Transfer Process Between Health Homes and Waiver Programs for Care Management Services

When a member/participant receiving care management services chooses to receive care management services from a different program, steps must be taken to ensure a timely transition with a warm handoff. **Open communication and coordination between all parties involved is necessary for a smooth and successful transition to occur**.

Enrollment into another program should not occur until all proper steps have been taken to complete disenrollment from the current program. This document outlines the procedural steps necessary to complete the transfer of members/participants between the NYS Medicaid Health Home Program (Health Homes Serving Children and Health Homes Serving Adults) to/from Traumatic Brain Injury (TBI), Nursing Home Transition and Diversion (NHTD), or NYS Office for People With Developmental Disabilities (OPWDD) Waiver Programs.

When there is a request by/on behalf of the member/participant to transfer from one program to the other, it is important that the current care manager/service coordinator explains the various options, services, providers, and eligibility processes to the member/participant to ensure an informed decision is made. Proper consent should be obtained from the member/participant while planning for transition to ensure that the current care manager/service coordinator can share all the necessary information with the parties outlined below assisting in the transition process.

Health Homes (HH), Regional Resource Development Centers (RRDC), Developmental Disabilities Regional Offices (DDRO) must ensure that a member/participant's eligibility status is reviewed in ePaces/eMedNY before proceeding with a transfer request. This is especially important in the event the member/participant initiates transfer to another program without notifying their care manager/service coordinator first. In the event an issue is identified that could affect the transfer, the member/participant must be informed.

The current care manager/service coordinator will continue to work with the member/participant using the current Plan of Care (POC) while transitional activities are occurring to guarantee no disruption in services occurs. The current care manager/service coordinator will document all activities conducted to support the transition in the member/participant's care management record, and also document eligibility and services in the member/participant's POC.

Throughout the transition process, if the member/participant remains eligible for his or her current services/waiver, enrollment should be maintained until such time the member/participant is found eligible for the new program/waiver to ensure no gap in service occurs. Once eligibility and availability for the new program/waiver is confirmed, the transition to the new program/waiver can occur. The existing care manager/service coordinator and the new care manager/service coordinator must coordinate the transfer to ensure a specific timeframe and date for the transfer is established and communicated to the member/participant. This will also ensure that proper steps were taken to support billing for the receiving program/waiver

Definitions

Member: A person (adult or child) enrolled in the Health Home Program and CCO/HHs.

Participant: A person enrolled in the NHTD or TBI waiver.

NOTE: Use of *Member* and *Participant* includes the individual's parent(s), guardian and/or legally authorized representative, as appropriate.

A. Transfer of an Enrolled Health Home Member to a Waiver

1. The HHCM will obtain consent from the HH member to initiate a referral to a Waiver Program.

2. The HHCM notifies the Waiver Program contact (e.g. Developmental Disabilities Regional Office (DDRO) for OPWDD, or the Regional Resource Developmental Center (RRDC) for NHTD and TBI) via the Health Commerce System (HCS) secure file transfer that the member is interested in services under a specific Waiver of choice. This request must include the following: member's name, Client Identification Number (CIN), date of birth (DOB), and reasons why the change is being pursued (e.g., member choice, no-longer meets Health Home Program eligibility criteria, etc.).

   A listing of the **Regional Resource Development Centers (RRDC)** serving Nursing Home Transition and Diversion (NHTD) Waiver Program *and* Traumatic Brain Injury (TBI) Waiver Program participants can be found on the last two pages of this document.

   A listing of OPWDD's **Front Door Contact Numbers** can be accessed via the OPWDD website at: https://opwdd.ny.gov/contact-us

3. The HHCM schedules a phone conference with the receiving Waiver program to provide an overview of the next steps. The member must be invited to participate in this call.

4. If the member is pursuing enrollment into the OPWDD waiver/CCOHH and already has the Developmental Disability eligibility requirements established, proceed directly to **Step 6** below.

5. If the member/participant does not have Waiver eligibility established and a current Level of Care Eligibility Determination (LCED), the HHCM will work closely with the Waiver program contact (DDRO or RRDC) to coordinate and assist with eligibility and documentation requirements.

6. The receiving Waiver program will provide information on available agencies and coordinate with the HHCM to support the member's transition to the new Waiver. Once agency selection is made by the member the Waiver program will proceed with the process.

7. The HHCM will assist where necessary, in gathering information needed to complete the receiving Waiver's application, as follows:

   For NHTD:
   Refer to the *Nursing Home Transition and Diversion Medicaid Waiver Program Manual at:*
   https://www.health.ny.gov/facilities/long_term_care/nhtd/docs/manual.pdf

   For TBI:
   Refer to the *Traumatic Brain Injury Program Manual* at:
   https://www.health.ny.gov/health_care/medicaid/reference/tbi/

   For OPWDD:
   Refer to the document, *Transfer Process between Children's and OPWDD Comprehensive Waiver for Care Management and Waiver Services* at:
   https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/transfer_process_childrens_and_opwdd_comprehensive_waiver.pdf - Follow Step #5 - Completion of the OPWDD Comprehensive Waiver Application (on page 2).

8. The receiving Waiver program will review the application packet for completeness and when satisfactorily met, will confirm eligibility.

   NOTE: In the event the member/participant does not meet eligibility requirements for the chosen Waiver program, the HHCM will notify the member and discuss any other options available to the member.

9. The HHCM will document in the case record the choice of Waiver agency and other relevant information regarding the transfer decision and process.

10. The HHCM will provide the member's current Health Home Plan of Care (POC) to the Waiver program contact (DDRO or RRDC).

11. The HHCM will notify the member's care team of their choice to transition.

12. The receiving Waiver program will notify the HHCM and the member and establish an effective transfer date. (The effective date of the transfer must be a future date and must be the first of the month).

13. The HHCM must follow procedures as outlined in Health Home Program policy, Member Disenrollment From the Health Home Program #HH0007 (e.g., provide appropriate written notification to the member regarding his/her disenrollment; DOH 5204, etc.). The receiving Waiver program issues the appropriate form(s) documenting enrollment (e.g.Notice of Determination/Notice of Decision).

14. The HHCM will end the member's enrollment within their EHR/MAPP HHTS with

appropriate transition date to allow for billing and payment by the receiving Waiver program.

a. **Coding Changes for the Transfer From the Health Home Program –** effective the last day of the month in which the member discharges from the HH Program. HHCM ends MAPP segment (Recipient Restriction Exception Code RRE 'A' Codes) .This can and should be done in advance of the agreed upon end date (last day of the month). Health Homes should continue to serve the member until the end of the month but should not wait until then to end the segment in MAPP HHTS. Ending the segment in advance will not affect the member's enrollment through the end of the month but will serve to ensure that the 'A' codes show in eMedNY as ended, thereby allowing the receiving program to enter their codes for the first day of the following month.

b. **Coding Changes for Transfer into the Receiving Waiver Program** – effective the first day of the month immediately following the month of discharge from the Health Home program.

   The receiving Waiver program must follow their existing protocols for having the associated RRE code entered into eMedNY.

   NOTE: Waiver codes cannot be entered into eMedNY until the Member's Health Home codes are ended.

15. The member/participant is enrolled in the receiving Waiver program. All Health Home care management services end.

B. Transfer of an Enrolled Waiver Participant to the Health Home Program

1. The service coordinator/care manager from the Waiver Program will obtain consent from the participant/member to initiate a referral to a Health Home Program.

2. The service coordinator/care manager from the Waiver program must notify the Health Home serving within the region where the participant/member resides or receives the majority of healthcare services/care via HCS; or, contact the participant/member's Medicaid Managed Care Plan directly of the member/participant's choice to be referred to the Health Home Program. The MMCP will move the referral on to the appropriate HH. The referral must include the following: member/participant's name, CIN, DOB, and reasons why the change is being pursued (e.g., member/participant's choice).

   A listing of Health Homes by county and contact information can be accessed via the Department's *FIND A HEALTH HOME* page at: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_map/index.htm

   A listing of *Managed Care Plan Contacts for Health Homes and Care Management*

Agencies can be accessed at: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/managed_care/mc_hh_contacts.htm

3. Once the Health Home confirms receipt of the referral, the Care Management Agency (CMA) will be assigned. The CMA/HHCM will contact the Waiver program (RRDC or DDRO) and request any required information and documentation be sent by the Waiver program via the HCS.

4. The CMA/HHCM confirms eligibility requirements have been met.

   a. If the member/participant is eligible for HH enrollment the HHCM notifies the service coordinator/care coordinator and proceeds with required activities to support transition (proceed to Step 5).

   b. In the event the member/participant is determined **not** to be eligible for HH enrollment, the HHCM must notify the member/participant and the Waiver program contact. The HHCM will then issue the Notice of Determination for Denial of Enrollment in the New York State Health Home Program (DOH 5236)

5. The Waiver program will schedule a phone conference with the CMA/HHCM to provide an overview of the next steps that need to occur and collaboratively agree upon a transfer date. The member/participant must be invited to participate in the call.

   NOTE: The date of Health Home enrollment will occur on the first day of the month as agreed upon for the transition.

6. The HHCM works with the member/participant to complete the appropriate Health Home consent form(s) required for enrollment (e.g., DOH 5055, DOH 5201 and FAQs, and DOH 5203).

7. The Waiver program will provide the HHCM with the member/participant's current Plan of Care/Life Plan.

8. The Waiver program issues the appropriate form to disenroll their participant/member from the waiver as follows

   For NHTD: *Notice of Intent to Discontinue from the Waiver Program*

   For TBI: *Notice of Intent to Discontinue from the Waiver Program*

   For OPWDD: For members enrolled in a CCO/HH, the appropriate procedures must be followed related to withdrawing consent (adults/children).

9. The HH/CMA must issue the *Notice of Determination for Enrollment in the New York State Health Home Program* (DOH 5234).

10. The Waiver program will end the member/participant's enrollment with appropriate transition date to allow for billing and payment by the Health Home program.

    a. Coding Changes for the Transfer from a Waiver Program – effective the last day of the month in which the member/participant was discharged from the Waiver program.
        - The waiver must end their associated RRE code in eMedNY to reflect the last day of the month in which the discharge occurs.

11. HH will start the enrollment segment as follows:

    b. Coding Changes for the Transfer into the Health Home Program – effective the first day of the month immediately following the month of discharge from the Waiver program.
        - HHCM must open an enrollment segment in MAPP HHTS with a start date reflecting the first day of the month of enrollment into the Health Home program. (The HH RRE codes A1 and A2, appear in eMedNY generally within two days).

    NOTE: Health Home RRE codes cannot be entered into eMedNY until the member/participant's Waiver code is ended.

12. The member/participant is now enrolled in the HH program and therefore, the HHCM may now provide care management services to the member.

NEW YORK STATE DEPARTMENT OF HEALTH – DIVISION OF LONG TERM CARE
Nursing Home Transition and Diversion (NHTD) Waiver Program and
Traumatic Brain Injury (TBI) Waiver Program
Regional Resource Development Center (RRDC) Contact List (updated: 8/26/21)

Region & Counties Served	Regional Resource Development Center
Adirondack Region: Fulton, Montgomery, Saratoga, Washington, Warren, Hamilton, Essex, Franklin and Clinton	**Glens Falls Independent Living Center** **d/b/a Southern Adirondack Independent Living (SAIL)** 71 Glenwood Avenue Queensbury, NY 12804 **Phone: (518) 792-3537** **Fax: (518) 792-0979** www.sailhelps.org
Binghamton/Southern Tier Region: Broome, Steuben, Schuyler, Tioga, Delaware, Tompkins, Cortland, Chenango, Cayuga, Chemung, Allegany and Otsego	**Southern Tier Independence Center (STIC)** 135 East Frederick Street Binghamton, NY 13904 **Phone: (607) 724-2111** **Fax: (607) 772-3617 or 607-772-3609** www.stic-cil.org
Buffalo Region: Erie, Chautauqua, Cattaraugus, Wyoming, Orleans and Niagara	**Headway of Western New York, Inc.** 2635 Delaware Avenue, Suite E Buffalo, NY 14216 **Phone: (716) 408-3120** **Fax: (716) 882-1289 or (716) 817-2530** www.headwayofwny.org
Capital Region: Albany, Schenectady, Greene, Rensselaer, Schoharie and Columbia	**Sunnyview Hospital and Rehabilitation** 1270 Belmont Avenue Schenectady, NY 12308 **Phone: (518) 382-4559** **Fax: (518) 386-3519** www.sunnyview.org
Long Island Region: Nassau and Suffolk	**Self-Initiated Living Options, Inc.** **Suffolk Independent Living Organization (SILO)** 3253 Route 112, Building 10 Medford, NY 11763 **Phone: (631) 320-1662 or (631) 880-7929** **Fax: (631) 320-1664** www.siloinc.org

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Nursing Home Transition and Diversion (NHTD) Waiver Program and
Traumatic Brain Injury (TBI) Waiver Program
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Region & Counties Served	Regional Resource Development Center
Lower Hudson Valley Region: Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster and Westchester	**Westchester Independent Living Center (WILC)** 10 County Center Road White Plains, NY 10607 **914-682-3926 (Westchester Office)** **914-682-8518 (Westchester Fax)** **Putnam Independent Living Services** 1441 Route 22, Suite 204 Brewster, NY 10509 **Phone: (845) 228-7457 (Putnam Office)** **Fax: (845) 228-7460 (Putnam Fax)** www.putnamils.org or www.wilc.org
New York City: New York, Bronx, Kings, Queens and Richmond	**Westchester Independent Living Center (WILC)** 10 County Center Road White Plains, NY 10607 **Phone: (718) 816-3555** **Fax: (718) 816-3560** www.wilc.org
Rochester Region: Monroe, Wayne, Ontario, Seneca, Genesee, Livingston and Yates	**Rochester Regional Health System** Unity Health – St. Mary's Campus, 5th Floor 89 Genesee Street Rochester, NY 14611 **Phone (585) 368-3766** **Fax: (585) 368-3567**
Syracuse Region: Onondaga, Madison, Herkimer, Oneida, Oswego, Lewis, Jefferson and St. Lawrence	**ARISE Child and Family Service, Inc.** 635 James Street Syracuse, NY 13203 **Phone (315) 472-3171** **Fax: (315) 671-2936** www.ariseinc.org