youth. The need for FPSS must be recommended by a licensed practitioner of the healing arts and included within a treatment plan. Activities included must be intended to achieve the identified goals or objectives as set forth in the child/youth's treatment plan. Family is defined as the primary care-giving unit and is inclusive of the wide diversity of primary caregiving units in our culture. Family is a birth, foster, adoptive, or self-created unit of people residing together, with significant attachment to the individual, consisting of adult(s) and/or child(ren), with adult(s) performing duties of parenthood/caregiving for the child(ren)even if the individual is living outside of the home.

Core Services

FPSS has four core service components:

- Engagement, Bridging and Transition Support
- Self-Advocacy, Self-efficacy and Empowerment
- Parent Skill Development
- Community Connections and Natural Support

Modality

- Individual, or Group

- Group limits refers to number of child/youth participants, regardless of payer. Groups cannot exceed 12 children/youth.
- Consideration for group limits, or the inclusion of an additional group clinician/facilitator, should be based on, but not limited to: the purpose/nature of the group, the clinical characteristics of the participants, age of participants, developmental level and severity of needs of participants, inclusion of collaterals in group; as well as the experience of skill of the group clinician/facilitator

Additional Information

Refer to the Updated CHILDREN AND FAMILY TREATMENT AND SUPPORT SERVICES (CFTSS) MANUAL for more information about:

- Service Components
- Settings
- Limitations/Exclusions
- Certification/Provider Qualifications
- Training Requirements

Substance Abuse

Under the insurance law changes effected by CHAPTER 69 and 71 of the Laws of 2016 (effective JANUARY 1, 2017), no prior authorization is necessary for in-network inpatient services for the treatment of any substance use disorders, including detoxification, rehabilitation and residential treatment. Medically necessary treatment is determined by the OASAS designated tool (LOCADTR) during admission and retrospective review.

- Providers must notify UnitedHealthcare within 48 hours of admission and submit an initial treatment plan and LOCADTR result. In compliance with this new law
- UnitedHeathcare will not conduct concurrent utilization review for the first 14 days of treatment for In-Network Providers
- Out of Network Providers will be subject to utilization review
- Providers are required to assess patients for the need for continued stay during the initial 14 days of treatment using the LOCADTR
- During these initial 14 days, any consultation between the provider and UnitedHealthcare is not a mechanism for utilization review, but an opportunity for collaboration between the provider and UnitedHealthcare

This limitation on utilization review continues to apply when a patient transfers from one inpatient or residential facility to another and when a patient steps down from one level of care to another. The JANUARY 1, 2017 law change does not apply for detox in a medical bed, only for detox in OASAS licensed units.

- Admissions are subject to UnitedHeathcare retroactive review and can be denied retroactively
- Members are to be held harmless
- A provider must give notice to the UnitedHealthcare any time a patient separates from treatment, including patients who are discharged, leave against medical or clinical advice, or are missing
- The Provider should provide notice to the UnitedHeathcare within 24 hours

For more information refer to the New York State Laws and Regulations that pertain to the OFFICE OF ALCOHOL AND SUBSTANCE ABUSE SERVICES at the following:

OASAS.NY.GOV/REGS/INDEX.CFM

Crisis Services

Hospital Based Medically Managed Inpatient Detoxification

PART 815.6 MEDICALLY MANAGED WITHDRAWAL AND STABILIZATION services are provided in a hospital setting and are designed for individuals who are acutely ill from alcohol-related and/or substance-related addictions or dependence, including:

- The need for medical management of persons with severe withdrawal or risk of severe withdrawal symptoms
- May include individuals with, or at risk of, acute physical or psychiatric co-morbid conditions
- 48 hour observation bed

Individuals who have stabilized in a Medically Managed Detoxification service may step-down to a medically supervised service within the same service setting or may be transferred to another service setting.

Medically Supervised Inpatient Withdrawal and Stabilization

PART 816.7 MEDICALLY SUPERVISED AND STABILIZATION services is physician directed and staffed 24 hours a day 7 days per week with medical staff and includes 24 hour emergency medical coverage. Medically supervised withdrawal services provide:

- Bio-psycho-social assessment
- Medical supervision of intoxication and withdrawal conditions
- Pharmacological services
- Individual and group counseling
- Level of Care determination
- Referral to other appropriate services

Medically Supervised Withdrawal and Stabilization services are appropriate for persons:

- Who are intoxicated by alcohol and/or substances,
- Who are experiencing or are expected to experience, withdrawal symptoms that require medical oversight.

Individuals who have stabilized in a medically managed withdrawal service may step-down to a Medically Supervised Outpatient service.

Medically Supervised Outpatient Withdrawal and Stabilization

PART 816.8 MEDICALLY SUPERVISED OUTPATIENT WITHDRAWAL AND STABILIZATION service is based on a medical and bio-psycho-social evaluation, providers of services otherwise certified by OASAS may provide outpatient medically supervised withdrawal services to:

- Clients who suffer moderate alcohol or substance withdrawal
- Do not meet the admission criteria for medically managed or inpatient medically supervised detoxification services
- Who have emotional support and a home environment able to provide an atmosphere conducive to outpatient withdrawal leading to recovery

In addition to the general services required above, outpatient medically supervised withdrawal patients must:

- Be seen by a medical professional every day
- Engage in counseling services, have access to a 24 hour hotline with access to a medical professional that can provide consultation about acuity of symptoms of withdrawal
- Assessment of need for higher level of care
- Other supports for patient and family

Outpatient Withdrawal services can be provided under a separate certification as and Medically Supervised Outpatient Withdrawal Service or may be provided in an outpatient setting with the approval of the OASAS Medical Director that is documented as a designation on the outpatient certification as an ancillary withdrawal service.

Inpatient Services

Inpatient Rehabilitation

PART 818 CHEMICAL DEPENDENCE INPATIENT REHABILITATION service is OASAS-certified 24-hour, structured, short-term, intensive treatment services provided in a hospital or free-standing facility.

Medical and individualized treatment services are provided to individuals:

- With substance use disorders who are not in need of medical detoxification or acute care
- Are unable to participate in, or comply with, treatment outside of a 24-hour structured treatment setting.

- Individuals may have mental or physical complications or co-morbidities that require medical management or may have social, emotional or developmental barriers to participation in treatment outside of this setting.

Treatment is provided under direction of a physician medical director and the staff includes nursing and clinical staff 24 hours, 7 days per week.

Activities are structured daily to:

- Improve cognitive and behavioral patterns and improve functioning
- Allow for the development of skills to manage chronic patterns of substance use
- Develop skills to cope with emotions and stress without return to substance use

People who are appropriate for inpatient care have co-occurring medical or psychiatric conditions or are using substances in a way that puts them in harm. Many experience decreases in ability to reason and have impaired judgment that interferes with decision making, risk assessment, and goal setting and need a period of time for these consequences of substance use to diminish.

Residential Services

Residential Stabilization and Rehabilitation Services

PART 820.11 AND PART 820.12 RESIDENTIAL STABILIZATION AND REHABILITATION service is an OASAS-certified providers of residential programs that provide medical and clinical services including:

- Medical Evaluation
- Ongoing Medication Management
- Limited Medical Intervention
- Ancillary Withdrawal and Medication Assisted
- Substance Use Treatment
- Psychiatric Evaluation and Ongoing Management
- Group, Individual and Family Counseling

Within the safety of the residence, counseling is focused on:

- Stabilizing the individual i
- Increasing coping skills until the individual is able to manage
  - ✓ Feelings, urges and craving
  - ✓ Co-occurring psychiatric symptoms and
  - ✓ Medical conditions

This service has a physician who serves as medical director, psychiatrist, nurse practitioner and/or physician assistants to provide and oversee medical and psychiatric treatment. Medical staff are available in the residence daily, but 24 hour medical/nursing services are not. There is medical staff available on call 24/7 and there are admitting hours 7 days per week.

NOTE: Optum will offer to contract with all OASAS residential programs. In the event members are placed outside of UnitedHealthcare Community Plan's service area and the OASAS residential program is not contract, single case agreements will be offered.

Outpatient Services

Outpatient Clinic

PART 822 OUTPATIENT CLINIC is an OASAS-certified outpatient services have multi-disciplinary teams which include medical staff and a physician who serves as medical director. These programs provide treatment services to individuals who suffer from substance use disorders and their family members and/or significant others. Outpatient services may be delivered at different levels of intensity responsive to the severity of the problems presented by the patient. The length of stay and the intensity (as measured by frequency and duration of visits) will vary during the course of treatment. In general, persons are engaged in more frequent outpatient treatment visits earlier in the treatment process; visits generally become less frequent as treatment progresses.

Treatment includes the following procedures:

- Group and individual counseling
- Education about, orientation to, and opportunity for participation in relevant and available self-help groups
- Alcohol and substance abuse disorder awareness and relapse prevention
- HIV and other communicable disease education, risk assessment
- Supportive counseling and referral
- Family treatment

Procedures are provided according to an individualized assessment and treatment plan.

Outpatient Rehabilitation

PART 822.15 OUTPATIENT REHABILITATION is an OASAS-certified service designed to assist individuals with chronic medical and psychiatric conditions.

These programs provide:

- Social and health care services
- Skill development in accessing community services
- Activity therapies
- Information and education about nutritional requirements
- Vocational and educational evaluation

Individuals initially receive services three to five days a week for at least four hours per day. There is a richer staff to client ratio for these services compared to other outpatient levels and these services are required to have a half-time staff person qualified in providing recreation and/or occupational services and a half-time nurse practitioner, physician's assistant, or registered nurse. Like medically supervised outpatient, outpatient rehabilitation services require a physician medical director and medical staff

are part of the multi-disciplinary team. The clinical team includes Credentialed Alcohol and Substance Abuse Counselors and other qualified health professionals.

A treatment plan is required to address functional needs of the individual including cognitive, behavioral, employment, and interpersonal.

Opioid Treatment Services

Opioid Treatment Program (OTP)

PART 822.16 OPIOID TREATMENT PROGRAM (OTP) is an OASAS-certified sites where methadone or other approved medications are administered to treat opioid dependency following one or more medical treatment protocols as defined by 14 NYCRR PART 822

OTPs offer:

- Medical and support services
- Counseling
- Educational and vocational rehabilitation
- NARCOTIC TREATMENT PROGRAM (NTP) as defined by the FEDERAL DRUG ENFORCEMENT AGENCY (DEA) in 21 CFR SECTION 13
- Individual, family, and group counseling

A physician serves as medical director and physician and nursing staff assess each individual and approve the plan of care. Clinical staff provides individual, family and group counseling. Patients are prescribed and delivered medication assisted treatment which is expected to be long term medication management of a chronic disorder. Many patients are provided treatment over a lifetime similar to chronic management of diabetes or a heart condition.

Off Site Services

Programs are now able to offer services to patients in the community, at a school, in criminal justice setting or other sites where Substance use Disorder patients maybe in need of clinic services. All services that can be provided and billed in a clinic are eligible to be provided in the community including peer services. For Medicaid billing, this provision applies to Medicaid Managed Care only until the OASAS State Plan moving services to Rehabilitation is approved. For specific billing guidance see Section Four of the OASAS CERTIFIED PART 822 PROGRAMS SERVICES IN THE COMMUNITY CLINICAL AND BILLING GUIDANCE.

Services must be provided to individuals who are enrolled in an outpatient program or seeking services from an OASAS certified PART 822 OUTPATIENT CLINIC OR OPIOID TREATMENT PROGRAM (OTP). They must be delivered in accordance with a treatment plan that is in compliance with all OASAS AND MEDICAID BILLING REGULATIONS or delivered as a part of an assessment or continuing care plan.

The clinic may not use the offsite provision to do screenings for a general population (for example: in a criminal justice or child welfare setting), but they may work with a program/provider to engage people who are in need of services. For example, They may provide brief intervention and referral to treatment services for individuals who have already screened positive and are in need of SUD treatment. PEER SUPPORT services are billable in an OASAS clinic and can be billed as an offsite service as described above. This will allow programs to provide outreach.

NOTE: Requests for coverage at out of network inpatient or residential facilities are subject to review upon admission.

Notification Protocol

The following is the notification protocol:

1. The State developed initial treatment plan within 48 hours

   For more detailed information refer to the document "Guidance for the Implementation of Coverage and Utilization Review Changes Pursuant to Chapters 69 and 71 of the Laws of 2016". This document can be located through the following link:

   OASAS.NY.GOV/MANCARE/DOCUMENTS/INSURANCELAWGUIDANCEFINAL.PDF

2. LOCADTR 3.0 Report

   Written notification can be sent via secure fax or email:

   Fax: 1-877-339-8399
   Email: NYHARPAUTHORIZATIONS@UHC.COM

   Inquiries should be directed to:

   Toll-free line: 1-866-362-3368

Peer-to-Peer Reviews

All denial, grievance and appeal decisions are subject to specific behavioral health requirements including peer-to-peer review. When there is disagreement about the frequency, duration, or level of care being requested, a peer-to-peer review is scheduled:

- A physician who is board certified in child psychiatry must review all inpatient denials for psychiatric treatment

- A physician who is certified in addiction treatment must review all inpatient denials for substance use disorder treatment
- A physician must review all denials for services for a medically fragile child.
- Determinations will take into consideration the needs of the family/caregiver
- All other denials are reviewed by an independently licensed psychologist (PhD) and/or a board certified psychiatrist or physician who is certified in addiction treatment

Access to Care

- Members with appointments shall not routinely be made to wait longer than one hour
- Providers are encouraged to address all walk-in appointments (for non-urgent care) in a timely manner to promote access to appropriate care and actively engage the Member in treatment
- Provider policies need to address both Member access to care and engagement in treatment

To ensure all Members have access to appropriate treatment as needed the following network access standards have been put into place. These are general standards and are not intended to supersede sound clinical judgment as to the necessity for care and services on a more expedient basis, when judged clinically necessary and appropriate. Unless otherwise specified, refer to APPENDIX F for more specific time lines.

Clinical Standards

Providers shall comply with New York State Medicaid guidance including requirements for documentation, relevant performance improvement specification documents or manuals, and policies governing prior authorization, concurrent or retrospective review. Further details can be obtained through the:

New York State Department of Health Health Home Standards and Requirements:

HEALTH.NY.GOV/HEALTH_CARE/MEDICAID/PROGRAM/MEDICAID_HEALTH_HOMES/DOCS/HH_MCO_CM_STANDARDS.PDF

New York State OMH Clinic Standards of Care:

OMH.NY.GOV/OMHWEB/CLINIC_STANDARDS/CARE_ANCHORS.HTML

New York State OASAS Clinical Guidance:

OASAS.NY.GOV/AMED/RECOMMEND/RECOMMENDATIONS.CFM

Referrals to Out of Network Provider Due to Network Inadequacy

To request a referral to an Out-Of-Network (OON) Provider, call the toll-free Member phone number on the Member's Health Plan ID card; for mental health and substance use disorder services, call the Mental Health phone number on the Member's ID card. If the Member wishes to have someone else represent them for this request, please tell us and we will send you the form needed to designate a representative.

Referral requests will be reviewed in a timely manner, as appropriate for a Member's condition. Please be sure to tell us if you have an emergency case—where a health service is necessary to treat a condition or illness that, without medical attention, would seriously jeopardize the patient's life, health or ability to regain maximum function, or would cause the Member to be in danger to self or others.

What to Do if Your Request for a Referral to an Out-of-Network Provider is Not Approved

If the Member's or Provider's request for a referral to an Out-Of-Network (OON) Provider is denied and you don't agree with our decision, the Member or Member's representative may request a grievance review. This is the process for asking us to reconsider a decision. The person who reviews the Member's grievance will not be the person, or a subordinate of that person, who made the original decision. A grievance request must be submitted within 180 days from when the denial is received for a referral to an Out-Of-Network (OON) Provider due to network inadequacy.

Utilization Management

When conducting initial or concurrent review of the treatment plan or POC inclusive of HCBS, the provider will:

- Ensure the clinical appropriateness of care based on the child's current condition, effectiveness of previous treatment, environmental and family supports, and desired outcomes.
- Address gaps in care, including appropriate use of Evidence Based Practices, and request changes to treatment plans to address unmet service needs that limit progress toward treatment and quality of life goals. For children, this includes quality of life goals for the child and family as a whole.
- Promote resilience principles for children including promoting family-driven, youth-guided, culturally competent, person-centered planning, trauma informed care, and the use of Certified Youth Peer or Family Support Services. This includes natural supports, and other services that promote positive advancement of

developmental milestones, family functioning and self-reliance including crisis intervention/prevention plans.

- Promote relapse/crisis prevention planning that goes beyond crisis intervention to include development and incorporation of advance directives in treatment planning and the provision of treatment for individuals with an acute risk or a history of frequent readmissions, residential placement, out-of-home/child welfare placement or crisis system utilization.

As enrollees achieve recovery goals, the Provider shall ensure that person-centered planning focuses on adjusting services to meet individualized needs so that improvements in functional impairments can be maintained when there is a reasonable expectation that withdrawal or premature reduction of services may result in loss of rehabilitation gains or goals attained by the enrollee. Refer to APPENDIX B for additional guidance regarding Utilization Management MMCPs may apply utilization review criteria, as permitted in the Medicaid Managed Care Model Contract, and in compliance with parity laws, for those services which were included in the managed care benefit package for children prior to this transition. Services in the benefit package are:

- Inpatient Psychiatric Services
- Licensed Outpatient Clinic Services
- OASAS Inpatient Rehabilitation Services
- Medically Managed Detoxification (Hospital Based)
- Medically Supervised Inpatient Detoxification
- Medically Supervised Outpatient Withdrawal

Some services are subject to annual or daily limits. Service utilization in excess of the annual claim limits and daily unit limits listed throughout each service description, and on the accompanying crosswalks, will be subject to medical necessity and possible post-payment review. Documentation of the medical necessity for extended durations must be kept on file in the consumer's record for the applicable period of time as defined by New York State Medicaid regulations.

Compensation and Claims Processing

Unless otherwise directed by Optum, providers shall submit claims using the current 1500 CLAIM FORM (V 02/12) or UB-04 FORM, (its equivalent or successor) whichever is appropriate, with applicable coding including, but not limited to,

- INTERNATIONAL CLASSIFICATION OF DISEASE, 10TH REVISION, CLINICAL MODIFICATION (ICD-10-CM) diagnosis code(s)
- CURRENT PROCEDURAL TERMINOLOGY (CPT) Codes
- Revenue
- HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS) Codes

NOTE: Effective October 1, 2014 Optum implemented use of the DSM-5 for assessment. Effective October 1, 2015, in compliance with FEDERAL REGULATIONS, ICD-10-CM billing codes were implemented.

Providers shall include all data elements necessary to process a complete claim including:

- Member Identification Number
- Customary Charges for the MHSA Services rendered to a Member during a single instance of service
- Provider's FEDERAL TAXPAYER IDENTIFICATION NUMBERS (TAX ID)
- NATIONAL PROVIDER IDENTIFIER (NPI)
- Code Modifiers and/or other identifiers requested

In addition, you are responsible for billing of all services in accordance with the nationally recognized CMS CORRECT CODING INITIATIVE (CCI) standards. Please visit the CMS WEBSITE for additional information on CCI BILLING standards.

For Optum and UnitedHealthcare Community Plan claims use Payer ID 87726

Although claims are reimbursed based on the network fee schedule or facility contracted rate, your claims should be billed with your usual and customary charges indicated on the claim. Providers must adhere to timely filing guidelines as outlined in their contract with the MMCP. When a clean claim is received by the MMCP they must adjudicate per prompt pay regulations.

EDI/Electronic Claims

ELECTRONIC DATA INTERCHANGE (EDI) is the exchange of information for routine business transactions in a standardized computer format; for example, data interchange between a practitioner (physician, psychologist, social worker) and a payer. You may choose any clearinghouse vendor to submit claims through this route. Because Optum has multiple claim payment systems, it is important for you to know where to send claims. When sending claims electronically, routing to the correct claim system is controlled by the PAYER ID

Clinician Claim Forms: Paper claims can be submitted using the 1500 CLAIM FORM (V 02/12) the UB-04 claim form or their successor forms in accordance with your Agreement. The claims should include all itemized information such as:

- Diagnosis
  - ✓ INTERNATIONAL CLASSIFICATION OF DISEASES, 10TH REVISION, CLINICAL MODIFICATION (CD-10-CM)
  - ✓ DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (DSM-5)

- Length of Session
- Member and Subscriber Names
- Member and Subscriber Dates of Birth
- Member Identification Number
- Dates of Service
- Type and Duration of Service
- Name of Clinician (i.e., individual who actually provided the service)
- Credentials
- FEDERAL TAXPAYER IDENTIFICATION NUMBERS (TAX ID)
- NATIONAL PROVIDER IDENTIFIER (NPI) NUMBERS

Claims/Customer Service:

Toll-free line:	1-866-362-3368
Mailing Address:	Optum Behavioral Health P.O. Box 30760 Salt Lake City, UT 84130-0760

Important Information

- Each service has a unique rate code. If an individual receives multiple services in the same day with the same CPT code, but separate rate codes, all services would be payable
- Clean Claims (Electronic), including adjustments, will be adjudicated within 30 days of receipt
- Clean Claims (Paper), including adjustments, will be adjudicated within 45 days of receipt
- The procedure for submitting and processing claims will be modified as necessary to satisfy any applicable state or federal laws

Facility Claim Forms:

Paper claims should be submitted using the UB-04 billing format, or its successor, which includes all itemized information such as:

- Diagnosis:
  - ✓ INTERNATIONAL CLASSIFICATION OF DISEASES, 10TH REVISION, CLINICAL MODIFICATION (CD-10-CM)
  - ✓ DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (DSM-5)
- Member Name
- Member Date of Birth
- Member Identification Number
- Dates of Service Dates of Service
- Procedure or Revenue Codes
- Name of Facility

- Federal Tax ID Number of the Facility
- NPI of the Facility and Admitting Physician
- Billed Charges for the Services Rendered

After receipt of all of the above information, participating facilities are reimbursed according to the appropriate rates as set forth in the facility's Agreement. Facilities may file claims through an EDI vendor. Agency claims that are subject to Ambulatory Patient Group (APG) payment methodology per New York State regulations must be submitted on the UB-04 claim form using the applicable coding as designated by New York State. For more information about utilization of the UB-04 form refer to the Billing Overview resource on the Community Technical Assistance Center Of NY (CTAC) And The Managed Care Technical Assistance Center Of New York's (MCTAC) website: Billing.Ctacny.Org/

- When billing for more than one service on the same day, you must use Modifier 25.
- Providers should refer to their Agreement with Optum to identify the timely filing deadline that applies.

Billing Codes

In accordance with New York State Regulations (14 NYCRR Part 599) APG billing and reimbursement methodology will be applied to Medicaid Managed Care. New York State requires that Medicaid MCOs pay the equivalent of APG rates for OMH and OASAS clinics. On July 1, 2018 in New York State, Plans are required to pay 100% of the Medicaid Fee-For-Service (FFS) rate (aka, "government rates" for all authorized behavioral health procedures delivered to individuals enrolled in Medicaid Managed Care plans. This requirement will remain in place for at least two full years. New York State requires payment of government rates for the following categories of services:

DOH Government Rate Services

Health Home Care Management

Billing guidance for Health Home services can be found in the DOH "Health Home Program Updated Billing Guidance at the following link:

health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/update_bill_guidance.pdf

OASAS Government Rate Services

- Part 816 Withdrawal and Stabilization Services
- Part 818 Inpatient Rehabilitation
- Part 820 Residential Services

- Part 822 Outpatient Clinic
- Part 822 Outpatient Rehabilitation Services
- Part 822 Opioid Treatment Program (OTP)

For more information about Ambulatory Patient Groups (APG) billing refer to the OASAS Ambulatory Patient Groups (APG) Policy and Medicaid Billing Guidance document. See: oasas.ny.gov/admin/hcf/APG/documents/APGManual.pdf

Part 816 Withdrawal and Stabilization Services and 818 Inpatient Rehabilitation

For more information about billing for Part 816 and Part 818 OASAS services, refer to the Reimbursement Page on the OASAS website:

oasas.ny.gov/admin/hcf/reimburs.cfm

Part 820 Residential Services

For more information about Part 820 Residential Services billing, refer to the NY OASAS documented located at following link:

oasas.ny.gov/ManCare/BHO/documents/Part820MedicaidContractingandBilling_ProviderFocus_Final.pdf

Part 822 Outpatient Clinic, Rehabilitation, and OTP Billing

Refer to the Updated Claiming Guidance document for more information on billing for Part 822 services at the following link:

omh.ny.gov/omhweb/bho/claiming-guidance-for-clinics.pdf

OHM Government Rates

- Community Psychiatric Supports & Treatment (CPST)
- Assertive Community Treatment (ACT)
- Continuing Day Treatment (CDT)
- Family Peer Support Services
- Other Licensed Practitioner (OLP)
- Psychosocial Rehabilitation (PSR)
- OMH Clinic
- Comprehensive Psychiatric Emergency Program (CPEP)
- Partial Hospitalization
- Personalized Recovery Oriented Services (PROS)
- Continuing Day Treatment (CDT)

For a list of Provider-Specific Rates for Federally Qualified Health Centers (FQHCs) or for more information about and OMH approved Rates and Rate Codes refer to the Medicaid Reimbursement Rates page on the New York State OMH Website:

OMH.NY.GOV/OMHWEB/MEDICAID_REIMBURSEMENT/

Children and Family Treatment Supports and Services Billing

For more information about billing for CFTSS services, refer to the "NEW YORK STATE CHILDREN'S HEALTH AND BEHAVIORAL HEALTH (BH) SERVICES – CHILDREN'S MEDICAID SYSTEM TRANSFORMATION GUIDANCE FOR THE TRANSITIONAL PERIOD OF JANUARY 1, 2019-JANUARY 1, 2020" at the following link:

HEALTH.NY.GOV/HEALTH_CARE/MEDICAID/REDESIGN/BEHAVIORAL_HEALTH/CHILDREN/DOCS/NYS_CHILD_TRANS_BILL_SUPP.PDF

OMH Clinic, OMH PROS, and OMH ACT Programs

For more information about billing for OMH and OASAS Clinics and Opioid Treatment (OTP), OMH PROS, and OMH ACT programs, refer to the following link:

OMH.NY.GOV/OMHWEB/BHO/CLAIMING-GUIDANCE-FOR-CLINICS.PDF

Comprehensive Psychiatric Emergency Program (CPEP), Extended Observation Beds (EOB) Billing

For more information about billing for CPEP and EOB services, refer to the New York State Document located at the following link:

OMH.NY.GOV/OMHWEB/BHO/CPEP_EXTENDED_OBSERVATION_BEDS-GUIDANCE.PDF

Continuing Day Treatment

For detailed information about billing for Continuing Day Treatment Services, refer to the NEW YORK STATE HEALTH AND RECOVERY PLAN (HARP) / MAINSTREAM BEHAVIORAL HEALTH BILLING AND CODING MANUAL at the following link:

OMH.NY.GOV/OMHWEB/BHO/HARP-MAINSTREAM-BILLING-MANUAL.PDF

Integrated Outpatient Clinic Billing

Generally, integrated services providers, including FQHCs, will be encouraged to submit a single APG claim for each visit (including those comprising multiple service types) with all the procedures/services rendered on that date of service using the host's assigned INTEGRATED SERVICES RATE CODES.

Approved integrated service clinics dependent on the licenses they hold may bill for primary care, mental health and/or substance use disorder procedures/services. All visits (Medicaid managed care or fee for service) rendered by an approved integrated service clinic should be billed using one of the INTEGRATED SERVICE RATE CODES.

Refer to the New York State INTEGRATED OUTPATIENT IMPLEMENTATION GUIDANCE at the following link for more information about billing for Integrated Outpatient Clinic services:

OASAS.NY.GOV/LEGAL/CERTAPP/DOCUMENTS/IOSGUID.PDF

Licensed Behavioral Health Practitioners Billing

Refer to the New York State document entitled "Licensed Behavioral Health Practitioner (LBHP) Benefit under Medicaid Managed Care: Guidance for Practitioners and MMCOs" for detailed information about billing for LBHP services at the following link:

Billing Requirements

These billing requirements do not apply to office-based practitioner billing (for example, outpatient professional claims). It applies only to behavioral health services that can be billed under Medicaid Fee-For-Service RATE CODES by OMH-licensed or OASAS-certified programs and to the HCBS services that will be delivered by OMH and OASAS "designated" providers.

Electronic claims will be submitted using the 837i (institutional) claim form. This will support your use of required RATE CODES, which will inform the Plans regarding the type of behavioral health program and the service(s) being provided.

Providers will enter the RATE CODE in the header of the claim as a value code. This is done in the value code field by first typing in "24" followed by the appropriate four digit rate code.

Billing requirements depend on the type of service provided; however, every claim submitted will require at least the following:

- Use of the 837i claim form
- Medicaid Fee-For-Service rate code
- Valid procedure code(s)
- Procedure code modifiers (as needed)
- Units of service Single Case Agreements (SCAs) with non-participating providers will be executed to meet clinical needs of children when in-network services are not available. Optum shall monitor the use of SCAs to identify high-volume, non-participating providers for contracting opportunities and to identify network gaps and development needs.

Refer to: "NEW YORK STATE'S CHILDREN'S HEALTH AND BEHAVIORAL HEALTH (BH) SERVICES – CHILDREN'S MEDICAID SYSTEM TRANSFORMATION GUIDANCE FOR THE TRANSITIONAL PERIOD OF JANUARY 1, 2019-JANUARY 1, 2020" or

NEW YORK STATE HEALTH AND RECOVERY PLAN (HARP) / MAINSTREAM BEHAVIORAL HEALTH BILLING AND CODING MANUAL FOR INDIVIDUALS ENROLLED IN MAINSTREAM MEDICAID MANAGED CARE PLANS AND HARPS

For more information refer to the manual at the following link:

HEALTH.NY.GOV/HEALTH_CARE/MEDICAID/REDESIGN/BEHAVIORAL_HEALTH/CHILDREN/DOCS/NYS_CHILD_TRANS_BILL_SUPP.PDF

Multiple Services Provided on the Same Date to the Same Individual

In some cases, an individual can receive multiple services on the same day. This can include multiple services within the same program type (e.g., an evaluation and a family counseling session or an individual session and group session), or services provided by separate programs (e.g., OLP and Family Peer Support). If these services are allowed per the service combination grid in this manual they would both be reimbursable when billed using the appropriate rate code and CPT code.

Single Case Agreements

In the event an SCA is required, Optum will reimburse all services at Medicaid fee for services rates. The Plan must pay at least the FFS fee schedule for 24 months for all SCAs. To request an SCA, please contact:

Toll-free line:	1-866-362-3368
Fax:	1-877-339-8399
Email:	NYNETWORKMANAGEMENT@OPTUM.COM

The Foster Care Liaison is able to assist with enrollment, disenrollment, and access to care issues (including facilitation of SINGLE CASE AGREEMENTS when a child is placed outside of the Plan's service area). If a provider does not have a contract or a SINGLE CASE AGREEMENT in place with the MMCP, the claim can be denied.

General Information or Contractual Questions

For general information and contractual questions, contact Network Management or your Facility Contract Manager through:

Network Services: 1-866-362-3368

Additional resources can be found on our New York Dedicated page on PROVIDEREXPRESS.COM including:

- OPTUM NATIONAL NETWORK MANUAL
- LEVEL OF CARE GUIDELINES
- BEST PRACTICE GUIDELINES

- Ability to update provider demographic information

Appeals and Grievances

For information regarding appeals and the grievance process, please refer to the section titled "Chapter 6: Our Claim Process" in the New York Physician, Health Care Professional, Facility and Ancillary Providers Care Provider Manual located at uhcprovider.com/en/admin-guides/cp-admin-manuals.html

General Information or Contractual Questions

For general information and contractual questions, contact Network Management or your Facility Contract Manager through:

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Additional resources can be found on providerexpress.com including:

- Optum National Network Manual
- Level of Care Guidelines
- Best Practice Guidelines
- Ability to update provider demographic information

Care Advocate Questions

The Clinical Operation site is open for standard business operations Monday through Friday from 8 a.m. to 6 p.m. Eastern time. In addition, Care Advocates are available 24hours a day, 7 days a week, including holidays and weekends, to discuss urgent and emergent situations such as inpatient admissions, clinical benefit determinations and decisions, appeals, or any other questions about the care advocate process.

When a Member in crisis contacts the Member call center during regular business hours the call will be warm-transferred to one of the Care Advocates located in Latham, New York. If a Member's crisis call is received outside of business hours the call will be warm-transferred to the after-hours clinical team.

Crisis calls are triaged based on urgent or emergent need. Intervention is recommended based on the level of need. Emergent crises are addressed while the Member is on the phone with the Care Advocate. Member safety is confirmed through contact with mobile crisis, emergency services or a natural support. Urgent needs are addressed with adequate referrals to appropriate services agreed upon by Member. The care advocate will contact the Member to ensure the Member has followed through and has access to the referral including transportation, convenient location and appointment time.

Clinical Operations Site Location:	13 Cornell Road Latham, NY 12210
Phone:	1-866-362-3368

Contact Information

Behavioral health providers can reach their Network Management support in the following ways:

Toll-free line:	1-866-362-3368
Fax:	1-877-958-7745
Email:	NYNETWORKMANAGEMENT@OPTUM.COM

For questions about using this site, issues with requesting a User ID and password, or for technical issues, call:

Provider Express Support Center	1-866-209-9320 (toll-free)
Hours of Operation	7 a.m. to 9 p.m. Central Time.

Appendix A

Sentinel Event Reporting

A Behavioral Health Provider Sentinel Event is a serious or unexpected occurrence involving a member in any of the following ways:

- A completed suicide by a member who, at the time of his/her death, was engaged in treatment at any level of care or was engaged in treatment within the previous 60 calendar days
- A serious suicide attempt by a member, requiring an overnight admission to a hospital medical unit, that occurred while the member was receiving facility based treatment (e.g., BH inpatient, residential, partial hospital, intensive outpatient) OR within 30 days of discharge from facility based treatment;
- An unexpected death of a member that occurred while the member was receiving facility based treatment
- A serious injury of a member, requiring an overnight admission to a hospital medical unit, that occurred on facility premises while the member was receiving facility based treatment
- A serious physical assault of or by a member, requiring medical intervention, that occurred on facility premises while the member was receiving facility based treatment
- A report of a sexual assault of or by a member that occurred on facility premises while the member was receiving facility based treatment
- A homicide that is attributed to a member who, at the time of the homicide, was engaged in treatment at any level of care or was engaged in treatment within the previous 60 calendar days
- A report of an abduction of a member that occurred on facility premises while the member was receiving facility based treatment
- An instance of care (at any level) ordered or provided to a member by someone impersonating a physician, nurse or other health care professional
- A medication error that required significant medical intervention (requiring an emergency room visit or inpatient hospital stay)
- Use of restraints/seclusion (Physical, Chemical, Mechanical) with significant medical intervention, requiring an emergency room visit or inpatient hospital stay
- Allegations of abuse/neglect (physical, sexual, verbal); including peer to peer or allegations of member exploitation.

Sentinel Events must be reported by providers as soon as possible, or no later than one business day following the event.

Appendix B

Utilization Management Guidelines for Children's Behavioral Health Services

Service	Authorizations		Additional Guidelines
	Prior	Concurrent	
Outpatient Clinic: Services including initial assessment; psychosocial assessment; and individual, family/collateral, group psychotherapy and Licensed Behavioral Practitioner (LBHP)	No	Yes	MMCOs/HARPS must pay for at least 30 visits per calendar year without requiring authorization. MMCOs/HARPS must ensure that concurrent review activities do not violate parity law. NOTE: the 30-visit count should not include: a) FFS visits or visits paid by another MMCO/HARP or b) psychiatric assessment and medication management visits. Multiple services received on the same day shall count as a single visit (and must be delivered consistent with OMH clinic restructuring regulations)
Mental Health Clinic Services; Psychiatric Assessment; Medication Treatment	No	No	MH Clinic visits exclusively for medication Management or Psychiatric Assessment will not count towards the 30 visits per calendar year.
Psychological or Neuropsychological Testing	Yes	N/A	
OMH Partial Hospitalization	Yes	Yes	
OMH Continuing Day Treatment (CDT)	Yes	Yes	
Personalized Recovery Oriented Services (PROS) Pre-Admission Status	No	No	Begins with initial visit and ends when Initial Service Recommendation (IRS) is submitted to Plan. Providers bill the monthly Pre-Admission rate but add-ons are not allowed. Pre-Admission is open-ended with no time limit.
PROS: Admission: Individualized Recovery Planning	Yes	No	Admission begins when Individual Service Recommendation (ISR) is approved by Plan.
PROS: Active Rehabilitation	Yes	Yes	
Assertive Community Treatment (ACT) *(continued on next page)*	Yes	Yes	Plans will collaborate with Single Point of Access (SPOA) agencies to facilitate referrals and around the determination of eligibility and appropriateness for ACT following NYS Guidelines. New ACT referrals must be made through local SPOA Agencies. In NYC, the referring provider contacts MMCO/HARP to request ACT referral. Provider and MMCO/HARP care manager review patient eligibility for ACT and level of care admission criteria. The MMCO/HARP notifies the referring provider a level of service determination (LOSD) for ACT admission has been made. The provider sends the referral and LOSD to SPOA. In ROS, the referring provider makes a SPOA referral and contacts MMCO/HARP to request an ACT level of service

Service	Authorizations Prior	Concurrent	Additional Guidelines
Assertive Community Treatment (ACT) *(continued)*			determination. The referring provider and MMCO/HARP care manager review whether the member meets ACT level of care admission criteria. Simultaneously, SPOA reviews the referral and assesses for capacity/availability of an ACT slot. The MMCO/HARP Notifies the referring provider and LGU/SPOA that a LOSD for ACT admission has been made.
OASAS Outpatient Rehabilitation Programs	No	Yes	
OASAS Outpatient Clinic and Opioid Treatment Services	No	Yes	
OASAS Outpatient and Residential Addiction Services	No	Yes	
OASAS Residential Supports and Services	No	Yes	
Other Licensed Practitioner (OLP) Community Psychiatric Supports and Treatment (CPST) Psychosocial Rehabilitation (PSR) Family Peer Supports and Services (FPSS)	No	Yes	MMCOs may not require prior authorization for the initial provider assessment. As indicated in the SPA all treatment plans* must be prior authorized by DOH or its designee, in this case that designee is MMCO. Therefore, the MMCO will review the treatment plan, inclusive of the provider assessment to evaluate medical necessity for authorization prior to receipt of further services. The initial authorization must be inclusive of at least 30 service visits. The MMCO will review services at reasonable intervals thereafter (as determined by the MMCO and consistent with the child's treatment plan and/or Health Home plan of care). The MMCO must ensure that prior and concurrent review activities do not violate parity law. NOTE: the 30 –visit count should not include a.) FFS visits or visits paid by another MMCO; or b) psychiatric assessment and medication management visits. Multiple services received on the same day shall count as a single visit. *Treatment plan in this context indicates the needed clinical or functional information the MMCO needs from the treating provider in order to evaluate medical necessity for each service in the applicable MMCO benefit package.

Appendix C

Authorization Grid for Children's Behavioral Health Services

OMH Program	Service	Prior Authorization	Concurrent Authorization
Outpatient Clinic	Initial Assessment Psychosocial Assessment Individual, Family/Collateral, or Group Psychotherapy	No	Yes
	Psychiatric Assessment or Medication Therapy	No	No
	Psychological or Neuropsychological Testing	Yes	N/A
Partial Hospitalization		Yes	Yes
Continuing Day Treatment (CDT)		Yes	Yes
Personalized Recovery Oriented Services (PROS)	Pre-Admission Status	No	No
	Individualized Recovery Planning	Yes	No
	Active Rehabilitation	Yes	Yes
Assertive Community Treatment		Yes	Yes
Children and Family Treatment and Support Services (CFTSS)	Other Licensed Practitioner (OLP) Community Psychiatric Supports and Treatment (CPST) Psychosocial Rehabilitation (PSR) Family Peer Support Services (FPSS)	No	No
Outpatient Rehabilitation Programs		No	Yes
Outpatient Addiction Services		No	Yes
Opioid Treatment Programs (OTP)		No	Yes
Residential Addiction Services		No	Yes
Part 822 Clinic Services		No	Yes
Medically Supervised Outpatient Substance Withdrawal		No	Yes

Appendix D

Community Habilitation Guidelines

Person Centered Planning will define areas of skill & areas of need or support and may be defined in a Health Home Comprehensive Plan of Care (POC) or a Home and Community Based Service POC.

NOTE: The age ranges outlined below should be considered guidance for general support needs. Unique situations occur and upon justification the top of the recommended range can be exceeded. *

Child/youth 0-2 years old *Average hours per week = 0	• Skill building typically met through parental support or natural caregivers & use of services such as Early Intervention (EI) and educational/school programs. Services necessary at this age typically are provided by licensed practitioners including OT, PT, and ST • CH will only be authorized if clear documentation exists of a lack of availability of EI services, EI Respite and/or OPWDD Respite and natural supports (e.g., parent has a disability and the provision of Community Habilitation supports the child and parent skill development or the family has significant stressors that impact ability to support child)
Child/youth 3-9 years old *Average hours per week = 3	• Supports to facilitate community inclusion, relationship building, & adaptive/social skill development. May include social skills groups, music or art programs where the child is working to develop specific goals on their person-centered plan such as appropriate social interaction and mimicking others • Average hours and need for CH typically increase over the years to support a growing level of developmental independence • Not allowed during school/educational hours
Child/youth 10-13 years old *Average hours per week = 10	• Supports to facilitate community inclusion, relationship building & adaptive/social skill development • Average hours and need for CH typically increases over years to support a growing level of development and independence. • Not allowed during school/education hours
Child/youth 14-17 years old *Average hours per week = 15	• Focus on transition activities including increased independence/life skill building including skills such as riding the bus, grocery shopping, using the library, understanding health issues, personal appearance, and hygiene • Not allowed during school/education hours • If graduates/discontinues K-12 education services, CH can increase to meet additional need for skill building. (Utilize adult guidelines)

Appendix E

Training Grid

Providers must have the following in place:

- Written policies and procedures that describe staff orientation
- Mandatory training and other offered trainings for staff
- Staff has the required training to provide care that is trauma informed, culturally competent, and appropriate to the developmental level of the population served
- Maintain documentation of staff completion of required trainings in accordance with the Children's HCBS Provider Manual and be able to provide training records to the State upon request to review. Additional information on State reviews will follow

Mandatory training components can be delivered in a single training or a series of trainings. The HCBS provider will need to maintain training records and training curriculum as evidence of meeting the requirements. Providers can seek community training available to them, partner with another agency and/or develop training within their organization to address the required training components.

- For staff hired before April 1, 2019, training must be completed within six (6) months of the 1915(c)
- Children's Waiver implementation
- For staff hired on or after April 1, 2019, training must be completed within six (6) months of hire date

Training Required	Training Components Required
Personal Safety/ Safety in the Community	• Safety Awareness/Office and Community Safety • Prevention/Risk assessment for the field visits • Use of Safety Technology (e.g., use of mobile phones) • Transporting Children/Youth/Families • Safety Training/Self-Protection strategies • De-escalation techniques • Emergency Protocols and Resources (includes agency policies that address emergency procedures while delivering HCBS in the community and resources available to staff in the event of an emergency (e.g., 911), on-call supervision) • Post incident reporting and response (includes agency policies that address incident reporting and procedures for staff providing HCBS in the community) • To ensure safety and protection of child/ youth, trainings will address professional boundaries, relationship boundaries, trauma, and a code of ethics for staff working with children/youth

Strength Based Approaches	What are Strength-based approaches? • Person-centered planning/Strength based information gathering • Collaboration with child/youth/family and community (e.g. family-guided, youth driven, etc.) • Identifying strengths, protective factors and assets • Cultural and linguistic competence
Suicide Prevention	Myths and Misconceptions of suicide • Risk factors • High risk populations • Warning signs • How to help (assess for risk of suicide and harm, encourage appropriate professional help) • Action/Safety Planning - identify resources in the community (e.g., emergency services and mental health professionals)
Domestic Violence Signs and Basic Interventions	What is Domestic Violence? • Prevalence • Types of abuse • Cycle of violence/Pattern of abuse • Domestic violence effects on children • How to help • Action/Safety planning
Trauma Informed Care	What is Trauma? • Prevalence/Findings (e.g. ACES) • Impact of trauma • Trauma informed care approach (e.g., strength-based, person and family centered, culturally aware, meeting language needs, performing collaborative and coordinated care, etc.)

Appendix F
Access Standards for Children Under 21

Service Type	Emergency	Urgent	Non-Urgent MH/SUD	BH Specialist (Non-Urgent)	Follow-up to Emergency or Hospital Discharge	Follow-up to Jail/Prison Discharge
MH Outpatient Clinic PROS Clinic		Within 24 hours of request	Within 1 Week of Request		Within 5 Days of Request or as Clinically Indicated	Within 5 Days of Request or as Clinically Indicated
Community Mental Health Services					Within 5 Days of Request or as Clinically Indicated	Within 5 Days of Request or as Clinically Indicated
ACT		Within 24 Hours of Request		Within 2-4 Weeks of Request	5 Days of Request or as Clinically Indicated	5 Days of Request or as Clinically Indicated
PROS		Within 24 Hours of Request		Within 2-4 Weeks of Request	Within 5 Days of Request or as Clinically Indicated	Within 5 Days of Request or as Clinically Indicated
Continuing Day Treatment				Within 2-4 Weeks of Request	Within 5 Days of Request or as Clinically Indicated	Within 5 Days of Request or as Clinically Indicated
Intensive Psychiatric Rehabilitation Treatment (IPRT)				Within 2-4 Weeks of Request	Within 5 Days of Request or as Clinically Indicated	Within 5 Days of Request or as Clinically Indicated
Partial Hospitalization					Within 5 Days of Request or as Clinically Indicated	Within 5 days of request or as clinically indicated
Inpatient Psychiatric Services	Immediately Upon Presentation at Service Delivery Site				Within 5 Days of Request or as Clinically Indicated	Within 5 Days of Request or as Clinically Indicated
Comprehensive Psychiatric Emergency Program (CPEP)	Immediately Upon Presentation at Service Delivery Site				Within 5 Days of Request or as Clinically Indicated	Within 5 Days of Request or as Clinically Indicated

Service Type	Emergency	Urgent	Non-Urgent MH/SUD	BH Specialist (Non-Urgent)	Follow-up to Emergency or Hospital Discharge	Follow-up to Jail/Prison Discharge
SUD Outpatient Clinic		Within 24 Hours of Request	Within 1 Week of Request		Within 5 Days of Request or as Clinically Indicated	Within 5 Days of Request or as Clinically Indicated
SUD Inpatient Detoxification	Immediately Upon Presentation at Service Delivery Site				Within 5 Days of Request or as Clinically Indicated	Within 5 Days of Request or as Clinically Indicated
SUD Inpatient Rehabilitation	Immediately Upon Presentation At Service Delivery Site	Within 24 Hours of Request			Within 5 Days of Request or as Clinically Indicated	Within 5 Days of Request or as Clinically Indicated
SUD Residential Stabilization Treatment Services		Within 24 Hours of Request			Within 5 Days of Request or as Clinically Indicated	Within 5 Days of Request or as Clinically Indicated
SUD Residential Rehabilitation Treatment Services		Within 24 Hours of Request		Within 2-4 Weeks of Request	Within 5 Days of Request or as Clinically Indicated	Within 5 Days of Request or as Clinically Indicated
SUD Opioid Treatment Program		Within 24 Hours of Request			Within 5 Days of Request or as Clinically Indicated	Within 5 Days of Request or as Clinically Indicated
HCBS Crisis Intervention/ Respite	Immediately Upon Presentation at Service Delivery Site	Within 24 Hours of Request			Within 5 Days of Request or as Clinically Indicated	Within 5 Days of Request or as Clinically Indicated
HCBS Psychosocial Rehabilitation			Within 2 Weeks of Request		Within 5 Days of Request or as Clinically Indicated	Within 5 Days of Request or as Clinically Indicated
HCBS Community Psychiatric Services and Treatment			Within 2 Weeks of Request		Within 5 Days of Request or as Clinically Indicated	Within 5 Days of Request or as Clinically Indicated