



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

New York Children's Health and Behavioral Health Benefits

Draft Final Transition Plan for the Children's Medicaid Health and Behavioral Health System Transformation

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Draft Final Transition Plan for the Children's Medicaid Health and Behavioral Health System Transformation

A. Overview

The State has been working with CMS to implement the Children's Medicaid System Transformation. On May 9, 2017, the State submitted to CMS a proposed 1115 Waiver Amendment and on November 14, 2017, the State submitted to CMS a Draft Transition Plan (which included comments from stakeholders) to implement the proposed 1115 Waiver Amendment. In April 2018, the State submitted to CMS a revised 1115 Waiver Amendment (April 24, 2018) and a revised Draft Transition Plan (April 30, 2018) to reflect changes to the timeline for implementing the Children's Medicaid System Transformation. On June 21, 2018, CMS advised the State that 1915 waiver vehicles, rather than the sole use of the 1115 Waiver Amendment, must be used to implement the Children's Medicaid System Transformation. As a result, the State is now proposing the Children's Medicaid System Transformation be implemented under concurrent 1915(c) waiver and 1115 waiver amendments.

This revision of the Draft Transition Plan updates the previous version that was submitted to CMS and made available to stakeholders on April 30, 2018, to reflect the proposed concurrent 1915(c) and 1115 waiver amendment approach to implement the Children's Transformation. This Draft Transition Plan, as well as the concurrent waivers and implementation timelines, require the approval of CMS and therefore may be subject to further modifications.

Overview of Concurrent 1915(c) Children's Waiver and 1115 Waivers

Effective no earlier than April 1, 2019, the following six 1915(c) Home and Community Based Services (HCBS) waivers will be consolidated into a single, 1915(c) Children's Waiver:

- Office of Mental Health (OMH) Serious Emotional Disturbance (SED) waiver #NY.0296;
- Department of Health (DOH) Care at Home (CAH) I/II waiver #NY.4125;
- Office for People with Developmental Disabilities (OPWDD) Care at Home waiver #40176; and
- Office of Children and Families (OCFS) Bridges to Health (B2H) SED waiver #NY.0469, B2H Developmental Disability (DD) waiver #NY.0470, and B2H Medically Fragile waiver #NY.0471.

The 1915(c) Children's Waiver will:

- Streamline the children's HCBS administration to have more consistent eligibility processes and benefits across all populations.

- Provide a single HCBS benefit package to children meeting institutional level of care (LOC) functional criteria. Over a three-year period, eliminate the use of waiting lists related to HCBS capacity under the waiver. All of the HCBS services authorized under the six current 1915(c) children's waivers will continue to be authorized as either an HCBS authorized under the 1915(c) Children's Waiver or a new State Plan service. (See Attachments B and E).
- Provide Health Home care management to children eligible for HCBS and an administrative alternative for children that may opt of Health Home. Children currently enrolled in one of the six 1915(c) waivers will begin to transition to Health Home no earlier than January 1, 2019.

The 1915(c) Children's Waiver is also available to the public on-line at https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/1115_waiver_amend.htm

The 1115 waiver, which will be implemented concurrently with the 1915(c) Children's Waiver will:

- Incorporate certain Medicaid State Plan behavioral health services into the Mainstream Medicaid Managed Care and HIV Special Needs Plan benefit packages for enrollees under age 21.
- Include newly aligned children's HCBS authorized under the 1915(c) Children's Waiver in the Mainstream Medicaid managed care and HIV Special Needs Plan benefit package.
- Remove the exemption from mandatory enrollment into Mainstream managed care for children in the 1915(c) Children's Waiver, unless the child is otherwise exempt or excluded from enrollment. e.g., available comprehensive Third Party Health Insurance and/or Medicare, or Medically Needy child who is provisionally eligible. Children who are otherwise exempt or excluded from enrollment into Mainstream managed care and who are enrolled in the 1915(c) Children's waiver will receive Medicaid services, including aligned children's HCBS through the FFS delivery system.,
- Offer State Plan CFCO services to LOC children eligible for Medicaid solely because of receipt of HCBS (i.e., Family-of-One children not eligible under the State Plan but who meet institutional admission criteria and receive aligned children's HCBS).
- No earlier than July 2019, remove the exclusion from Medicaid managed care enrollment for children in the care of a voluntary foster care agency, and include Residential Supports and Services (to be authorized under a separate State Plan Amendment) in mainstream Medicaid managed care and HIV Special Needs Plan benefit package.
- Authorize transitional rates for waiver providers under six children's 1915(c) waivers that will transition from waiver care management rates to Health Home rates. Provide conflict free case management for children receiving aligned children's HCBS and Health Home care management.

- Authorize Family Peer, Youth Peer, and Crisis Intervention to HCBS eligible children between April 1, 2019 and the dates those services become State Plan services (July 1, 2019 for Family Peer and January 1, 2020 for Youth Peer and Crisis Intervention).
- No earlier than 2022, expand Medicaid services to offer an HCBS benefit package identical to the 1115 HCBS package (but not including State Plan CFCO services) to children that meet targeting criteria and having functional needs at-risk of institutional care under the Demonstration, i.e., “at-risk” HCBS Level of Need (LON) services.

The 1115 waiver amendment continues to be available to the public at:

<https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ny/ny-medicaid-rdsqn-team-pa.pdf>. AND https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/child_1115_waiver_amend.pdf. No programmatic changes are proposed to that public submission. Only the authorities requested to implement the amendment are changing

B. Major Objectives

1. Health Home Care Management for Children

Health Home is a care management model for individuals enrolled in Medicaid with chronic conditions, including complex medical and/or behavioral health needs. Health Home care managers are responsible for developing a person-centered, family and youth driven, comprehensive care plan that includes all the medical, behavioral health (mental health and substance use) and community and social supports and services the member needs. There are 16 Health Homes that have been designated to provide Health Home care management to children. Health Homes for children began operating in December of 2016. A list of Health Homes designated to serve children, and their contact information can be found at:

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_children_designations.pdf

Children who are eligible for and receive HCBS are required to have a care plan and receive care management. Children who are eligible for HCBS will be eligible for, and receive, Health Home care management, as authorized under the State Plan. This includes children who now receive HCBS from one of the six children’s 1915(c) waiver programs that will transition to and receive newly aligned HCBS under the new 1915(c) Children’s Waiver and children who are

now enrolled in Health Homes or Medicaid that will meet HCBS Eligibility criteria and receive aligned children's HCBS under the 1915(c) Children's Waiver.

Providers and Care Management agencies that provide care management to children under the 1915(c) waivers will transition to Health Home care management (e.g., contract with Health Homes to provide Health Home care management). This will ensure the expertise of the 1915(c) care managers and agencies is transferred to the Health Home program and will preserve continuity of care by providing children transitioning from the six 1915(c) children's waivers to Health Home care management the option to continue to work with their current care manager and agency (see [Section II.A](#) for more details).

Health Homes will develop one comprehensive plan of care that includes HCBS, as well as all the other services the member needs (e.g., health, behavioral health, specialty services, other community and social supports, etc.).

As described in Section II.C in more detail, additional continuity of care protections will ensure transition to the 1915(c) Children's Waiver, including the new array of aligned children's HCBS and Health Home care management, as well as the transition to managed care through the removal of the exemption from mandatory enrollment in managed care for children in the 1915(c) Children's Waiver through the concurrent 1115 waiver, does not disrupt receipt of services for children currently enrolled in the six 1915(c) waiver programs.

For Medicaid enrolled children, Health Homes will be responsible for determining and documenting HCBS eligibility. Members eligible for HCBS must meet target population, risk factor, and functional criteria.

Please see the [Health Homes Serving Children homepage](#) for more information on the implementation of the program, and Health Home standards and requirements for serving children.

2. New State Plan Services and Alignment of Children's HCBS

Beginning January 1, 2019, Other Licensed Practitioners, Community Psychiatric Support and Treatment, and Psychosocial Rehabilitation Supports will be implemented; beginning July 1, 2019, Family Peer Support Services will be implemented; and beginning January 1, 2020 Crisis Intervention and Youth Peer Support and Training will be implemented. Children receiving HCBS services similar to the new State Plan services of Family Peer Support Services, Youth Peer Support and Training and Crisis Intervention under the former 1915(c) waivers will continue to receive these services. To ensure continuity of care and

maintain system capacity, the Concurrent 1115 MRT Waiver will authorize Family Peer, Youth Peer, and Crisis Intervention to HCBS eligible children between April 1, 2019 and the dates those services become State Plan services (July 1, 2019 for Family Peer and January 1, 2020 for Youth Peer and Crisis intervention). These services and implementation timeline are listed in [Attachment A](#). Beginning April 1, 2019, with the transition of the 1915(c) waivers to the Concurrent 1115 MRT Waiver and Children's 1915(c) Waiver authority, the State will provide the newly aligned children's HCBS to children transitioning from and enrolled in 1915(c) Waiver programs.

Under the State's Transition Plan and in preparation for the April 1, 2019 implementation and effective date of the 1915(c) Children's Waiver, between January 1, 2019 and March 31, 2019, all 1915(c) Transitioning Children (i.e., children currently enrolled in one of the six 1915(c) waivers), will transition to Health Home Care Management.

On and after April 1, 2019, HCBS eligibility will be determined using new target population, risk factor and functional eligibility criteria.

The State will offer the newly aligned HCBS to newly eligible children who meet LOC criteria between April 1, 2019 and July 1, 2019 based on combined capacity under the current waivers (See section II.B).

Beginning on July 1, 2019, expansion beyond the current waivers for newly eligible children meeting Level of Care (LOC) criteria will begin and is anticipated to be phased in over a three-year period, subject to the availability of Global Cap Resources. For a complete list of services transitioning, refer to [Attachment B](#).

To manage the capacity under the current waivers and the expansion of HCBS for children that meet LOC that will begin on July 1, 2019, the State will use a centrally maintained statewide list of children who have been identified as eligible, but due to capacity limitations are unable to access HCBS at the time of eligibility.

Health Homes will make HCBS Eligibility Determinations (i.e., work with providers to determine and document if members meet target population, risk factors, and functional criteria) for children who are covered by Medicaid and who may be eligible for HCBS. A State-contracted Independent Entity (IE) will make HCBS Eligibility Determinations for children who are not enrolled in Medicaid and who may be eligible for HCBS.

The newly aligned children's HCBS will be available through both the fee for service (FFS) and managed care delivery systems. Care coordination provided under the 1915(c) waivers will be fully transitioned to Health Home care management by 3/31/2019.

Members who opt out of Health Home care management will be referred to the State Independent Entity who will develop HCBS plan of care and arrange for HCBS (see [Section II.A.4](#) for more details).

3. Transition of Populations into Medicaid Managed Care (Mainstream or HIV Special Needs Plan)

On April 1, 2019, the authority for the provision of HCBS provided under the following six 1915(c) waivers will transition to the Concurrent 1115 MRT Waiver and Children's 1915(c) Waiver:

- SED 1915(c) waiver (NY.0296)
- DOH Care at Home (CAH) I/II 1915(c) waiver (NY.4125)
- OPWDD Care at Home 1915(c) waiver (NY.40176)
- OCFS Bridges to Health (B2H) SED 1915(c) waiver (NY.0469)
- OCFS B2H Medically Fragile 1915(c) waiver (NY.0471)
- OCFS B2H DD 1915(c) waiver (NY.0470)

Under the Concurrent 1115 MRT Waiver and Children's 1915(c) Waiver, beginning April 1, 2019 statewide, children/youth who were exempt from enrollment in Medicaid managed care because they participated in one of the above 1915(c) waivers, will be required to enroll in a Medicaid Managed Care Plan (MMCP) and receive services from the Medicaid managed care delivery system (this does not include children/ youth currently in B2H who are also placed in Foster Care).

Beginning July 1, 2019 statewide, children/youth in the care of a Voluntary Foster Care Agency, and children/youth in direct care of the LDSS who are also in receipt of aligned children's HCBS, will be required to enroll in a Medicaid Managed Care Plan and receive services from the Medicaid managed care delivery system.

Following full implementation of the transition of existing 1915(c) Waiver participants and LOC a new demonstration expansion population, called at-risk HCBS level of need (LON) population, including community eligible LON

individuals and Medicaid Family of One individuals will be available no earlier than January 2022.

No other population exemptions or exclusions indicated in New York's 1115 Special Terms and Conditions (STCs) will be changed as part of this transition.

Children/youth who are otherwise excluded from enrollment in a Medicaid Managed Care Plan, will continue to receive Medicaid benefits, including Health Home care management, the six new State Plan services and the aligned children's HCBS, from the Medicaid fee-for-service delivery system.

Children/youth who are otherwise exempt from enrollment in a Medicaid Managed Care Plan will continue to have the option of enrolling in an MMCP or receiving Medicaid benefits from the Medicaid fee-for-service delivery system.

4. Transition of State Plan and Concurrent 1115 & Children's 1915(c) Waiver Services into Medicaid Managed Care

Beginning January 1, 2019, three of the six new children's State Plan services (Other Licensed Practitioners, Community Psychiatric Support and Treatment, and Psychosocial Rehabilitation Supports) will take effect and be included in the Medicaid Managed Care Plan benefit package, for children under 21 years of age who meet medical necessity criteria. Beginning July 1, 2019, Family Peer Support Services will be implemented; and beginning January 1, 2020 Crisis Intervention and Youth Peer Support and Training will be implemented. Children may have been receiving HCBS services similar to the new State Plan services of Family Peer Support Services, Youth Peer Support and Training and Crisis Intervention under the former 1915(c) waivers. To ensure continuity and maintain system capacity, the Concurrent 1115 MRT Waiver will authorize Family Peer, Youth Peer, and Crisis Intervention to HCBS eligible children between April 1, 2019 and the dates those services become State Plan services (July 1, 2019 for Family Peer and January 1, 2020 for Youth Peer and Crisis Intervention).

These services and the implementation timeline are listed in [Attachment A](#).

Beginning April 1, 2019, the newly aligned children's HCBS will be included in the Medicaid Managed Care Plan benefit.

Beginning July 1, 2019, Medicaid Managed Care Plans will be responsible for providing previously carved-out behavioral health services for enrollees under 21 years of age. See [Attachment C](#).

5. Transition of Children in the Care of Voluntary Foster Care Agencies (VFCA) and Children in Receipt of HCBS Placed in Foster Care into Managed Care

On July 1, 2019, the State will remove the exclusion from enrollment in Medicaid managed care for children in the care of a Voluntary Foster Care Agency (VFCA). As of that date, children in VFCAs and children in direct care of the LDSS who are also in receipt of aligned children’s HCBS, will be mandated to enroll in Medicaid Managed Care to access Medicaid services (unless otherwise exempt or excluded from Medicaid managed care). As described in [Section II.D](#), continuity of care protections will ensure these children continue to access needed services, even when placed outside of the MMCP’s service area.

Beginning July 1, 2019, Medicaid Managed Care Plans will be responsible for provision of aligned HCBS for children placed in foster care in the direct care of the LDSS. Beginning July 1, 2019, Medicaid Managed Care Plans will be responsible for reimbursing VFCAs for Medicaid costs incurred by VFCAs to meet State and Federal child welfare requirements. As described in [Section IV.F](#), the State is facilitating contracting between VFCAs and managed care plans by licensing VFCAs. In addition, the State is developing a proposed State Plan Amendment to authorize a VFCA “Residual Per Diem” that will be paid to the VFCAs by Medicaid Managed Care Plans for certain Medicaid costs incurred by the VFCA (primarily staffing costs) to meet child welfare requirements that are not “transferable” to a Medicaid Managed Care capitated rate.

The chart below summarizes the transition HCBS for and enrollment of children placed in foster care into Medicaid Managed Care.

Population	HCBS Benefit Transitions to Aligned Children’s HCBS under the Concurrent Waiver; provided through FFS	Aligned Children’s HCBS Benefit Transitions to MMC	Population enrolled in MMC**
Current and new children placed in foster care in direct care of the LDSS without B2H/HCBS	N/A	N/A	4/1/2013
Current children placed in foster care in the direct care of the LDSS and in B2H	1/1/2019	7/1/2019	7/1/2019

New children placed in foster care in the direct care of the LDSS and in need of HCBS	1/1/2019*	7/1/2019	7/1/2019
Current and new children in the care VFCA without B2H/HCBS	N/A	N/A	7/1/2019
Current children in care of VFCA with B2H	1/1/2019	7/1/2019	7/1/2019
New children placed in care of VFCA and in need of HCBS	1/1/2019*	7/1/2019	7/1/2019
Current children discharged from foster care and in B2H	N/A	4/1/2019	4/1/2019
New children discharged from foster care and in need of HCBS	N/A	4/1/2019*	4/1/2019

*in accordance with the State’s capacity management system

**required to enroll unless the individual is otherwise exempt or excluded from Medicaid Managed Care.

C. Transition Team

The State has developed a transition team that comprises the Department of Health, Office of Mental Health, Office of Children and Family Services, Office for People With Developmental Disabilities, and Office of Alcoholism and Substance Abuse Services. This transition team routinely solicits feedback from Children’s Health and Behavioral Health Medicaid Redesign Team Subcommittee and external stakeholders and will continue to do so throughout the transition period. In addition, throughout the transition period, the State will hold webinars, and in-person meetings to educate stakeholders regarding the processes to implement the provisions of the Concurrent Waiver amendment. This draft document was posted online for stakeholder comment and this version reflects feedback provided during that comment period. The State will continue to meet (at least monthly) with the MRT Children’s Behavioral Health and Health Subcommittee, Medicaid Managed Care Plans and Health Home providers.

D. Legal Authority

The State has reviewed New York State law and regulation to assure consistency with the Children’s transition. Current New York State law authorizes the State to qualify Health Maintenance Organizations to serve Medicaid enrollees and to mandatorily enroll (with some exceptions) Medicaid eligible individuals in qualified Medicaid Managed Care Plans. An amendment to Title 18 NYCRR Part 505 was published for public comment in the New York State Register on July 12, 2017, codifying provision of the six new children’s State Plan services and authorizing State designation of service

providers for the children's State Plan services. This regulation was promulgated on January 3, 2018.

The Concurrent 1115 MRT Waiver and 1915(c) Children's Waiver and State Plan Amendments for the six new services are subject to federal CMS approvals.

II. 1915(c) Transitioning Children into State Plan and Concurrent Waiver Services

A. Informed, Transparent and Seamless Transition for Children Enrolled in One of the Six 1915(c) Waiver Programs

Children receiving services through one of the following six 1915(c) waiver programs will transition to the new children's State Plan or aligned children's HCBS by a series of carefully organized and communicated steps, throughout which children and families will be well informed of their options and rights, and experience no interruption of care.

- OMH SED 1915(c) waiver (NY.0296)
- DOH Care at Home I/II 1915(c) waiver (NY.4125)
- OPWDD Care at Home 1915(c) waiver (NY.40176)
- OCFS B2H SED 1915(c) waiver (NY.0469)
- OCFS B2H Medically Fragile 1915(c) waiver (NY.0471)
- OCFS B2H DD 1915(c) waiver (NY.0470)

Throughout this document "1915(c) Transitioning Children" means children transitioning from one of the six 1915(c) waiver programs to new children's Medicaid State Plan or the newly aligned children's HCBS beginning on January 1, 2019 or April 1, 2019, respectively.

Continuity of care protections will ensure 1915(c) Transitioning Children maintain eligibility for HCBS and retain level of service and maintain provider relationships as they transition to the managed care delivery system. Throughout the transition and thereafter, the State will closely monitor the transition to ensure access to Medicaid and services are appropriately preserved (see [Section VI](#)). Children/families and providers can report issues and/or file complaints to the State, their MMCO, the Health Home, or the Independent Entity for resolution of their concerns.

1. Consumer Engagement

During 2017 (and even well before that) the State has been engaging consumers on the transition, and will continue to do so throughout the transition process.

The State will continue to hold community forums and webinars and provide educational materials, fact sheets and public question and answer sessions to announce and explain the provisions and Transition Plan for the Children's Medicaid Health and Behavioral Health System Transformation.

2. Federal Authority Change

Pending federal approval, authority for aligned children's HCBS under the Children's 1915(c) Waiver will begin on April 1, 2019. The last day for service provision under the six 1915(c) waiver programs will be March 31, 2019. The State will send notice to beneficiaries and to CMS regarding termination of the five 1915(c) waivers and transfer to waiver #NY.4125 at least 30 days in advance of the requested effective date.

On April 1, 2019, all 1915(c) Transitioning Children will seamlessly transition to the new aligned children's HCBS.

Children transitioning from one of the six 1915(c) waiver programs may continue to access their current care coordination agency. As described in more detail below, the current care coordination providers under the 1915(c) waivers will transition to Health Home care management. This will provide children transitioning from the 1915(c) the option to keep their current care coordination agency as they transition to Health Home Care Management.

Under the State's Transition Plan and in preparation for the April 1, 2019 implementation, between January 1, 2019 and March 31, 2019, all 1915(c) Transitioning Children will transition to Health Home Care Management, with the consent of the child/parent, guardian, or legally authorized representative. Transitioning children that have been working with a 1915(c) waiver care coordinator that has transitioned to Health Home will not need to change care managers. If consent to enroll in Health Home is obtained, then the Health Home care manager will develop a Health Home Comprehensive Plan of Care and arrange for HCBS to continue. The Health Home care manager may also begin preliminary care planning around the new services that will be made available April 1, 2019. During the Transition Process, a Health Home Comprehensive Plan of Care that includes HCBS will continue authorization of HCBS.

All existing current 1915(c) services the child receives will be cross walked in the Health Home comprehensive plan of care to either new children's State Plan services or aligned children's HCBS in the child's plan of care. The Health Home

plan of care will allow authorization for 1915(c) HCBS through March 31, 2019, and will remain in place when services change to 1915(c) Waiver authority on April 1, 2019. This will ensure 1915(c) Transitioning Children have no interruption of services during the authority change. (See [Attachment E](#) for the crosswalk of 1915(c) HCBS to children's State Plan or aligned children's HCBS).

To ensure continuity of care and no service disruptions, under the Transition Process, 1915(c) Transitioning Children will be reassessed for HCBS eligibility one year after the date of their completed initial Child and Adolescent Needs and Strengths New York (CANS-NY) assessment (as described in [Section II A.8](#) below) or at any time the participant experiences a significant change of condition (Ex – 90 day's post continued hospitalization).

For additional information please see "Transition to Health Home Care Management" and "Level of Care and Continued Access" below.

3. Transition to Health Home Care Management

Health Home Care Managers will be integral partners in assisting children to fully transition to children's State Plan and Concurrent 1115 MRT Waiver and Children's 1915(c) Waiver Services.

To preserve the expertise of existing 1915(c) coordinators and preserve existing relationships with children and families, Care Management Agencies who historically provided care coordination for children enrolled in one of the six 1915(c) waivers will transition to Health Home and become Health Home Care Management Agencies. The State has already begun work to facilitate Health Home affiliations with Care Management Agencies who now provide 1915(c) care coordination. Many 1915(c) care managers are affiliated with care management agencies that also provided care management under the Office of Mental Health Targeted Case Management programs that transitioned to Health Homes in the first part of 2017.

Beginning in Fall 2018, 1915(c) care coordinators who transition to Health Home Care Managers will begin talking to their 1915(c) Transitioning Children and families about the Children's Medicaid Health and Behavioral Health System Transformation, and supported by State guidance and training, will explain in general terms what it means to enroll in a Medicaid Managed Care Plan (if the child is not already enrolled), what Health Home benefits are, how access to services and providers they work with today will continue without disruption, the

expanded services that will become available in April 2019, why the State is transforming children's services, and when these changes will take place.

Starting January 1, 2019, these former 1915(c) and now Health Home Care Managers will continue the education process mentioned above by meeting with 1915(c) Transitioning Children and families on a one-to-one basis and begin the process of enrolling 1915(c) Transitioning Children in Health Home. The enrollment process includes obtaining consents for Health Home enrollment and sharing of information with other providers that will be involved in care planning and service provision. For individuals who may choose not to enroll in Health Home, the Health Home care manager will explain this means they will not be able to access comprehensive Health Home care management services, but will still be required to work with an entity (i.e., the State's Independent Entity) to develop an HCBS POC that is required to access HCBS. The Health Home Care Manager will assure individuals who decline Health Home enrollment are referred to the State's Independent Entity (see below).

For 1915(c) Transitioning Children electing Health Home enrollment, the Health Home Care Manager will continue the person-centered planning process toward development of a Health Home comprehensive plan of care that includes HCBS the child is already receiving (or for a newly eligible child, will begin to receive), inclusive of the child and family's goals. This process includes convening a multi-disciplinary team meeting, completing a comprehensive assessment to determine service needs beyond HCBS, and the CANS-NY. For children who are enrolled in Medicaid managed care, the MMCP will monitor access to care and coordinate with the Health Home regarding the comprehensive plan of care. For children who are not enrolled in a Medicaid Managed Care Plan, the Health Home and the State's Independent Entity will monitor access to care, including HCBS, that will be delivered via Medicaid fee-for-service. (See also [Attachment G: HCBS and Care Management/ Coordination Process](#))

Health Home care managers (i.e., transitioning 1915(c) care coordinators) will work to enroll all 1915(c) Transitioning Children on their case loads into Health Home, or refer children who decline Health Home care management, to the Independent Entity, by providing a warm hand off with the goal of completing an HCBS POC no later than April 1, 2019.

4. Role of Independent Entity

Beginning February 1, 2019, the Independent Entity will be available to accept referrals of 1915(c) Transitioning Children who are in receipt of HCBS and who

opt out of Health Home enrollment. The Independent Entity will develop a person-centered plan of care for provision of HCBS and assist with transitioning HCBS services that will now be provided under the authority of the State Plan (See [Attachment E](#).) For children who are enrolled in Medicaid managed care, the MMCP will monitor access to care and coordinate with the Independent Entity to maintain the HCBS plan of care. For children who are not enrolled in a Medicaid Managed Care Plan, the Independent Entity will work with the State to monitor access to care, including HCBS, delivered via Medicaid fee-for-service. (See [Attachment G](#))

5. Level of Care and Continued Access to Services

The child's plan of care (either the Health Home comprehensive plan of care or the Independent Entity HCBS plan of care) will include all 1915(c) HCBS cross-walked to the corresponding new children's State Plan or aligned children's HCBS to ensure no interruption in services. This plan of care will serve as FFS authorization of these services for 1915(c) Transitioning Children. This plan of care will be shared with the child's Medicaid Managed Care Plan, as applicable, to ensure authorization of services. (See [Attachment E](#) for the crosswalk of 1915(c) HCBS to children's State Plan or aligned children's HCBS).

To ensure continuity of care and no service disruptions, 1915(c) Transitioning Children will not be reassessed for HCBS eligibility until one year after the date of their completed initial CANS-NY assessment or, for children who opt out of Health Home, the date the Independent Entity opens their case record (as described in [Section II A.8](#) below) and at any time the participant experiences a significant change of condition (Ex – 90 day's post continued hospitalization).

6. Medicaid Managed Care Enrollment

On April 1, 2019, the State will remove the exemption from Medicaid managed care enrollment for children transitioning from one of the six 1915(c) waiver programs. This change will not affect current children in the care of a Voluntary Foster Care Agency with B2H, new children placed in care of VFCA and in need of HCBS, current children placed in foster care in the direct care of the LDSS and in B2H, new children placed in foster care in the direct care of the LDSS and in need of HCBS, current and new children in the care of VFCA without B2H/HCBS, as these children will transition to Medicaid managed care on July 1, 2019.

The State will include information about selecting an MMCP in its materials and question and answer sessions with families. 1915(c) Transitioning Children that

have been previously exempt from Medicaid Managed Care (unless otherwise excluded from Medicaid managed care for a different reason, such as in receipt of comprehensive third-party health insurance) may elect to enroll in an MMCP at any time.

Beginning in December 2018, the State's Enrollment Broker will appropriately notice children who will be required to enroll in an MMCP due to the removal of the 1915(c) waiver exemption from Medicaid managed care. Notices will continue to be sent on an ongoing basis, to move affected 1915(c) Transitioning Children in FFS to managed care enrollment, with most enrollments anticipated to be effective April 1, 2019.

1915(c) Transitioning Children will be given 60 days to select an MMCP. The Enrollment Broker can aid in identifying the Medicaid Managed Care Plan whose network of providers most closely matches the current providers seen by the child and family. Supporting the Health Home Care Manager's conversations with the child and family, the State's Enrollment Broker will perform at least one additional outreach by phone or other method, to assist the child and family in MMCP selection.

For individuals who do not select an MMCP, the State's Enrollment Broker will follow existing auto assignment procedures, and select a "best match" MMCP based location and network (current provider/provider types) and send notice of the assignment. The individual will have at least 10 days to request a change of MMCP before enrollment becomes effective, and will have 90 days after enrollment to change their MMCP.

No earlier than March 1, 2019, and as soon as it is known which MMCP the child is or will be enrolled in, the Health Home Care Manager, or the Independent Entity, will share the plan of care with the Medicaid Managed Care Plan (where consents for data sharing are in place). The Medicaid Managed Care Plan will use this information to load current authorizations for the child's HCBS into their system, and confirm relationships with the child's providers, in preparation for service provision and billing through the MMCP benefit package beginning April 1, 2019. Medicaid Managed Care Plans will also have access to the CANS-NY assessment and the HCBS Eligibility Determination for the child. After April 1, 2019, and MMCP enrollment, the Medicaid Managed Care Plan is responsible for monitoring access to HCBS for their enrollees in accordance with the plan of care. Health Homes will ensure Health Home enrollment and consent forms to

share information are updated to include the child's Medicaid Managed Care Plan.

7. Transition to Concurrent Waiver Services and New Children's State Plan Services

Beginning January 1, 2019, services previously provided under six children's 1915(c) HCBS waivers will become a State Plan benefit or will be aligned and transitioned to the Concurrent 1115 MRT Waiver and Children's 1915(c) Waiver authority on April 1, 2019. These services will be available through the FFS and the Medicaid Managed Care delivery system. Beginning July 1, 2019, Medicaid Managed Care Plans also become responsible for the provision of previously carved out children's behavioral services that are moving into the Medicaid managed care benefit package.

Medicaid Managed Care Plans will be required to meet continuity of care provisions (see Sections [II.C](#) and [II.D](#) below) for 1915(c) Transitioning Children, including covering transitional HCBS and Long Term Services and Supports (LTSS) for 180 days from the date of April 1, 2019 transition, supporting a seamless transition with no interruption of services.

Beginning January 1, 2019, Health Home Care Managers will meet with 1915(c) Transitioning Children and families, on a one-to-one basis and in a person-centered manner, to identify and refer to expanded Medicaid services now available, consistent with the individual's goals. For children who opt out of Health Home the Independent Entity will be available to accept referrals beginning February 1, 2019. The Health Home Care Manager/Independent Entity will update the plan of care accordingly, and, if the child is enrolled in a Medicaid Managed Care Plan and in receipt of HCBS, share the updated plan of care with the MMCP. Health Home Care Managers and the Independent Entity will complete this initial review for the expanded services by March 31, 2019.

8. Post April 1, 2019 Transition

For 1915(c) Transitioning Children enrolled in a Medicaid Managed Care Plan, the MMCP will be responsible for monitoring access to care in accordance with the plan of care. The MMCP will also be responsible for ensuring appropriate re-assessments for HCBS occur through the Health Home, (or the Independent Entity if the enrollee opts out of Health Home), at least annually. During the first 180 days of MMCP enrollment, the plan, providers, Health Home, and child and family, all have an opportunity to clarify any discrepancies; request or evaluate

the need for new services. During this first 180 day-period it is generally expected the parties will work together to ensure service provision and continuity of care.

1915(c) Transitioning Children will be reassessed for HCBS at least annually one year from the date the initial CANS-NY was completed (i.e., a date between January 1, 2019 and March 31, 2019) by the Health Home or one year after their referral to the IE is accepted and a case record is opened by the Independent Entity or at any time the participant experiences a significant change of condition (Ex – 90 day's post continued hospitalization). The reassessment for HCBS Eligibility Determination, will include verifying target population, risk factors and functional criteria. Depending upon the target population, the functional criteria will be determined by an HCBS algorithm that is applied to a subset of CANS-NY questions or by the Developmental Disabilities Regional Office (DDRO) to determine developmental disability. Reassessed 1915(c) Transitioning Children meeting LOC HCBS Eligibility Determination will continue to be eligible for HCBS. Children who are no longer eligible for HCBS may continue to be enrolled in Health Home provided they meet Health Home eligibility and appropriateness criteria.

B. Children Newly in Need of HCBS beginning April 1, 2019

On April 1, 2019, the State will continue to work with local government unit, local department of social services and provider referral processes to identify children newly in need of HCBS. See [Attachment G: HCBS and Care Management/Coordination Process](#).

On and after April 1, 2019, HCBS eligibility will be determined using new target population, risk factor and functional eligibility criteria.

Between April 1, 2019 and July 1, 2019 new children can found eligible through the HCBS Eligibility Determination and will be offered the aligned HCBS based on combined capacity under that was available under the 1915(c) Waivers.

Beginning on July 1, 2019, the State will begin to expand HCBS capacity beyond that of the combined 1915(c) Waivers for newly eligible children meeting Level of Care (LOC) criteria.

To manage combined capacity that was available under the 1915(c) Waivers beginning April 1, 2019, and the expansion of HCBS for children that meet LOC that

will begin on July 1, 2019, the State will use a centrally maintained statewide list of children who have been identified as eligible through the HCBS Eligibility Process, but due to capacity limitations are unable to access HCBS at the time of eligibility. This list will be reflective of the UAS outcome of HCBS eligibility and LOC type combined with other data source(s) containing enrollment/disenrollment information. Monitoring will include review of capacity per LOC type and region to ensure statewide continuity and preservation of existing capacity needs.

The following HCBS processes will occur in accordance with available capacity.

1. For children who are enrolled in Medicaid and newly in need of HCBS

For a child who is already enrolled in a Health Home:

The State anticipates some children already enrolled in Health Homes (prior to the Children's Medicaid Health and Behavioral Health System Transformation) will be identified as in need of the new children's State Plan services or eligible for newly aligned children's HCBS. Health Home Care Managers will work one-to-one with these families to explain the new children's State Plan services and aligned children's HCBS that are available beginning in January 2019 and April 2019, and work with providers to determine and document the HCBS Eligibility Determination process (i.e., does the child meet target population, risk factors and functional criteria). Through the person-centered planning process, the Health Home Care Manager will update the Health Home comprehensive plan of care accordingly. If the child is enrolled in a Medicaid Managed Care Plan, and the child is eligible for HCBS, the plan of care will be shared with the MMCP to authorize and monitor access to needed services.

For a child who is enrolled in Medicaid and not enrolled in a Health Home:

If the child appears eligible for Health Home, a local referral may be made directly to a Health Home. The Health Home Care Manager will work with providers to determine and document eligibility for Health Home and perform HCBS Eligibility Determination. If the child is determined to be HH and/or HCBS eligible, and with the consent of the child/family or legally authorized representative or guardian, the Health Home Care Manager will enroll the child in the Health Home.

The Health Home Care Manager will develop a Health Home comprehensive plan of care that also includes aligned children's HCBS, inclusive of the child

and family's goals. If the child is enrolled in a Medicaid Managed Care Plan, and the child is eligible for HCBS, the plan of care will be shared with the MMCP to authorize and monitor access to needed services.

For individuals who may choose not to enroll in Health Home but are eligible and wish to receive aligned children's HCBS, the Health Home care manager will explain this means they will not be able to access comprehensive Health Home care management services, but will still be required to work with an entity (i.e., the State's Independent Entity) to develop an HCBS POC that is required to access HCBS. The Health Home Care Manager, with appropriate consents from the child/family or legally authorized representative or guardian, will assure individuals who decline Health Home enrollment are referred to the State's Independent Entity. The Independent Entity will develop a person-centered plan of care for provision of HCBS. For children who are enrolled in Medicaid managed care, the MMCP will monitor access to care and coordinate with the Independent Entity to maintain the HCBS plan of care. For children who are not enrolled in a Medicaid Managed Care Plan, the Independent Entity will work with the State to monitor access to care, including HCBS, delivered via Medicaid fee-for-service.

For a child who is enrolled in Medicaid, not enrolled in a Health Home, and is referred to Independent Entity:

If a local referral is made, with the appropriate consents from the child/family or legally authorized representative or guardian, to the Independent Entity, the Independent Entity will determine if the child is eligible for Health Home. If so, the Independent Entity will provide information about Health Home and, if the child/family or legally authorized representative or guardian does not opt out of Health Home, with the appropriate consents from the child/family or legally authorized representative or guardian, the Independent Entity will refer the child to a Health Home. With consent of the child/family, the Health Home Care Manager will verify Health Home eligibility and enroll the child in the Health Home. The Health Home Care Manager will then develop a Health Home comprehensive plan of care that also includes aligned children's HCBS, inclusive of the child and family's goals. If the child is enrolled in a Medicaid Managed Care Plan, and the child is eligible for HCBS, the plan of care will be shared with the MMCP to authorize and monitor access to needed services.

For individuals who may choose to not enroll in Health Home (do not accept the referral to the Health Home), the Independent Entity will perform the HCBS Eligibility Determination and, with the appropriate consents from the child/family or legally authorized representative or guardian, will develop a person-centered plan of care for provision of HCBS. For children who are enrolled in Medicaid managed care, the MMCP will monitor access to care and coordinate with the Independent Entity to maintain the HCBS plan of care. For children who are not enrolled in a Medicaid Managed Care Plan, the Independent Entity will work with the State to monitor access to care, including HCBS, delivered via Medicaid fee-for-service.

2. For children who are not yet Medicaid eligible

For the child who is not yet Medicaid eligible and is newly in need of services, the local referral will be made to the Independent Entity. With the appropriate consents from the child/family or legally authorized representative or guardian, the Independent Entity will confirm the child is likely to be eligible for Medicaid, Health Home and/or HCBS; and:

- Perform HCBS Eligibility Determination (i.e., determine if the child meets target population, risk and functional HCBS eligibility criteria);
- If HCBS eligible, assist the family in completing the Medicaid application and submit the application to the local social service district;
- Refer the child and family to the Enrollment Broker for help with plan selection; and
- Once determined eligible for Medicaid, assist the child with Health Home selection and referral; or
- If the child opts out of Health Home, develop an HCBS plan of care, inclusive of the child and family's goals, and:
 - If the child enrolls in an MMCP, share the HCBS POC with the MMCP; or
 - If the child remains in FFS, monitor access to care.

C. Continuity of Care for 1915(c) Transitioning Children

In addition to standard continuity of care provisions for all beneficiaries, the State has ensured that no 1915(c) Transitioning Children will lose access to services due to the transition to the Concurrent 1115 waiver and Children's 1915(c) authorities.

1. 1915(c) Transitioning Children will continue to be eligible for HCBS until at least one year after the date of their completed initial Health Home CANS-NY

assessment (i.e., sometime between January 1, 2019 and March 31, 2019) or, for 1915(c) Transition Children opting out of Health Home, the date the Independent Entity accepts referral and opens a case record. Reassessment will still occur at any time the participant experiences a significant change of condition (Ex – 90 day's post continued hospitalization). Reassessed 1915(c) transitioning Children meeting HCBS Eligibility Determination will continue to be eligible for aligned children's HCBS and Health Home care management.

2. Children will not be required to change their Care Management Agency due to this transition.
3. For 1915(c) Transitioning Children, the Health Home comprehensive plan of care, or independent entity HCBS plan of care, will preserve access to 1915(c) HCBS by cross-walking their services to the new State Plan or aligned children's HCBS.
4. For all 1915(c) Transitioning Children, Medicaid Managed Care Plans are required to authorize covered HCBS and LTSS in accordance with the existing plan of care (including access to the same provider) for 180 days from the date April 1, 2019, or until a new plan of care is in place, whichever is later, unless the beneficiary requests a change in the services provided.
5. For all 1915(c) Transitioning Children, Medicaid Managed Care Plans will not conduct utilization review or require service authorization for new children's State Plan or aligned children's HCBS added to plans of care for 180 days from the transition date of April 1, 2019.
6. Medicaid Managed Care Plans must allow 1915(c) Transitioning Children to continue with their current provider for a current episode of care for up to 24 months, regardless of that provider's participation with the plan.
7. Aligned children's HCBS and new children's State Plan services are comparable to or enhanced from the HCBS services currently provided under the 1915(c) authorities.

D. Continuity of Care for Current State Plan Services Carved into Medicaid Managed Care

MMCPs are not permitted to apply utilization review for 90 days following implementation of the children's new State Plan services moving into the MMCP benefit

package, including: January 1, 2019 implementation of Other Licensed Practitioners; Community Psychiatric Support and Treatment; and Psychosocial Rehabilitation Supports; July 1, 2019 implementation of Family Peer Support Services; and January 1, 2020 Youth Peer Support and Training. MMCP's will not be permitted to apply utilization review to Crisis Intervention to be implemented January 1, 2020.

MMCPs are not permitted to apply utilization review for 90 days following the implementation of current behavioral health State Plan services moving into the MMCP benefit package for enrollees under age 21 on July 1, 2019.

Certain continuity of care provisions will continue for 24 months from the date the benefits are included in Medicaid managed care:

1. For new enrollees transitioning from FFS, Medicaid Managed Care Plans are required to authorize covered HCBS and LTSS in accordance with the existing plan of care (including access to the same provider) for 180 days, or until a new plan of care is in place, whichever is later, unless the beneficiary requests a change in the services provided.
- 2.. Medicaid Managed Care Plans must allow FFS children enrolling in the MMCP to continue with their current provider for a current behavioral health episode of care for up to 24 months from the benefit inclusion date, regardless of that provider's participation with the MMCP.
- 3.. Medicaid Managed Care Plans must offer contracts to OMH or OASAS licensed or certified providers that serve five or more of their enrollees who are under age 21, as identified by the State, and maintain such contracts for at least 24 months of the benefit inclusion date, provided quality standards are met.

In addition, Medicaid Managed Care Plans must ensure children placed in foster care (including children who are not in receipt of HCBS and who do not have a Plan of Care) outside of the plan's services area can access providers that traditionally treated children involved in foster care and all medically necessary benefit package services.

E. Billing and Claims Adjudication

All 1915(c) service providers will continue to bill applicable current 1915(c) rate codes through March 31, 2019, as per the Department's published transitional billing manual. For the period January 1, 2019 through March 31, 2019, once a 1915(c) Transitioning Child enrolls in a Health Home (i.e., signed consent to enroll), Health Home rate codes will be billed for care management. In addition, providers transitioning to Health Home

care management will be subject to the standards and requirements of the Health Home program, which will include ensuring Health Home plans of care that include HCBS also satisfy HCBS plan of care requirements. Such providers will be prohibited from billing 1915(c) care coordination rates for any child enrolled in a Health Home.

The State will develop transitional Health Home rates for 1915(c) providers whose 1915(c) care management rate is higher than the Health Homes rates. Rates would transition down to Health Home rates in three phases over 24 months. Providers that are subject to transitional rates will bill HH rate codes and an additional transitional rate code for difference between HH rate and the 1915(c). This will provide a period to transition to new rates and curtail cash flow instability. Beginning April 1, 2019, all former 1915(c) waiver service rate codes, including those for care coordination, will become inactive and new 1915(c) Children's Waiver rate codes will become effective. See Billing manual for 1915(c) service rate codes, with new children's Medicaid State Plan and aligned children's HCBS rate codes (collectively Concurrent rate codes) for billing after April 1, 2019.

Beginning January 1, 2019 for new children's Medicaid State Plan services (OLP, CPST, PSR) providers will bill new SPA rate codes. Between January 1, 2019 and March 31, 2019 current 1915(c) rate codes for remaining SPA services (Family Peer, Youth Peer and Crisis Intervention) will be active in accordance with Billing manual. Beginning April 1, 2019 for aligned children's HCBS, providers will bill using 1915(c) Children's Waiver rate codes in accordance with the Billing Manual. Both the fee-for-service system and Medicaid Managed Care Plans will be prepared to accept the new State Plan and 1915(c) Children's Waiver rate codes for the new children's State Plan and aligned children's HCBS. The State will end payment for current 1915(c) services rendered on or after the time the waivers are terminated (i.e., April 1, 2019).

Aligned children's HCBS will be reimbursed at government rates on a non-risk basis during the 24-month transition period. New children's State Plan services will be included in the MMCPs capitated rates on the dates the services are moved to MMC.

III. Infrastructure, Operations, and Systems

Under an operational readiness plan, the State will develop materials, guidance, and infrastructure to support this transition. See [Attachment D](#) for key operational milestones.

A. HCBS Eligibility Determination Criteria

The State will implement new HCBS Eligibility Determination criteria. The criteria and assessment tools employed below will replace criteria and tools used under the 1915(c) waivers.

The State has established Level of Care (LOC) HCBS Eligibility Determination criteria and Level of Need (LON) HCBS Eligibility Determination criteria. Children who are found eligible for children's HCBS are eligible for Health Home. The LOC HCBS Eligibility Determination will take effect on April 1, 2019 for newly identified children and the LON HCBS Eligibility Determination Criteria is anticipated to take effect following full implementation of LOC, no earlier than July 2022.

The criteria for both LOC and LON HCBS includes three components applied in this order 1) target population criteria, 2) risk factors and 3) functional criteria. With the exceptions noted above in [Section II D "Continuity of Care for 1915\(c\) Transitioning Children"](#), members must meet all three components to be eligible for HCBS.

The State first ensures that the child meets the target criteria and risk factors.

The LOC target criteria include that the child is under age 21 and falls within one of the following criteria:

- Serious Emotional Disturbance (SED)
- Medically Fragile Children (MFC)
- Developmental Disability (DD) and Medically Fragile
- Developmental Disability (DD) and in Foster Care

The LON target populations include:

- Serious Emotional Disturbance
- Abuse, Neglect, Maltreatment or Health Home Complex Trauma (ANMCT)

The child must also meet the risk factors that have been established for each of the LOC and LON populations.

After the child has been determined to meet the target criteria and risk factors, the child must be determined to meet the functional limitations criteria.

The functional limitations criteria for the LOC population is determined by ensuring that the child meets the institutional admission criteria for: 1) nursing facilities or hospitals by applying an LOC algorithm to the Child and Adolescent Needs and Strengths New York (CANS-NY) tool for SED and MFC population or 2) Intermediate Care Facilities (ICFs)

by applying an LOC determination by the Office for People With Developmental Disabilities (OPWDD) for children who are in foster care or for medically fragile children who are living at home and require DD eligibility for services.

The functional limitations criteria for LON population is determined by applying an LON algorithm to the Child and Adolescent Needs and Strengths New York (CANS-NY) tool for SED and the abuse, neglect maltreatment, or complex trauma population.

The CANS-NY tool is now housed in the Uniform Assessment System and is operational under the Health Home program. It will be augmented and ready for use by January 1, 2019 and to include HCBS Eligibility Determination tool (target population, risk factors, and functional criteria which will use the CANS-NY and for children entering through the DDRO the ICF-IIID LOC determination). Health Homes, DDRO and the Independent Entity will have access to the UAS which houses the CANS-NY and HCBS Eligibility Determination tool.

In addition, as indicated below in the HCBS Eligibility Determination tables, for children who meet the HCBS eligibility criteria, if the child is not financially eligible for Medicaid under regular community budgeting rules, parental income and resources will be waived and the child's Medicaid eligibility will be determined based on a family of one.

Under the 1915(c) Children's waiver and the State Plan Amendment Children who are eligible for aligned children's HCBS are eligible for care management through the Health Home. The definition of Serious Emotional Disturbance for HCBS Eligibility Determination include more SED diagnoses than the SED eligibility criteria for Health Home. Children who have an SED diagnosis that is included in the HCBS SED definition but not the Health Home SED diagnoses are eligible for care management through the Health Home under the Demonstration (not the Health Home State Plan authority). Please see [Attachment F](#) for comparison of Health Home SED definition and HCBS SED Definition.

Children who are Medically Fragile with a Developmental Disability which has not yet been determined by OPWDD may access HCBS more expeditiously using the HCBS Eligibility Determination tool to determine LOC functional criteria under the HCBS LOC Medically Fragile Child (MFC) Eligibility Determination criteria. However, to ensure the child has access to adult HCBS services provided under the OPWDD HCBS Waiver and other State Plan clinic services, the child should also subsequently engage with OPWDD for a determination of DD eligibility and ICF-IIID LOC which should occur well before the child's 21st birthday. For children already engaged with the DDRO or children and families who elect to go through the DDRO first they will have their HCBS Eligibility

Determination completed by the DDRO. The DDRO will then refer the child to HH or the Independent Entity for those who opt-out of Health Home.

The table below more fully describes the HCBS Eligibility Determination criteria for each of the LOC and LON target populations. Licensed Practitioner of the Healing Arts (LPHA) include a: Physician, Psychiatrist, Licensed Psychoanalyst, Registered Professional Nurse, Nurse Practitioner, Clinical Nurse Specialist, Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist, Licensed Mental Health Counselor, Licensed Psychologist, Licensed Master Social Worker (LMSW), Clinical Nurse Specialist, and Physician Assistants.

Level of Care (LOC) HCBS Eligibility Determination Criteria Serious Emotional Disturbance (SED) Effective April 1, 2019	
Target Criteria	<ol style="list-style-type: none"> 1. Age 0 through child's 21st Birthday, and 2. Child has Serious Emotional Disturbance: <i>Serious emotional disturbance (SED)</i> 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, as determined by a licensed mental health professional. 3. SED is defined to include any one of the following Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnoses: <ul style="list-style-type: none"> - Schizophrenia Spectrum and Other Psychotic Disorders - Bipolar and Related Disorders - Depressive Disorders - Anxiety Disorders - Obsessive-Compulsive and Related Disorders - Trauma- and Stressor-Related Disorders - Dissociative Disorders - Somatic Symptom and Related Disorders - Feeding and Eating Disorders - Disruptive, Impulse-Control, and Conduct Disorders - Personality Disorders - Paraphilic Disorders - Gender Dysphoria - Elimination Disorders - Sleep-Wake Disorders - Sexual Dysfunctions - Medication-Induced Movement Disorders - Attention Deficit/Hyperactivity Disorder - Tic Disorders
Risk Factors	<p>The child meets one of the factors 1-4 as well as factor 5.</p> <ol style="list-style-type: none"> 1. The child is currently in an out-of-home placement, including psychiatric hospital, or

	<p>2. The child has been in an out-of-home placement, including psychiatric hospital within the past six months, or</p> <p>3. The child has applied for an out-of-home placement, including placement in psychiatric hospital within the past six (6) months, or</p> <p>4. The child currently is multi-system involved (i.e., two or more systems) and needs complex services/supports to remain successful in the community</p> <p>AND</p> <p>5. A licensed practitioner of the healing arts (LPHA), who has the ability to diagnose within his/her scope of practice under State law, has determined in writing, that the child, in the absence of HCBS, is at risk of institutionalization (i.e., hospitalization). The LPHA has submitted written clinical documentation to support the determination.</p> <p>Out-of-home placement in LOC Risk Factor #1-4 includes: RRSY, RTF, RTC, or other congregate care setting such as SUD residential treatment facilities, group residences, institutions in the OCFS system or hospitalization.</p> <p>Multi-system involved means two or more child systems including: child welfare, juvenile justice, OASAS clinics or residential treatment facilities or institutions, OMH clinics or residential facilities or institutions, OPWDD services or residential facilities or institutions, or having an established IEP through the school district.</p>
Functional Criteria	Algorithm applied to a subset of questions from the Child and Adolescent Needs and Strengths New York (CANS-NY)
Financial Criteria	<p>If a child is already Medicaid eligible, then a child meeting LOC SED HCBS target criteria, risk factors, and functional criteria is eligible to receive HCBS.</p> <p>If a child is not already eligible for Medicaid and qualifies under no community eligibility rules, then a child meeting LOC SED HCBS target criteria, risk factors, and LOC functional criteria can be considered for Medicaid eligibility under the Family of One financial criteria.</p>

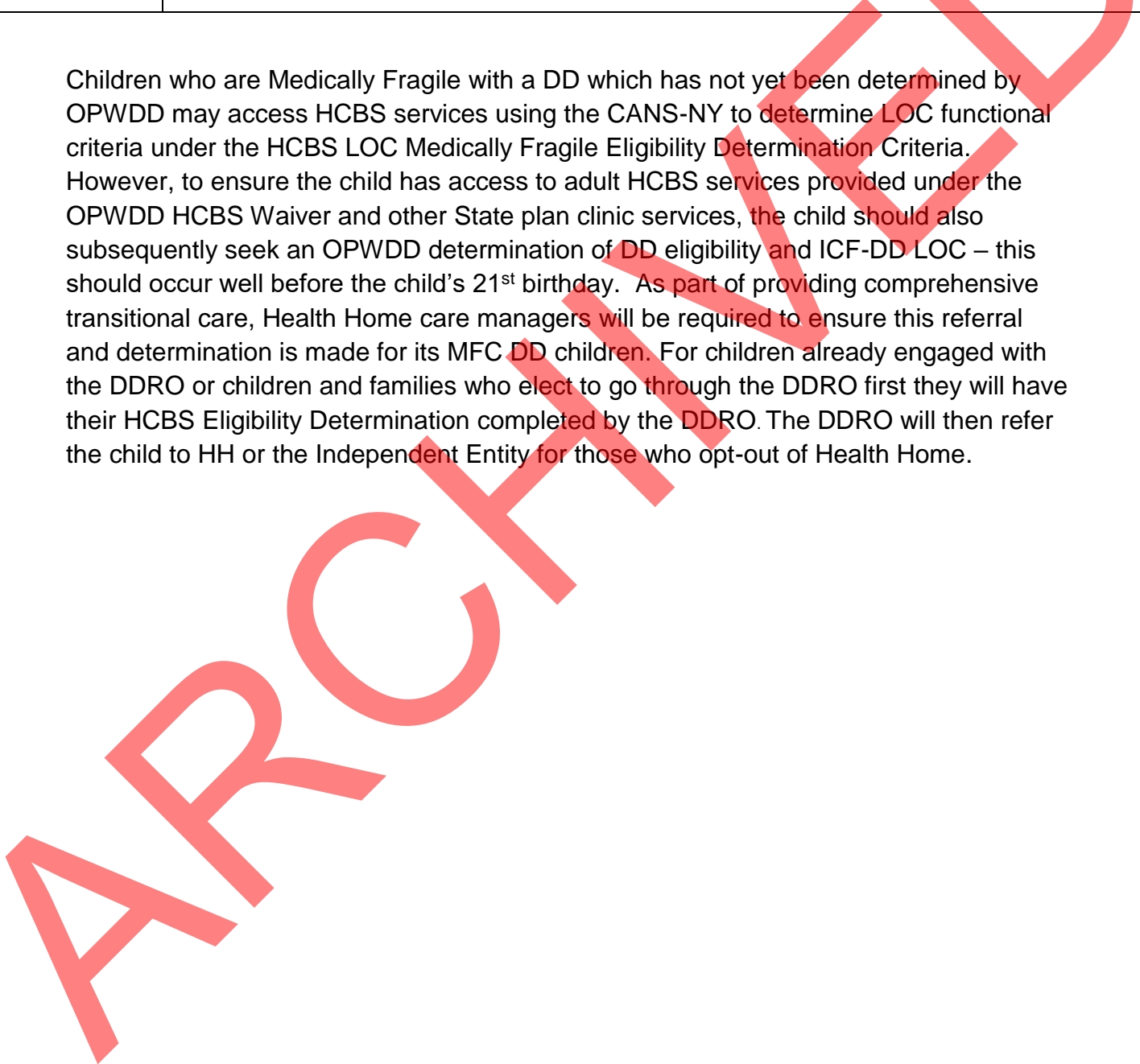
Level of Care (LOC) HCBS Eligibility Determination Criteria	
Medically Fragile Child (MFC) Population Effective April 1, 2019	
Target Criteria	<p>1. Age 0 through child's 21st Birthday, and</p> <p>2. The child must have documented physical disability using the following protocols:</p> <ul style="list-style-type: none"> i. Current SSI Certification or ii. LDSS-639 disability certificate or iii. Forms: OHIP 0005, OHIP 0006 and OHIP 0007 completed by appropriate professionals and caregivers to be reviewed and approved by an LPHA
Risk Factors	<p>A licensed practitioner of the healing arts (LPHA), who has the ability to diagnose within his/her scope of practice under State law, has determined in writing, that the child, in the absence of HCBS, is at risk of institutionalization (i.e., hospitalization or nursing facility). The LPHA has submitted written clinical documentation to support the determination.</p> <p>For the Risk Factor for Medically Fragile, institutionalization is defined as hospitalization or nursing facility.</p>

Functional Criteria	Algorithm applied to a subset of questions from the Child and Adolescent Needs and Strengths New York (CANS-NY)
Financial Criteria	<p>If a child is already Medicaid eligible, then a child meeting LOC MFC HCBS target criteria, risk factors, and functional criteria is eligible to receive HCBS.</p> <p>If a child is not already eligible for Medicaid and qualifies under no community eligibility rules, then a child meeting LOC Medically Fragile HCBS target criteria, risk factors, and functional criteria can be considered for Medicaid eligibility under the Family of One financial criteria.</p>

<p>Level of Care HCBS Eligibility Determination Criteria: Developmental Disability and Medically Fragile Child (MFC) Effective April 1, 2019</p> <p>*NOTE: Children who qualify as both DD and MFC may more expeditiously access HBCS services by using the Medically Fragile process and then at a later date pursue DD eligibility; (see page 26)*</p>	
Target Criteria: DD MFC	<ol style="list-style-type: none"> 1. Age 0 through child's 21st Birthday, and 2. Medically Fragile as defined by subset of questions from CANS-NY Algorithm 3. Child has developmental disability as defined by OPWDD which meets one of the criteria a-c as well as criteria d, e and f <ol style="list-style-type: none"> a. is attributable to intellectual disability, cerebral palsy, epilepsy, neurological impairment, familial dysautonomia, Prader-Willi syndrome or autism; or b. is attributable to any other condition of a child found to be closely related to intellectual disability because such condition results in similar impairment of general intellectual functioning or adaptive behavior to that of a child with intellectual disability or requires treatment and services similar to those required for such children; or c. is attributable to dyslexia resulting from a disability described above; and d. originates before such child attains age 22; and e. has continued or can be expected to continue indefinitely; and f. constitutes a substantial handicap to such child's ability to function normally in society.
Risk Factors: DD MFC	The child must be Medically fragile as demonstrated by a licensed practitioner of the healing arts (LPHA), who has the ability to diagnose within his/her scope of practice under State law, has determined in writing, that the child, in the absence of HCBS, is at risk of institutionalization (*i.e., hospitalization or nursing facility) The LPHA has submitted written clinical documentation to support the determination.
Functional Criteria: DD MFC	Office for People With Developmental Disabilities (OPWDD) ICF-IID Level of Care and/or Algorithm applied to a subset of questions from the Child and Adolescent Needs and Strengths New York (CANS-NY)

Financial Criteria: DD MFC	<p>If a child is already Medicaid eligible, then a child meeting LOC DD MFC HCBS target criteria, risk factors, and functional criteria is eligible to receive HCBS.</p> <p>If a child is not already eligible for Medicaid and qualifies under no community eligibility rules, then a child meeting LOC DD MFC HCBS target criteria, risk factors, and functional criteria can be considered for Medicaid eligibility under the Family of One financial criteria.</p> <p>Note: Children with DD and not meeting these target criteria and risk factors would be served by the OPWDD HCBS delivery system.</p>
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Children who are Medically Fragile with a DD which has not yet been determined by OPWDD may access HCBS services using the CANS-NY to determine LOC functional criteria under the HCBS LOC Medically Fragile Eligibility Determination Criteria. However, to ensure the child has access to adult HCBS services provided under the OPWDD HCBS Waiver and other State plan clinic services, the child should also subsequently seek an OPWDD determination of DD eligibility and ICF-DD LOC – this should occur well before the child’s 21st birthday. As part of providing comprehensive transitional care, Health Home care managers will be required to ensure this referral and determination is made for its MFC DD children. For children already engaged with the DDRO or children and families who elect to go through the DDRO first they will have their HCBS Eligibility Determination completed by the DDRO. The DDRO will then refer the child to HH or the Independent Entity for those who opt-out of Health Home.



Level of Care HCBS Eligibility Determination Criteria: Developmental Disability and Foster care Effective April 1, 2019	
Target Criteria: DD Foster care	<ol style="list-style-type: none"> 1. Age 0 through child's 21st Birthday, and 2. Child has developmental disability as defined by OPWDD which meets one of the criteria a-c as well as criteria d, e and f. <ol style="list-style-type: none"> a. is attributable to intellectual disability, cerebral palsy, epilepsy, neurological impairment, familial dysautonomia, Prader-Willi syndrome or autism; or b. is attributable to any other condition of a child found to be closely related to intellectual disability because such condition results in similar impairment of general intellectual functioning or adaptive behavior of a child with intellectual disability or requires treatment and services similar to those required for such children; or c. is attributable to dyslexia resulting from a disability described above; and d. originates before such child attains age 22; and e. has continued or can be expected to continue indefinitely; and f. constitutes a substantial handicap to such child's ability to function normally in society.
Risk Factors: DD Foster Care	<p>The child must meet either criteria 1 or 2</p> <ol style="list-style-type: none"> 1. a current Foster Care (FC) child in the care and custody of Local Departments of Social Services (counties and New York City) (LDSS) or a child in the custody of OCFS Division of Juvenile Justice and Opportunities for Youth (DJJOY) or 2. a FC child who enrolled in HCBS originally while in the care and custody (LDSS) or (DJJOY). Once enrolled, eligibility can continue after the child is discharged from LDSS and OCFS DJJOY custody so long as the child continues to meet targeting, risk and functional criteria (no break in coverage permitted). This risk factor continues Maintenance of Effort for children up through, but not including, their 21st birthday).
Functional Criteria: DD Foster Care	Office for People With Developmental Disabilities (OPWDD) Level of Care using the ICF-IID LOC eligibility tool
Financial Criteria: DD Foster care	<p>If a child is already Medicaid eligible, then a child meeting LOC DD FC target criteria, risk factors, and functional criteria is eligible to receive HCBS.</p> <p>If a child is not already eligible for Medicaid and qualifies under no community eligibility rules, then a child meeting LOC DD FC target criteria, risk factors, and functional criteria can be considered for Medicaid eligibility under the Family of One financial criteria.</p> <p>Note: Children with DD not meeting these target criteria and risk factors would be served by the OPWDD HCBS delivery system.</p>

Level of Need Eligibility Criteria

Level of Need HCBS Eligibility Determination Criteria Serious Emotional Disturbance (SED) (Effective no earlier than July 2022)	
Target Criteria	<p>1. Age 0 through child's 21st Birthday, and</p> <p>2. Child has Serious Emotional Disturbance <i>Serious emotional disturbance (SED) 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, as determined by a licensed mental health professional.</i></p> <p>3. SED is defined to include any one of the following Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnoses:</p> <ul style="list-style-type: none"> - Schizophrenia Spectrum and Other Psychotic Disorders - Bipolar and Related Disorders - Depressive Disorders - Anxiety Disorders - Obsessive-Compulsive and Related Disorders - Trauma- and Stressor-Related Disorders - Dissociative Disorders - Somatic Symptom and Related Disorders - Feeding and Eating Disorders - Disruptive, Impulse-Control, and Conduct Disorders - Personality Disorders - Paraphilic Disorders - Gender Dysphoria - Elimination Disorders - Sleep-Wake Disorders - Sexual Dysfunctions - Medication-Induced Movement Disorders - Attention Deficit/Hyperactivity Disorder - Tic Disorders <p><i>Disqualifying diagnoses and enrollment: A child may not solely have a developmental disorder (299.xx.315.xx.319.xx.) or Organic Brain syndrome (290.xx.293.xx.294xx) or Autism spectrum disorder 299.00 (F84.0) (unless if co-occurring with SED) and may not be enrolled in an OPWDD waiver.</i></p>
Risk Factors	<p>The child must meet all three of the Factors 1, 2 and 3.</p> <ol style="list-style-type: none"> 1. The child has a reasonable expectation of benefiting from HCBS and 2. The child requires HCBS to maintain stability, to improve functioning, to prevent relapse to an acute inpatient level of care and/or to maintain residence in the community and 3. A licensed practitioner of the healing arts (LPHA), who has the ability to diagnose within his/her scope of practice under State law, has determined in writing, that the child, in the absence of HCBS, is at risk of treatment in a more restrictive setting. The LPHA has submitted written clinical documentation to support the determination.

	More restrictive setting is defined as: RRSY, RTF, RTC, or other congregate care setting such as SUD residential treatment facilities, group residences, institutions in the OCFS system or hospitalization.
Functional Criteria	Algorithm applied to a subset of questions from the Child and Adolescent Needs and Strengths New York (CANS-NY)
Financial Criteria	<p>If a child is already Medicaid eligible, then a child meeting LON SED HCBS target criteria, risk factors, and functional criteria is eligible to receive HCBS.</p> <p>If a child is not already eligible for Medicaid and qualifies under no community eligibility rules, then a child meeting LON SED HCBS target criteria, risk factors, and functional criteria can be considered for Medicaid eligibility under the Family of One financial criteria.</p>

Level of Need HCBS Eligibility Determination Criteria - Abuse, Neglect and Maltreatment or Health Home Complex Trauma (No earlier than July 2022)	
Target Criteria	<ol style="list-style-type: none"> 1. Age 0 through child's 21st Birthday, and 2. Children who have experienced physical, emotional, or sexual abuse or neglect, or maltreatment and are currently in the custody of LDSS, or 3. Have Complex Trauma as defined by Health Home and Complex Trauma Assessment and Determination Tools see Department of Health website for definition and tools at: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/health_homes_and_children.htm
Risk Factors	<p>The child must meet the following risk factors (a and (b or c) and d and e):</p> <ol style="list-style-type: none"> a. The child has a reasonable expectation of benefiting from HCBS and either b or c. b. The child requires HCBS to maintain stability, improve functioning, prevent relapse to an acute inpatient level of care and maintain residence in the community or c. The child who, but for the provision of HCBS, would be at risk for a more restrictive setting <p>and</p> <ol style="list-style-type: none"> d. A licensed practitioner of the healing arts (LPHA), who has the ability to diagnose within his/her scope of practice under State law, has determined in writing, that the child, in the absence of HCBS, is at risk of treatment in a more restrictive setting. The LPHA has submitted written clinical documentation to support the determination; <p>and</p> <ol style="list-style-type: none"> e. And one or more of the following risk factors <ol style="list-style-type: none"> i. Medicaid Community Eligible ii. A former FC child who was enrolled in HCBS originally while in the care and custody of LDSS with no break in eligibility. <p>More restrictive setting is defined as: RRSY, RTF, RTC, or other congregate care setting such as SUD residential treatment facilities, group residences, institutions in the OCFS system or hospitalization.</p>

Functional Criteria	Algorithm applied to a subset of questions from the Child and Adolescent Needs and Strengths New York (CANS-NY)
Financial Criteria	<p>If a child is already Medicaid eligible (i.e., either currently in foster care or eligible through community eligibility rules), then a child meeting LON HCBS ANM or Complex Trauma target criteria, risk factors, and functional criteria is eligible to receive HCBS.</p> <p>If a child is not already eligible for Medicaid and qualifies under no community eligibility rules, then a child meeting such criteria must be a former foster care child who was enrolled in HCBS originally while in the care and custody of LDSS with no break in HCBS eligibility. If the child continues to meet LON HCBS ANM or Complex Trauma target criteria, risk factors, and functional criteria, the child should be considered for Medicaid eligibility under the Family of One financial criteria.</p> <p>Children meeting Health Home complex trauma criteria and risk factors who are not in foster care or were not formerly in foster care when enrolled in HCBS are not eligible for Medicaid under Family of One financial criteria.</p>

B. State Guidance and Infrastructure

To ensure smooth implementation and operationalization of this transition, the State will work closely with stakeholders to develop and release documentation and guidance. The State has been collecting feedback from stakeholders related to assumptions, potential issues, risks, and concerns regarding the Children’s Medicaid Health and Behavioral Health System Transformation.

The State will issue major guidance materials that govern all populations and benefits impacted by this transition, but will also issue separate guidance for specific groups and will work with individual providers and counties as needed to ensure a smooth transition. Major guidance materials include a Children’s Medicaid Health and Behavioral Health System Transformation Transition Policy for MMCPs, a MMCP qualification document (the Medicaid Managed Care Organization Children’s System Transformation Requirements and Standards) a cross walk of former 1915(c) HCBS to the State Plan or aligned children’s HCBS, billing manual, provider service manuals, provider standards, utilization review criteria, and reporting requirements. The State will facilitate relationships between involved entities, including HCBS providers, MMCPs, Health Homes, LDSS, OCFS, VFCA, LGU, and the Independent Entity by issuing formal workflows, overseeing the update or execution of business associate agreements, and requiring liaisons positions at key organizations for children in foster care.

- Guidance will describe, in detail: Requirements for formalizing relationships between Health Homes, MMCPs, and the Independent Entity, as well as for

establishing linkages between these entities and government and local resources, including State and city agencies, local department of social services, child protective services, voluntary foster care agencies, and other child serving organizations.

- Governing policies and operational processes, (e.g. referrals to assessment, services, Health Home, Independent Entity; billing information and processes; MMCP-provider contracting; timeframes; roles and responsibilities; continuity of care requirements across FFS and managed care delivery systems; and eligibility processes, etc.)
- Workflows describing processes at the program, member, provider, MMCP, and local district levels, including communication paths
- Descriptions of expectations for specific scenarios (e.g., a medically fragile child between 18-21 who is eligible for aligned children's HCBS and may enroll in a mainstream MMCP or a Managed Long Term Care Plan; a child in foster care who is in the custody of Kings county but is placed in Erie county)
- Reporting requirements and other requirements related to State oversight
- Service descriptions and criteria

The Medicaid Managed Care Model Contract permits changes to covered populations and benefits upon DOH 60 days' notice to MMCPs. The Children's Medicaid Health and Behavioral Health System Transformation Transition Policy for MMCPs will be incorporated into this notification and binding on the MMCPs. The Medicaid Managed Care Model Contract will be amended to reflect federal and state requirements of the transition in the following amendment cycle.

C. Information Systems

The State will ensure systems for eligibility, enrollment, cost reporting, encounter data, and claims payment support the transition. The State will develop population identifiers on State eligibility systems to support Medicaid managed care enrollment and ensure access to services. The State will develop changes to claims and billing systems to authorize fee for service reimbursement, ensure defined allowable scope of benefits, and monitor expenditures.

IV. Implementation Readiness

A. Health Home

Health Homes Serving Children in NYS have undergone a thorough application, readiness review process, and designation process and began serving children in December 2016.

The State issued guidance and communications to Health Homes related to updating their Administrative Service Agreements with Medicaid Managed Care Plans to include provision of assessments and care management for children eligible (or potentially eligible) for aligned children's HCBS.

The State will issue directions to care managers currently serving 1915(c) waiver recipients, describing how to become affiliated with a Health Home Serving Children and why this affiliation is necessary. Training and system connectivity regarding Health Home processes, policies and procedures are being and continue to be conducted to prepare 1915(c) waiver providers for Health Home care management.

Health Homes will ensure they have adequate network of former 1915(c) waiver providers for the number of 1915(c) Transitioning Children in the Health Home county designation they serve.

The State will expand on existing guidance and requirements issued to Health Homes Serving Children to specifically describe policies and procedures relating to treatment of children potentially eligible for aligned children's HCBS or in receipt of HCBS, including workflow, necessary checks, oversight and benchmarking, referral processes, transitional care rules, systems training, etc. This guidance will include establishing effective communications with MMCPs to share plans of care and other information necessary for children's referral and access to services.

The State will continue to monitor Health Home staffing and training to ensure individual Health Homes and affiliated Care Management Agencies are ready to serve an expanded population of high-need children.

B. Transitioning 1915(c) Care Coordinators to Health Home Care Managers

The State has established timelines to complete the transition of care coordination models under the 1915(c) waiver programs to Health Home care management. All Care Management Agencies from each of the 1915(c) Waiver programs will be engaged in training and technical assistance that will include the standards and requirements for delivering Health Home care management in accordance with the State Plan and State guidance, as well requirements and training around the use of Health Home Health Information Technology (HIT) and electronic care management records, and other

Health Home systems. All Health Home and Health Home care managers will be trained on the requirements for developing care plans that include HCBS, and aligned children's HCBS and new children's State Plan services.

In addition to structural and systemic readiness activities for care management agencies, additional training will be provided, along with written education materials and scripts, to assist the care managers serving HCBS enrolled youth in preparing children and families for the transition. The State will be working closely with the agencies to assure the care managers have the tools and language necessary to help "walk" families through the changes and assure freedom of choice along the way. The training and technical assistance provided will pay close attention to assuring continuity of care and the seamless provision of the services they need.

C. Independent Entity

The State will contract with an Independent Entity (IE) to perform various functions under the Concurrent Waiver including:

- Making referrals to Health Homes, and/or performing HCBS Eligibility Determinations (i.e., does the child meet LOC or LON target population, risk factors, and functional criteria), as appropriate, for children who may need and be eligible for aligned children's HCBS,
- Performing HCBS Eligibility Determinations, and developing HCBS plans of care for children who choose not to enroll in Health Home. For members that opt out of Health Home, i) the IE will monitor the HCBS plan of care and access to services for fee-for-service members, and ii) the MMCP will monitor the HCBS plan of care and access to services for members enrolled in Plans,
- Performing HCBS Eligibility Determinations for children not enrolled in Medicaid,
- Assisting children and their families who are not enrolled in Medicaid and eligible for aligned children's HCBS in applying for Medicaid, and referring children who become eligible for Medicaid to Health Homes,
- Developing HCBS plans of care for children who opt out of Health Home, and continue to educate individuals about the availability of Health Home;
- Working with the State to monitor access to aligned children's HCBS and HCBS plans of care for children not enrolled in an MMCP and receiving these services fee-for-service, and for LOC and LON Family of One members. In carrying out its functions, the IE will ensure it has appropriate consents from the child/family, or legally authorized representative or guardian, and

- In carrying out its functions, the IE will establish single point of contact relationships with MMCPs, Health Homes and local government units to facilitate referrals and linkages to other services where appropriate.

The State has defined and documented the scope of work and expectations of the Independent Entity. This includes specified components such as administrative care management role and monitoring requirements. For individuals remaining in FFS who opt out of Health Home, the Independent Entity will meet all person-centered planning requirements under 42 CFR 441 Subpart M.

The Independent Entity will be required to follow all State guidance on the HCBS Eligibility Determination process, including required assessment tools used during determination of eligibility for aligned children's HCBS and ongoing care coordination and/or monitoring. The State will also provide access and training on appropriate systems to: make Health Home referrals as appropriate, make referrals to the State Enrollment Broker, and monitor access to care for children receiving benefits FFS.

The State will confirm readiness of the Independent Entity through desk review of business requirement documents, work plans, key personnel; on-site readiness review; and ongoing monitoring activities.

D. Service Providers

1. Designation Process

The State has released a Provider Designation Application, for providers of the six new children's State Plan services and aligned children's HCBS.

The State will review applications from providers on a rolling basis and issue designations to provide new children's Medicaid State Plan services and aligned children's HCBS throughout the State. Priority will be given to providers currently serving children in 1915(c) waivers programs. Designations began in May 2018 and are subject to federal approval of the children's SPAs and Concurrent 1115 and Children's 1915(c) Waiver.

Lists of designated, Medicaid-enrolled providers will be provided to Medicaid Managed Care Plans to facilitate network development and the provider/MMCP contracting process.

2. Provider Training

The State will produce a list of suggested training for providers, on topics such as managed care provider contracting, training, utilization management, claims, workflow for service access, medical necessity criteria, authorization requirements, documentation requirements, etc.

The State will provide additional support and guidance to 1915(c) waiver providers of services transitioning from a Home and Community Based service to a State Plan service under the Children's Medicaid Health and Behavioral Health System Transformation. Training and technical assistance will address when State Plan services have additional provider requirements over the 1915(c) HCBS, and how access to State Plan services differ from access to aligned children's HCBS. For example, State Plan services are accessed by referral from a licensed practitioner, guided by medical necessity criteria and are part of a treatment or service plan; while HCBS are made available based on eligibility criteria and accessed through a person-centered plan of care developed from a comprehensive assessment.

The State will also meet regularly with and provide education and technical assistance to providers to ensure that children, youth, and families are appropriately educated on the transition from the 1915(c) to Concurrent Waiver authority. This will include ensuring that children/youth will not experience a disruption in services during the transition period.

3. Contracting with MMCPs

The State will continue to provide technical assistance to providers regarding contracting with Medicaid Managed Care Plans.

As mentioned above, the State will provide lists of designated Medicaid providers of the six new State Plan and aligned children's HCBS to Medicaid Managed Care Plans to facilitate network development and the contracting process. Additionally, the State, through a contracted entity for training and technical assistance, will offer in-person network contracting fairs to facilitate introductions between MMCPs and providers.

After contracting and credentialing is completed, MMCPs and providers will be required to perform claims testing to ensure a smooth transition to Medicaid managed care billing and payment.

4. Medical Record Access

Sharing of medical records with new service providers occurs between the MMCP, Health Home, the independent Entity and the new service provider in accordance with the consents in place for the child. Consistent with federal and State law, enrollees and their providers are able to obtain copies of the enrollee's medical records, as appropriate. See <https://www.health.ny.gov/publications/1443/> for more information.

E. Medicaid Managed Care Plans

The State will qualify Medicaid Managed Care Plans that currently operate a mainstream plan and/or HIV Special Needs Plan to manage benefits being carved into the Medicaid managed care benefit package under this transition.

The qualification document, [Medicaid Managed Care Organization Children's System Transition Requirements and Standards](#), contains detailed requirements for personnel, organization and management, network requirements, member services and access to care guidelines. The document was released on July 31, 2017. Plans were required to submit responses on or before October 31, 2017.

The following areas will be incorporated into the Readiness requirements and can be found in the qualification document:

- MMCPs will have sufficient member services support beginning February 1, 2019 for children's HCBS to respond to questions related to expanded children's benefits and provider network participation. The State expects member services staff to be adequately trained and any additional staff needed to support the volume of calls to be hired.
- To begin authorization of new services on April 1, 2019, beginning March 1, 2019, MMCPs will be ready to accept plans of care from Health Homes or the Independent Entity for current enrollees and for children for whom the Health Home Care Manager or Independent Entity has obtained consent to share the POC with the MMCP and the family has demonstrated the Plan selection process has been completed.
- MMCPs will expand its mechanisms to monitor service quality, develop quality improvement initiatives, and solicit feedback/recommendations from key stakeholders to improve quality of care and member outcomes through the involvement of consumer and other stakeholder advisory boards.
- MMCPs will have all operational systems in place by April 1, 2019 to ensure continuity of care provisions for transitioning members, to accept enrollments with new identifiers for HCBS-eligible children, to authorize services for HCBS-

eligible members and pay HCBS claims, to collect data and report on issues daily.

- MMCPs will contract with (or amend contracts with) providers beginning Spring 2018 and will begin claims testing with providers January 2019. The State and MMCPs will test encounter data submissions beginning November 1. MMCPs will provide training to providers relating to claims submissions, network status, credentialing, etc. as contracts are executed.

After MMCPs submit their responses to the qualification document, the State will conduct a desk review, followed by on-site readiness reviews, to ensure that the required components of the children's transition have been met by the applicant MMCP. The readiness review process will address each MMCP's capacity to serve the enrollees, including but not limited to, adequate network capacity, staff hiring plans including job description, training schedule and materials, policies and procedures, practice guidelines, and operational readiness to provide intensive levels of support. A complete list of deliverables and submissions requested of each MMCP is located in the qualification document and MMCPs will begin this phase of readiness review in the spring of 2018. Onsite Readiness Reviews will be conducted beginning in Fall of 2018. A team comprised of State agency staff will visit each MMCP and review their organization's preparedness for the transition.

MMCPs will be notified of their qualification status (qualified, conditionally qualified pending corrective actions). The State will monitor corrective actions and work with conditionally qualified MMCPs to ensure qualification standards and requirements are met by the implementation date of each service into MMCP the benefit package. MMCPs that remain conditionally qualified at implementation will continue to be monitored and may be subject to additional conditions and safeguards ensuring enrollee access to services.

The State will hold regular meetings with MMCPs during and following the transition, to identify and work through implementation and operational issues.

As per the Medicaid Managed Care Model Contract, the State will provide at least 60 days' notice to Medicaid Managed Care Plans regarding the transition of populations and benefits into managed care. Additional context and direction will be provided to Medicaid Managed Care Plans in the Children's Medicaid Health and Behavioral Health System Transformation Policy Paper, and any additional topic-specific guidance. The Medicaid Managed Care Model Contract will be amended to reflect these requirements.

MMCPs have ongoing access to historical FFS data for new enrollees. In addition, DOH has provided MMCPs with historical utilization and cost data for 1915(c) waiver participants and other children likely to receive services under this transition.

MMCPs will be prepared to accept the POCs of 1915(c) Transitioning Children from either the Health Home or the Independent Entity as these are developed between January 1, 2019 and March 31, 2019, and will receive POCs for children newly in need of aligned HCBS thereafter. MMCPs will be required to ensure timely access to care and comply with continuity of care requirements. The State will continue to monitor these standards by incorporating the requirements set forth by this transition in ongoing monitoring and surveillance activities.

F. Voluntary Foster Care Agencies

Effective July 1, 2019, the VFCA will transition to Medicaid managed care. Medicaid managed care plans will be responsible for providing aligned children's HCBS.

The State recognizes that Voluntary Foster Care Agencies provide customized health and behavioral health care services to children and youth in foster care to comply with federal, state and local mandates and do so in a trauma-informed manner. To maintain continuity of care, New York State Department of Health will promulgate regulations governing the licensure of Voluntary Foster Care Agencies under a new limited health licensure category. Upon licensure, the Voluntary Foster Care Agencies and Medicaid Managed Care Plans will initiate contracting.

Medicaid Managed Care Plans will be responsible for reimbursing VFCAs for Medicaid costs incurred by VFCAs to meet State and Federal child welfare requirements for children in the care and custody of the LDSS that are not "transferable" to the Managed Care capitated rates. The State is developing a proposed State Plan Amendment to authorize a VFCA "Residual Per Diem" that will be paid to the VFCAs by Medicaid Managed Care Plans for certain Medicaid costs incurred by the VFCA (primarily staffing costs) to meet child welfare requirements that are not "transferable" to a Medicaid Managed Care capitated rate.

Medicaid Managed Care Plans will be required to offer a contract to all Voluntary Foster Care Agencies that provide Medicaid services in their service area. Medicaid Managed Care Plans will be required to provide Single Case Agreements to Voluntary Foster Care Agencies that provide health and/or behavioral health care to enrolled children and

youth placed outside of the MMCP's service area. The State will provide training to support the process of contracting and billing between Voluntary Foster Care Agencies and Medicaid Managed Care Plans.

The State will confirm readiness of Voluntary Foster Care Agencies, as well as Medicaid Managed Care Plans, through review of written materials, on site reviews, confirmation of contracts and claims testing.

G. Enrollment Broker

The State Enrollment Broker, will meet updated requirements for this transition, including: enrollment and disenrollment procedures, affected populations/population identifiers, noticing processes, contingency plans, member outreach calendars, and training requirements.

The State will ensure the Enrollment Broker provides adequate customer service support for transition period and will require a dedicated core team to handle calls from 1915(c) Transitioning Children and new mandatory enrollees. To provide assistance and minimize the number of auto assignments, this team will be available to counsel enrollees on MMCP enrollment options and will provide outreach to individuals who do not respond to MMCP selection notices. Call Center staff will make available staff who speak the non-English prevalent languages in New York State. Customer Service scripts prepared by the call center will be reviewed and approved by the State. The State Enrollment Broker will establish a contingency plan to be used in the event of any natural disaster, including but not limited to floods, fire, situations that would prevent or cause potential harm to staff personnel at the job site.

The State Enrollment Broker will continue to report call volume and enrollment information to the State, which will support State monitoring during the transition.

Member materials will be drafted and approved by the State, including materials for consumer and enrollment notices. All written materials will be available in alternative formats for special needs populations such as visually limited and limited reading proficiency.

The State Enrollment Broker will update and test the auto assignment algorithm.

The State will monitor the State Enrollment Broker's readiness to perform these activities through conference calls, reports, and materials review.

Beginning, July 1, 2019, the State will remove the exclusion of children in the care of Voluntary Foster Care Agencies (VFCA) from Medicaid Managed Care enrollment.

In preparation for this change, beginning May 1, 2019, the State's Enrollment Broker will engage VFCA and LDSS in an MMCP selection process for children in the care of a VFCA. The State's Enrollment Broker will propose an MMCP based on 'best match,' taking into consideration location, current providers, and previous MMCP enrollment (if any), and the VFCA or LDSS will confirm the enrollment (unless the child is otherwise exempt or excluded), to be effective July 1, 2019.

The State will develop a process by which the State's Enrollment Broker may propose a MMCP enrollment as part of the child's foster care placement, including allowing children already enrolled in a Medicaid Managed Care Plan to remain enrolled in that MMCP, if appropriate.

H. Local Social Service District (LDSS)

The Department of Health will provide extensive communication through Administrative Directive, (ADM), General Information System (GIS), desk aids and frequently asked questions (FAQs) as guidance to LDSS on the new processes associated with the termination of the 1915(c) waiver programs and transition to the Concurrent Waiver authority.

The LDSS will continue to be responsible for establishing Medicaid eligibility for children, or referring community eligible applicants as appropriate to the New York State of Health (New York's health benefits exchange). Medicaid eligibility rules will remain unchanged by this transition.

The Independent Entity will provide the LDSS with documentation verifying Family of One children meet the HCBS eligibility criteria (i.e., the Independent Entity HCBS Eligibility Determination). The Family of One eligibility process will be expanded to children who meet at-risk Level of Need (LON) criteria and are determined Medicaid eligible through Family of One and receive HCBS. The State will inform and provide guidance to the LDSS on the HCBS eligibility criteria used by the Independent Entity to make HCBS Eligibility Determinations.

LDSS will also be provided instructions and guidance on the MMCP selection process of children placed in the care of a VFCA.

V. Communication Plan

Information for Consumers, Families, and Advocates

The State will issue brochures and other educational materials in print, in-person presentations, and web-based formats to explain benefit carve-ins, population

transitions into Medicaid Managed Care, how to select a Medicaid Managed Care Plan, how to access services, right to continuity of care, changes to processes including changes to the assessment process for aligned children's HCBS, role of Health Homes, and other topics as needed. Materials will be written in plain language, translated in prevalent languages and made available in a manner consistent with State accessibility protocols. Health Home Care Managers have established relationships and routine contact with families, they will be the primary source of information to families. To facilitate and support this method of education, the State will also provide talking points to Health Home Care Managers.

Consumers will receive notice informing them of changes to their benefits, as applicable, notice of 1915(c) waiver program termination no later than 30 days prior to the effective date of the termination, and a notice prompting selection of a Medicaid Managed Care Plan. In accordance with law and regulation, timely and adequate appeal and fair hearing rights notices will be provided to consumers whenever a determination is made on Medicaid eligibility, HCBS eligibility, or authorization for services.

Consumers already enrolled in a Medicaid Managed Care Plan (MMCP) during the transition period will receive a benefit announcement letter from their plan, which will include written notice of transitional care policies. Consumers who are mandated to select a plan as a result of this transition will receive written explanation of MMCP transitional care policies in the initial enrollment notice.

All consumer-facing notices will be posted to the DOH website and shared with providers.

VI. Monitoring, Oversight, and Controls

The State's monitoring and oversight of the Children's Medicaid Health and Behavioral Health System Transformation includes data collection, reporting and analysis as required to carry out the Concurrent 1115 MRT Demonstration Evaluation Plan and 1915c Children's Waiver, the state's Quality Strategy (as amended to meet 1115 Special Terms and Conditions for the children's transition, and budget neutrality/fiscal oversight (including cost reporting and encounter data).

The State has identified dependency relationships between the major objectives of this transition. See [Attachment H](#). This information will be used by the State to confirm that readiness has been achieved at each step and assess the need for a delay in implementation of any dependent element.

The State will also have staff and information systems in place to monitor all aspects of the transition in “real time,” including, but not limited to: Medicaid Managed Care Plan selection and oversight; call center volume; complaints and critical incidents; Health Home enrollment; Health Home care management engagement; assessment volume and results; plan of care development; access to HCBS; access to new State plan services; consistent application of medical necessity criteria and service standards; service authorization utilization review adverse determinations (where permitted); network adequacy; issues with provider claiming or provision of benefits carved into the Medicaid managed care benefit package.

The State will continue to engage with stakeholders through the transition period through conference calls; in person meetings; webinars; and web postings to quickly identify and resolve issues or concerns occurring at the community or health care delivery system level. The State will leverage Regional Planning Consortium meetings to work through identified barriers to care in a collaborative environment.

In addition, the State will continue its ongoing monitoring of Health Homes, MMCPs, and providers, updating surveillance and oversight tools to reflect the requirements of the Children’s Medicaid Health and Behavioral Health System Transformation. This includes:

A. Health Home Oversight

Health Homes Serving Children are subject to ongoing performance monitoring and management. Health Homes will be required to undergo a re-designation process (designations are active for up to three years), based on key performance measures identified by the State and unique to children. In the interim years, case reviews, site visits, routine calls, data and standards compliance reviews and monthly Health Home discussions with the Department of Health will occur. Additionally, the State requires Health Homes to report, review, track and addresses complaints and critical incidents.

Underperforming Health Homes, in accordance with severity of underperformance, will be subject to remediation measures. Remediation measures could include the submission of performance improvement plans, and routine review of policies and procedures, network guidance and Health Home operations.

B. Medicaid Managed Care Plans Ongoing Monitoring and Oversight

The State oversees MMCPs using a combination of desk reviews and on-site reviews guided by a survey tool. Plan reporting will be expanded to include key metrics related to the populations and benefits affected by this transition.

Each Managed Care Organization undergoes a Public Health Law Article 44 operational review. An on-site, comprehensive operational survey is conducted every two years, beginning one year after certification. In the off year of the comprehensive operational survey, a targeted operational survey is conducted to assess implementation of a Plan of Correction (for citations found during the operational survey), as well as the review of new or revised policies or organizational changes. These surveys are completed to comply with statutes, regulations, provisions within the Medicaid Managed Model Contract, and standards outlined in Medicaid qualification documents. Surveys include desk reviews of written material, which may include review of networks, policies and procedures, staff qualifications, and on-site reviews, which may include review of claim systems, and interviews with staff at various levels. If deficiencies are cited, the MMCP is required to implement a corrective action plan, which is re-evaluated during the next survey. The State also conducts periodic focus surveys, including but not limited to: network capacity assessment; evaluations of access and availability of the provider network; testing of member services phone lines; review of provider directory information and accuracy; and compliance with fair hearing directives.

C. State Plan and HCBS Providers

All service providers will be required to maintain, or gain, appropriate State licensing, registration or certification for the service they intend to offer and population they intend to serve, as a condition of State Designation as a new children's State Plan or HCBS provider. The State has developed a Standards of Care and Monitoring Tool to monitor providers of new children's State Plan services. This tool will follow the format of provider monitoring tools used by the State to oversee care delivery. The State will meet all monitoring requirements of HCBS as defined within the 1915(c) Children's Waiver.

D. Independent Entity

The State will monitor the activities of the Independent Entity. The IE will collect data and submit reports to the State regarding screening, assessments, complaints, critical incidents, and percentage of children assisted and ultimately found eligible as a Family of One and other information as necessary to meet monitoring requirements of HCBS as defined within the 1915(c) Children's Waiver. The

Independent Entity will also be assessed in their capacity to arrange referrals to needed services pursuant to the HCBS plan of care and, maintain relationships/communications with providers to assure services are delivered to children for whom they monitor access to care.

E. Ongoing Operations Meetings

The State will establish ongoing meetings, open to stakeholders involved in the transition, to report and work through identified operational issues.

The State will continue to maintain and publicize email addresses and toll-free phone numbers for providers, consumers, MMCPs, and other entities to report problems, complaints, incidents, and submit questions for State investigation and response.

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Attachment A: New Medicaid State Plan Services and Implementation timeline
[subject to CMS federal approval]

To be Implemented January 2019

New State Plan Service

- Other Licensed Practitioner (OLP)

Services transitioning from 1915-c waivers to Medicaid State Plan

- Community Psychiatric Support and Treatment (CPST)
- Psychosocial Rehabilitation Supports (PSR)

To be Implemented July 2019

- Family Peer Support Services

To be Implemented January 2020

- Youth Peer Support and Training
- Crisis Intervention

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Attachment B: Aligned Array of Children’s Home and Community Based Services

April 1, 2019

Health Home Care Management (if not otherwise eligible under the State Plan)

and

- Accessibility Modifications
- Adaptive and Assistive Equipment
- Caregiver/Family Supports and Services
- Community Self-Advocacy Training and Support
- Community Habilitation
- Day Habilitation
- Non-Medical Transportation*
- Palliative Care: Bereavement Service
- Palliative Care: Massage Therapy
- Palliative Care: Expressive Therapy
- Palliative Care: Pain and Symptom Management
- Prevocational Services
- Respite
- Supported Employment

January 1, 2019- June 30, 2019 (Under State Plan benefit definition)

- Family Peer Support Services

January 1, 2019 – December 31, 2019 (Under State Plan benefit definition)

- Crisis Intervention
- Peer Supports and Services

*Non-Medical Transportation will be paid Fee-for-Service for eligible children/youth, regardless of whether the child/youth is enrolled in Medicaid Managed Care, to leverage the existing Medicaid Fee-for-Service transportation infrastructure.

See the HCBS Service Manual for more information:

https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/2016-12-06_draft_hcbs_prov_manual.pdf

Attachment C: Existing Medicaid State Plan Services to be included in the Medicaid Managed Care Benefit Package for Enrollees Under 21 Years of Age

- Assertive Community Treatment (ACT)
- Comprehensive psychiatric emergency program (including Extended Observation Bed)
- Continuing Day Treatment
- Health Home Care Management
- Medically managed detoxification (hospital based)
- Medically supervised detoxification
- Medically supervised outpatient withdrawal
- Licensed outpatient clinic services (OMH clinic services)
- OASAS Outpatient and Opioid Treatment Program (OTP) services
- OASAS Outpatient Rehabilitation services
- OASAS Outpatient Services
- Residential Addiction Services
- Partial Hospitalization
- Personalized Recovery Oriented Services (PROS)
- Residential Supports and Services (VFCA) (New Early and Periodic Screening, Diagnostic and Treatment [EPSDT] Prevention effective 7/1/2019)

Attachment D: Key Operational Milestones

The Key Operational Milestones for implementing the Draft Transition Plan, as well as the concurrent 1915(c) and 1115 waivers, and State Plan Amendments, require the approval of CMS and therefore may be subject to further modifications.

Date	Milestone	Completed
Dec 28, 2016	OLP SPA submitted to CMS for approval	✓
Dec 28, 2016	Rehab SPA submitted to CMS for approval	✓
May 9, 2017	1115 Children's transition waiver amendment submitted to CMS for approval	✓
Jun 26, 2017	Released Updated Provider Designation Application	✓
Jul 31, 2017	Released MMCP Qualification Standards	✓
Aug 1, 2017	Public education on Children's Medicaid Health and Behavioral Health System Transformation begins	✓
Aug 9, 2017	Released Draft Children's Medicaid System Transition Plan for Public Comment	✓
Oct 31, 2017	MMCP qualification applications submissions due	✓
Nov 15, 2017	State confirms MMCP qualification application complete	✓
Nov 16, 2017	CMS approval of children's SPA	✓
Nov 20, 2017	Preliminary provider designation letters released (for current 1915(c) providers)	✓
Dec 15, 2017	MMCP utilization review and clinical management qualification documentation due	✓
Jan 3, 2018	State Title 18 regulations for children's SPA promulgated	✓
Jan 30, 2018	Interim MMCP Qualification Report	✓
May 16, 2018	First round of provider formal designation letters released (priority given to current 1915(c) providers)	✓
Jul 15, 2018	Begin MMCP monitoring of provider network development, personnel recruitment and training	✓
Sep 1, 2018	CMS Approval of Transition Plan	<input type="checkbox"/>
Sep 15, 2018	Two State Plan Amendments 17-001 and 17-004 for the Six SPA Services resubmitted to CMS (CMS originally approved November 16, 2017) to make Other Licensed Practitioner; Psychosocial Rehabilitation, and Community Psychiatric Treatment and Supports, effective January 1, 2019 and Family Peer Support effective July 1, 2019. (A subsequent SPA will be submitted to make Youth Peer Support and Crisis Intervention effective January 1, 2020)	<input type="checkbox"/>

Date	Milestone	Completed
Oct 1, 2018	State submission of SPA for Residential Supports and Services for VFCA providers participating with MMCPs	<input type="checkbox"/>
Oct 1, 2018	Begin provider/MMCP children's SPA Other Licensed Practitioner; Psychosocial Rehabilitation, and Community Psychiatric Treatment and Supports claims testing window	<input type="checkbox"/>
Oct 15, 2018	60 Days' notice to MMCP for addition to benefit package provision for 2019 SPA and aligned children's HCBS as per implementation timeline	<input type="checkbox"/>
Nov 1, 2018	CMS Approval anticipated to terminate five existing 1915(c) children's Waivers and amend waiver #NY.4125 on 3/31/19 close of business	<input type="checkbox"/>
Nov 1, 2018	CMS Concurrent 1115 Waiver Approval anticipated	<input type="checkbox"/>
Nov 15, 2018	State begins licensing of VFCAs	<input type="checkbox"/>
Nov 15, 2018	State informational letter to 1915(c) waiver families regarding Children's Medicaid Health and Behavioral Health System Transformation	<input type="checkbox"/>
Dec 1, 2018	State 60 days' notice to MMCPs of benefit change for Member Services and children's network availability	<input type="checkbox"/>
Dec 1, 2018	Begin Announcement Letters to affected beneficiaries for April 1, 2019 Medicaid Managed Care mandatory enrollment	<input type="checkbox"/>
Dec 1, 2018	Begin contracting between MMC Plans and VFCAs	<input type="checkbox"/>
Dec 15, 2018	Tribal notice for closure of 1915(c) waivers	<input type="checkbox"/>
Jan 1, 2019	Begin Other Licensed Practitioners; Community Psychiatric Support and Treatment; and Psychosocial Rehabilitation Supports as State Plan services in FFS and managed care	<input type="checkbox"/>
Jan 1, 2019	Transition to Health Home Care Management begins	<input type="checkbox"/>
Jan 1, 2019	Earliest date that care manager will transition a 1915(c) Transitioning Child to Health Home care management	<input type="checkbox"/>
Jan 1, 2019	Earliest date that Health Home Care Manager will assess 1915(c) Transitioning Child	<input type="checkbox"/>
Jan 1, 2019	Earliest date that a new children's HCBS identifier may appear on a child's record	<input type="checkbox"/>
Jan 1, 2019	Earliest date that a care management agency will bill under Health Home infrastructure	<input type="checkbox"/>
Jan 1, 2019	Begin provider/MMCP aligned children's HCBS claims testing window	<input type="checkbox"/>
Jan 15, 2019	Publication of public notice regarding closure of 1915(c) waivers	<input type="checkbox"/>
Feb 1, 2019	MMCP Children's HCBS network substantially completed	<input type="checkbox"/>
Feb 1, 2019	Earliest date that Independent Entity will accept referrals for transitioning 1915(c) children opting out of Health Home	<input type="checkbox"/>
Feb 15, 2019	Notice to 1915(c) waiver program children and families regarding closure of the 1915(c) waivers	<input type="checkbox"/>
Feb 15, 2019	State Letter to CMS closing 1915(c) waivers	<input type="checkbox"/>
Feb 15, 2019	State 30-day notice to local social service districts regarding HCBS process changes	<input type="checkbox"/>

Date	Milestone	Completed
Feb 15, 2019	State qualifies MMCP to provide expanded children's services/serve expanded children's population (may be conditional qualification pending corrective action plan)	<input type="checkbox"/>
Mar 1, 2019	MMCPs begin receiving Health Home POCs/HCBS POCs	<input type="checkbox"/>
Mar 1, 2019	CMS Approval of New State Plan Amendment for Residential Supports and Services for foster care providers that will be included in Managed Care benefit package	<input type="checkbox"/>
Mar 1, 2019	Begin Medicaid managed care enrollment notifications for children in receipt of HCBS placed in foster care in care of the LDSS for July 2019 enrollment	<input type="checkbox"/>
Mar 14, 2019	Last day for affected beneficiaries to select an MMCP for April 2019 enrollment	<input type="checkbox"/>
Mar 31, 2019	Care managers complete case load transition to Health Home care management	<input type="checkbox"/>
Mar 31, 2019	(5) 1915(c) waiver programs termination and transfer to waiver #NY.4125 effective close of business	<input type="checkbox"/>
Apr 1, 2019	Concurrent 1915(c) Children's Waiver and 1115 Waivers authority begins	<input type="checkbox"/>
Apr 1, 2019	Health Home Care Management for Children Eligible for HCBS under the 1115 Waiver authority begins	<input type="checkbox"/>
Apr 1, 2019	Remove exemption for mandatory enrollment for children previously enrolled in 1915(c) waivers (not including B2H children placed in foster care); 1 st day of plan enrollment for affected children	<input type="checkbox"/>
Apr 1, 2019	Begin provider billing under 1915(c) Children's Waiver HCBS rate codes	<input type="checkbox"/>
Apr 1, 2019	Begin new HCBS/LOC Eligibility Determination Process	<input type="checkbox"/>
Apr 1, 2019	LDSS begins to accept documentation in support of Medicaid applications under HCBS Eligibility Process (in accordance with the State's capacity management system)	<input type="checkbox"/>
Apr 3, 2019	Begin VFCA/MMCP claims testing window	<input type="checkbox"/>
Apr 31, 2019	Confirm no billing of 1915(c) care coordination for 1915(c) Transitioning Children enrolled in HH during Jan 1, 2019 – Mar 31, 2019	<input type="checkbox"/>
May 1, 2019	Begin plan selection process for children in care of VFCA	<input type="checkbox"/>
Jul 1, 2019	Begin Family Peer Services as state plan service in FFS and managed care	<input type="checkbox"/>
Jul 1, 2019	Begin MMCP coverage of current BH SPA services for children under 21	<input type="checkbox"/>
Jul 1, 2019	IE begins evaluation of children new to Medicaid in need of HCBS in accordance with the State's capacity management system	<input type="checkbox"/>
Jul 1, 2019	Begin MMCP enrollment for children in care of VFCA and children in receipt of HCBS placed in foster care in care of the LDSS	<input type="checkbox"/>
Jul 1, 2019	Begin MMCP coverage of VFCA Residual Per Diem and HCBS for children placed in foster care in care of the LDSS	<input type="checkbox"/>
Jan 1, 2020	Begin Youth Peer Support & Training and Crisis Intervention as state plan services in FFS and managed care	<input type="checkbox"/>

**Attachment E: 1915(c) Waiver Services to State Plan and Children’s 1915(c)
Waiver Service Crosswalk**

Existing CAH I/II Waiver Services	Existing OCFS B2H Waiver Services	Existing OMH SED Waiver Services	Existing OPWDD CAH Waiver Services	New Children and Family Treatment and Support Services	Newly Aligned HCBS Benefits
	Immediate Crisis Response Services	Crisis Response Services		Crisis Intervention Community Psychiatric Supports and Treatment – Crisis Component OLP – Crisis Component	
	Crisis Avoidance, Management & Training AND Intensive In-Home Services	Intensive In-Home Services		Community Psychiatric Supports & Treatment	
		Family Peer Support Services		Family Peer Support Services	
		Youth Peer Advocacy and Training		Youth Peer Advocacy and Training	
				Other Licensed Practitioner	
	Skill Building	Skill Building		Psychosocial Rehabilitation Services	

Case Management	Health Care Integration	Individualized Care Coordination	Case Management		HH Care Management
	Crisis & Planned Respite	Respite Services	Respite		Respite
	Prevocational Services	Prevocational Services			Prevocational Services
	Family/Caregiver Support Services				Caregiver/Family Support & Services
	Supported Employment	Supported Employment			Supported Employment
	Special Needs Community Advocacy and Support (SNCAS)				Community Self-Advocacy Training and Support
	Day Habilitation				Day Habilitation
					Community Habilitation
	Adaptive and Assistive Equipment		Assistive Technology – Adaptive Devices		Adaptive and Assistive Equipment
Home and Vehicle Modifications	Accessibility Modifications		Environmental Modifications (Home Accessibility)		Accessibility Modifications
Palliative Care (Family Education, Bereavement Service, Massage Therapy,					Palliative Care Pain & Symptom Management
					Palliative Care Bereavement

Expressive Therapy)					Palliative Care Massage Therapy
					Palliative Care Expressive Therapy
					Non-Medical Transportation
					Customized Goods & Services

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Attachment F: Comparison of Health Home SED and HCBS SED Definitions

DSM-V Category	Health Home SED^	HCBS SED target criteria*
	Only ADHD (criteria below)	Only ADHD and Tic Disorders
Neurodevelopmental Disorders		
Schizophrenia Spectrum and Other Psychotic Disorders	X	X
Bipolar and Related Disorders	X	X
Depressive Disorders	X	X
Anxiety Disorders	X	X
Obsessive-Compulsive and Related Disorders	X	X
Trauma- and Stressor-Related Disorders	X	X
Dissociative Disorders	X	X
Somatic Symptom and Related Disorders	X	X
Feeding and Eating Disorders	X	X
Disruptive, Impulse-Control, and Conduct Disorders	X	X
Personality Disorders	X	X
Paraphilic Disorders	X	X
Gender Dysphoria	X	X
Elimination Disorders		X
Sleep-Wake Disorders		X
Sexual Dysfunctions		X
Medication-Induced Movement Disorders		X
Substance-Related and Addictive Disorders		
Neurocognitive Disorders		
Other Mental Disorders		
Other conditions that may be the focus of clinical attention		

Health Home ADHD with the following criteria (have utilized any of the following services in the past three years):

- Psychiatric Inpatient
- Residential Treatment Facility
- Day Treatment
- Community Residence
- HCBS Waiver

- Targeted Case Management

^HH SED: Any diagnosis in the indicated DSM categories can be used when evaluating a child for SED. However, any diagnosis that is secondary to another medical condition is excluded.

*HCBS SED list as of March 2016

Both the HH and the former OMH SED functional criteria contain the following wording for functional limitations (HCBS functional limitations will now be determined using the CANS algorithm):

The functional limitations must be moderate in at least two of the following areas or severe in at least one of the following areas:

- (i) ability to care for self (e.g. personal hygiene; obtaining and eating food; dressing; avoiding injuries); or
- (ii) 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
- (iii) 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
- (iv) 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
- (v) ability to learn (e.g. school achievement and attendance; receptive and expressive language; relationships with teachers; behavior in school).

Functional limitations are experienced:

HH: “over the past 12 months (from the date of assessment) on a continuous or intermittent basis.”

Former HCBS SED: “over the past 12 months on a continuous or intermittent basis.”

Attachment G: HCBS and Care Management/ Coordination Process

Child in MMC	Table 1.0				
	HCBS Eligibility Determination	Eligible for HCBS?	Plan of Care	Care Management	Monitor Access to Services
In Health Home	Health Home	Yes	HH Comprehensive POC with HCBS	Health Home	MMCP
Not yet Health Home	HH/IE	Yes, elects HH	HH - Comp POC with HCBS	Health Home	MMCP
	HH/IE	Yes, Opts out of HH	IE - HCBS POC	MMCP	MMCP
	HH/IE	No, but eligible for and elects HH	HH - Comp POC w/o HCBS	Health Home	MMCP

Direct referrals to Health Homes by community providers and plans should be made for children likely eligible for Health Home or HCBS (Children eligible for HCBS are eligible for Health Home)

Child in FFS	Table 2.0				
	HCBS Eligibility Determination	Eligible for HCBS?	Plan of Care	Care Management	Monitor Access to Services
In Health Home	Health Home	Yes	HH Comprehensive POC with HCBS	Health Home	Health Home
Not yet Health Home	HH/IE	Yes, elects HH	HH Comp POC with HCBS	Health Home	Health Home
	HH/IE	Yes, Opts out of HH	IE - HCBS POC		IE
	HH/IE	No, but eligible for and elects HH	HH - Comp POC w/o HCBS	Health Home	Health Home

Direct referrals to Health Homes by community providers and plans should be made for children likely eligible for Health Home or HCBS (Children eligible for HCBS are eligible for Health Home)

Child not Medicaid		HCBS Eligibility Determination	Eligible for HCBS?	Plan of Care	Care Management	Monitor Access to Services
	Not yet Health Home	IE	Yes	IE - initial HCBS POC	See Table 1.0 OR Table 2.0	See Table 1.0 OR Table 2.0
		IE	No, but eligible for and elects HH	HH- Comp POC w/o HCBS	Health Home	See Table 1.0 OR Table 2.0

Child DD in Foster Care		HCBS Eligibility Determination	Eligible for HCBS?	Plan of Care	Care Management	Monitor Access to Services
	In Health Home	DDRO	Yes	Health Home Comprehensive POC with HCBS	Health Home	Health Home or if enrolled, MMCP
	Not yet in Health Home	DDRO	Yes	See Table 1.0 OR Table 2.0	See Table 1.0 OR Table 2.0	See Table 1.0 OR Table 2.0

Child MF/DD		HCBS Eligibility Determination	Eligible for HCBS?	Plan of Care	Care Management	Monitor Access to Services
	In Health Home	Health Home OR DDRO	Yes	Health Home Comprehensive POC with HCBS	Health Home	Health Home or if enrolled, MMCP
	Not yet in Health Home	HH/IE OR DDRO	Yes	See Table 1.0 OR Table 2.0	See Table 1.0 OR Table 2.0	See Table 1.0 OR Table 2.0

Direct referrals to Health Homes by community providers and plans should be made for children likely eligible for Health Home or HCBS (Children eligible for HCBS are eligible for Health Home)

Attachment H: Transition Dependency Relationships

Children's Medicaid Systems Transformation Transition Dependency Relationships

