NEW YORK STATE | 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

Children's Medicaid Transformation Update:

Transition to Health Home Care management and Children's Waiver

February 13, 2019

Agenda

- Intent of Webinar
- Timeline
- HCBS Waiver Design
- Purpose of Authorities
- Continuity of Care
- Transition Process
- New Additional Guidance
- Transition Progress
- CFCO and the Children's Waiver
- Preparing for April 1, 2019 launch

Today's Presentation

The NYS Department of Health and State partners are continuing discussions with CMS regarding the intended design of the Children's Waiver and implementation timeline. Through these discussions, there are been a number of changes for implementation. Which will be reviewed today:

- Update stakeholders regarding the differences between a 1915c Waiver and 1115 Demonstration
- Outline the impact due to the separation of the 1915c and the 1115 implementation, based on recent issued guidance
- Review current implementation progress
- Share information regarding interaction with other services
- Describe the planning that is occurring for implementation
- Obtain Stakeholder feedback

Current Status

Transition Timeline	Scheduled Date
• Implement three of the six new Children and Family Treatment and Support Services (CFTSS) (Other Licensed Practitioner, Psychosocial Rehabilitation, Community Psychiatric Treatment and Supports) in Managed Care and Fee-For-Service	January 1, 2019
• Waiver agencies must obtain the necessary LPHA recommendation for CFTSS that crosswalk from historical waiver services and revise service names in Plan of Care for transitioning waiver children. This is the last billable date of waiver services that crosswalk to CPST and/or PSR.	**January 31, 2019**
• Transition from Waiver Care Coordination to Health Home Care Management	January 1- March 31, 2019
• 1915(c) Children's Consolidated Waiver is effective and former 1915c Waivers will no longer be active (pending CMS approval)	April 1, 2019
• **1915(c) Children's Consolidated Waiver Services carved-in to Managed Care*** • **Children enrolled in the Children's 1915(c) Waiver are mandatorily enrolled in managed care*** • **Children residing in a Voluntary Foster Care Agency are mandatorily enrolled in managed care*** • Implement Family Peer Support Services as State Plan Service in managed care and fee-for-service • Children residing in a Voluntary Foster Care Agency are mandatorily enrolled in managed care • BH services already in managed care for adults 21 and older are available in managed care for individuals 18-20 (e.g. PROS, ACT, etc.) • SSI children begin receiving State Plan behavioral health services in managed care • Three-year phase in of Level of Care (LOC) expansion begins ** The State continues to work with CMS surrounding the 1115 and implementation timeline*	July 1, 2019
• Implement Youth Peer Support and Training and Crisis Intervention as State Plan services in managed care and fee-for-service	January 1, 2020

1915c Children's Waivers Transitioning to a consolidated 1915c Children's Waiver

Between January 1, 2019 through March 31, 2019, the following six 1915c Home and Community Based Services (HCBS) Waivers' case management providers are transitioning to become Health Home care managers and transitioning their enrolled waiver children into Health Home care management or if the child chooses to opt-out of Health Home to the Independent Entity now known as "C-YES" (Child and Youth Evaluation Services), in preparation for the launch of the new Children's Waiver on April 1, 2019

- OMH SED HCBS 1915(c) waiver
- DOH Care at Home (CAH) I/II 1915(c) waiver
- OPWDD Care at Home (CAH) 1915(c) waiver
- OCFS Bridges to Health (B2H) SED 1915(c) waiver
- OCFS B2H Medically Fragile (Med Frag) 1915(c) waiver
- OCFS B2H DD 1915(c) waiver

New 1915c Children's Waiver Design

The six current 1915c Waivers authorities, regulations and slots are still in operation during the transition period until these six 1915c waivers close on March 31, 2019 with their historic processes (unless otherwise directed in guidance)

On April 1, 2019, the new consolidated 1915c Children's Waiver will give authority to provide Home and Community Based Services (HCBS) to all children who meet HCBS Level of Care determination under one wavier

- One set of service descriptions and rates for all eligible children
- Consistent Health Home Care Management services
- One State Medicaid agency with partner agency team to support delivery, monitoring and oversight
- Expanded array of services for all HCBS children
- One process for services to families and children

Different Authorities

- Originally, the entire Children's Design was developed within a 1115 Demonstration project, which would give NYS the flexibility to develop and to implement the design in creative ways to serve varying populations

- Since NYS already had 1915c waivers in-place, CMS requested that the consolidation of the six current 1915c waivers be under a 1915c construct. The 1115 Demonstration would only be used for items that could not be waived under the 1915c authority (i.e. Behavioral Health and Home and Community Based Services (HCBS) exemption to be managed by Medicaid Managed Care)

- NYS has worked diligently with CMS to separate the Children's Design into a single 1915c waiver with an 1115 amendment while ensuring that no currently served child or population loses services or has a gap in care, although some design items have been adjusted.

- The State is continuing work to ensure that the Vision of the Children's Design is implemented as originally designed.

Home and Community Based Services (HCBS)

The following HCBS Requirements are needed to be in place to transition a current 1915c Waiver child:

- Receiving Medicaid
- Must meet Level of Care (LOC) eligibility
- Required to have some type of care management / coordination through the Health Home or C-YES
- Developed a person-centered Plan of Care with HCBS services
- Receiving at least one HCBS regularly (usually monthly)

Connecting Children and Families to Services

The new 1915c Children's Waiver design outlines that the care management / coordination for HCBS will be Health Home comprehensive care management unless the child/family opts-out to C-YES" for HCBS ***only*** case management

- **Children who are eligible for HCBS are eligible for Health Home without Health Home eligibility and appropriateness needing to be determined**
- **Children who are Health Home eligible are NOT automatically eligible for HCBS**
- **Children who are no longer eligible for HCBS will also lose HH care management unless they are found Health Home eligible and appropriate**

When a child is HCBS eligible, they are eligible for the ENTIRE HCBS array beginning April 1, 2019; however, the child should only utilize services needed to remain in the community or achieve their personal goals.

Transition Processes

Transitioning to CFTSS

During the month of January 2019, current 1915c waiver children's services were cross walked to the new State Plan Services of Children and Family Treatment Support Services (CFTSS)

- Providers must update the HCBS Plan of Care using an addendum/progress note to amend the existing 1915c HCBS waiver service names with the new names of CFTSS
- The HCBS Plan of Care may be used as the CFTSS Treatment Plan until March 31, 2018
- CFTSS Treatment Plan must be in place by April 1, 2019
- Typically waiver children who transition to only CFTSS, would need to be discharged from 1915c Waiver
    - In this circumstance, children with only CFTSS can receive Health Home care management services, but Health Home eligibility and appropriateness must be documented (See appendix and Lead Health Home for HH eligibility process)
    - However, if a child is a Family of One child, they will lose Medicaid eligibility by transitioning to CFTSS only and the child's goals are not yet met, the provider should work to ensure that the child retains at least one HCBS to retain eligibility until approval of the 1115 amendment

HCBS Transition

During the transition period of January 1, 2019 – March 31, 2019, current 1915c waiver children will transition to either Health Home care management or C-YES to remain in waiver services for the new Children's Waiver beginning April 1, 2019

Newly transitioned Health Home care managers will determine which month to transition each child on their case load based upon the transition steps required (as outlined here: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_children/docs/1915c_transition_steps.pdf)

Transitioning Health Home or C-YES plan of care must be updated to reflect the new service names of the new expanded array of HCBS under the new consolidated Children's Waiver (See the appendix for crosswalk of HCBS)

Care managers, HCBS and CFTSS providers should work collectively with the family to ensure alignment of services, the conversion of the HCBS plan of care and that the child is transitioned appropriately

NO Health Home Outreach

During the transition period of January 1, 2019 – March 31, 2019, all waiver child transitioning to Health Home care management MUST be ***Enrolled*** in Health Home through the MAPP HHTS after proper consent has been obtained.

No transitioning waiver child should be placed into Outreach. Any transitioning waiver child placed in outreach cannot have an outreach claim / bill or payment. Lead Health Home must ensure that transitioning waiver children are not billed though outreach.

MAPP HHTS enrollment within the Health Home alone is not the completed process to count the waiver child as transitioned

Required Transition Steps:
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_children/docs/1915c_transition_steps.pdf

Transition Step – Transition Timeline

During the January 2019 – 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 (unless otherwise directed)

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
- ❑ 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 C-YES

Once the above is determined, pursue the outlined steps to transition the child to Health Home or C-YES

Maintaining Services and Processes Throughout the Transition

There are a number of services and processes that are in place that MUST be maintained throughout the Transition. Some of these services are part of the HCBS Waiver, while others coordinate with the HCBS waiver processes.

All long term services and supports (i.e. Consumer Directed Personal Assistance Program (CDPAP), Personal Care Services, Private Duty Nursing Services) need to continue during this period

- These services may be accessed if the child is eligible through the 1915c HCBS Waiver
- These are State Plan services and require specific assessments, Home Assessment Abstract, Doctor's orders, etc. MUST be maintained regardless of the child and/or waiver transition occurring
- These processes and requirements are being examined to find opportunities for consistency and streamlining. Changes and updates will be shared with stakeholders

Pending Environmental and Vehicle Modifications

Goal: Ensure that children with an identified need and have already begun the modification process continue without delays or gaps

- For all children who have a current pending or approved Modification, the processes should continue. This transition should not stop or delay the Modification completion.
- If the Modification is completed by March 31, 2019, then payment and finalization of that modification should continue based upon the waiver and process established
- For any Modification that is pending, approved or started on or after April 1, 2019, guidance will be forth coming regarding finalization and payment of these Modifications but they should continue without delay.
- New streamlined processes are being developed for April 1, 2019 and beyond for Modifications to be approved and completed

Billing – Transitional Rate

Beginning January 1, 2019 to assist providers in successfully transitioning from OCFS B2H Health Care Integration (HCI) and OMH SED Individualized Care Coordination (ICC) to Health Home Care Management, a developed Health Home Transitional Rate may be billed in addition to the Health Home CANS-NY acuity rate codes, over a two year period

OCFS B2H HCI or OMH SED ICC providers have been told the number of allotted transitional rates allowed to be billed each month through a transitional rate allocation letter.

Providers that provide both OMH SED ICC and OCFS B2H HCI services will receive a separate letter containing the allotted number of Transitional Rates given for each waiver as the transitional rate amounts for B2H HCI and SED ICC are different.

Transitional Rates:
https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/childrens_hh_transition_rates.pdf

Transitional Rate Billing - Continued

Transitional Rates can begin to be billed within the month a 1915c Waiver child is transitioned from OCFS B2H HCI or OMH SED ICC to Health Home Care Management.

The Health Home Transitional Rate Codes may be billed ***only*** when the Health Home core requirements have been met.

Health Home CANS-NY acuity billing is completed through the Lead Health Home and their IT billing platform in which the child was enrolled.

Once a monthly Health Home claim has been submitted due to meeting the Health Home core requirements, the care manager organization will also submit a supplemental claim directly to Medicaid Fee-for-Service (FFS) for the transitional rate code that coincides with the Health Home CANS-NY acuity rate code.

Transitional Rate Billing - Continued

The number of allotted Health Home Transitional Rates are *not* attached to a specific child; the provider organization may determine which children to attach the Transitional Rate Codes to each month and it does not have to be the same children each month.

The intent of the Transitional Rate allocation is to assist providers during this transition period, continuity of care for waiver children within the OCFS B2H and OMH SED waiver during the transition and to ensure those providers with knowledge and expertise in serving the waiver population continue to serve waiver children within the Health Home program.

NYS Children's Health and Behavioral Health Services Transitional Billing Supplement – February 14, 2019

Consumer Closure Letter and Information

A 1915c HCBS Waiver Closure Letter was sent to all 1915c Waiver providers regarding the requirement to provide this letter to all waiver families https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_children/docs/1915c_closure_letter.pdf

The letter briefly explains that the child's care coordinator will help move waiver children to the new Children's waiver.

After all children are moved to the new Children's waiver, the 1915(c) waivers that were listed on the letter will close – "This means the 1915(c) waiver you had will close March 31, 2019"

There is a **Special Note,** that the Department of Health Care at Home I/II 1915(c) waiver will NOT close and that children in this waiver would automatically be moved to the new Children's waiver

CAH I/II providers should explain to families that this waiver will **not officially** be closing, rather is being used and amended for the application to CMS for the new Children's Waiver.

Additional Guidance And Changes to Accommodate Differing Authorities

Ensuring Continuity of Services and Processes Throughout the Transition

Continuity of Care for All Children Transitioning

A waiver participant may be eligible for Medicaid due to “Family of One” determination (a child whose family income is waived and receives Medicaid solely for the purpose of receiving HCBS) or Community Eligibility

All children must have at least one HCBS waiver service from the new array of HCBS under the consolidated Children's Waiver on their Plan of Care (POC)

If a Family of One child is discharged from HCBS then he or she will lose Medicaid eligibility. “Family of One” children who meet targeting, risk, and Level of Care (LOC) must have at least one HCBS on their POC to maintain eligibility.

Continuity of Care for All Children Transitioning

The State will meet continuity of care by authorizing services under the 1915c Children's waiver

- Any Family of One 1915c Waiver child receiving only HCBS case management today must have one of the expanded array of HCBS on their POC to maintain eligibility for April 1, 2019
  - This additional service (such as respite) will need to be provided on a quarterly basis until the 1115 amendment is approved instead of monthly provision to maintain eligibility and receive the HCBS for April 1, 2019 through July 1, 2019
  - When the 1115 is approved, NYS has requested that Family of One eligibility will be based upon receipt of CFCO, HCBS or Health Home Care Management if the child meets the target, risk and functional requirements of the 1915(c) waiver. The HCBS provision under the Children's 1915(c) will return to requiring monthly provision of HCBS to remain on the waiver.

Serious Emotional Disturbance HH Definition

In order to ensure that all children eligible for HCBS are eligible for Health Home, New York is updating its definition of Serious Emotional Disturbance (SED) as a single qualifying condition, to align with the HCBS definition of SED utilized by the historic Office of Mental Health 1915(c) Children's SED waiver

- If a child has one of these conditions or attributes they are eligible for HCBS and Health Home.
- A new change is that if they are no longer eligible for HCBS, they will retain their Health Home eligibility so long as they retain the condition under the new SED diagnosis, retain active Medicaid, and Health Home appropriateness
- Please refer to the table in the next slide for guidance on HCBS and Health Home eligibility criteria.
- Additional guidance will be issued to Health Homes Serving Children

Serious Emotional Disturbance HH Definition

Health Home Eligibility Criteria Compared to HCBS Eligibility Criteria Examples Include:		
Note: if the child is eligible for HCBS, the child is eligible for Health Home. If a child is eligible for Health Home, the child may or may not be eligible for HCBS	**HCBS Eligible? (if Meet Target Risk and Functional Criteria)**	**Health Home Eligible Without HCBS Eligibility**
SED: Elimination Disorders*	Yes	Yes (New)
SED: Sleep Wake Disorders*	Yes	Yes (New)
SED: Sexual Dysfunctions*	Yes	Yes (New)
SED: Medication Induced Movement Disorders*	Yes	Yes (New)
SED: Tic Disorder*	Yes	Yes (New)
SED: ADHD*	Yes	Yes (New
All other SED Health Home Conditions (see appendix for SED HH Definition)*	Yes	Yes
Medically Fragile	Yes	Yes, if have two or more HH chronic conditions or single qualifying HH condition
Complex Trauma (Health Home Definition)	Yes	Yes

*Serious emotional disturbance means a child or adolescent has a designated mental illness diagnosis according to the most current Diagnostic and Statistical Manual of Mental Disorders (DSM) AND has experienced functional limitations due to emotional disturbance over the past 12 months on a continuous or intermittent basis. (See the appendix for HH eligibility)

Pending CFTSS Process Until Implementation

Additional State Plan Services of CFTSS will be implemented:

- Family Peer Support and Services on July 1, 2019
- Youth Peer Support and Training in January 1, 2020
- Crisis Intervention in January 1, 2020

However, these services of Family Peer Support and Services, Youth Peer Support and Training, and Crisis Intervention will continue to be authorized in the 1915c Children's waiver till they are authorized under the State Plan Service (based upon the dates above)

Therefore, current 1915c waiver children who receive these cross walked services today, will continue to receive these services on and after April 1, 2019 with the new 1915c Children's Waiver

Additionally, ALL eligible HCBS waiver children can receive these services from a designated provider as a HCBS until the services get implemented as a CFTSS State Plan service.

- The month prior to the date these services become a State Plan Service of CFTSS, HCBS children receiving these services will need to modify their Plan of Care to reflect that the services will be provided under the State Plan (additional guidance will be forth coming)

Key Provisions Related to the Transition - LOC

To ensure all transitioning and HCBS waiver children have continued services, a yearly annual Level of Care (LOC) recertification must be in place. Per the January 11, 2019 Guidance for ALL Waiver children population:

This is a change:

- 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

Guidance Clarification for Care at Home Providers

On January 25, 2019 – Clarification Guidance was issued specifically for Transitioning 1915c DOH and OPWDD Care at Home Waiver Providers regarding the LOC process during the transition period of January 2019 – March 31, 2019 for a child currently enrolled in the OPWDD CAH or DOH CAH I/II Waivers.

- During this timeframe, if a child has an annual LOC or six-month POC that comes due during the transition period window, the Plan of Care (POC), Physician's Orders, and Level of Care (LOC) must be completed in order to remain in compliance with CMS directives.

For more information regarding the guidance and the allowable flexibility https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_children/docs/1915c_transition_clarification.pdf

Clarification - Level of Care Determination

Level of Care documentation – for OPWDD and DOH Care at Home Providers ***Only***

For the OPWDD CAH Waiver - the Level of Care form is completed by the DDRO, but the process for completing the Level of Care and maintaining the Plan of Care requires actions by the Care Manager. The Plan of Service, Physician's Orders, Home Assessment Abstract, and Level of Care form should be coordinated with OPWDD DDRO staff to facilitate completion.

For the CAH I/II Waiver - the care manager may complete either the Pediatric UAS or the CANS-NY within the UAS. However, if the care manager completes the CANS-NY, it must ensure that a physician or other qualified practitioner confirms that the child meets an institutional level of care. A CANS-NY is already required to complete the transition to Health Home care management.

Not Required: The Budget - requirement is waived

Special Note: If the Home Assessment Abstract (HAA) Form and/or Pediatric UAS is essential for a child's access to existing State Plan Services (such as Consumer Directed Personal Assistance Services -CDPAS, Private Duty Nursing, Person Care Services, etc.) then the HAA process and/or the Pediatric UAS must be completed as required.

Transitioning Waiver Children and the New HCBS/LOC Determination Process

Any transitioning 1915c HCBS Waiver child, who annual LOC recertification is due on or after April 1, 2019, the new HCBS/LOC Eligibility Determination will need to be completed.

- If an annual LOC recertification is due for a Transitioning child between April 1, 2019 – March 31, 2020, and the child does not meet the new HCBS/LOC criteria but is at risk for institutionalization in absence of the waiver, the Health Home care manager or C-YES will contact the waiver capacity manager team at capacitymanagement@health.ny.gov for a review of eligibility so that the child can stay on the waiver.
- Additional documentation may be needed by the State from the HHCM/IE to determine if the child will remain eligible for the new Children's waiver under old eligibility criteria for the first year. The HHCM/IE will only be contacted, and documentation will only be needed if the State notifies the HHCM/IE.

Note: This will not occur in certain circumstances such as ICF-IDD eligibility where the eligibility criteria and tools have remained the same.

If the child is eligible under the former Waiver, a Level of Care exception will be issued for one year. The exception process will no longer exist after April 1, 2020.

New Guidance Ensuring Continuity of Care and Services

Transitioning Waiver Children Opt-Out of Health Home and Annual LOC Due in April 2019

If an annual LOC recertification is due for a Transitioning child 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.

However, the State is also requiring that for any transitioning waiver child whose annual recertification is **ONLY** due in the month of April 2019 **AND ONLY** for waiver children that opt-out of Health Home to C-YES, *the current waiver provider MUST complete the LOC forms under existing waivers processes to assist C-YES in being able to immediately and adequately serve the child.*

- The waiver provider can complete such LOC within the month of March while transitioning the child to C-YES through the outline referral process
- C-YES will then be responsible for any follow up required Home and Community Based LOC

Change to 18 year-old Care At Home Discharge

Current DOH / OPWDD Care at Home Waivers serve children up to the age of 18 years of age. The new consolidated 1915c Children's Waiver will serve children up to the age of 21 years of age.

For youth in the DOH / OPWDD Care at Home 1915c Waivers who turn 18 years old during the transition period of January 2019 through March 31, 2019, the care manager should meet with the youth and their families regarding the types of services and supports that will best meet their needs and assist them in making a choice to be either:

1) Discharged from the children's Care at Home waiver and transitioned to the OPWDD larger HCBS waiver or other services, **OR**

2) Remain in the current Care at Home waiver and transition to the new consolidated Children's Waiver beginning April 1, 2019. The LOC based on the recertification date under the former waiver will remain intact.

To ensure continuity of care and stability of services for youth in Waiver services, they will be allowed to transition to the new consolidated Children's Waiver regardless of turning 18 years old.

The following comparison chart of OPWDD and the Children's Waiver services should be reviewed with the youth and family.
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_children/docs/childrens_opwdd_services_compare.pdf

Pending Medicaid Eligibility During the Transition

There are a number of children who have been determined HCBS eligible under the current waivers who do not yet have active Medicaid

These children have a pending Medicaid application and with functional eligibility for HCBS

During this transition period, any child who is HCBS eligible and found Medicaid eligible on or before March 31, 2019, for whom there is a vacant slot on an existing waiver; should be transitioned immediately to either Health Home care management or C-Yes, to be counted as a transitioning child for the New 1915c Children's Waiver on April 1, 2019

Please note: This applies to both Community Eligible and those with "Family of One" budgeting that have pending Medicaid application

Pending Medicaid Eligibility After the Transition

Should the child be found Medicaid eligible based on either Community Eligible or “Family of One” budgeting on or after April 1, 2019, their previous waiver HCBS LOC will be honored for one year.

If a previous waiver provider, SPOA, etc. is in continued contact with the child and family, they should contact the NYS DOH Capacity Management Team to determine if there is an available slot to begin receiving services. If the Family of One child does not have a slot, he/she cannot be Medicaid eligible until there is a slot and the child is enrolled.

During this transition period, providers assisting families with their Medicaid application and/or determined their HCBS LOC, should contact the NYS DOH Capacity Management team to identify each child with a pending case with the LDSS/HRA for tracking purposes.

* OMH SED Waiver providers who are serving children in waiver pending Medicaid eligibility need to contact the capacity management team at capacitymanagement@health.ny.gov or their DOH liaison

Transitioning a child and Inpatient Occurs

All children in a 1915c HCBS Waiver MUST be transitioned by March 31, 2019 to be counted as a transitioning child and ensure that there is no gap in waiver services.

Any waiver child that is planning to be transitioned or in process of being transitioned and becomes hospitalized, inpatient, residential, etc. should continue to be transitioned to Health Home care management

This will ensure that the child is properly transitioned for no gap in HCBS, should they be discharged from inpatient after April 1, 2019.

Each of the six 1915c HCBS Waivers today have differing regulations regarding when a waiver child will be disenrolled from waiver services due to an inpatient, hospitalization, etc. The Children's Waiver will consistently disenroll children after 90 days of institutionalization.

Transitioning a child and Inpatient - Example

Should a waiver transitioning child become hospitalize, inpatient, etc., PLEASE contact your lead Health Home to assist with ensuring the child is properly enrolled in Health Home

Case Scenario:

A CAH child is hospitalized for 45 days during the transition period of January 2019 – March 31, 2019. The 1915c Waiver case manager transitions the child to Health Home following the appropriate transition steps.

- The child is not discharged from CAH Waiver
- The child is “PENDED” in the Health Home system and cannot be billed for while hospitalized (Talk with your lead Health Home in these cases)
- The Health Home care manager needs to follow the Health Home rules for members who enter an excluded setting

Already in Health Home and Waiver Slot Available

There are a number of children that have been enrolled in Health Home while awaiting an available Waiver slot.

If a current Health Home child's slot comes available, during the transition period, AND the Health Home CMA and Waiver Agency are different agencies, then the following steps should be followed:

- The Health Home CM and a Waiver staff should meet with the family and discuss the transition that is occurring. The family may choose to stay with the Health Home CM and potentially lose their waiver slot **OR** transition to the Waiver provider HH CMA

Family's Choice - to Stay in Health Home:

1. The Health Home care manager will continue to work with the family
2. Prepare to complete the new HCBS/LOC Eligibility Determination on or after April 1, 2019
3. The HHCM should work with the waiver provider to begin the planning process to ensure proper connection to the HCB services and designated providers

Already in Health Home and Waiver Slot Available

Family's Choice - to Transition to Waiver Provider HH CMA:

1. The family will **REMAIN** in Health Home; no discharge is needed
2. If the Waiver provider CMA is in the same lead Health Home network, then a CMA transfer conducted by the Health Home will occur to transfer the child to the Waiver provider CMA
3. If the Waiver provider CMA is in a different lead Health Home network, then the current Health Home will transfer the child to the new Health Home of the Waiver provider CMA and the Waiver provider CM will be assign
4. Once the child is assigned to the Waiver provider CM, the HH care manager will ensure they have proper HH consent, the child is in an MAPP enrollment segment and will complete a New CANS-NY to identify the child as a transitioning child (Follow the steps to transition)
5. The HH care manager MUST ensure that the child has the waiver service code of 23, 62, 63, 65, 72, 73, or 74 (see slide 47) on their file prior to April 1, 2019
6. The HH CM MUST contact their DOH liaison to ensure this new transitioning child is counted

* Communication between Waiver Provider CMA and their lead Health Home will be key to expediting this process

Serving Transitioning Children

It has always been the intent of the State to preserve the expertise of existing 1915c waiver providers in the Children's Transformation and in Health Homes, while all existing 1915(c) waiver Care Managers/Agencies providing care management under the six Waivers transitioned to Health Homes

- ***All current 1915(c) Transitioning Children who will transition to Health Home care management will transition with their current care manager/agency (by choice and with consent)***
- This linkage between care managers and children and families will preserve care manager relationships with the child and their family, continuity of care and help ensure a seamless transition

Serving Transitioning Children - continued

- These are the providers that have been trained to transition their waiver children
- These are the providers that are currently approved waiver providers under the existing six waivers and these waivers are still in effect until March 31, 2019

Therefore, ***Only*** transitioning 1915c Waiver Providers of the six Waivers can transition a 1915c Waiver child to Health Home care management or to C-Yes. Should the waiver child want to be transitioned to Health Home, they can ***ONLY*** be served by 1915c Waiver provider, not any other Health Home care management agency. Families always have choice to request another care manager or agency, however during the transition it must be a 1915c Waiver provider

- **Please Note:** Any Health Home care manager that has enrolled a 1915c Waiver child in Health Home while the child has been in waiver services, will have to disenroll the waiver child and cannot bill for that child, so that the Waiver provider can enroll the child in Health Home or to C-YES.
- It is a requirement of the Health Home program that eMedNY is checked monthly by the care manager to ensure proper enrollment and billing

RR/E codes to interaction with the Health Home Program
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/restriction_exception_codes.pdf

New Recipient Restriction/Exemption (RR/E) codes

RR/E Codes - Enrollment in Health Home

The Health Home RRE Codes are A1 and A2

For transitioning children these codes indicate that they have been enrolled in the Health Home Program

A1 in eMedNY shows the Care Management Agency's Name

A2 in eMedNY shows the Health Home Name

In ePACES the organization names appear in the "Medicaid Restricted Recipient" field and the A1/A2 appear in the "Member Exceptions" field

A1 and A2 are compatible with all waiver codes and should appear on any member's file that has transitioned into the Health Home Program.

The New 1915c Children's Waiver and RR/E Codes

The new 1915c HCBS Children's Waiver that will begin on April 1, 2019 will have new Recipient Restriction/Exemption (RR/E) codes to identify children who are eligible for waiver services and their specific population category

Some current 1915c Waiver children who are transitioning may have these new RR/E codes on their eMedNY file as a bulk upload of these RR/E codes went up at the end of December 2018 to capture the current waiver children

Another bulk upload will occur after April 1, 2019 to capture all new eligible waiver children for the new Children's Waiver

There will be more information forth coming regarding these new Children's Waiver RR/E codes and how they will be placed on new eligible child's file and when they will be taken down from the child's file when discharged from waiver

K Codes RR/E for New Children's Waiver

RR/E code	RE code Description
K1	HCBS LOC
K2	HCBS LON (will not be in use < 2021)
K3	HCBS Serious Emotional Disturbance (SED)
K4	HCBS Medically Fragile (MF)
K5	HCBS Developmentally Disabled (DD)
K6	HCBS Developmentally Disabled and Medically Fragile (DD & MF)
K7	HCBS Complex Trauma (will not be in use < 2021 with LON)
K8	Voluntary Foster Care Agency
K9	Foster Care
KK	Family of One

Current 1915c RR/E Waiver Comparison to K Codes

1915c RR/E Codes	1915c RR/E Code Description	K Code RR/E Series	K Code RR/E Series Description
23	OMH SED HCBS Waiver	K1	HCBS LOC
		K3	HCBS SED
62	DOH Care at Home MF HCBS Waiver	K1	HCBS LOC
		K4	HCBS MF
63	DOH Care at Home MF HCBS Waiver	K1	HCBS LOC
		K4	HCBS MF
65	OPWDD Care at Home MF HCBS Waiver	K1	HCBS LOC
		K6	HCBS DD/MF
72	OCFS B2H SED HCBS Waiver	K1	HCBS LOC
		K9	Foster Care
		K3	HCBS SED
73	OCFS B2H DD HCBS Waiver	K1	HCBS LOC
		K9	Foster Care
		K5	HCBS DD Foster Care
74	OCFS B2H MF HCBS Waiver	K1	HCBS LOC
		K9	Foster Care
		K4	HCBS MF

Community First Choice Option (CFCO) and Interaction with the 1915c Children's Waiver

CFCO Interaction and the Children's Waiver

There is currently implemented CFCO services that are available for Children's Waiver enrolled children

On July 1, 2019 expanded CFCO services will be available in which the Children's Waiver enrolled children will have access

- As of July 1, 2019, the Family of One children will get the CFCO services through the Children's waiver. So even if a child doesn't have a CF or CO on their RE codes, they will get all of the CFCO services. (See RR/E codes on following slides)

More Guidance will be forthcoming – CFCO Webinar on February 20, 2019

CFCO Services

- **Current CFCO Services:**
  - Consumer Directed Personal Assistance Services (CDPAS)
  - Home Health Aide
  - Homemaker/Housekeeper (Personal Care Level 1)
  - Personal Care Level 2
  - Personal Emergency Response System (PERS)
  - Non-Emergency Medical Transportation (NEMT)
- **Additional CFCO Services**
- **Available July 1, 2019:**
  - Assistive Technology (AT)
  - Environmental Modification (E-Mod)
  - Vehicle Modification (V-Mod)
  - Moving Assistance
  - Community Transitional Services (CTS)
  - Skill Acquisition Maintenance and Enhancement (SAME)
  - Home Delivered/Congregate Meals

https://www.health.ny.gov/health_care/medicaid/redesign/community_first_choice_option.htm

CFCO RR/E Code Overview

CFCO eligible individuals must be identified in the eMedNY system through a unique Recipient Restriction/Exemption (RR/E) code on the individual's eligibility file. For individuals deemed eligible for CFCO, RR/E code placement started on **April 1, 2018.**

Two (2) RR/E Codes were created to identify CFCO eligible individuals. The CFCO RR/E Codes are 'CF' and 'CO' and contain the following system attributes:

CF: Community First Choice Option (Non OPWDD)

- Short Description: 'CFCO'
- Long Description: COMMUNITY FIRST CHOICE OPTION (Non OPWDD)

CO: Community First Choice Option (OPWDD)

- Short Description: 'CFCO-OPWDD'
- Long Description: COMMUNITY FIRST CHOICE OPTION OPWDD

CFCO and Consolidated Children's Waiver Allowable RR/E Combinations

RR/E	CF	CO	Justification
K1 (HCBSLOC)	Y	N	Consumers enrolled in the Children's Waiver may be eligible for CFCO. DOH and the LDSS are responsible for connecting these consumers to CFCO, unless the consumer is enrolled in a MMC plan.
K3 (HCBS SED)	Y	N	
K4 (HCBS MF)	Y	N	
K5 (HCBS DD)	Y	N	
K6 (HCBS MF/DD)	Y	N	

RR/E codes to interaction with the Health Home Program
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/restriction_exception_codes.pdf

CFCO and CCO/HH

People First Care Coordination Organization Health Homes (CCO/HHs) are designated to serve individuals with I/DD

OPWDD uses the following RR/E codes for the CCO/HHs:

RR/E	Description
I5	CCO/HH Enrollment Level 1
I6	CCO/HH Enrollment Level 2
I7	CCO/HH Enrollment Level 3
I8	CCO/HH Enrollment Level 4
I9	CCO/Basic HCBS Plan Support

I5-I9 can only co-exist with a CO RR/E code (to be loaded by OPWDD).

LDSS can identify the associated CCO/HH provider name and ID through eMedNY.

CCO/HH is responsible for the plan of care.

OPWDD provider contact information:
https://opwdd.ny.gov/sites/default/files/documents/CCO_Coverage_Chart.pdf

List of Upcoming Trainings

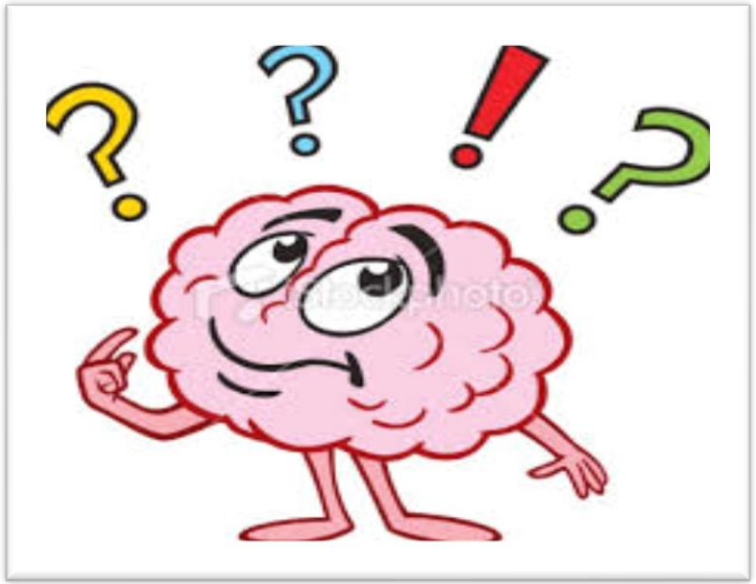
HCBS Service Specific Webinars
March: 1, 8, 15, 22, 28 at 10 am

The Consumer webinars
February 27 AND March 21 at 5:30-6:30pm

HCBS Eligibility
March 13

Capacity Management
March 27

Questions



Contact Information

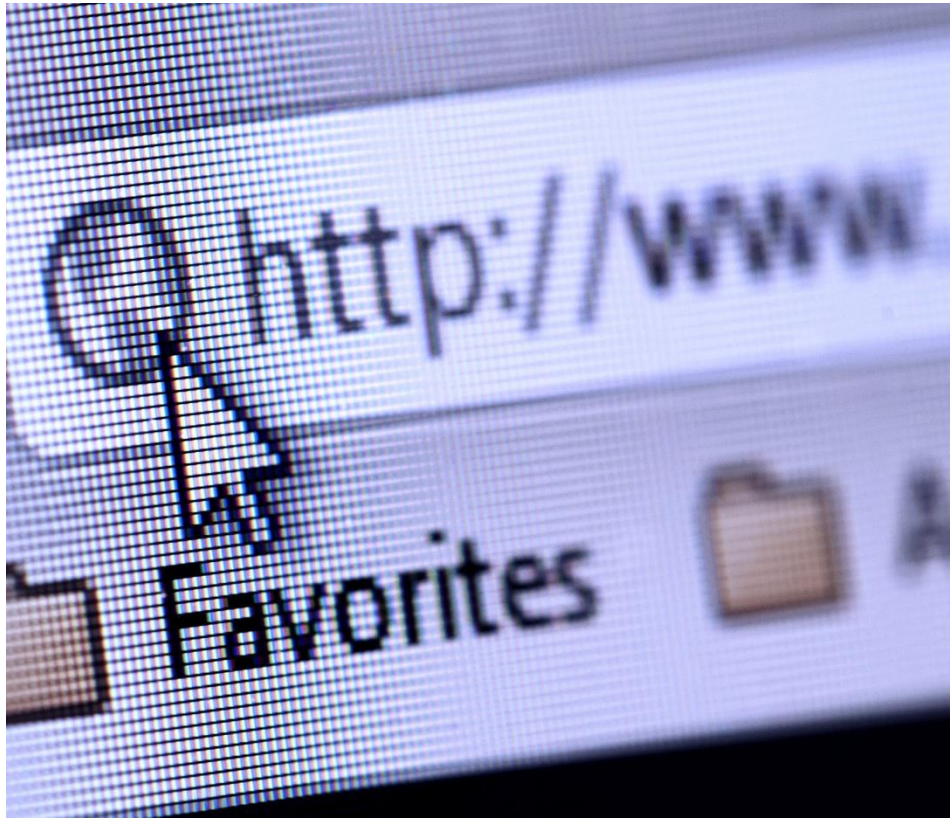
Questions/Comments:

BH.Transition@health.ny.gov

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
- C-YES: Child and Youth Evaluation Service
- 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

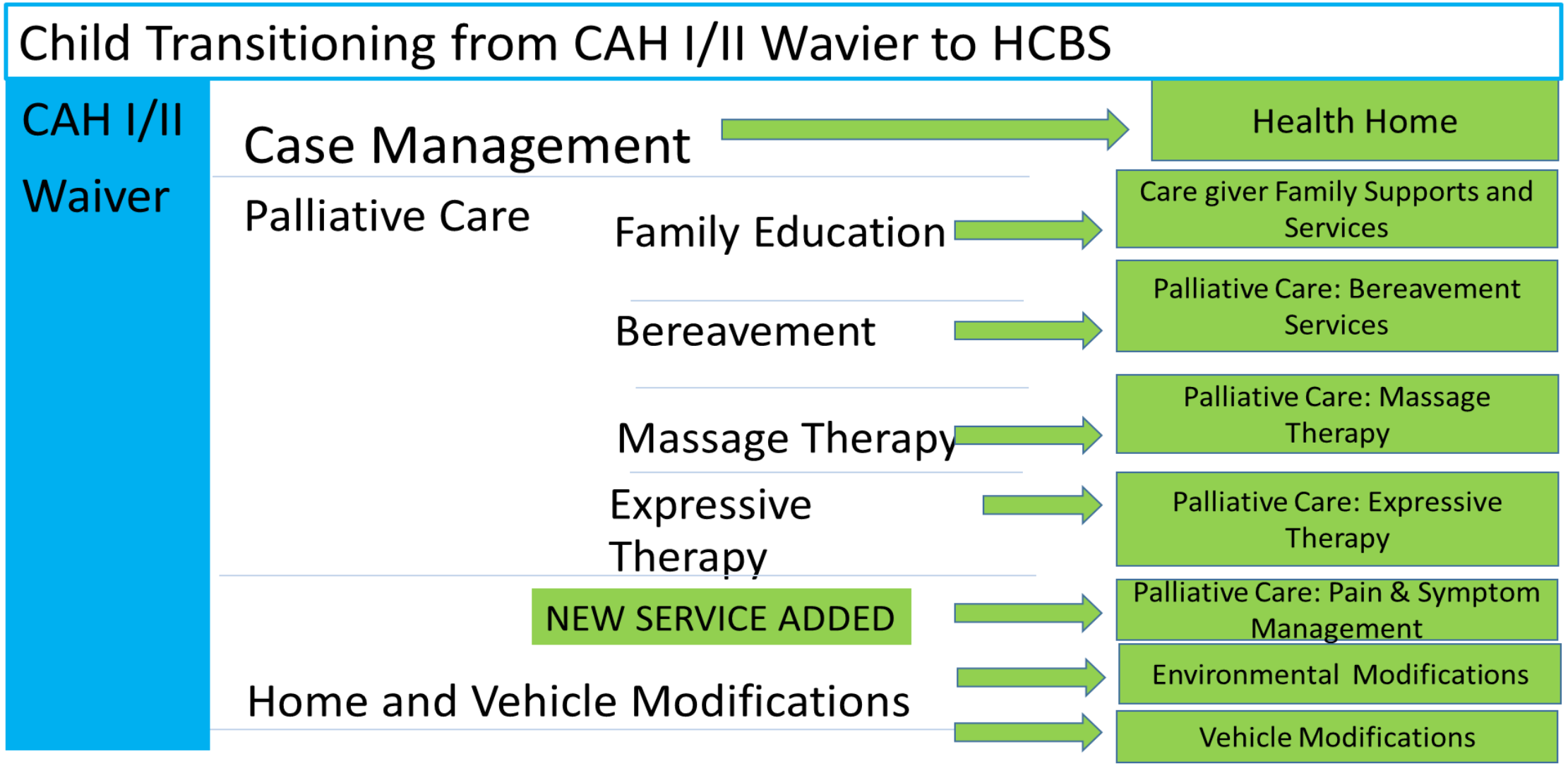
Health Homes Serving Children
List of Acronyms

- 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

Appendix

The Six Current 1915c HCBS Waiver Services Cross walked to the New Children's Waiver HCBS Array

Transition Step – Plan of Care Services Crosswalk



Continue Step – Plan of Care Services Crosswalk

Child Transitioning from OCFS B2H Waiver to HCBS

OCFS B2H Waiver		
	Health Care Integration →	Health Home Care Management
	Crisis & Planned Respite →	Respite: Crisis and Planned
	Prevocational Services →	Prevocational Services
	Family Caregiver Support Services →	Caregiver/Family Support & Services
	Supported Employment →	Supported Employment
	Special Needs Community Advocacy and Support (SNCAS) →	Community Self Advocacy Training and Support
	Day Habilitation →	Community Habilitation
	Day Habilitation →	Day Habilitation

Continue Step – Plan of Care Services Crosswalk

Child Transitioning from OCFS B2H Waiver to HCBS

OCFS B2H Waiver

Adaptive and Assistive Equipment	Adaptive and Assistive Equipment
Accessibility Modifications	Vehicle Modifications
	Environmental Modifications

Children and Family Treatment Support and Services

OCFS B2H Waiver

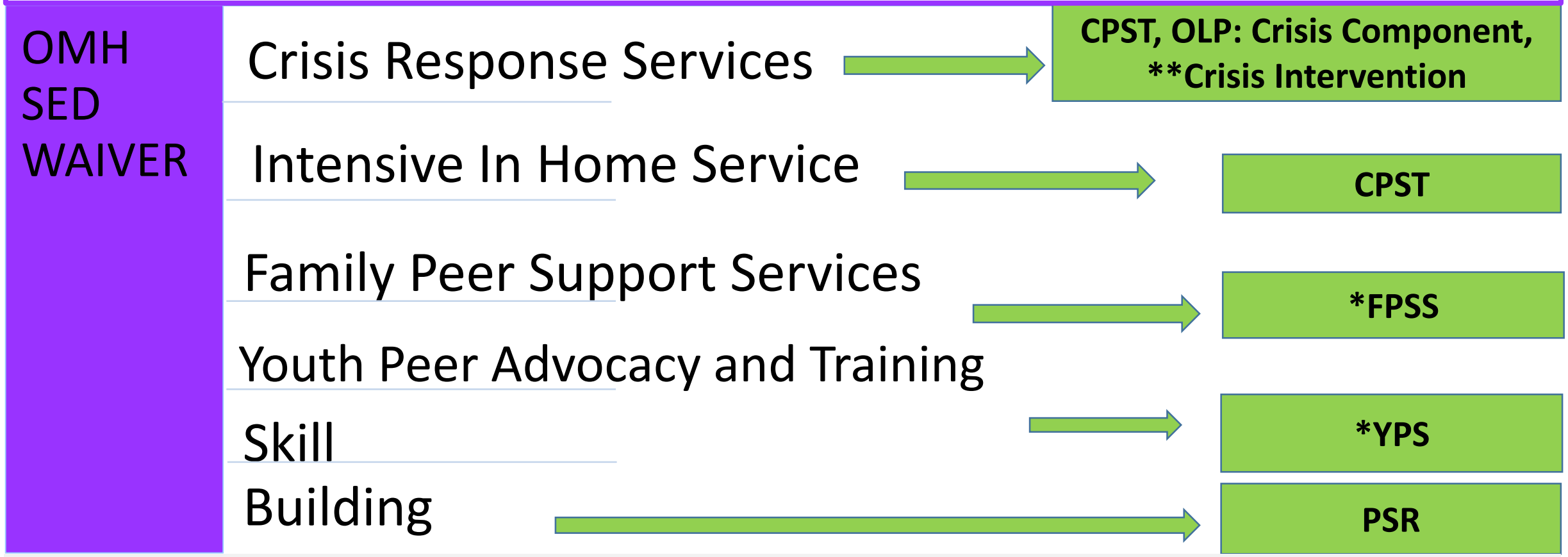
Crisis Avoidance, Management & Training	**CPST**
Immediate Crisis Response Services	**CPST, OLP: Crisis Component, **Crisis Intervention**
Skill Building	**PSR**

*From 4/1/2019 through 6/30/2019 Family Peer Support Services will be authorized under the 1915c for ALL children who are HCBS eligible. From 4/1/2019-12/31/2019 Youth Peer Supports will be authorized under the 1115 for all children who are HCBS eligible. Both services will be provided by designated providers identified with the interagency designation team and delivered consistent with the service descriptions and staff/provider qualifications outlined in the CFTSS provider manual found here:
https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/updated_spa_manual.pdf
**Crisis Intervention as defined in the CFTSS provider manual expands the qualifications, requirements and description of services beyond what today's waiver provides. Crisis Intervention as described in the CFTSS manual is scheduled for implementation on 1/1/2020.

Child Transitioning from OMH Waiver to HCBS

OMH SED WAIVER		
Individualized Care Coordination	→	Health Home
Respite Services	→	Respite: Crisis and Planned
Prevocational Services	→	Prevocational Services
Supported Employment	→	Supported Employment

Child Transitioning from OMH Waiver to CFTSS Services



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https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/updated_spa_manual.pdf
**Crisis Intervention as defined in the CFTSS provider manual expands the qualifications, requirements and description of services beyond what today's waiver provides. Crisis Intervention as described in the CFTSS manual is scheduled for implementation on 1/1/2020.

Child Transitioning from OPWDD Waiver to HCBS

OPWDD CAH WAIVER	HCBS
Case Management	Health Home
Respite	Respite: Crisis and Planned
Assistive Technology Adaptive Devices	Adaptive and Assistive Equipment
Environmental Modifications (Home Accessibility)	Vehicle Modifications Environmental Modifications

Health Home *Chronic Condition* Eligibility Criteria

- The individual **must** be enrolled in Medicaid
- Medicaid members eligible to be *Enrolled* in a Health Home **must** have:
  - Two or more chronic conditions (e.g., Substance Use Disorder, Asthma, Diabetes*) **OR**
  - One single qualifying chronic condition:
    - ✓ HIV/AIDS or
    - ✓ Serious Mental Illness (SMI) (Adults) or
    - ✓ Serious Emotional Disturbance (SED) or Complex Trauma (Children)

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

- Chronic Condition Criteria is NOT population specific (e.g., being in foster care, under 21, in juvenile justice etc. does not alone/automatically make a child eligible for Health Home)
- In addition, the Medicaid member **must** be appropriate for the intensive level of care management services provided by Health Home, i.e., satisfy appropriateness criteria

Serious Emotional Disturbance (SED)

SED Definition for Health Home - SED is a single qualifying chronic condition for Health Home and is defined as a child or adolescent (under the age of 21) that has a designated mental illness diagnosis in the following Diagnostic and Statistical Manual (DSM) categories* as defined by the most recent version of the DSM of Mental Health Disorders *AND* has experienced the following functional limitations due to emotional disturbance over the past 12 months (from the date of assessment) on a continuous or intermittent basis

*Any diagnosis in these categories can be used when evaluating a child for SED. *However, any diagnosis that is secondary to another medical condition is excluded.*

SED Definition for Health Home - Continued

Functional Limitations Requirements for SED Definition of Health Home

To meet definition of SED for Health Home the child must have experienced the following functional limitations due to emotional disturbance over the past 12 months (from the date of assessment) on a continuous or intermittent basis. The functional limitations must be **moderate in at least two** of the following areas or **severe in at least one** of the following areas as determined by a licensed mental health professional:

- Ability to care for self (e.g. personal hygiene; obtaining and eating food; dressing; avoiding injuries); or
- Family life (e.g. capacity to live in a family or family like environment; relationships with parents or substitute parents, siblings and other relatives; behavior in family setting); or
- Social relationships (e.g. establishing and maintaining friendships; interpersonal interactions with peers, neighbors and other adults; social skills; compliance with social norms; play and appropriate use of leisure time); or
- Self-direction/self-control (e.g. ability to sustain focused attention for a long enough period of time to permit completion of age-appropriate tasks; behavioral self-control; appropriate judgment and value systems; decision-making ability); or
- Ability to learn (e.g. school achievement and attendance; receptive and expressive language; relationships with teachers; behavior in school).

Complex Trauma – Single Qualifying Condition for Health Home

This guidance on complex trauma draws upon the domains within the definition of serious emotional disturbance (SED). While there may be similarities in the condition(s) and symptoms that arise in either complex trauma or SED, the therapeutic approaches associated with the same diagnoses may vary significantly when the symptoms arising from traumatic experiences are identified as such. Trauma experts indicate that with complex trauma, the clinical diagnoses may be more severe and typically present as comorbidities or multiple diagnoses.

Definition of Complex Trauma

a. The term complex trauma incorporates at least:
   i. Infants/children/or adolescents' exposure to multiple traumatic events, often of an invasive, interpersonal nature, and
   ii. the wide-ranging, long-term impact of this exposure.

b. Nature of the traumatic events:
   i. often is severe and pervasive, such as abuse or profound neglect;
   ii. usually begins early in life;
   iii. can be disruptive of the child's development and the formation of a healthy sense of self (with self-regulatory, executive functioning, self-perceptions, etc.);
   iv. often occur in the context of the child's relationship with a caregiver; and
   v. can interfere with the child's ability to form a secure attachment bond, which is considered a prerequisite for healthy social-emotional functioning.

c. Many aspects of a child's healthy physical and mental development rely on this secure attachment, a primary source of safety and stability.

d. Wide-ranging, long-term adverse effects can include impairments in:
   i. physiological responses and related neurodevelopment,
   ii. emotional responses,
   iii. cognitive processes including the ability to think, learn, and concentrate,
   iv. impulse control and other self-regulating behavior,
   v. self-image,
   vi. relationships with others and
   vii. dissociation

Process to Determine Health Home Complex Trauma Eligibility

Completed by Non-Licensed Professional or Licensed Professional w/o access to tools

- Complete the Complex Trauma Exposure Screen
- Referral Cover Sheet
- Other family and child history and information obtained
  - ➢ If positive for Complex Trauma (on Exposure Screen) – Referral can be made for HH

Eligibility determined by Licensed Professional with access to tools

- Complex Trauma Exposure Assessment Form
- Functional Impairment Assessment through the completion of the appropriate identified NCTSN guideline list of domain assessment tools
- Complex Trauma Eligibility Determination Form
- Other family and child history and information obtained
  - ➢ If positive *Determination* of Complex Trauma – Referral can be made for HH and Child is Eligible for Health Home under Complex Trauma single qualifying condition

Health Home Appropriateness Criteria

Individuals must meet the Chronic Condition Criteria AND be Appropriate for Health Home Care Management

Appropriateness Criteria: Individuals meeting the Health Home eligibility criteria must be appropriate for the intensive level of care management provided by Health Homes. Assessing whether an individual is appropriate for Health Homes includes determining if the person is:

- ✓ At risk for an adverse event (e.g., death, disability, inpatient or nursing home admission, mandated preventive services, or out of home placement)
- ✓ Has inadequate social/family/housing support, or serious disruptions in family relationships;
- ✓ Has inadequate connectivity with healthcare system;
- ✓ Does not adhere to treatments or has difficulty managing medications;
- ✓ Has recently been released from incarceration, placement, detention, or psychiatric hospitalization;
- ✓ Has deficits in activities of daily living, learning or cognition issues, or
- ✓ Is concurrently eligible or enrolled, along with either their child or caregiver, in a Health Home

Determining Health Home Eligibility

- The Health Home care manager is responsible for documenting and verifying children meet the eligibility criteria, e.g., work with health care professionals to determine and document eligibility conditions
- The State has developed a set of forms and procedures for determining if a child has complex trauma (i.e., meets the Health Home definition of complex trauma)

Overview of the Six Core Health Home Services

1. Comprehensive Care Management
   - A comprehensive health assessment that identifies medical, mental health, chemical dependency and social service needs is developed.
2. Care Coordination and Health Promotion
   - The Health Home provider is accountable for engaging and retaining Health Home members in care; coordinating and arranging for the provision of services; supporting adherence to treatment recommendations; and monitoring and evaluating a patient's needs, including prevention, wellness, medical, specialist and behavioral health treatment, care transitions, and social and community services where appropriate through the creation of an individual plan of care.
3. Comprehensive Transitional Care
   - The Health Home provider has a system in place with hospitals and residential/rehabilitation facilities in their network to provide the Health Home prompt notification of an individual's admission and/or discharge to/from an emergency room, inpatient, or residential/rehabilitation setting.

Overview of the Six Health Home Core Services

4. Patient and Family Support
   - Patient's individualized plan of care reflects patient and family or caregiver preferences, education and support for self-management, self-help recovery, and other resources as appropriate.

5. Referral to Community Supports
   - The Health Home provider identifies available community-based resources and actively manages appropriate referrals, access, engagement, follow-up and coordination of services.

6. Use of Health Information Technology (HIT) to Link Services
   Health Home providers will make use of available HIT and access data through the regional health information organization/qualified entities to conduct these processes as feasible

For detailed description of each core service please see: http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/provider_qualification_standards.htm