Preparing for the Transition of 1915(c) Waiver
Care Coordination Under the Children’s Medicaid Waiver

Information for the Local Department of Social Services (LDSS) Specific to the Department of Health (DOH) Care at Home (CAH) I/II Waiver

Transition and Readiness Training to Ensure Smooth Transition

January 22, 2019
Overview of Today’s Training

- Welcome and Introductions
- Medicaid Redesign Team (MRT) Vision
- Key Elements of the Children’s Design
- The Children’s Medicaid Transformation and Today’s Training
- Verification that ALL 1915(c) Children Transition
- Options and Requirements for LDSS’ who are serving children in waiver
- Transition Steps
  - Health Home (HH)
  - The Independent Entity (IE) for HH opt-out
- Next Steps
Medicaid Redesign Team (MRT) – Vision and Goals for Transforming the Delivery of Health Care for Children
Medicaid Redesign Team Development

In 2010 Governor Andrew M. Cuomo commissions the New York Medicaid Redesign Team (MRT).

✓ MRT is a collaborative of state agencies, stakeholders, providers, and patient advocates representing virtually every sector of the health care delivery system.

✓ MRT developed a series of recommendations that lowered immediate spending but also proposed important reforms that will:
  ✓ Overhaul the states entire Medicaid program
  ✓ Improve quality of care
  ✓ Reduce costs
  ✓ Prevent adverse health outcomes
  ✓ Eliminate institutional silos
Vision and Goals for Transforming the Delivery of Health Care for Children

✓ Vision and Goals for the Children’s Medicaid Redesign
  ✓ Keep children on their developmental trajectory
  ✓ Focus on recovery and building resilience
  ✓ Identify needs early and intervene
  ✓ Maintain child at home with support and services
  ✓ Maintain the child in the community in least restrictive settings
  ✓ Prevent escalation and longer term need for higher end services
  ✓ Maintain accountability for outcomes and quality
  ✓ Maintain access to services for children without Medicaid as a “Family of One”
The Principles for Transformation

Multi-faceted Children’s Redesign Plan

• Increase access to appropriate interventions by enhancing the service array available in the continuum of care (Care Management, including Health Homes for Children, State Plan, and Home and Community Based Services (HCBS))
  o Right services, at the right time, in the right amount

• Expand the number of children that can obtain community based services
  o Requires Centers for Medicare and Medicaid (CMS) approvals

• Offer children Medicaid services within a Managed Care (MC) delivery system
  o Integrate the delivery of physical and behavioral health services
  o Integrate approaches to care planning and service provision
  o Maintain levels of care (do no harm), ensure continuity of care
Population Transformation

Who?

- Children and youth younger than 21
- Children with Serious Emotional Disturbance (SED)
- Children in Foster Care
- Medically fragile/complex children, require significant medical or technological health supports
- Developmental Disability medically fragile
- Youth with Substance Use Disorders
Key Values for Transforming the Behavioral Health System

Person-Centered

Recovery-oriented

Integrated

Data-driven

Evidence-based
The Children’s Medicaid Transformation
Key Components of Children’s Medicaid System Transformation

✓ Transition of six 1915(c) waivers to consolidated Children’s Waiver authority
  • Office of Mental Health (OMH) Serious Emotional Disturbance (SED) Waiver;
  • Department of Health (DOH) Care at Home (CAH) I/II waiver;
  • Office for People with Developmental Disabilities (OPWDD) Care at Home Waiver
  • Office of Children and Families (OCFS) Bridges to Health (B2H) SED,
  • OCFS B2H Developmental Disability (DD) and
  • OCFS B2H Medically Fragile Waivers

✓ Alignment of 1915(c) Home and Community Based Services (HCBS) under one array of Home and Community Based Services (HCBS) authorized under the Children’s Waiver

✓ Transition to Health Home Care Management
  ✓ Current 1915(c) Waiver providers transition to Health Homes to become Health Home care managers and will provide Health Home Care Management services
Key Components of Children’s Medicaid System Transformation

✓ Transition of Behavioral Health Benefits to Managed Care (MC)
✓ Remove exemption from MC enrollment for children participating in 1915(c) waivers
✓ Transition of Volunteer Foster Care Agency (VFCA) children to MC
✓ Expansion of Children’s HCBS for Community Eligible and Family of One Level of Need Population
✓ All services available to eligible members through Fee-for-Service (FFS) that are exempt or excluded from MC
### Draft, Preliminary Timeline Subject to CMS Timely Approvals

<table>
<thead>
<tr>
<th>Event Description</th>
<th>Preliminary Draft Date</th>
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<tbody>
<tr>
<td><strong>Transition to Health Home Begins for the six current 1915c waiver</strong>&lt;br&gt;OMH SED, DOH Care at Home (CAH) I/II, OPWDD Care at Home, OCFS Bridges to Health (B2H) SED, OCFS B2H Medically Fragile, OCFS B2H DD&lt;br&gt;<em>The foster care population will transition to Health Home</em></td>
<td><strong>January 1, 2019 through March 31, 2019</strong></td>
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<tr>
<td>Implement three of Six New State Plan Services*&lt;br&gt; (Other Licensed Practitioner (OLP), Psychosocial Rehabilitation (PSR), Community Psychiatric Supports and Treatment (CPST))</td>
<td><strong>January 1, 2019</strong></td>
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<tr>
<td><em>Children and Family Treatment and Support Services (CFTSS)</em></td>
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<tr>
<td>1915(c) Children’s Consolidated Waiver, new array of HCBS in Managed Care, remove exemption and exclusion for 1915(c) Consolidated Waiver children from Managed Care</td>
<td><strong>April 1, 2019</strong></td>
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<td>Three year phase in of Level of Care (LOC) Criteria for HCBS</td>
<td><strong>July 1, 2019</strong></td>
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<td>Behavioral Health Benefits to Managed Care</td>
<td><strong>July 1, 2019</strong></td>
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<tr>
<td>Foster Care Fee-for-Service (FFS) Population to Managed Care</td>
<td><strong>July 1, 2019</strong></td>
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<tr>
<td>Implement Family Peer Supports – CFTSS</td>
<td><strong>July 1, 2019</strong></td>
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<tr>
<td>Implement Remaining New State Plan Services - Youth Peer Support and Training and Crisis Intervention</td>
<td><strong>January 1, 2020</strong></td>
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Primary, Most Important Goal of Transition

Ensure that the Transition is Seamless for Children and their Families

✓ Continuity of Care for Providers and Services

✓ Well informed children, families, providers

✓ Access to the State for information and assistance

✓ Partnership with providers, plans and stakeholders to make transition seamless
Ensuring a Smooth Transition

Today’s Training session focuses on explaining the process of the transition from current 1915(c) waiver care management to Health Home care management or those that opt out of Health Home going to the Independent Entity.

Ensuring a seamless transition as possible for the children and families serve today during the transition period of January 2019 through March 31, 2019.

**ALL** children in one of the six waivers MUST transition by March 31, 2019 or lose waiver eligibility.

The transition to Health Home is a key element of the Children’s Transformation and to ensuring the other elements of the Transformation are implemented as smoothly as possible.
Verification that ALL 1915(c) Children Transition
Verification and Tracking Transition Children

• Prior to the transition, a report was ran by provider and waiver children that have been billed for by existing 1915c waiver providers

• On a weekly basis throughout the transition period of January 2019 through March 31, 2019, tracking of children transitioning to HH care management will occur through:
  • The CANS-NY assessment completion within the Uniformed Assessment System (UAS),
  • Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS)
  • The required Independent Entity (IE) report,
  • Through discussion with each 1915(c) Waiver provider

• The LDSS’ that are case managing families have not been billing for waiver case management services, so these children were not initially identified by the DOH transition team

• DOH transition team will work with LDSS’ who are case managing children in waiver to assist with transitioning these families and ensure that the children do not lose waiver services

• DOH is tracking all transitioning waiver children by their Client Identification Number (CIN) to ensure that all children transition properly
Option for LDSS Case Managers to Transition Children In Waiver
Connecting Children and Families to Services

Children who are in a waiver have met Level of Care (LOC) eligibility and are in a Home and Community Based Services (HCBS) Waiver (regardless of the name i.e. Care at Home)

➢ Children who are eligible for HCBS are required to have some type of care management services and a Plan of Care (POC) for their HCBS services

The new consolidated Children’s Waiver that begins April 1, 2019 indicates that:

• *Children who are eligible for HCBS are eligible for Health Home and will receive HH care management services*

• *If the family opt-out of HH, they will receive case management from the Independent Entity (IE)*

• *Children who are no longer eligible for HCBS will also lose HH care management or the IE case management*
Option for the LDSS to Transition a Child in Waiver Services

- It is imperative that all families receiving waiver services are informed about the transformation that is occurring by their case manager, so the family can give informed consent regarding how they would like to transition.

After the family has been educated regarding the Transformation, they have the following options:

1. Transition to a current waiver provider that are becoming Health Home care managers and receive comprehensive care management services to assist with the management of their HCBS and other identified needs and services  OR

2. Opt-out of transitioning and receiving Health Home care management services and transition to the Independent Entity

* Detailed information regarding the above options are in the following slides
Transition Children In Waiver Requirements
Population and Services Effected During the January 1, 2019 to March 31, 2019 Transition Period

• The populations and services effected during this transition period:
  • Waiver children in one of the six (6) Waivers
    • Office of Mental Health (OMH) Serious Emotional Disturbance (SED) Waiver;
    • Department of Health (DOH) Care at Home (CAH) I/II waiver;
    • Office for People with Developmental Disabilities (OPWDD) Care at Home Waiver
    • Office of Children and Families (OCFS) Bridges to Health (B2H) SED,
    • OCFS B2H Developmental Disability (DD) and
    • OCFS B2H Medically Fragile Waivers
  • Waiver Home and Community Based Services (HCBS)
  • Processes for State Plan Services (SPA) and other services such as CDPAP or Private Duty Nursing (PDN) will remain intact unless otherwise notified
  • Regardless of the waiver child’s insurance status (i.e. 3rd party insurance, straight Medicaid, Managed Care) or other services they may be receiving – **ALL waiver children MUST transition to either Health Home or the Independent Entity by March 31, 2019**
Key Provisions Related to the Transition to Health Home and the January 1, 2019 to March 31, 2019 Transition Period

• Transitioning Children are children who are currently enrolled in one of the six current 1915(c) waivers (3 B2H, 2CAH, OMH SED). Enrolled means:
  o Level of Care Home and Community Based Services (HCBS) Determination
  o Plan of Care
  o Receiving HCBS service

• Transitioning Children need a current Level of Care (LOC) Determination –
  o If a child’s annual LOC recertification is due during the transition period, than the current waiver LOC process will continue to be completed
  o If a child’s annual LOC recertification is due on or after April 1, 2019, than the new HCBS/LOC Eligibility Determination will be completed during the month the recertification is due by the current care management provider
Key Provisions Related to the Transition to Health Home

• During the January – March 2019 period, all other requirements and rules applicable to the current six 1915(c) waivers will remain in effect, including eligibility requirements, slots and current HCBS services available under each respective waiver

• On April 1, 2019 (with CMS approvals) Transitioning Children will automatically be transition to new consolidated 1915(c) Children’s Waiver and will have access to the newly aligned array of HCBS authorized under that new waiver

➢ This transition period between January 2019 through March 31, 2019, is to prepare for April 1, 2019 implementation and to ensure no loss of services for children in waiver
New Waiver Children During the Transition Period

During the Transition period of January through March 31, 2019, the LDSS should continue to work with new applications for Medicaid eligibility and/or Waiver services – as current processes are still in place until March 31, 2019.

For any new waiver child to be counted as a transitioning child by **March 31, 2019**, they **MUST**:

- Have active Medicaid in place
- Have been assessed and meet Waiver Level of Care eligibility
- Be linked to a waiver provider who will create a HCBS POC
- The waiver child needs to be transition to either HH or the IE

Current e-mods/vehicle modifications that are in the process of being completed should continue **EVEN BEYOND** March 31, 2019. LDSS should not terminate any projects or approvals in process.
Transition Steps

1. Explain Transition
   ▪ Inform Families
   ▪ Explain Health Home care management
   ▪ Opt-out and the Independent Entity (IE)

2. Planning for Transition
   ▪ Transition and timeline
   ▪ Case load planning

3. Transition to the IE
   ▪ IE Process

4. Plan of Care Transition
Step 1 –
Explaining the Transition
Transition Step – Inform Families

- It is important to explain to current waiver families of the changes that will be occurring in 2019. This will assist families:
  - To have the necessary information to make an informed decision regarding continued services and enrollment in Health Home care management services
  - Limit anxiety by ensuring that there will be no changes to service access, no gap in services, or change in care
  - Continuity of Care - Continuation of connection with same staff/agency

- To support waiver staff ability to discuss changes with families, a number of tools have been created:
  - Talking points for waiver staff to explain transition
  - Medicaid Managed Care Plan (MMCP) Brochure
  - MMCP Continuity of Care Desk Aid
  - Care Manager FAQ
  - Health Home Brochure
  - UAS-NY CANS-NY Reference Sheet
  - HH care manager Roles and Responsibilities
  - HH care manager Core Service Billing

Can be found here under the 1915(c) Resource Tab:
Transition Step – Notification to Families

• Children and families will receive required notifications and other information about the changes that will occur to will implement the Children’s Medicaid Transformation

• Waiver providers and HH will be notified in advance of the distribution of the letters to the families. Current 1915(c) waiver providers may be called upon to help distribute letters to families to ensure every family receives the appropriate and timely notifications

• Additionally, families will be notified that their current waiver will be closed on March 31, 2019 and starting April 1, 2019 they will be in the new Children’s Waiver
Health Home Serving Children
Health Home: Benefits that Provides Comprehensive Care Management

- Health Home is an optional State Plan benefit authorized under Section 2703 of the Affordable Care Act (ACA) to coordinate care for people with Medicaid who have chronic conditions – **there is choice**
- Health Home is a Care Management model that provides:
  - Enhanced care coordination and integration of primary, acute, behavioral health (mental health and substance abuse) services, and
  - Linkages to community services and supports, housing, social services, and family services for persons with chronic conditions
- In New York State, the Health Home model has been a central feature of the Medicaid Redesign Team (MRT) initiatives for adults and children, and overall efforts to integrate behavioral and physical health and social supports, transition the behavioral health benefit to managed care for children and adults, and provide “Care Management for All,”
Tailoring Health Home Model to Serve Children

• The Health Home model has been designed to incorporate the expertise of existing care managers, including Early Intervention, Office of Mental Health Targeted Care Management (OMH TCM) providers that have and will operate under the Health Home program to provide care management and develop plan of care
• Health Homes were implemented across the State in January 2012 for adults and Health Home enrollment for children began in December 2016
• There are 16 Health Homes that serve children and 13 of these Health Homes also serve adults
• Health Homes are usually regionally based however several Health Homes are in just one or two counties

To Locate a Health Home:
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_map/index.htm
Health Home care management is “whole-person” and “person-centered” and integrates a care philosophy that includes both physical/behavioral health care with family and social supports.

Detailed description of activities that comprise the six core services available at http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_serving_children_app_part_II.pdf
Transition Step – Education about Health Home

Children who are eligible for Home and Community Based Services (HCBS) are required to have care management and a care plan for their HCBS

• Medicaid Health Home Care Management serves children with complex behavioral health needs

• Health Homes provides comprehensive care management that focuses on the medical, behavioral, and social service needs of the child with an emphasis on health promotion and overall well-being – 360 degree approach

• Health Home is an optional Medicaid benefit, therefore participation/enrollment are voluntary

• Health Home care management is a cross-system approach to ensure a child receives care management regardless of the door they enter – health, behavioral health, community and social supports, specialty services etc.

• Managed Care Plans, Lead Health Homes and Care Management Agencies will work together to ensure quality services and outcomes for children
Transition Step – Opt-out of Health Home

Families have the right to elect not to transition to Health Home care management for Home and Community Based Services coordination

- If a family chooses to opt-out of HH care management, they still need care management and a plan of care in order to access HCBS
- The Independent Entity (Maximus) will develop a plan of care for children who opt-out of Health Home care management

Therefore, families must be educated about the difference between the Health Home care management and the Independent Entity before they make the selection.
Transition Step – Independent Entity (IE)

The role of the Independent Entity (IE):
- Will have a presence regionally and Statewide number
- Will provide care coordination and a plan of care only for HCBS, not comprehensive care management like in HH Care Management
- Make referrals to HCBS for the child
- Maintain the HCBS plan of care and make referrals for children who are FFS
- If the child is enrolled in a Managed Care Plan (MCP), the MCP will manage the HCBS plan of care once the child is enrolled in MC
- The IE will conduct HCBS eligibility and HCBS re-eligibility determinations if the child is enrolled with MC

Please note: Other non-HCBS child needs and/or services will have to be obtained and managed by the family and/or other service providers and community resources
Step 2 – Planning for Transition
Transition Step – LDSS Transfer Planning

After educating the family regarding the transformation:
If the family would like to be transitioned to Health Home care management
1. Determine if there are other current waiver providers that are able to take on another case for transition
2. If there is, share the information with the family and obtain agreement from the family that they will work with the provider
3. Outline with the provider who will accomplish what tasks to properly transition the family
   • If annual LOC recertification is need prior to April 1, 2019, then the LDSS should complete this and update the Plan of Care prior to transitioning the family to the new provider
   • A team meeting with the family, the LDSS and the new provider should be held to ensure a smooth transition to the new provider and Health Home care management
   • The new provider with assistance of the LDSS will complete the other transition steps (i.e. Obtaining HH consent, MAPP enrollment, completion of the CANS-NY, etc.)
Transition Step – LDSS Transfer Planning

If the family would like to be transitioned to Health Home care management

1. Determine if there are other current waiver providers that are able to take on another case for transition

2. If there is no available waiver providers that can take another family to transition or the family is not willing to work with the provider available, then the LDSS will need to work with the family to transition them to the Independent Entity

3. The Independent Entity begins accepting opt-out of Health Home referrals in February 2019

4. The family can always ask at a later date to be transferred back to a Health Home for HCBS comprehensive care management services
Transition Step – LDSS Transfer Planning

If the family would like to opt-out of Health Home and be transitioned to the Independent Entity

1. The Independent Entity begins accepting opt-out of Health Home referrals in **February 2019**

2. The LDSS will follow the referral process outlined to transition the child to the IE

3. The LDSS is responsible for the annual LOC recertification if it is needed prior to April 1, 2019, then the LDSS completed referral packet to the Independent Entity will include a completed LOC and update the Plan of Care prior to transitioning the family
Step 3 –
Process to Transition the Independent Entity (CYES)

After educating the child/family on the transition and explaining the differences between HH CM and the IE, follow the **required** transition processes described in subsequent slides:
Transition Step – Process to Transition to the IE

The IE program name for the Children’s Waiver is Children and Youth Evaluation Services (CYES)

1. Beginning February 1, 2019, the CYES will begin accepting referrals for transitioning children who opt out of Health Home

2. The child/family confirms their understanding of the transition, the difference between HH care management and Independent Entity (CYES) care coordination roles, and opt-out of Health Home by completing the Health Home Opt-out form (DOH-5059)


There will be an IE webinar held by DOH on January 31, 2019
Continued Step – Process to Transition to the IE

3. A completed CYES Referral Packet MUST be **Sent and Accepted** by the CYES through the Health Commerce System (HCS). A complete CYES Referral Packet includes all of the following:
   - CYES Referral form
   - Health Home Opt-out form (DOH-5059)
   - Agency consent form to share information with the Independent Entity
   - Date of the Level of Care Recertification is needed (if not already determined during the transition period)
   - Previous HCBS/LOC eligibility assessments, especially those that were determined during the transition period
   - Historical clinical, treatment and service information
   - Current Plan of Care identifying involved providers and services

4. The LDSS will receive a response from the CYES through HCS, either accepting the referral or declining with a reason or a request for additional information
Next Steps
LDSS Tracking of Children in Waiver

• Please contact DOH Health Home Program ASAP if there are any concerns with completing any steps to transition a family as outlined **AND**

• Please contact DOH Health Home Program ASAP if you are serving any waiver child, as there is no way for the State to know
  
  hhsc@health.ny.gov or DOH Health Home Program at 518.473.5569

• DOH Transition Team has assigned a LDSS liaison to be the main contact to assist LDSS transitioning children and/or answer questions regarding the new Children’s Waiver

• DOH liaison will reach out to all LDSS to:
  • Determine if your county is serving waiver children
  • Review Information and how to transition waiver children
  • Track these children transitioning to another waiver provider to move to HH or to CYES

• A plan will be made to ensure all children in waiver are transitioned so there is no loss of service
Updates, Resources, Training Schedule and Questions

- Please send any questions, comments or feedback on Health Homes Serving Children to: hhsc@health.ny.gov or contact the Health Home Program at the Department of Health at 518.473.5569

- Stay current by visiting our website: http://www.health.ny.gov/health_care/medicaid//program/medicaid_health_homes/health_homes_and_children.htm

- Subscribe to the HH Listserv http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/listserv.htm
Health Homes Serving Children  List of Acronyms

- ACS: NYC Administration of Children Services
- AI: AIDS Institute
- ALP: Assisted Living Program
- ASA: Administrative Service Agreement
- BAA: Business Associate Agreement
- BHO: Behavioral Health Organization
- CAH: Care at Home
- CBO: Community Based Organizations
- CMA: Care Management Agency
- CFTSS: Children and Family Treatment and Support Services
- CPST: Community Psychiatric Support and Treatment
- CYES: Children’s Waiver is Children and Youth Evaluation Services
- DEAA: Data Exchange Agreement Application
- EI: Early Intervention
- Emedny: Electronic Medicaid system of New York
- FFS: Fee For Service
- HCBS: Home and Community Based Services
- HCS: Health Commerce System
- HH: Health Home
- HHSC: Health Home Serving Children
- HHTS: Health Home Tracking System
- HIT: Health Information Technology
- IE: Independent Entity
- LDSS: Local Department of Social Services
- LGU: Local Government Unit
Health Homes Serving Children
List of Acronyms

• MAPP: Medicaid Analytics Performance Portal (Health Home Tracking System HHTS)
• MCO/MCP: Managed Care Organization / Managed Care Plan
• MRT: Medicaid Redesign Team
• MMIS #: Medicaid Management Information Systems
• NPI #: National Provider Identifier
• OASAS: Office of Alcoholism and Substance Abuse Services
• OCFS: Office of Children and Family Services
• OLP: Other Licensed Practitioner

• OMH: Office of Mental Health
• OMH-TCM: Office of Mental Health Targeted Case Management
• OPWDD: Office of People with Developmental Disabilities
• PMPM: Per Member Per Month
• PSR: Psychosocial Rehabilitation
• SED: Serious Emotional Disturbance
• SMI: Serious Mental Illness
• SPA: State Plan Amendment
• SPOA: Single Point of Access
• SPOC: Single Point of Contact
• TCM: Targeted Case Management
• UAS-NY: Uniformed Assessment System
• VFCA: Voluntary Foster Care Agency