Guide to Edits for Process for Transferring Health Home Enrolled Members to Another Health Home and/or Health Home Care Management Agency HH0018

Summary: As of October 2026, the Process for Transferring Health Home Enrolled Members to Another Health Home and/or Health Home Care Management Agency HH0018 policy now reflects revised language (indicated by text in red) alongside prior language (indicated by text crossed out text in black). The revised October 2026 policy supersedes all previous policies and reflects an implementation date of 02/01/2027. If there are discrepancies between the policy and this guide to edits, please adhere to the language in policy, and notify the Department via the Health Home BML- subject policy.

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Page 2, Definitions	Definitions have been added to support revisions made throughout the policy.	*Passive Disenrollment* The process of disenrolling a member that is unable to – after diligent efforts by the Health Home (HH)/Care Management Agency (CMA) – to be contacted after diligent search activities conducted during a Health Home closure/merger. If the member cannot be reached and a "passive transfer" cannot occur, the Health Home (HH) can disenroll the member from the program. *Passive Transfer* The process of transferring a member that is unable - after diligent efforts by the Health Home (HH)/Care Management Agency (CMA) - to be contacted to obtain their choice during a Health Home closure/merger. Health Homes (HH) can transfer the member to another Health Home (HH) that is willing to attempt to continue efforts to reengage the member.	New terms to existing list
Page 4, II. Procedure	An additional step has been added to clarify responsibilities of the transferring Health Home regarding assessments and other required documentation.	For all transfers, the Health Home Care Manager (HHCM): 7. Reviews and ensures the member's record is complete and up to date, including but not limited to: assessments, encounter notes, Health and Community-Based Services (HCBS) Level of Care Determination, CANS-NY, Plan of Care, Yearly Appropriateness (Children), and CES Tool (Adults). Members may not be transferred if their record is incomplete. The transferring Health Home makes sure all requirements are completed prior to the transfer. Receiving Health Homes will flag incomplete records prior to acceptance and the transferring Health Home will be required to provide the missing components of the member's record.	New item to existing list
Page 5-6, II. Procedure	Language has been added to clarify the expectation that a Health Home (HH) must make all reasonable efforts to obtain the member's choice.	**If a member's choice cannot be obtained** In the event a member does not respond and cannot be contacted to discuss the transfer outlined above, the Health Home ~~would~~ continues to make all efforts to contact the member to obtain their choice. If the member is still unable to be contacted after all reasonable efforts have been made, the Health Home has the option to proceed with one of the following ~~scenarios~~ processes: 1. If the closing Care Management Agency (CMA) provides Care Management services within the network of another Health Home, the current Health Home should communicate with that Health Home	New and revised language

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	Further details have been added regarding the passive transfer and passive disenrollment, along with a reference to the Member Disenrollment From the Health Home Program Policy #HH0007.	to ~~establish if they~~ determine if that Health Home serves the member's area of residence and whether would accept members within the same Care Management Agency (CMA). • If the receiving Health Home agrees to accept members who have not communicated a decision, then the current Health Home may ~~do a~~ conduct a passive transfer to the receiving Health Home. In such cases, the receiving Health Home would then notify the members of their enrollment status in the new Health Home. • If the receiving Health Home will not accept these members, then the current Health Home may ~~move the members to~~ proceed with a passive disenrollment, issuing the NOD, etc. The current Health Home may also elect (with the agreement of the Care Management Agency (CMA)) to passively transfer such members to another Care Management Agency (CMA) within the current Health Home if the option of remaining within the same Care Management Agency (CMA) in a different Health Home cannot be executed. For member's being disenrolled, refer to the Member Disenrollment From the Health Home Program Policy #HH0007, which can be found here.	
Page 6, **III. Guidance for the Transfer of Documents Required for Transition for Health Homes Serving Adults and Health Homes Serving Children (administrative only)**	Language that was previously stated across the scenarios has been consolidated and added to the beginning of the section.	Health Homes are to monitor the transfer of information for all members involved in a transition including Health Home consent, current Comprehensive Assessment and other recent assessments, and the most current Plan of Care accessed through the Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS) transfer function. When the transfer function is used, the most current Initial Appropriateness determination transfers with the new segment. (In all other instances when a new segment is started (e.g., when the Transfer Function is not used), a new Initial Appropriateness determination is to be submitted within twenty-eight (28) days). Depending on whether a member's Care Management Agency (CMA) remains the same or changes as a result of a transition, certain rules apply regarding transfer of the Health Home consent, Plan of Care, Assessments, Educational Records, Care Management documentation, and clinical documentation, as follows:	New language
Page 6-7, **If the member's CMA will remain the same under a new Health Home (HH)**	Language has been added to reflect that the CES Tool does transfer with the member. Language has been	• **If the member's Care Management Agency (CMA) will remain the same under a new Health Home (HH):** o (For Adults) ▪ The currently signed Health Home (HH) consent is valid and will continue to be used until the time the member's Plan of Care (POC) is due. ▪ The Continued Eligibility for Services (CES) Tool does ~~not~~ transfer with the member. If a member's CES Tool's due date falls within the first two (2) months of the new segment (transfer) start date, the due date will be pushed	New and revised language

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	added and revised to clarify that the Plan of Care (POC) may be used to calculate the next review date. Language has also been revised and added for additional clarification and examples throughout.	out two (2) months from the segment (transfer) start date. For example, if the new segment start date is 10/01/2025, any due dates from 10/01/2025 to 11/30/2025 would be pushed out so that the billing block would not go into effect until 12/01/2025. ▪ The currently active Plan of Care remains valid and may be used by the receiving Care Management Agency (CMA). Due dates for subsequent Plans of Care and Comprehensive Re-assessments are driven by the current Plan of Care’s expiration date. For example, if a member’s Plan of Care was finalized in one Health Home (HH) on 02/28/2025, their next Plan of Care (POC) is due 02/28/2026, even if they are transferred to another Health Home (HH). While Health Homes (HH) may elect to complete a new Plan of Care (POC) sooner, the Department allows the use of the existing Plan of Care through its expiration date to support continuity of care and reduce administrative burden. o (For Children/Youth) ▪ The currently signed Health Home (HH) consent is valid and will continue to be used until the time the member’s Plan of Care (POC) is due. This includes consents such as the DOH 5055, DOH 5201, DOH 5203, etc. For example, if a member’s date of transfer is 01/01/2026 and their next Plan of Care update is due is due 04/01/2026, a new consent and updated plan of Care will be due 04/01/2026. ▪ The Children’s Home and Community Based Services (HCBS) Eligibility Determination, and the Comprehensive Assessment (inclusive of Child Adolescent Needs and Strengths – NY (CANS-NY)) will be done at the time the next review is due, based off the dates the prior Children’s Home and Community Based Services (HCBS) Eligibility Determination, and, Comprehensive Assessment (inclusive of Child Adolescent Needs and Strengths – NY (CANS-NY) CA) were signed/finalized. For example, if a member’s date of transfer is 01/01/2026 and the Comprehensive Assessment (inclusive of Child Adolescent Needs and Strengths – NY (CANS-NY) is due 04/01/2026, the due date will not be affected by the transfer and will remain due 04/01/2026. ▪ For Health Homes Serving Children, Health Homes are to maintain the member’s recent Initial or Yearly Appropriateness at the time of transfer, and the due date for the next Yearly Appropriateness review will be twelve months from the date of transfer. For example, if a member was transferred on 01/01/26, the most recent appropriateness code will transfer with the member, and the Yearly Appropriateness review will be due by 01/01/27. ▪ The ~~receiving Health Home (HH) uses the member’s~~ currently active Plan of Care (POC), Children’s Home and Community Based Services (HCBS) Eligibility Determination, and Comprehensive Assessment (inclusive of Comprehensive Assessment (inclusive of Child Adolescent Needs and Strengths – NY (CANS-NY) ~~due dates to establish the timeline for the next review and update.~~ may be used by the receiving Health Home. Due dates for	

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		subsequent Plans of Care and Comprehensive Re-assessments may be driven by the current Plan of Care's expiration date. For example, if a member's Plan of Care was finalized in one Health Home (HH) on 02/28/2025, their next Plan of Care (POC) is due 02/28/2026, even if they are transferred to another Health Home (HH). While Health Homes (HH) may elect to complete a new Plan of Care (POC) sooner, the Department allows the use of the existing Plan of Care through its expiration date to support continuity of care and reduce administrative burden.	
Page 7-8, If the member's Care Management Agency (CMA) is changing but the member remains within the current Health Home (HH) network as a result of a transition	Language has been added to reflect that the CES Tool does transfer with the member. Langue has been added and revised to clarify that the Plan of Care (POC) may be used to calculate the next review date. Language has also been revised and added for additional clarification and examples throughout.	• **If the member's Care Management Agency (CMA) is changing but the member remains within the current Health Home (HH) network as a result of a transition:** o (For Adults) ▪ The currently signed Health Home (HH) consent (DOH 5055) remains valid for up to ninety (90) calendar days (or the equivalent of three (3) segment months) of the member's transition date in order for needed updates to be made for the Care Management Agency (CMA) and any other providers. Members of the Care Team listed in the consent are made aware of the new Care Management Agency (CMA) and are offered and provided with a copy of the updated consent. For example, if a member's date of transfer is 01/01/2026, an updated consent form must be completed no later than 04/01/2026. ▪ The currently active Plan of Care remains valid and may be used by the receiving Care Management Agency (CMA). Due dates for subsequent Plans of Care and Comprehensive Re-assessments may be driven by the current Plan of Care's expiration date. For example, if a member's Plan of Care was finalized in one Health Home (HH) on 02/28/2025, their next Plan of Care (POC) is due 02/28/2026, even if they are transferred to another Health Home (HH). While Health Homes (HH) may elect to complete a new Plan of Care (POC) sooner, the Department allows the use of the existing Plan of Care through its expiration date to support continuity of care and reduce administrative burden. ▪ The Continued Eligibility for Services (CES) Tool does not transfer with the member. If a member's CES Tool's due date falls within the first two (2) months of the new segment (transfer) start (transfer) date, the due date will be pushed out two (2) months from the segment (transfer) start date. For example, if the new segment (transfer) start date is 10/01/2025, any due dates from 10/1/25 to 11/30/25 would be pushed out so that the billing block would not go into effect until 12/01/2025. o (For Children/Youth) ▪ The currently signed Health Home (HH) consent remains valid for up to ninety (90) ~~calendar~~ days (or the equivalent of three (3) segment months) of from the member's transition date in order for needed updates to be made to the Care Management Agency (CMA) and any other providers. may Members of the	New and revised language

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		Care Team listed in the consent are made aware of the new Care Management Agency (CMA) and are offered and provided with a copy of the updated consent. This includes consents such as the DOH 5055, DOH 5201, DOH 5203, etc. For example, if a member's date of transfer is 01/01/2026, an updated consent form must be completed no later than 04/01/2026. ▪ For Health Homes Serving Children, Health Homes are to maintain the member's recent Initial or Yearly Appropriateness at the time of transfer, and the due date for the next Yearly Appropriateness review will be twelve months from the date of transfer. For example, if a member was transferred on 01/01/26, the most recent appropriateness code will transfer with the member, and the Yearly Appropriateness review will be due by 01/01/2027. ▪ The ~~receiving Care Management Agency (CMA) uses the~~ member's currently active Plan of Care (POC), and Comprehensive Assessment (inclusive of Child Adolescent Needs and Strengths – NY (CANS-NY) may be used by the receiving Health Home. Due dates for subsequent Plans of Care and Comprehensive Re-assessments may be driven by the current Plan of Care's expiration date. For example, if a member's Plan of Care was finalized in one Health Home (HH) on 02/28/2025, their next Plan of Care (POC) is due 02/28/2026, even if they are transferred to another Health Home (HH). While Health Homes (HH) may elect to complete a new Plan of Care (POC) sooner, the Department allows the use of the existing Plan of Care through its expiration date to support continuity of care and reduce administrative burden. ▪ For the Children's Home and Community Based Services (HCBS) Eligibility Determination, the due date is determined based on when it was last signed/finalized.	
Page 8-9, If the member's Health Home (HH) AND Care Management Agency (CMA) are both changing	Language has been added to reflect that the CES Tool does transfer with the member. Language has been added and revised to clarify that the Plan of Care (POC) may be used to calculate the next review date. Language has also been revised and added for additional clarification and	• **If the member's Health Home (HH) AND Care Management Agency (CMA) are both changing:** o (For Adults) ▪ A new consent (DOH 5055) is obtained by the receiving Health Home (HH) within ninety (90) ~~calendar~~ days (or the equivalent of three (3) segment months) of the member's transition date. For example, if a member's date of transfer is 01/01/2026, an updated consent form must be completed no later than 04/01/2026. ▪ The ~~receiving Health Home uses the member's~~ currently active Plan of Care (POC) and Comprehensive Assessment) may be used by the receiving Health Home. Due dates for subsequent Plans of Care and Comprehensive Re-assessments may be driven by the current Plan of Care's expiration date ~~due dates to establish the timeline for the next review and update~~ For example, if a member's Plan of Care was finalized in one Health Home (HH) on 02/28/2025, their next Plan of Care (POC) is due 02/28/2026, even if they are transferred to another Health Home (HH). While Health Homes (HH) may elect to complete a new Plan of Care (POC) sooner, the Department allows the use of the existing	New and revised language

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Page 11, **III. Guidance for the Transfer of Documents Required for Transition for Health Homes Serving Adults and Health Homes Serving Children (administrative only)**	Disclaimer for the upcoming changes to the Yearly Appropriateness logic, which will be released late 2026.	**Note for Health Homes Serving Children:** As of the MAPP update 5.0 (which will be released in late 2026), the current Yearly Appropriateness due dates will transfer with the member and the procedure for Yearly Appropriateness will mirror the logic for the CES Tool, as outlined in the section above. If a member’s Yearly Appropriateness due date falls within the first two (2) months of the new segment start date, the due date will be pushed out two (2) months from the segment start date. For example, if the new segment start date is 10/01/2025, any due dates from 10/01/2025 to 11/30/25 would be pushed out so that the billing block would not go into effect until 12/01/2025.	New and revised language
Page 15, **Appendix A**	A chart has been added with example scenarios and new due dates based on the date of transfer.	**Please refer to the policy for more information and to view new examples**	New section and chart