Department of Health | Office of Mental Health | Office of Alcoholism and Substance Abuse Services | Office of Children and Family Services | Office for People With Developmental Disabilities

Required Steps to be Completed for the Transition of 1915(c) Waiver Care Coordination to Health Home Care Management or the Independent Entity Under the Children's Medicaid Transformation

Explaining the Transition:

Families must be educated regarding the Medicaid Transformation that is occurring and their need to transition to either Health Home care management or the Independent Entity to continue receiving waiver services. Waiver children and families MUST make informed consent to transition to Health Home or opt-out of Health Home to the Independent Entity.

For more information and resource, utilize the 1915c Waiver Provider Transition Resource webpage:
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/Health Home_children/index.htm

Health Home Care Management provides comprehensive care coordination and Plan of Care for health, behavioral health, community and social supports, specialty services etc. Whereas the Independent Entity will provide care coordination and a plan of care ***only*** for HCBS. Other non-HCBS needs and/or services will have to be obtained and managed by the family and/or other services providers and community resources.

For more information Independent Entity role during the transition:
https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/ie_training_trans_phase.pdf

Steps to Transition to Health Home Care Management:

The following steps **MUST** be completed in its entirety by March 31, 2019 for the waiver child to be counted as transitioned officially to Health Home care management and not risk a gap in waiver services.

STEPS:

1. Health Home consents are reviewed and signed by the appropriate individual(s)
    a. FAQ, 5200 and 5201 or 5055 for Health Home enrollment and to share information
    b. Functional Assessment Consent form 5230, is required to enter PHI in the UAS for CANS-NY
    c. Release of Educational Record form 5203, is required for all individuals attending an educational setting, the requirements of who can consent is different that the Health Home consent rules

For more information regarding Health Home consents and requirements: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/Health Homesc_consent_form_guidance.pdf

2. Health Home Referral and Enrollment with the MAPP system
   a. All children must be entered into the MAPP Health Home Children's Referral Portal
   b. To keep the child with your same waiver agency – answer **YES** to the following question: "Have you been engaged and in communication with the child and want to outreach, or consent to enroll in the Health Home"
   c. Waiver children during the transition should choose the "HCBS only" referral reason instead of "Chronic Conditions only" or "Chronic Conditions and HCBS"
   d. The child (member) must be placed in an enrollment segment, as all transitioning children will automatically transition to Health Home enrollment
      - **No outreach segments are allowed or can be billed for transitioning waiver children**
   e. Enrollment in the correct Health Home needs to occur prior to beginning the CANS-NY

3. Completion of the CANS-NY with a signature and finalized date
   a. Within the CANS-NY "Intake Demographic" section a Transitional Questions **MUST** be answered for all transitioning children

   https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/Health Home_children/docs/1915c_transition_quickguide.pdf

   b. It is essential when completing the CANS-NY within the UAS, that both the correct Assessment Type is chosen and that the link to the correct Health Home in which the child has been enrolled is accurate.

   https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/Health Home_children/docs/cansny_support.pdf

4. Development/Transition of the Plan of Care (POC)
   a. Review the current waiver Plan of Care with the child/family and add any new services requested
   b. Obtain updated consents for new services
   c. Make referral as appropriate to new provider
   d. Update the POC to a Health Home POC
   e. Update to crosswalk to the new HCBS service name and service description to prepare for April 1, 2019
   f. Update the target dates for goals and objectives
   g. If new services have been added, then referrals to new providers will occur and documented in the POC
   h. To have a completed Health Home POC, it must be reviewed with the child/family and signatures obtained

All Health Home requirements are not immediately needed during the transition period but will be required later.

- The focus between January – March 2019 is properly transitioning all current and newly eligible and enrolled waiver children
- However, a strategy must be developed to ensure compliance with Health Home standards regarding the member's Health Home care record
- At the six-month re-assessment CANS-NY or earlier than six-month re-assessment CANS-NY (due to a significant life change in the child's life), all the requirements of the Health Home program should be met and the member's record updated:
    - Comprehensive Assessment
    - Documentation of Interdisciplinary Team Meeting
    - Update of the POC
- Transitioning children's files will be audited by the State to ensure proper transition

<u>Steps to Transition to the Independent Entity (IE) / C-YES:</u>

After a waiver family has been informed about the transition and a choice has been made between care coordination services, the waiver family must provide informed consent to opt-out of transitioning with their waiver provider to Health Home care management services.

STEPS:

1. On February 1, 2019, the Independent Entity called Children and Youth Evaluation Services (C-YES) began accepting referrals for transitioning children who opt out of Health Home

2. The child/family signature on DOH-5059 (Opt-Out Form) confirms their understanding of the transition, the difference between Health Home care management and the C-YES role and documents their decision to opt-out of Health Home.

3. The waiver provider completes a C-YES Referral Packet

4. A complete C-YES Referral Packet includes all of the following:
    - CYES Referral form
    - Health Home Opt-out form (DOH-5059)
    - The 1915c provider Agency consent form to share information with C-YES
    - 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

- Updated Plan of Care identifying involved providers and services cross walked to new service names

5. The Waiver provider will receive a response from C-YES, it will either accept the referral packet or decline it with a reason or a request for additional information.

6. Once the referral has been accepted by C-YES, then the waiver child is officially transitioned.

Transition New Waiver Eligible Children between January 1, 2019 and March31, 2019

Newly Eligible Waiver Children

Any child can be referred for waiver services during the transition months of January 1, 2019 through March 31, 2019 to access current waiver services.

Any new child determined ***eligible and enrolled*** for an existing 1915c waiver *between March 8, 2019 through March 31, 2019* without a plan of care and/or in receipt of HCBS, will be considered a transitioning child if the following is met:

- DOH capacity management team is notified and the child is recorded as a transition child at capacitymanagement@health.ny.gov
- Waiver LOC eligibility is documented in the child's case record
- Processes to develop the plan of care and referrals to HCBS providers have begun
- The child/family has consented to HH care management and a referral and enrollment has occurred in the MAPP system **or**
- The child/family has opted-out of HH care management to the C-YES

Once the above is determined, then pursue the matching step as outlined above to transition the child to either Health Home Care Management or Independent Entity / C-YES as child/family has chosen

Please Remember:

- Level of Care (LOC) forms must be completed as currently required under existing waivers for any transitioning child who is due for annual recertification between January 2019 through March 31,2019, even if the child has already transitioned to Health Home during this period.
- For any transitioning waiver child whose annual recertification is on or after April 1, 2019, based on the recertification date under the former waiver, the new HCBS/LOC Eligibility Determination will be completed within the month of the due annual recertification.

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_children/docs/transition_to_hh_cm_guidance_for_providers.pdf