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HCBS Transitional Care Coordination (TCC):

MAY 12, 2026

Orientation for TCC Providers & Health Homes

Agenda:

- ✓Introduction to TCC
- ✓TCC Workflow
- ✓TCC Care Coordination Requirements
- ✓TCC & Health Home Billing

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INTRODUCTION TO TRANSITIONAL CARE COORDINATION (TCC) SERVICE

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INTRODUCTION TO TCC

What is TCC?

- TCC is a Children's Waiver service designed to **address barriers to discharge** from institutional care and **support safe, timely transitions** to home and community settings.
- The service promotes **continuity of care** by supporting coordination across settings, timely communication among providers and connection to appropriate follow-up services for children and families.
- Provides coordination of needed services and support to families during the transition period to maintain stability after discharge.

Objectives of TCC:

1. Identify appropriate candidates for TCC
2. Identify and address discharge barriers
3. Provide aftercare follow-up 60 days post-discharge
4. Bridge institutional care and community services through person-centered coordination

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INTRODUCTION TO TCC

Who is served by TCC?

TCC is for children and youth who:

- Are in an institutional level of care e.g., hospital, inpatient, nursing home setting for **at least 1 year**
  - Children ages 1 up to 21 years **OR**
  - Infants 12 weeks under 1 year of age
- Can be medically discharged within the next 6 months however…
  - Are experiencing non-medical barriers to discharge
  - There is a safety and/or continued care concern

Key eligibility consideration

Eligible individuals are those who can be safely discharged from an acute or institutional setting within six (6) months of eligibility determination, with the support of transitional care coordination.

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INTRODUCTION TO TCC

When can TCC be provided?

- TCC services may be provided up to **180 days pre-discharge** from an institution and up to **60 days post-discharge**

TCC providers must develop a Transitional Service Plan that outlines the barriers that need to be addressed to safely allow the child/youth to be discharged to home and community.

The TCC can document other needs and services of the child/youth/family to help support once discharged but will only address those specifics for safe discharge.

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INTRODUCTION TO TCC

Service Components

Supports and coordination of services provided by the Transitional Care Coordinator may include but are not limited to:

- ✓Communication with the participant/family, members of the treatment team, identified support agencies, and community service providers
- ✓Parent/caregiver and informal/formal supports education/training regarding the participant's needs and condition to support entry/re-entry to home/community
- ✓Identification and connection to needed community health services/resources
- ✓Connection to needed care, services, equipment
- ✓Facilitation of HCBS Transitional Service Requests
- ✓Housing connection, supports and access
- ✓Changes to the environment and Environmental Modifications requests
- ✓Arrangements for medical equipment, medication, community specialists, doctors, therapies, transportation
- ✓Connection to caregiver supports and resources

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ROLES AND RESPONSIBILITIES ACROSS THE TRANSITION

Service Name	Transitional Service Coordinator	Health Home Care Manager
Service Timing	Short-term and focused on the transition period and barrier resolution only Up to 180 days pre-discharge and up to 60 days post discharge	Long-term ongoing support at time of discharge and after the child/youth goes home. HHCM can begin care coordination activities 30 days prior to discharge
Service Intent	Support discharge planning and resolve barriers to community transition	Provide ongoing comprehensive care management to address all participant needs after the child is discharged

TCC & HHCM must work collaboratively to ensure a safe transition and timely connection to needed services and supports.

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ROLES AND RESPONSIBILITIES ACROSS THE TRANSITION

Service Name	Transitional Service Coordinator	Health Home Care Manager
Primary Transition Activities	• Identify non-medical barriers to discharge (housing, caregiver readiness, service gaps) • Develop the Transitional Service Plan which identifies barriers to discharge, a plan to address them and the supports/services needed to transition to the community • Collaborate with institution discharge planners • Facilitate referral to DOH C-YES to determine HCBS eligibility • Discuss Health Home options and complete Freedom of Choice • Share timely updates and necessary documentation to support continuity of care • Coordinate and convene the IDT meeting • Help the child/family plan for discharge and transition to the community • Monitors stabilization and ensures transition supports are in place	• Collaborate with the TCC Provider to gather necessary documentation to support continuity of care • Engage with the child/family 30- days before discharge • Attend the IDT meeting • Complete the CANS-NY • Develop the comprehensive Plan of Care (POC) and capture supports/services needed after discharge • Update the POC to encompass outstanding Transitional Service Plan items

TCC PROVIDERS & INSTITUTION MATCHES

Health Homes, HCBS providers, care management agencies, and other providers were solicited to determine their interest in providing TCC.

The Department has been working with several potential TCC providers, and they are currently going through the HCBS designation process.

The Department will be working with TCC providers closely to launch this new service and ensure its success in assisting children/youth discharging from institutional settings

- **TCC providers are matched to a particular institution**
- **Referrals will not be made through IRAMS**
- **Determination of child/youth for TCC service will be determined through a collaborative process of the TCC provider and the institution**
- **TCC is carved out of Medicaid Managed Care and only billed Fee for Service**

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TCC WORKFLOW

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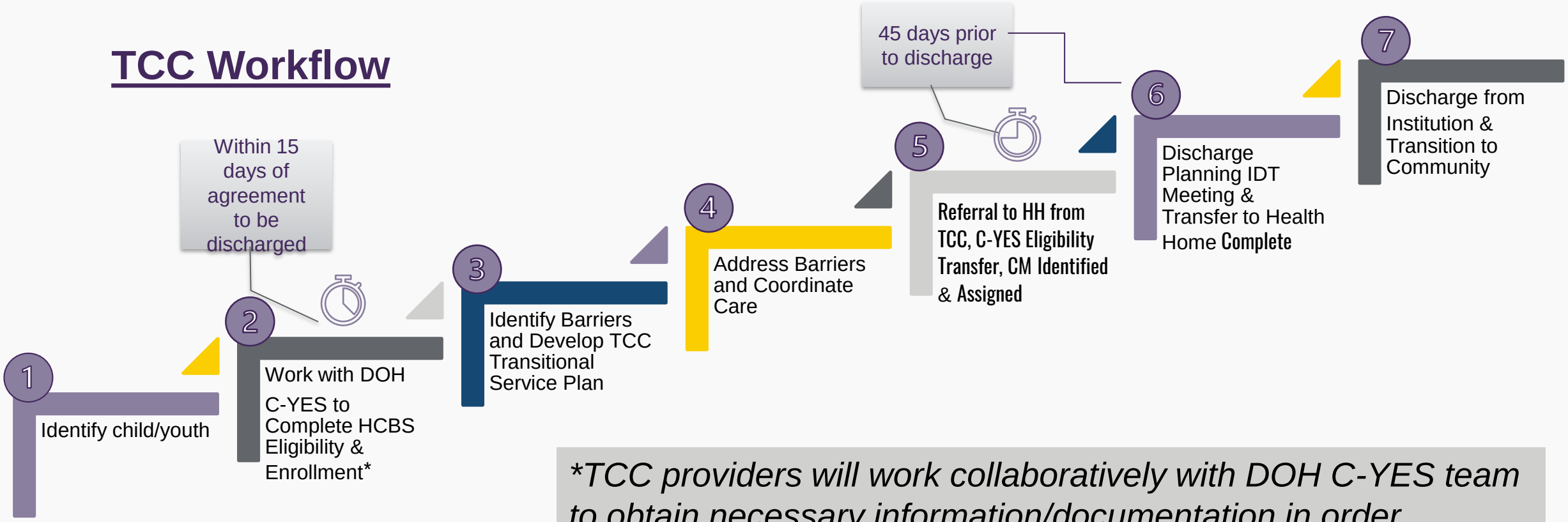
TCC WORKFLOW

TCC Workflow



**TCC providers will work collaboratively with DOH C-YES team to obtain necessary information/documentation in order to complete the HCBS eligibility determination as soon as the child/youth is identified.*

*HHCMs **will not** complete initial HCBS eligibility determinations for TCC participants.*

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TCC WORKFLOW

1 Identify Child/Youth

- **TCC Provider:** Establishes relationship with institution
- **Institution:** Works with the TCC provider to identify children/youth who are likely eligible for TCC, confirm appropriateness of identified children/youth

2 Work with DOH C-YES to Complete HCBS Eligibility & Enrollment

- **TCC Provider:** Contacts the youth/family after collaborative discussion with the Institution;
  - o Discuss needs to assist with discharge from the institution
  - o Confirms TCC eligibility and notifies DOH C-YES of a potential eligible youth
  - o Gathers information and documentation that will assist with the HCBS eligibility determination.
- **Institution:** Provides TCC requested records to support HCBS eligibility determination completion.
- **DOH C-YES:** Completes HCBS eligibility determination. Notifies all involved of the HCBS eligibility outcome and issues NOD to the child/youth/family.

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TCC WORKFLOW

- **TCC Provider:** Completes the *TCC Identification of Need Tool*, confirms discharge tasks
  - o Establish a working relationship with involved professionals and family, educate about TCC.
  - o Develop the Transitional Service Plan that identifies barriers to discharge and actions/supports the participant will need for a successful transition to the community.
  - o TCC can begin billing for TCC once K-codes have been added to participant's file

3 **Identify Barriers and Develop TCC Transitional Service Plan**

4 **Address Barriers and Coordinate Care**

- **TCC Provider:** Coordination with the institution, other involved professionals, family, and other supports, advancing transition planning and barrier resolution
  - o Make referrals,
  - o Address identified barriers,
  - o Assist with requests for Transitional Services,
  - o Educate family, family members, and family supports

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TCC WORKFLOW

- **TCC Provider:** Makes referral to HH and provides overview of case
  - o Shares Transitional Service Plan and other relevant documents/information
- **C-YES:** Complete the transfer of eligibility documentation to the chosen HH
- **Health Home:** Enroll the participant and connect with the TCC provider to prepare for participant discharge.
  - o HHCM will begin enrollment requirements: CANS-NY, comp. assessment, development of the Plan of Care, and other enrollment tasks.

5 **Referral to Health Home and CM identified & assigned**

6 **Discharge Planning IDT Meeting & Discharge from Institution**

- **TCC Provider:** Confirms discharge task progress and planning for discharge
  - o Coordinate and schedule the in-person IDT meeting
  - o Work with the institution to ensure discharge
  - o Ensure Medicaid coverage post discharge
  - o Outlines TCC role for 60 days after discharge
- **Institution:** Confirms anticipated discharge date
  - o Institutional discharge team and specialty care providers attend the IDT meeting
- **Health Home:** HHCM attends the IDT meeting
  - o Education of HH program and role of the CM
  - o Outline of the Plan of Care based on the identified aftercare needs

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TCC WORKFLOW

- **TCC Provider:** Monitors stabilization and helps ensure transition supports are in place, resolves remaining transition items,
  - Follow up with participant/family to check if transitional steps are successful
  - Shares final Transitional Service Plan and outstanding follow-ups.
- **Health Home:** Begins comprehensive care management, completes/updates the Plan of Care with outstanding TCC items
  - Ensures activation of HCBS/State Plan/community supports.

7 **Transition to Community & Warm handoff to Health Home Care Manager**

8 **Post Discharge**

- **TCC Provider:** Provides time-limited follow-up for up to 60 days
  - Closes the TCC case
- **Health Home:** Continues ongoing care management to address outstanding needs

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TCC REQUIREMENTS

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TCC CORE SERVICES

Monthly Contacts

TCC providers must have:

- ***At least* five (5) Core Services each month,**
- ***At least* one in-person meeting with the child/youth/caregiver**

Interdisciplinary Team (IDT) Meetings

TCC providers must convene and lead an IDT meeting with the institutional care team, Health Home care manager, other identified supports, and the child/youth/caregiver within **45 days prior to discharge** to align on the transition plan and responsibilities.

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REQUIRED DOCUMENTATION

For each participant, the TCC provider must:

- ❑ **Develop a Case Record**
  - All TCC activities must be documented in the Case Record, including but not limited to:
    - Acknowledgement of TCC Appropriateness
    - IDT participation
    - Coordination with the child/youth, family, HHCM, institutional staff, and other providers
    - Identified barriers to discharge and actions taken to address
    - Institutional documentation indicating medical clearance for discharge
    - Monthly progress documentation towards successful discharge, with supportive documentation from professionals, family, institution

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TCC TRANSITIONAL SERVICES PLAN

The TCC must develop a **Transitional Service Plan which must include:**

- Identification of barriers to discharge and how they will be addressed.
- Identification of actions/supports needed for successful transition to the community.

- The Transitional Service Plan must be developed **within 30 days from HCBS eligibility determination**
- The TCC must update the Transitional Service Plan **within 45 days prior to the discharge** from institution
- The TCC must have the Transitional Services Plan updated, if needed, **prior to the IDT discharge planning meeting** and available to share with members of the participants care team.

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TCC CARE COORDINATION REQUIREMENTS

The TCC provider will provide the HHCM **prior to discharge** all necessary documentation, including the **Transitional Service Plan**, so the HHCM can complete the **CANS-NY, Comprehensive Assessment** and develop the initial POC.

- The TCC **must** collaborate with the HHCM so most of required documentation can be completed **prior to discharge** and additional HCBS, if needed, can begin **immediately** after the participant returns home.

The TCC will work with the participant/family for **60 days** once home to monitor the discharge plan and services.

- Then close out the Transitional Service Plan and case.

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TCC & HEALTH HOME BILLING

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TCC & HEALTH HOME BILLING

Transitional Care Coordination is carved out of Managed Care.
All TCC will be billed through the FFS Delivery System

- **C-YES must complete the HCBS Eligibility Determination prior to the TCC provider being able to bill the TCC PMPM.**

- The participant **must** have **active Medicaid, active K codes, and an active HCBS eligibility determination** to bill for TCC. Claims for participants that do not meet this criteria will be denied.

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TCC & HEALTH HOME BILLING

Once Waiver enrolled:

TCC can be billed for:

- Up to **180 days prior to the date of discharge**, and
- Up to **60 days post-discharge**.

The Health Home will bill per current HH billing policy.

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Q&A

FOR ADDITIONAL POLICY QUESTIONS, OPERATIONAL AND IMPLEMENTATION SUPPORT, PLEASE CONTACT **BH.TRANSITION@HEALTH.NY.GOV**

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