FAQ Regarding Process for Transferring Health Home Enrolled Members to Another Health Home and-or Health Home Care Management Agency policy #HH0018 November 2024 Updates

Instructions
There is an index below that allows the user to click the category they want to see and will automatically scroll to that section of the spreadsheet. Please reach out to health@health.ny.gov with questions and/or feedback.

NOTE: Reference to page numbers and sections included in questions below may no longer be applicable. As adjustments were made to revise this policy, certain page numbers/sections may have been altered.

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Topic	Question	Department of Health Response
Consent	**Pg 4.** *1. Ascertains the member's informed choice to transfer and obtains permission to contact the receiving Health Home (HH)/Care Management Agency (CMA)/Children and Youth Evaluation Service (C-YES) to initiate and complete the transfer.* Section II, Number 1 "For all transfers the Health Home Care Manager…" mentions that the HHCM "ascertains the member's informed choice and obtains permission to contact the received Health Home." We understand this to be updating the consent and request that it be specifically mentioned or other permissible situations outside of formally updating the consent be defined if that is DOH's intent.	Correct. This is the intent.
Consent	**Pg 4.** *Refer to Connection Between Continued Eligibility for Services (CES) Tool and Billing Instances in the Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS) v.4 for the member's new segment's Continued Eligibility for Services (CES) Tool due date.* They don't have to wait till the annual POC due date to get the new HH consent done. But it needs to by done by then...or what?	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.
Consent	**Pg. 5** *The currently signed Health Home (HH) consent remains valid for up to ninety (90) calendar day of the member's transition date in order for needed updates to be made in the CMA and any other providers. All entities listed in the consent are made aware of the new Care Management Agency (CMA) and receive a copy of the updated consent* Are all entities required to be notified of and receive a copy of the updated consent, or is it based on provider/ member request?	Per Access to/Sharing of Personal Health Information (PHI) and the Use of Health Home Consents #HH0009 policy language references "offer and provide to member". In the course of care management work, the new CMA should make those consented entities actively involved in the care of the member aware of their new role providing Care Management Services to the member. The Department has changed the policy to state 'members of the Care Team' rather than ALL Care Team Members.
Consent	**Pg 5**. *A new consent is obtained by the receiving Health Home (HH) within ninety (90) calendar days of the member's transition date. This includes consents such as the DOH 5055, DOH 5201, DOH 5203, etc.* Recommend using end of the 3rd segment month...and what happens if it is not done? Have to disenroll? Not bill?	Transfers become effective on the first day of the month. The Health Home consent remains valid for up to ninety (90) days (or the equivalent to three segment months). If this is not completed within the required timeframe, billing cannot occur. If after all attempts to work with the member to complete a new consent do not result in a signed Health Home consent, the member is disenrolled.
Consent	**Pg. 5** *The currently signed Health Home (HH) consent remains valid for up to ninety (90) calendar day of the member's transition date in order for needed updates to be made in the CMA and any other providers. All entities listed in the consent are made aware of the new Care Management Agency (CMA) and receive a copy of the updated consent.* Policy states new consents for a new HH are required within 90 days of transfer. If the consent date is after the enrollment segment start date in MAPP, does that not impact any of the MAPP logic with IA, POC, etc.? I thought segments could be system closed if the consent is not valid?	Response pending from the Department.
Consent	**Pg 5.** *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.* Even though they are changing Health home the member does not need a new consent under the new health home?	Policy defines when a new consent is required for members maintaining current CMA but changing to a new HH.
Consent	**Pg 6.** *the currently signed Health Home (HH) consent remains valid for up to ninety (90) calendar day of the member's transition date in order for needed updates to be made in the CMA and any other providers. All entities listed in the consent are made aware of the new Care Management Agency (CMA) and receive a copy of the updated consent."* So the current HH consent is good for only 90 days so every transfer we will need to track and manually check to see if an updated consent happened; this could get very messy because if it is over 90 days does that mean the person is no longer consented for HH should the new CMA be unable to get an updated consent – anything could happen in that 90 days.	Policy has been updated to state: 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 (for both Adults and Children/Youth).
Consent	**Pg. 6** ***NOTE:*** *For a member-driven transfer request, a new consent completed at the time of transfer.* This is unclear - does this apply to all the scenarios above (Change of HH, Change of CMA, Change of HH and CMA), or is it just about the change of HH and CMA? what does "time of transfer" mean? We have seen transfers delayed because the new HH is forcing the CMA to get a new consent done first. Why not be consistent and make it 3 segment months?	Policy has been adjusted to show that for member-driven transfer requests, a new consent is completed regardless of whether the member requests a change in Health Home, a change in Care Management agency or a change in both. As a member-driven transfer, a new Health Home consent is in place at the time of transfer (on the first of the month).

Consent	**Pg 7.** *Additionally, if the member is enrolled in the Home and Community Based Services (HCBS) Children's Waiver, all documentation for such enrollment is also transferred (e.g. Freedom of Choice Form, etc.).* Is there any concern with redisclosing information from external providers that was shared with a previous HH/CMA with a new HH/CMA?	Based on prior feedback from the Department's Legal Counsel, information can be shared with the receiving Health Home. Health Home's must use a secure file transfer process to transfer documentation.
Responsibilities of Entities	**Pg 2.** *Open communication and coordination between all entities is imperative to support a smooth, safe, and timely transfer for the member. This includes proper notification to the member about the reason for the transition and the member's selection, to include the member's choice not to transfer rather to disenroll from the Health Home (HH) program, if this is their desire.* The policy outlines the communication requirements/expectations between lead health homes. Are there any other activities lead health homes must complete beyond MAPP and quality oversight of CMA activity?	Health Homes must establish a structured transfer plan which includes regular reviews of the status of each member involved in the transfer. Health Homes should define the role/scope of work they will conduct versus their care management agencies. The transferring Health Home is obligated to provide all required available data/documentation. Members must be eligible and appropriate for enrollment and must have an active Plan of Care in MAPP HHTS on the date of transfer.
Responsibilities of Entities	**Pg 5.** *The receiving Health Home (HH) uses the member's current Plan of Care (POC), Children's Home and Community Based Services (HCBS) Eligibility Determination, Child Adolescent Needs and Strengths – NY (CANS-NY), and Comprehensive Assessment (CA) due dates to establish the timeline for the next review and update.* Due to our system configurations and reports, we would have the CM use the current documentation to build out and review the POC, Eligibility, etc. in our system/chart but new documents would be required to be completed based on the logic in our system and MAPP builds. New timelines for due dates, except for HCBS LOC and CANS, would be based on the new segment date in our system.	This policy states what is allowed. If the Health Home's system requires additional steps to onboard a new member appropriately, the Health Home has the right to implement such steps as they need.
Responsibilities of Entities	**Pg 6.** *Health Homes Serving Children (HHSC) ensure that the Assessments, Child Adolescent Needs and Strengths – New York (CANS-NY) Acuity Score, and the Home and Community Based Services (HCBS) Eligibility Determination have been appropriately transmitted under the member's new Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS) segment.* Which Health Home is responsible for ensuring that the above listed documents are transmitted under the new segment? How can Health Homes ensure this documentation is transferred over? Assessment is not captured in MAPP.	The transferring Health Home is obligated to provide all available required data/documentation. Minimally, members must be eligible and appropriate for Health Home enrollment and must have an active plan of care in MAPP HHTS on the date of transfer. Children receiving HCBS must have an up-to-date Eligibility Determination. Documentation must be shared in the most efficient way possible. The Comprehensive Assessment is completed in alignment with the Plan of Care and must be share with the receiving Health Home/Care Management Agency via available means. When a new function is built into MAPP HHTS, manual process will be eliminated.
Due Dates	**Pg 4.** *Refer to Connection Between Continued Eligibility for Services (CES) Tool and Billing Instances in the Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS) v.4 for the member's new segment's Continued Eligibility for Services (CES) Tool due date.* We again ask that the CES Tool End Date be pre-populated for new segments.	The Department will take this under advisement with the MAPP Team.
Due Dates	**Pg 5.** *The Children's Home and Community Based Services (HCBS) Eligibility Determination, Child Adolescent Needs and Strengths – NY (CANS-NY) and, Comprehensive Assessment (CA) will be done at the time the next review is due.* What review? The annual POC review/signature? Or do you mean the due dates for the HCBS LOC, CANS, and CA continue to be based off the dates the prior HCBS LOC, CANS, and CA were signed/finalized?	The due dates for the HCBS LOC, CANS, and Comprehensive Assessment continue to be based off the dates that the prior HCBS LOC, CANS, and Comprehensive Assessment were signed/finalized.
Due Dates	**Pg 5.** *The receiving Health Home (HH) uses the member's current Plan of Care (POC), Children's Home and Community Based Services (HCBS) Eligibility Determination, Child Adolescent Needs and Strengths – NY (CANS-NY), and Comprehensive Assessment (CA) due dates to establish the timeline for the next review and update.* Won't MAPP still look for a POC signature within 60 days to bill? POC received in MAPP?	The Plan of Care in MAPP HHTS remains active across transfers so that the receiving Health Home can continue to use it until the next update would be required.
Transfer Process	**Pg 4.** *Establishes a date for disenrollment or transfer with the member (Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS) first day of month).* Disenrollments are always effective the last day of the month, and transfers between CMAs/HHs must have agreed upon end dates/start dates for the applicable MAPP segments, which are always last day/first day of month. Suggested read: Establishes a date for disenrollment or transfer via the Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS) effective the first day of the month.	The Department has edited policy to clarify and include last day/first day, where applicable. e.g., Confirms the disenrollment date (last day of month) or transfer date (first day of month) with the member.

Transfer Process	**Pg 4**. *7. Ensures transfer of the member's record, Plan of Care (POC), Assessments, Safety Plan, Child Adolescent Needs and Strengths- NY (CANS-NY), etc. to receiving Health Home (HH)/Care Management Agency (CMA)/ Children and Youth Evaluation Services (C-YES) are completed. within 5 business days after the receiving entity has accepted the case.* **Pg 6.** Health Homes Serving Children (HHSC) ensure that the Assessments, Child Adolescent Needs and Strengths – New York (CANS-NY) Acuity Score, and the Home and Community Based Services (HCBS) Eligibility Determination have been appropriately transmitted under the member's new Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS) segment. Don't these follow the child in UASNY?	The Department concurs that the CANS-NY follows the child in the UASNY.
Transfer Process	**Pg 5.** *The receiving Health home uses the member's current Plan of Care...* The HHCM will have to get a copy of the old POC and "re-enter" into the new EHR – this implies that we can send and generate POC's EHR to EHR.	The Department is not mandating how the receiving Health Home accesses the exisiting Plan of Care (which is available from MAPP). The Department is highlighting that the Plan of Care that is currently active from the previous HH or CMA can continue to be used to support on going service to the member upon transfer to the new Health Home. Additionally, a new Plan of Care does not need to be completed until the expiration date of the existing Plan of Care in MAPP.
Transfer Process	**Pg 6.** ***NOTE:*** *For Health Homes Serving Children, if the transfer is to occur within sixty (60) days of when the Children's Home and Community Based Services (HCBS) Eligibility Determination is due, the assessment is completed prior to the transfer. The assessment can be started two (2) months prior to the due date.* It should be stated if the CMA has the supporting documentation and is able to but if they don't have the proper documentation, then are we expected to hold up a transfer until this completed by the current CMA given the challenges with collecting some of the documentation? The new CMA would be aware of this requirement upon transfer. Assuming parent/member choice to transfer immediately would be allowed in this case.	The case must be up-to date at the time of transfer. The transferring Health Home is responsible to complete the Eligibility Determination.
Transfer Process	**Pg 7.** *Additionally, if the member is enrolled in the Home and Community Based Services (HCBS) Children's Waiver, all documentation for such enrollment is also transferred (e.g. Freedom of Choice Form, etc.).* How are these documents expected to be transmitted to the new HH/CMA/organization?	Health Homes must use a secure file transfer process to transfer documentation.
Transfer Process	How should Health Homes and CMAs address the known defect in MAPP that requires entry in the IA field for Heath Home to Health Home transfers from now until the MAPP HHTS 4.8 release scheduled for Summer 2025?	Submit the newly generated Initial Appropriateness value 'T' to the system within 28 days of the new segment begin date or new consent to enroll date (whichever one is most recent).
Member Acuity (HHSC)	If transferring a medium or low acuity case, CMs must identify when last in-person was received.	When new enrollment segment is started, the timing associated with the core service requirements renews.
Assisted Outpatient Treatment (AOT)	The policy outlines the ideal transfer use case. Clear guidance is welcomed on how to proceed in less ideal cases would be helpful such as how to proceed when a client disengages from care while the transfer is being set up or how to proceed when the transfer is related to court ordered AOT and is unwilling to engage in the transfer process.	An AOT order takes precedence over policy-driven requirements. In cases where a member under an AOT order is unwilling to engage in the transfer process, the transferring Health Home must work with the court and OMH to drive change in terms of the order. Members who become/are disengaged from care during the transfer process who cannot be located and reengaged in care are disenrolled.