



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* Transition Plan for the Children's Medicaid System Transformation**

August 15, 2017

DRAFT Transition Plan for the Children’s Medicaid System Transformation

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DRAFT Transition Plan for the Children’s Medicaid System Transformation

The DRAFT Transition Plan for the Children’s Medicaid System Transformation is being submitted to stakeholders for review and comment. Please note the Transition Plan is also subject to approval by the Centers for Medicare and Medicaid Services (CMS).

Comments are due no later than August 31, 2017. Comments must be submitted to BH.Transition@health.ny.gov . In the subject line please indicate “Draft Children’s Transition Plan Comments”. In your comments please indicate the section and page number to which your comment refers to.

I. Scope of Transition

A. Vision

With federal and State approval, beginning January 1, 2018, the State will initiate a Transition Plan for the Children’s Medicaid System Transformation. The Children’s System Transformation will improve access to services for high needs children by:

- Moving the various and disparate authorizations for home and community based services (HCBS) now provided under six separate Section 1915(c) waivers to New York State’s 1115 Medicaid Redesign Team Waiver (1115 Waiver);
- Aligning those separate HCBS authorizations into a single array of 12 HCBS available under the 1115 Waiver or the Medicaid State Plan;
- Unifying and providing care management for high needs children with chronic conditions under the Health Home program;
- Leveraging the Medicaid managed care delivery system to further integrate the delivery of services;
- Preventing escalation to higher end services and addressing needs earlier by creating six new Medicaid State Plan services for children and expanding eligibility criteria for aligned children’s HCBS from including only children that meet Level of Care (LOC) criteria (i.e., at risk of institutional level of care) to also include children that meet or Level of Need (LON) criteria (i.e., the child does not meet institutional level of care but does have extended impairment in functioning).

Children in receipt of 1915(c) waiver services will move from the Medicaid fee for service delivery system to the Medicaid managed care delivery system. Children

otherwise exempt or excluded from Medicaid managed care enrollment will continue to access these services through the fee for service delivery model.

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 need. 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 that are eligible for and receive HCBS are required to have a care plan and receive care management. Children that are eligible for HCBS will be eligible for, and receive, Health Home care management. This includes children that now receive HCBS from a 1915(c) waiver program that will transition to aligned children's HCBS under the 1115 Waiver, and children that become newly eligible for aligned children's HCBS under the 1115 Waiver. Children that are now enrolled in Health Homes may also meet eligibility criteria for, and receive, aligned children's HCBS

Providers that provide care management to children under the 1915(c) waivers will transition to Health Home care management. This will ensure the expertise of the 1915(c) care managers is transferred to the Health Home program and will preserve continuity of care by providing children transitioning from 1915(c) waiver to Health Home care management the option to continue to work with their current care manager (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 a member needs (e.g., health, behavioral health, specialty services, other community and social supports, etc.).

As described in Section II.D in more detail, additional continuity of care protections will ensure transition to the 1115 Waiver does not disrupt receipt of services for children currently enrolled in a 1915(c) waiver program.

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 July 1, 2018, the State will provide six new State Plan services for children under 21 years of age who meet medical necessity criteria. These services are listed in *Attachment A*.

Beginning July 1, 2018, the State will provide the newly aligned children's HCBS. For a complete list of services transitioning, refer to *Attachment B*.

On and after July 1, 2018, HCBS eligibility will be determined using new target population, risk factor and functional eligibility criteria.

A State-contracted Independent Entity (IE) will make HCBS Eligibility Determinations (i.e., determine if members meet target population, risk factors, and functional criteria) for members who are not enrolled in Medicaid and that may be eligible for HCBS. (The IE will work with OPWDD for individuals with Developmental Disabilities to make HCBS Eligibility Determinations).

The newly aligned children's HCBS will be available through both the fee for service (FFS) and managed care delivery systems. Care coordination for aligned children's HCBS will be fully transitioned to Health Home care management.

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 January 1, 2018, the authority for the provision of HCBS provided under the following six 1915(c) waivers will transition to the 1115 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 1115 Waiver, beginning July 1, 2018 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.

Beginning January 1, 2019 statewide, the following populations will be required to enroll in a Medicaid Managed Care Plan and receive services from the Medicaid managed care delivery system:

- 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; and
- Children/youth in the care of a Voluntary Foster Care Agency.

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 1115 Waiver Services into Medicaid Managed Care

Beginning July 1, 2018, 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*.

Beginning July 1, 2018, the six new children's State Plan services 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, 2018, the newly aligned children's HCBS will be included in the Medicaid Managed Care Plan benefit package.

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

On January 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 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 January 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.

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 1115 amendment. The State will continue to meet (at least monthly) with the MRT Children's Behavioral Health and Health Sub-Committee, 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. The State anticipates the rule making process to be completed in Fall 2017.

The 1115 MRT Waiver Amendment and State Plan Amendments for the six new services are subject to federal CMS approvals.

II. 1915(c) Transitioning Children into State Plan and 1115 Waiver Services

A. Informed, Transparent and Seamless Transition for Children Enrolled or Determined to be Eligible for 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 *or* children found eligible through the Interim Transition Process (discussed below) to receive Interim HCBS between January 1, 2018 and June 30, 2018. The term "Interim HCBS" means HCBS previously offered under one of the six 1915(c) waiver programs.

Current waiver service providers will continue to provide Interim HCBS in accordance with the child's person-centered plan of care; only Interim HCBS will be provided prior to July 1, 2018. For the period January 1, 2018 through June 30, 2018 all Interim HCBS will be provided through the FFS delivery system.

Continuity of care protections (see Section II.D) will ensure 1915(c) Transitioning Children maintain eligibility for HCBS for at least 12 months from their transition to Health Home care management, 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 for resolution of their concerns.

1. Consumer Engagement

Beginning in 2017 and continuing into early 2018, the State will 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 Children's System Transformation.

2. Federal Authority Change and the Interim Transition Process

On January 1, 2018, authority for the six 1915(c) waiver programs will end, and the 1115 Waiver authority will begin. The State will send notice to beneficiaries and to CMS regarding termination of the 1915(c) waivers 30 days in advance of the requested effective date.

Under the State's Transition Plan, all existing 1915(c) plans of care will remain in place and services will be considered authorized under 1115 Waiver authority, so that this authority change has no immediate impact on 1915(c) Transitioning Children receiving services under the waiver.

Under the State's Transition Plan, between January 1, 2018 and June 30, 2018, the State will implement an Interim Transition Process that will continue all the protocols used by each of the six 1915(c) waiver programs for referral, screening, and intake into waiver program services, including determining Level of Care. Medicaid application processes will remain the same. The State will continue existing Level of Care documentation standards required under the six 1915(c) waivers through June 30, 2018.

State agencies currently monitor children who were identified as eligible for one of the six 1915(c) waivers, but who could not access the programs due to slot limitations and were placed on waitlists. With the termination of the 1915(c) authority, and under the Interim Transition Process, the State will lift waiver program slots, and each State agency will work with the Department of Health to assure these children (children on wait list) gain access to Health Home care

management services, along with additional community supports and services, and/or access to available Interim HCBS.

Similarly, under the Interim Transition Process, all children newly identified by providers, local department of social services or local government units as potentially eligible for HCBS will experience no additional changes in the process for completing the supporting documentation, Medicaid application, and intake process necessary to establish Medicaid eligibility and access services, while the State completes the Children's System Transformation.

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

Between April 1, 2018 and June 30, 2018, all 1915(c) Transitioning Children, will transition with their existing care coordinator to Health Home Care Management, with the consent of the child/family or legally authorized representative or guardian. If consent to enrollment in Health Home is obtained, then the Health Home care manager will develop a Health Home comprehensive Plan of Care and arrange for Interim HCBS to continue or begin. The Health Home care manager may begin preliminary care planning around the new services that will be made available July 1, 2018. During the Interim Transition Process, a Health Home comprehensive Plan of Care that includes HCBS will continue or initiate authorization of Interim HCBS to be delivered via FFS.

To ensure continuity of care and no service disruptions, under the Interim Transition Process, 1915(c) Transitioning Children will not be reassessed for HCBS eligibility until one year after the date of their initial Child and Adolescent Needs and Strengths New York (CANS-NY) assessment (as described in Section II A.8 below).

On July 1, 2018, all 1915(c) Transitioning Children will seamlessly transition to the new aligned children's HCBS beginning July 1, 2018.

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 1115 Waiver Services.

To preserve the expertise of existing 1915(c) coordinators and preserve existing relationships with children and families, under the State's Transition Plan, care managers 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 Managers. The State has already begun work to facilitate Health Home affiliations with care managers that now provide 1915(c) care coordination. Many of these 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 early 2018, 1915(c) care coordinators that will transition to Health Home Care Managers will begin talking to their 1915(c) Transitioning Children and families about the Children's 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 July 2018, why the State is transforming children's services, and when these changes will take place.

Starting April 1, 2018, these former 1915(c) and now Health Home Care Managers will continue the education process 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 that 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 that 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 that 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.

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 that decline Health Home care management, to the Independent Entity, no later than July 1, 2018.

4. Role of Independent Entity

Beginning May 1, 2018 and through the end of the Interim Process (June 30, 2018), the Independent Entity will be available to accept referrals of 1915(c) Transitioning Children who are eligible for or in receipt of Interim HCBS and who opt out of Health Home enrollment. The Independent Entity will develop a person-centered plan of care for provision of HCBS. For children that 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 that 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.

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 Interim 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 also be shared with the child's Medicaid Managed Care Plan, as applicable, to ensure authorization of services. (See *Attachment E* for the crosswalk of Interim HCBS to children's State Plan or aligned children's HCBS).

To ensure continuity of care and no service disruptions, under the Interim Transition Process, 1915(c) Transitioning Children will not be reassessed for

HCBS eligibility until one year after the date of their initial CANS-NY assessment (as described in Section II A.8 below).

6. Medicaid Managed Care Enrollment

On July 1, 2018, the State will remove the exemption from Medicaid managed care enrollment for children transitioning from one of the six 1915(c) waiver programs or who became eligible for HCBS during the Interim Transition Process. This change will not affect children in the care of a Voluntary Foster Care Agency. 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, and will remain excluded from Managed Care), may elect to enroll in an MMCP at any time.

Beginning in March 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 July 1, 2018.

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 that 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 May 1, 2018, 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 July 1, 2018. Medicaid Managed Care Plans will also have access to the CANS-NY assessment for the child. After July 1, 2018, 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 full 1115 Waiver Services and New Children's State Plan Services

Beginning July 1, 2018, services previously provided under six children's 1915(c) HCBS waivers will be aligned and transitioned to 1115 Waiver authority or will become a Medicaid State Plan benefit. These services will be available through the FFS and the Medicaid Managed Care delivery system. 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 July 1, 2018 transition, supporting a seamless transition with no interruption of services.

Beginning July 1, 2018, Health Home Care Managers and the Independent Entity, as applicable, 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. 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 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 December 31, 2018.

8. Post July 1, 2018 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 reassessments for HCBS occur through the Health Home, (or the Independent Entity if the enrollee opts out of Health Home), at least annually or upon significant change in the child's status. During the first 180 days of enrollment, the plan, providers, Health Home, and child and family, all have an opportunity to clarify any discrepancies; request or assess 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 eligibility one year from the date the initial CANS-NY was completed (i.e., a date between April 1, 2018 and June 30, 2018) by the Health Home or by the Independent Entity. The reassessment, or 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 the CANS-NY or by the DDRO to determine developmental disability. HCBS LON eligibility criteria will take effect on January 1, 2019 and therefore will be in place at the time all 1915(c) Transitioning Children will require an HCBS Eligibility Determination reassessment. Reassessed 1915(c) Transitioning Children meeting either LOC or LON HCBS Eligibility Determination will continue to be eligible for HCBS. Children that are no longer eligible for HCBS may continue to be enrolled in Health Home provided they meet Health Home eligibility and appropriateness criteria.

See *Attachment F* for an overview of the Transition Plan time line.

B. Children Newly in Need of HCBS After July 1, 2018

On July 1, 2018, the State will continue to work with the local government unit, local department of social services and provider referral processes to identify children newly in need of HCBS.

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 service transition) will be identified as in need of the new children's State Plan services or 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 as of July 1, 2018, and perform HCBS Eligibility Determination (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 determine eligibility for Health Home and/or perform HCBS Eligibility Determination. If the child is determined to be 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 that 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, 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 that 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 that 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, and if so, will provide information about Health Home and, with the appropriate consents from the child/family or legally authorized representative or guardian, refer the child to a Health Home. With consent of the child/family, 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 that may choose to not enroll in Health Home (do not accept the referral to the Health Home), the Independent Entity, 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 that 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 that 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, and is not a child that meets LOC HCBS Eligibility Criteria for the Developmentally Disabled/Medically Fragile population, 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. For children who appear to be eligible, the Independent Entity will:

- 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;
- Once determined eligible for Medicaid, assist the child with Health Home selection and referral; and
- 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.

Children who have a Developmental Disability and are either Medically Fragile, or are currently or were formerly placed in foster care, will be referred to OPWDD to make an HCBS Eligibility Determination using the target population, risk factor and functional criteria established for the Developmental Disability LOC population (See Section III.A. for more information). If determined eligible for HCBS, the child will be referred to the Independent Entity to assist with applying for Medicaid, and following the steps outlined above.

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

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 1115 waiver authority.

1. 1915(c) Transitioning Children will continue to be eligible for HCBS until at least one year after the date of their initial Health Home CANS-NY assessment (i.e., sometime between April 1, 2018 and June 30, 2018). HCBS LON eligibility criteria will take effect on January 1, 2019 and therefore will be in place at the time all 1915(c) Transitioning Children require an HCBS Eligibility Determination reassessment. Reassessed 1915(c) Transitioning Children meeting either LOC or LON HCBS Eligibility Determination will continue to be eligible for HCBS.
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 July 1, 2018, or until a new plan of care is in place, whichever is later, unless the beneficiary requests a change in the services provided.
5. 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 July 1, 2018.
5. 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.
6. Aligned children's HCBS and new children's State Plan services are identical to or enhanced 1915(c) HCBS.
7. To meet maintenance of effort requirements with respect to Medicaid eligibility, as the State transitions to new HCBS Eligibility Determination criteria for LOC (effective July 1, 2018) and LON (effective January 1, 2019), during the period July 1, 2018 through December 31, 2018 new Family of One LOC children that meet HCBS LOC target and risk criteria but do not meet LOC functional criteria can be determined to be eligible for HCBS if the Independent Entity determines in the absence of HCBS the child would be institutionalized.
8. As the State transitions to new HCBS Eligibility Determination criteria for LOC (effective July 1, 2018) and LON (effective January 1, 2019), during the period July 1, 2018 through December 31, 2018 new community eligible Medicaid children that meet HCBS LOC target and risk criteria, but do not meet LOC functional criteria, may be determined to be eligible for HCBS if the Department of Health, or its designated Independent Entity, determines in the absence of HCBS the child would be institutionalized.

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

Generally, MMCPs are not permitted to apply utilization review for 90 days following the implementation of current State Plan services moving into the MMCP Benefit package.

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, 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 During the Transitional Period

The State will provide a cross-walk of 1915(c) service rate codes, with new children's Medicaid State Plan and aligned children's HCBS rate codes (collectively 1115 rate codes) for billing during the transition period.

Beginning on January 1, 2018, service providers will bill under 1115 rate codes for Interim HCBS. Beginning of July 1, 2018, service providers will bill for new children's Medicaid State Plan and aligned children's HCBS using the 1115 rate codes. Both the fee-for-service system and Medicaid Managed Care Plans will be prepared to accept the 1115 rate codes for either the Interim HCBS or new children's State Plan and aligned children's HCBS. This will ensure providers will continue to be reimbursed while the child's new plan of care is under development and services are transitioned to meet the new State Plan and 1115 Waiver standards (completed no later than December 31, 2018). The State will end payment under 1915(c) service rate codes at the time the waivers are terminated (i.e., January 1, 2018).

Care coordinators that provided care management under the six 1915(c) waivers that will transition to the Health Home, and that were paid a 1915(c) care coordination rate that exceeds the Health Home care management per member per month rates for

children, may receive transitional payments as determined by the Department of Health, for a transitional period (e.g., for no more than 24 months).

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 that will continue to be utilized during Interim Transition Process between January 1, 2018 and June 30, 2018 under the 1115 waiver.

The State has established Level of Care (LOC) HCBS Eligibility Determination criteria and Level of Need (LON) HCBS Eligibility Determination criteria. Children that are eligible for HCBS are eligible for Health Home. The LOC HCBS Eligibility Determination criteria will take effect on July 1, 2018 and the LON HCBS Eligibility Determination Criteria will take effect on January 1, 2019.

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 and Maintenance of Effort”, 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) for children who are also medically fragile; who are current foster care children; or who were foster care children when they first became eligible for HCBS.

The LON target populations include:

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

The child must also meet the risk factors that have been established for each of the LON and LOC 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) ICF-IDD by the Office for People with Developmental Disabilities (OPWDD) Level of Care for children who are in foster care or for children living at home the OPWDD ICF-IDD Level of Care and the Medical Care eligibility review for children with developmental disabilities who may be medically fragile or in foster care.

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 modified to include HCBS Eligibility Determination tool (target population, risk factors, and functional criteria which will use the CANS-NY and a confirmation if the child has been reviewed by OPWDD and found eligible for the ICF-IDD LOC). Health Homes and the Independent Entity will have access to 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.

Children that are eligible for HCBS are eligible for care management through the Health Home through two separate authorities: the Health Home State Plan Amendment and the HCBS health home care management under the Demonstration:

There are two primary groups of children eligible for HCBS health home care management under the demonstration and not under the State Plan.

- SED - As described in more detail below, the definition of Serious Emotional Disturbance for HCBS Eligibility Determination include more SED diagnoses than

the SED for Health Home. Children that 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 G* for comparison of Health Home SED definition and HCBS SED Definition.

- DD - Until the Health Home State Plan is amended to include developmental disability conditions, only children that are Family of One, currently in Foster care, or formerly in the custody of LDSS or OCFS DJJOY custody (i.e., Foster Care) that meet the HCBS Eligibility Determination for the Developmental Disability target population group may be enrolled in Health Home (unless they meet other currently authorized Health Home eligibility chronic condition criteria).

The table below more fully describes the HCBS Eligibility Determination criteria for each of the LOC and LON target populations.

Level of Care (LOC) HCBS Eligibility Determination Criteria Serious Emotional Disturbance (SED) Effective July 1, 2018	
Target Criteria	<ol style="list-style-type: none"> 1. Age 0 through child’s 21st Birthday, and 2. Child has Serious Emotional Disturbance 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	The child meets one of the factors 1-4 as well as factor 5. <ol style="list-style-type: none"> 1. The child is currently in an out-of-home placement, including psychiatric hospital, or 2. The child has been in an out-of-home placement, including psychiatric hospital within the past six months, or

	<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. The LPHA has submitted written clinical documentation to support the determination.</p> <p>Out-of-home placement or more restrictive setting in LOC Risk Factor #1-4 - This 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>For Risk Factor #5, institutionalization is defined as hospitalization.</p> <p>Multi-system involved is two or more systems and Child systems include: 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 target criteria, risk factors, and HCBS 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 SED target criteria, risk factors, and HCBS 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 Population Effective July 1, 2018	
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. 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 target criteria, risk factors, and HCBS 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 Medically Fragile target criteria, risk factors, and HCBS 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 Developmental Disability Effective July 1, 2018	
Target Criteria	<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 and e. <ol style="list-style-type: none"> a. is attributable to mental retardation, cerebral palsy, epilepsy, neurological impairment or autism; or b. is attributable to any other condition found to be closely related to mental retardation because such condition results in similar impairment of general intellectual functioning or adaptive behavior with mental retardation 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. has continued or can be expected to continue indefinitely; and e. constitutes a substantial handicap to such child's ability to function normally in society.
Risk Factors	<p>The child must meet either criteria 1, 2 or 3.</p> <ol style="list-style-type: none"> 1. Medically Frail <ol style="list-style-type: none"> a. 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. The LPHA has submitted written clinical documentation to support the determination. 2. 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). 3. 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 (B2H Waiver reference). <p>For Risk Factor 1, institutionalization is defined as ICF-IDD.</p>

Functional Criteria	Office for People with Developmental Disabilities (OPWDD) ICF-IDD Level of Care and CANS-NY HCBS eligibility Medical Care Screen.
Financial Criteria	<p>If a child is already eligible for Medicaid (e.g., currently in the care and custody of LDSS/DJJOY or was formerly in the care and custody of LDSS/DJJOY and is eligibility under community Medicaid eligibility rules), then a child meeting target criteria, risk factors, and HCBS 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 DD target criteria, risk factors (either medically frail or formerly in the care and custody of LDSS/DJJOY), and HCBS LOC functional criteria can be considered for Medicaid eligibility under the Family of One financial criteria.</p> <p><i>Note: Children with DD and not meeting these target criteria and risk factors would be served by the OPWDD HCBS delivery system.</i></p>

Level of Need HCBS Eligibility Determination Criteria	
Serious Emotional Disturbance (SED) (Effective January 1, 2019)	
Target Criteria	<p>1. Age 0 through child's 21st Birthday, and</p> <p>2. Child has Serious Emotional Disturbance</p> <p>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. <p>For more restrictive setting in LON Risk Factor #3 - This 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>
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 target criteria, risk factors, and HCBS 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 SED target criteria, risk factors, and HCBS LON functional criteria can be considered for Medicaid eligibility under the Family of One financial criteria.</p>

<p>Level of Need HCBS Eligibility Determination Criteria - Abuse, Neglect and Maltreatment and Health Home Complex Trauma (Effective January 1, 2019)</p>	
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

	<p>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> <p>For at-risk of out-of-home placement or more restrictive setting in LON- This 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>
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 target criteria, risk factors, and HCBS 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 target criteria, risk factors, and HCBS LON 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

To ensure smooth implementation and operationalization of this transition, the State will work closely with stakeholders to develop and release documentation and guidance throughout 2017 and early 2018. The State has been collecting feedback from stakeholders related to assumptions, potential issues, risks, and concerns regarding the Children’s 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 transition policy for MMCPs, a cross walk of former 1915(c) HCBS to the State Plan or aligned children’s HCBS, an operations manual, billing manual, provider service manuals, provider standards, utilization review criteria, and reporting requirements.

Guidance will describe, in detail:

- Governing policies and operational processes, (e.g. referrals to assessment, services, Health Home, Independent Entity; billing information and processes; contracting; timeframes; roles and responsibilities; eligibility processes)

- 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 will be amended to reflect federal and state requirements of the transition.

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 1115 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 HCBS,
- Performing HCBS Eligibility Determinations, and developing HCBS plans of care for children that 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 HCBS in applying for Medicaid, and referring children that 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 enrollment, access to HCBS and HCBS plans of care for members not enrolled in an MMCP and receiving fee-for-service HCBS, 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 Managed Care Plans, Health Homes and local government units to facilitate referrals and linkages to other services where appropriate.

The State will define and document the scope of work and expectations of the Independent Entity. This will include specified components such as administrative care management role and monitoring requirements. For individuals remaining 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 continuous engagement with the contractor 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 are anticipated to begin in October 2017.

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

2. Provider Training

The State will produce a list of suggested training for providers, on topics such as managed care contracting, network 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 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 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 1115 Waiver

authority. This will include ensuring that children/youth will not experience a disruption in services during the transition period.

3. Contracting with Plans

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 for 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.

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 are 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 May 1, 2018 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 July 1, 2018, beginning May 1, 2018, 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.

- MMCOs will have all operational systems in place by July 1, 2018 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.
- MMCOs will contract with (or amend contracts with) providers beginning November 2017 and will begin claims testing with providers April 2018. The State and MMCPs will test encounter data submissions beginning April 1, 2018. 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 Fall of 2017. Onsite Readiness Reviews will be conducted in Spring of 2018. A team comprised of State agency staff will visit each MMCO and review their organization's preparedness for the transition.

MMCOs 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 May 1, 2018 and July 1, 2018 implementation dates. Plans 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.

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 Policy Paper, Operations Manual, and any additional topic-specific guidance. The Medicaid Managed Care Model Contract will be amended to reflect these requirements.

MMCPs will be required to ensure timely access to care. 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 January 1, 2019, the VFCA population will transition to managed care. 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 “transferrable” to the Managed Care capitated rates. These costs are generally for staff (e.g., Licensed Behavioral Health Professionals, nursing staff, medical escorts). The State is developing a “Residual Per Diem” that will be paid to the VFCAs by the Medicaid Managed Care Plans and a State Plan Amendment to authorize the Residual Per Diem.

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 with 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, January 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 November 1, 2018, the State's Enrollment Broker will engage VFCAs 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 January 1, 2019.

Beginning January 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 1115 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 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, 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. Because Health Home Care Managers have established relationships and routine contact with families, they will be 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, 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.

VI. Monitoring, Oversight, and Controls

The State's monitoring and oversight of the Children's System Transformation includes data collection, reporting and analysis as required to carry out the 1115 Demonstration Evaluation Plan, 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 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 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 (or 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 will develop a Standards of Care and Monitoring Tool to monitor providers of aligned children's HCBS and new children's State Plan services. This tool will follow the format of provider monitoring tools used by the State to oversee care delivery in the 1915(c) waiver programs and other licensing requirements.

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

Attachment A: New Medicaid State Plan Services as of July 1, 2018, [approved by CMS (insert date)]

New State Plan Service

- Other Licensed Practitioner (OLP)

Services transitioning from 1915-c waivers to Medicaid State Plan

- Crisis Intervention
- Community Psychiatric Support and Treatment (CPST)
- Psychosocial Rehabilitation Supports (PSR)
- Family Peer Support Services
- Youth Peer Support and Training

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

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
- Habilitation (including Habilitative Skill Building)
- Non-Medical Transportation*
- Palliative Care
- Prevocational Services
- Respite
- Supported Employment
- Financial Management services for the Customized Goods and Services pilot
- Customized Goods and Services (pilot)

*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: State Plan and 1115 Waiver Services Moving into Medicaid Managed Care

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)
- CFCO State Plan Services for children meeting eligibility criteria
- Comprehensive psychiatric emergency program (including Extended Observation Bed)
- Continuing Day Treatment
- Health Home Care Management
- Intensive Psychiatric Rehabilitation Treatment (IPRT)
- 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 1/1/2019)

Attachment D: Key Operational Milestones

Dates are subject to federal approval and may change.

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	Release Updated Provider Designation Application	✓
Jul 31, 2017	Release MMCP Qualification Standards	✓
Aug 1, 2017	Public education on Children's System Transformation begins	✓
Aug 9, 2017	Release Draft Children's Medicaid System Transition Plan for Public Comment	✓
Oct 31, 2017	MMCP qualification applications submissions due	<input type="checkbox"/>
Oct 31, 2017	First round of provider designation letters released (priority given to current providers)	<input type="checkbox"/>
Nov 15, 2017	State confirms MMCP qualification application complete	<input type="checkbox"/>
Nov 15, 2017	Notice to 1915(c) waiver program children and families regarding closure of the 1915(c) waivers	<input type="checkbox"/>
Dec 1, 2017	Letter to CMS closing 1915(c) waivers	<input type="checkbox"/>
Jan 1, 2018	Begin provider billing under new 1115 HCBS, BH clinic, & 6 SPA rate codes	<input type="checkbox"/>
Jan 1, 2018	1915(c) program termination effective; 1115 Waiver authority begins	<input type="checkbox"/>
Jan 1, 2018	State to begins licensing Volunteer Foster Care Agencies	<input type="checkbox"/>
Jan 5, 2018	Begin MMCP monitoring of provider network development, personnel recruitment and training	<input type="checkbox"/>
Jan 15, 2018	Interim MMCP Qualification Report – conditional MMCP qualification pending on-site readiness review	<input type="checkbox"/>
Feb 1, 2018	30-day notice to local social service districts regarding HCBS process changes	<input type="checkbox"/>
Mar 1, 2018	60 days' notice to MMCP of benefit change for Member Services and children's network availability	<input type="checkbox"/>
Mar 1, 2018	Begin Announcement Letters to affected beneficiaries for July Medicaid Managed Care mandatory enrollment	<input type="checkbox"/>
Mar 28, 2018	MMCP network substantially completed	<input type="checkbox"/>
Apr 1, 2018	Transition to Health Home Care Management begins	<input type="checkbox"/>

Date	Milestone	Completed
Apr 1, 2018	Earliest date that care manager will transition a 1915 (c) Transitioning Child to Health Home care management	<input type="checkbox"/>
Apr 1, 2018	Earliest date that Health Home Care Manager will assess 1915(c) Transitioning Child	<input type="checkbox"/>
Apr 1, 2018	Earliest date that a new children's HCBS identifier may appear on a child's record	<input type="checkbox"/>
Apr 1, 2018	Earliest date that a care management agency will bill under Health Home infrastructure	<input type="checkbox"/>
Apr 1, 2018	Begin provider/MMCP claims testing window	<input type="checkbox"/>
Apr 6, 2018	Begin contracting between MMC Plans and VFCA's	<input type="checkbox"/>
Apr 28, 2018	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"/>
May 1, 2018	60 Days' notice to MMCP for addition to benefit package provision	<input type="checkbox"/>
May 1, 2018	Earliest date that Independent Entity will accept referrals	<input type="checkbox"/>
May 2, 2018	Distribute on-site review report to MMC Plans confirming qualification status	<input type="checkbox"/>
May 22, 2018	Last day for affected beneficiaries to select an MMCP for July enrollment	<input type="checkbox"/>
Jun 1, 2018	MMCPs begin receiving Health Home POCs/HCBS POCs	<input type="checkbox"/>
Jun 30, 2018	Last day of Interim HCBS assessment process and service structure	<input type="checkbox"/>
Jul 1, 2018	Care managers complete case load transition to Health Home care management	<input type="checkbox"/>
Jul 1, 2018	Begin FFS coverage of OLP, Rehab SPA, and aligned children's HCBS	<input type="checkbox"/>
Jul 1, 2018	Begin Medicaid Managed Care Plan coverage of OLP, Rehab SPA, Children's HCBS and other children's transition benefits	<input type="checkbox"/>
Jul 1, 2018	Remove exemption for mandatory enrollment for children previously enrolled in one of the six 1915(c) waivers; 1 st day of plan enrollment for affected children	<input type="checkbox"/>
Jul 31, 2018	Confirm no children remain under the Interim Transition Process HCBS structure	<input type="checkbox"/>
Oct 3, 2018	Begin VFCA/MMCP claims testing window	<input type="checkbox"/>
Jan 1, 2019	Begin Level of Need eligibility assessments and coverage	<input type="checkbox"/>
Jan 1, 2019	Begin MMCP enrollment for affected VFCA kids	<input type="checkbox"/>

Date	Milestone	Completed
Jan 1, 2019	Begin MMCP coverage of VFCA Residual Per Diem	<input type="checkbox"/>
Jan 1, 2019	Earliest Date MMCP begins administration of the Customized Goods and Services Pilot	<input type="checkbox"/>

Attachment E: Preliminary Draft of 1915(c) Waiver Services to State Plan and 1115 Service Crosswalk*

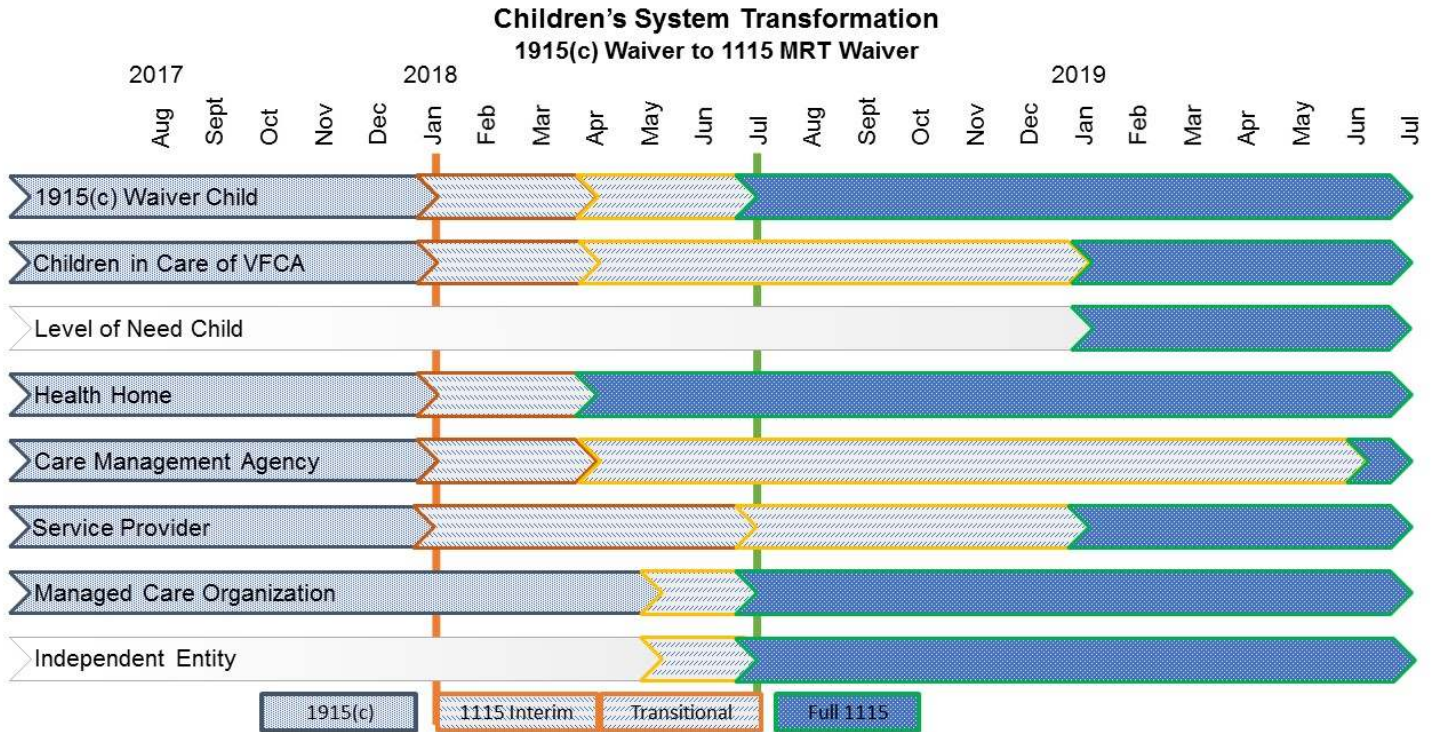
Existing CAH I/II Waiver Services	Existing OCFS B2H Waiver Services	Existing OMH SED Waiver Services	Existing OPWDD CAH Waiver Services	New Medicaid State Plan Services	Newly Aligned HCBS Benefits
	Immediate Crisis Response Services	Crisis Response Services		Crisis Intervention	
	Crisis Avoidance, Management & 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	
				Psychosocial Rehabilitation Services	
Care Coordination	Health Care Integration	Individualized Care Coordination	Case Management		HCBS Care Coordination

Existing CAH I/II Waiver Services	Existing OCFS B2H Waiver Services	Existing OMH SED Waiver Services	Existing OPWDD CAH Waiver Services	New Medicaid State Plan Services	Newly Aligned HCBS Benefits
	Skill Building	Skill Building			Habilitative Skill Building
Respite Care	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				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,					Palliative Care (Family Education, Pain &

Existing CAH I/II Waiver Services	Existing OCFS B2H Waiver Services	Existing OMH SED Waiver Services	Existing OPWDD CAH Waiver Services	New Medicaid State Plan Services	Newly Aligned HCBS Benefits
Pain & Symptom Management, Bereavement Service, Massage Therapy, Expressive Therapy)					Symptom Management, Bereavement Service, Massage Therapy, Expressive Therapy)
					Non-Medical Transportation
					Customized Goods & Services
* Crosswalk is preliminary and will be modified to include, where necessary, a crosswalk to Consumer First Choice Option (CFCO) services that will transition to Managed Care on April 1, 2018.					

Attachment F: Transition Plan for the Children’s Medicaid System Transformation Time Line

DRAFT



Attachment G: 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.”

1115 HCBS: consistent with the CANS algorithm data collection specifications