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State/Territory Name: New York

State Plan Amendment (SPA) #: 17-0053

This file contains the following documents in the order listed:

- 1) NY Regional Office Approval Letter
- 2) CMS-179 form
- 3) Approved SPA Pages



DIVISION OF MEDICAID AND CHILDREN'S HEALTH OPERATIONS

March 23, 2018

Jason Helgerson
Medicaid Director, Deputy Commissioner
Office of Health Insurance Programs
New York State Department of Health
Corning Tower (OCP-1211)
Albany, New York 12237

Dear Mr. Helgerson,

On December 26, 2017, the Centers for Medicare and Medicaid Services (CMS) received New York State Plan Amendment (SPA), transmittal number 17-0053, to implement a 2017-18 budget modification to reduce the case finding payment from \$135 to \$110 per member per month and to modify the claiming period for the case-finding fee from three months to two months, which may be extended for an additional two months. Effective May 1, 2018, this SPA will make revenue neutral modifications to simplify the adult health home rates, by replacing the upstate, downstate; High, Medium, and Low; HARP/Non-HARP rate structure with a modified rate structure for three categories of adult members, Health Home Plus/Care Management, Health Home High Risk/Need Care Management, and Health Home Care Management.

Based on the information provided, we are pleased to inform you SPA 17-005 was approved on March 23, 2018 with an effective date of October 1, 2017. Enclosed is a copy of the CMS 179 form as well as the approved pages for incorporation into the New York State Plan.

If you have any questions regarding this amendment, please contact Dominique Mathurin at dominique.mathurin@cms.hhs.gov or (212) 616-2422.

Sincerely,



Michael Melendez, LMSW
Associate Regional Director
Division of Medicaid and Children's Health Operation's

Enclosure

CC: Regina Deyette
Dominique Mathurin
Joanne Hounsell
Ricardo Holligan
Nicole McKnight
Mary Pat Farkas

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Reviewable Unit	Proposed Effective Date
Health Homes Intro	10/1/2017
Health Homes Population and Enrollment Criteria	10/1/2017
Health Homes Payment Methodologies	10/1/2017
Health Homes Services	10/1/2017

Executive Summary

+/-

Summary Description Including Goals and Objectives See Executive Summary within the Health Home Intro

Dependency Description

+/-

Description of any dependencies between this submission package and any other submission package undergoing review none

Disaster-Related Submission

+/-

This submission is related to a disaster

- Yes
- No

Federal Budget Impact and Statute/Regulation Citation

+/-

Federal Budget Impact

	Federal Fiscal Year	Amount
First	2018	\$-15000000
Second	2019	\$-10000000

Federal Statute / Regulation Citation

§1902(a) of the Social Security Act and 42 CFR 447

Governor's Office Review

+/-

- No comment
- Comments received
- No response within 45 days
- Other

Authorized Submitter

+/-

The following information will be provided by the system once the package is submitted to CMS.

Name of Authorized Submitter Regina Deyette
Phone number 5184733658
Email address regina.deyette@health.ny.gov
Authorized Submitter's Signature Regina Deyette

I hereby certify that I am authorized to submit this package on behalf of the Medicaid Agency.

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to average 40 hours per

response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.



CMS-10434 OMB 0938-1188

Approval Notice

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-14-26
Baltimore, Maryland 21244-1850

**Date:** 03/24/2018**Head of Agency:** Jason Helgerson**Title/Dept :** Medicaid Director**Address 1:** 99 Washington Ave.**Address 2:****City :** Albany**State:** NY**Zip:** 12210**MACPro Package ID:** NY2017MH00060**SPA ID:** NY-17-0053**Subject**

Notice Of Approval

Dear Jason Helgerson

This is an informal communication that will be followed with an official communication to the State's Medicaid Director.

The Centers for Medicare and Medicaid Services (CMS) is pleased to inform you that we are recommending approval for your request for NY-2017MH00060

Reviewable Unit	Effective Date
Health Homes Intro	10/1/2017
Health Homes Population and Enrollment Criteria	10/1/2017
Health Homes Payment Methodologies	10/1/2017
Health Homes Services	10/1/2017

Increase in Conditions Covered Yes No

No New FFP

Sincerely,

Nicole McKnight
branch manager

Approval Documentation

Name	Date Created	Type
No items available		

Package Information

TN: 17-0053
New York

Approval Date: 03/23/2018

Effective Date: 10/01/2017

Package ID NY2017MH0006O
Program Name NYS Health Home Program
SPA ID NY-17-0053
Version Number 2
Submitted By Regina Deyette
Package Disposition



Submission Type Official
State NY
Region New York, NY
Package Status Approved
Submission Date 12/26/2017
Approval Date 3/24/2018 7:45 AM EDT

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | NY2017MH0006O | NY-17-0053 | NYS Health Home Program

Not Started

In Progress

Complete

Package Header

Package ID NY2017MH0006O
Submission Type Official
Approval Date 3/24/2018
Superseded SPA ID N/A

SPA ID NY-17-0053
Initial Submission Date 12/26/2017
Effective Date N/A

State Information

State/Territory Name: New York

Medicaid Agency Name: Department of Health

Submission Component

State Plan Amendment

Medicaid

CHIP

Submission Type

Official Submission Package

Draft Submission Package

Allow this official package to be viewable by other states?

Yes

No

Key Contacts

Name	Title	Phone Number	Email Address
Deyette, Regina	NYS Medicaid State Plan Coordinatro	(518)473-3658	regina.deyette@health.ny.gov

SPA ID and Effective Date

SPA ID NY-17-0053

Reviewable Unit	Proposed Effective Date
Health Homes Intro	10/1/2017
Health Homes Population and Enrollment Criteria	10/1/2017
Health Homes Payment Methodologies	10/1/2017
Health Homes Services	10/1/2017

Executive Summary

Summary Description Including Goals and Objectives See Executive Summary within the Health Home Intro

Dependency Description

TN: 17-0053
New York

Approval Date: 03/23/2018

Effective Date: 10/01/2017

Description of any dependencies between this submission package and any other submission package undergoing review none

Disaster-Related Submission

This submission is related to a disaster

- Yes
- No

Federal Budget Impact and Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First	2018	\$-15000000
Second	2019	\$-10000000

Federal Statute / Regulation Citation

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- No comment
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Name of Authorized Submitter Regina Deyette
Phone number 5184733658
Email address regina.deyette@health.ny.gov

Authorized Submitter's Signature Regina Deyette

I hereby certify that I am authorized to submit this package on behalf of the Medicaid Agency.

Submission - Public Comment

MEDICAID | Medicaid State Plan | Health Homes | NY2017MH0006O | NY-17-0053 | NYS Health Home Program

Not Started

In Progress

Complete

Package Header

Package ID NY2017MH0006O **SPA ID** NY-17-0053
Submission Type Official **Initial Submission Date** 12/26/2017
Approval Date 3/24/2018 **Effective Date** N/A
Superseded SPA ID N/A

Name of Health Homes Program

NYS Health Home Program

Indicate whether public comment was solicited with respect to this submission.

- Public notice was not required and comment was not solicited
- Public notice was not required, but comment was solicited
- Public notice was required and comment was solicited

Indicate how public comment was solicited:

IR: 17-0053

Approval Date: 03/23/2018

Effective Date: 10/01/2017

- Newspaper Announcement
- Publication in state's administrative record, in accordance with the administrative procedures requirements
- Email to Electronic Mailing List or Similar Mechanism
- Website Notice
- Public Hearing or Meeting
- Other method

Upload copies of public notices and other documents used

Name	Date Created	Type

-
-
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-
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-
-
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No

No

Explain why this SPA is not likely to have a direct effect on Indians, Indian Health Programs or Urban Indian Organizations

Heath Home Outreach

- Even though not required, the state has solicited advice from Indian Health Programs and/or Urban Indian Organizations prior to submission of this SPA
- The state has not solicited advice from Indian Health Programs and/or Urban Indian Organizations prior to submission of this SPA

Complete the following information regarding any solicitation of advice and/or tribal consultation conducted with respect to this submission:

Solicitation of advice and/or Tribal consultation was conducted in the following manner:

All Indian Health Programs

Date of solicitation/consultation:	Method of solicitation/consultation:
6/15/2017	consultation mailed, no comments received

All Urban Indian Organizations

States are not required to consult with Indian tribal governments, but if such consultation was conducted voluntarily, provide information about such consultation below:

All Indian Tribes

Date of consultation:	Method of consultation:
6/15/2017	consultation mailed, no comments received

The state must upload copies of documents that support the solicitation of advice in accordance with statutory requirements, including any notices sent to Indian Health Programs and/or Urban Indian Organizations, as well as attendee lists if face-to-face meetings were held. Also upload documents with comments received from Indian Health Programs or Urban Indian Organizations and the state's responses to any issues raised. Alternatively indicate the key issues and summarize any comments received below and describe how the state incorporated them into the design of its program.

Name	Date Created	Type

Indicate the key issues raised (optional)

- Access
- Quality
- Cost
- Payment methodology
- Eligibility
- Benefits

Service delivery

Other issue

Submission - Other Comment

MEDICAID | Medicaid State Plan | Health Homes | NY2017MH0006O | NY-17-0053 | NYS Health Home Program

Not Started

In Progress

Complete

Package Header

Package ID NY2017MH0006O	SPA ID NY-17-0053
Submission Type Official	Initial Submission Date 12/26/2017
Approval Date 3/24/2018	Effective Date N/A
Superseded SPA ID N/A	

SAMHSA Consultation

Name of Health Homes Program

NYS Health Home Program

The State provides assurance that it has consulted and coordinated with the Substance Abuse and Mental Health Services Administration (SAMHSA) in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.

Date of consultation

11/20/2014

Health Homes Intro

MEDICAID | Medicaid State Plan | Health Homes | NY2017MH0006O | NY-17-0053 | NYS Health Home Program

Not Started

In Progress

Complete

Package Header

Package ID NY2017MH0006O	SPA ID NY-17-0053
Submission Type Official	Initial Submission Date 12/26/2017
Approval Date 3/24/2018	Effective Date 10/1/2017
Superseded SPA ID N/A	

Program Authority

1945 of the Social Security Act

The state elects to implement the Health Homes state plan option under Section 1945 of the Social Security Act.

Name of Health Homes Program

NYS Health Home Program

Executive Summary

Provide an executive summary of this Health Homes program including the goals and objectives of the program, the population, providers, services and service delivery model used

Summary description including goals and objectives:

New state plan amendment.

Supersedes transmittal # 16-0034

Transmittal # 17-0053 Case Finding and Engagement Restructuring

This State Plan Amendment is in Attachment 3.1-H of the State Plan, except for the Payment Methodologies section, which is in Attachment 4.19-B of the State Plan.

Part I: Summary of new State Plan Amendment (SPA) #17-0053

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for non-institutional services. The following changes are proposed:

Effective October 1, 2017, the purpose of this State Plan Amendment (SPA) is to implement a 2017-18 budget modification to reduce the case finding payment from \$135 to \$110 per member per month and to modify the claiming period for the case finding fee from 3 months to 2 months which may be extended for an additional 2 months. Effective May 1, 2018 this SPA will make revenue neutral modifications to simplify the adult health home rates, by replacing the upstate, downstate; High, Medium, and Low; HARP Non-HARP rate structure with a modified rate structure for three categories of adult members, Health Home Plus/Care Management, Health Home High Risk/ Need Care Management, and Health Home Care Management. Rates for children and Adult Home Transition members remain unchanged.

In addition, the SPA will delete a technical inaccuracy related to the assessment fee for the CANS-NY applicable to children.

Amendment #17-0053 located in MACPRO Unit 7, Health Home Payment Methodologies. **Approval Date:** 03/23/2018

Effective Date: 10/01/2017

New York

Part II: As instructed by CMS, all previously underlined and bracketed information concerning approved SPA 16-0034 has been removed in MACPro.

Part III: As requested by SAMHSA the definition of Complex Trauma has been amended to include "dissociation". This change can be found in Unit 2, Health Home Population and Enrollment Criteria

General Assurances

- The state provides assurance that eligible individuals will be given a free choice of Health Homes providers.
- The states provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services.
- The state provides assurance that hospitals participating under the state plan or a waiver of such plan will be instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Homes providers.
- The state provides assurance that FMAP for Health Homes services shall be 90% for the first eight fiscal quarters from the effective date of the SPA. After the first eight quarters, expenditures will be claimed at the regular matching rate.
- The state provides assurance that it will have the systems in place so that only one 8-quarter period of enhanced FMAP for each health homes enrollee will be claimed.
- The state provides assurance that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.

Health Homes Population and Enrollment Criteria

MEDICAID | Medicaid State Plan | Health Homes | NY2017MH0006O | NY-17-0053 | NYS Health Home Program

Not Started	In Progress	Complete
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Package Header

Package ID NY2017MH0006O	SPA ID NY-17-0053
Submission Type Official	Initial Submission Date 12/26/2017
Approval Date 3/24/2018	Effective Date 10/1/2017
Superseded SPA ID N/A	

Categories of Individuals and Populations Provided Health Homes Services

The state will make Health Homes services available to the following categories of Medicaid participants

- Categorically Needy (Mandatory and Options for Coverage) Eligibility Groups
- Medically Needy Eligibility Groups
 - Mandatory Medically Needy.
 - Medically Needy Pregnant Women
 - Medically Needy Children under Age 18
 - Optional Medically Needy (select the groups included in the population).

Families and Adults

 - Medically Needy Children Age 18 through 20
 - Medically Needy Parents and Other Caretaker Relatives

Aged, Blind and Disabled

 - Medically Needy Aged, Blind or Disabled
 - Medically Needy Blind or Disabled Individuals Eligible in 1973

Population Criteria

The state elects to offer Health Homes services to individuals with

- Two or more chronic conditions
 - Specify the conditions included**
 - Mental Health Condition
 - Substance Use Disorder
 - Asthma
 - Diabetes
 - Heart Disease
 - BMI over 25

Other (specify)

Name	Description
BMI over 25	BMI is defined as, at or above 25 for adults, and BMI at or above the 85 percentile for children.

One chronic condition and the risk of developing another

Specify the conditions included

- Mental Health Condition
- Substance Use Disorder
- Asthma
- Diabetes
- Heart Disease
- BMI over 25
- Other (specify)

Name	Description
HIV/AIDS	see description below
One Serious Mental Illness	see description below
SED/Complex Trauma	see description below

Specify the criteria for at risk of developing another chronic condition

HIV, Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED) and complex trauma are each single qualifying conditions for which NYS was approved. Providers do not need to document a risk of developing another condition in these cases.

New York's Medicaid program serves over 5 million enrollees with a broad array of health care needs and challenges. While many Medicaid enrollees are relatively healthy and access practitioners to obtain episodic and preventive health care, the Medicaid program also has several population groups who have complex medical, behavioral, and long term care needs that drive a high volume of high cost services including inpatient and long term institutional care.

Of the 5.4M Medicaid enrollees who access services on a fee for service or managed care basis, 975,000 (including dual eligibles) have been identified as high cost/high need enrollees with two or more chronic conditions and/or a Serious Persistent Mental Illness. These high cost/high need enrollees are categorized into four groups representing enrollees with intellectual disabilities, enrollees in need of long term care services, enrollees with behavioral health issues, and enrollees with two or more chronic medical conditions. One of NY's first health home initiatives will focus on enrollees with behavioral health and/or chronic medical conditions.

The NYS Medicaid program plans to certify health homes that build on current provider partnerships. Applicant health home providers will be required to meet State defined health home requirements that assure access to primary, specialty and behavioral health care that support the integration and coordination of all care. Recently passed New York State Law provides the Commissioners of Health, Mental Health, Alcoholism and Substance Abuse Services, and People with Developmental Disabilities the authority to integrate care delivery by synching health care, substance abuse services, and mental health certification requirements for health homes. Approved health homes will directly provide, or contract for, health home services to the identified eligible beneficiaries. To meet this goal, it is expected that health home providers will develop health home networks with primary, medical, specialty and mental health providers, substance abuse service providers, community based organizations, managed care plans and others to provide enrollees access to needed services.

To facilitate the use of health information technology by health homes to improve service delivery and coordination across the care continuum, NY has developed initial and final HIT standards for health homes that are consistent with NYS' Operational Plan for Health Information Technology and Exchange approved by CMS. Providers must meet initial HIT standards to implement a health home. Furthermore, applicants must provide a plan to achieve the final standards within eighteen months of program implementation.

approved as a health home provider.

To the extent possible health home providers will be encouraged to utilize regional health information organizations or qualified entities to access patient data and to develop partnerships that maximize the use of HIT across providers (i.e. hospitals, TCMS). Health home providers will be encouraged to utilize HIT as feasible to create, document, execute and update a plan of care that is accessible to the interdisciplinary team of providers for every patient. Health home providers will also be encouraged to utilize HIT as feasible to process and follow up on patient testing, treatments, community based services and provider referrals.

NY will target populations for health homes services in the major categories and the associated 3M Clinical Risk Group categories of chronic behavioral and medical conditions listed below.

Major Category: Alcohol and Substance Abuse

3M Clinical Risk Group (3M CRGs) Category

- 1. Alcohol Liver Disease
- 2. Chronic Alcohol Abuse
- 3. Cocaine Abuse
- 4. Drug Abuse - Cannabis/NOS/NEC
- 5. Substance Abuse
- 6. Opioid Abuse
- 7. Other Significant Drug Abuse

Major Category: Mental Health

3M Clinical Risk Group (3M CRGs) Category

- 1. Bi-Polar Disorder
- 2. Conduct, Impulse Control, and Other Disruptive Behavior Disorders
- 3. Dementing Disease
- 4. Depressive and Other Psychoses
- 5. Eating Disorder
- 6. Major Personality Disorders
- 7. Psychiatric Disease (Except Schizophrenia)
- 8. Schizophrenia

Major Category: Cardiovascular Disease

3M Clinical Risk Group (3M CRGs) Category

- 1. Advanced Coronary Artery Disease
- 2. Cerebrovascular Disease
- 3. Congestive Heart Failure
- 4. Hypertension
- 5. Peripheral Vascular Disease

Major Category: HIV/AIDS

3M Clinical Risk Group (3M CRGs) Category

- 1. HIV Disease

Major Category: Metabolic Disease

3M Clinical Risk Group (3M CRGs) Category

- 1. Chronic Renal Failure
- 2. Diabetes

Major Category: Respiratory Disease

3M Clinical Risk Group (3M CRGs) Category

- 1. Asthma
- 2. Chronic Obstructive Pulmonary Disease

Major Category: Other

3M Clinical Risk Group (3M CRGs) Category

- 1. Other Chronic Disease -conditions listed above as well as other specific diagnoses of the population.

Description of population selection criteria

The target population to receive health home services under this amendment includes categorically needy and medically needy beneficiaries served by Medicaid managed care or fee for service and Medicare/Medicaid dual eligible beneficiaries who meet health home selection criteria. NY will offer Health Home Services to individuals with two or more chronic conditions, individuals with HIV/AIDS, individuals with one serious mental illness, individuals with SED, and individuals with complex trauma.

Enrollees in the behavioral health category have been identified through claims and encounter data analysis as having received mental health or substance abuse services and/or having select mental health diagnoses. These enrollees often have co-morbid chronic, medical conditions. In addition, based on experience in working with this population, many of these enrollees have social issues, such as lack of permanent housing, that take priority to

medical condition category have been identified through claims and encounter data analysis as having two or three chronic medical conditions.

Complex trauma exposure in childhood has been shown to impair brain development and the ability to learn and develop social and emotional skills during childhood, consequently increasing the risks of developing serious or chronic diseases in adolescence and adulthood. Children who have experienced complex trauma and who are not old enough to have experienced long-term impacts are uniquely vulnerable. Childhood exposure to child maltreatment, including emotional abuse and neglect, exposure to violence, sexual and physical abuse are often traumatic events that continue to be distressing for children even after the maltreatment has ceased, with negative physical, behavioral, and/or psychological effects on the children. Since child maltreatment occurs in the context of the child's relationship with a caregiver, the child's ability to form secure attachment bonds, sense of safety and stability are disrupted. Without timely and effective intervention during childhood, a growing body of research shows that a child's experience of these events (simultaneous or sequential maltreatment) can create wide-ranging and lasting adverse effects on developmental functioning, and physical, social, emotional or spiritual well-being. Enrolling children who are experiencing complex trauma in Health Homes will work to prevent, while an individual is still in childhood, the development of other more complex chronic conditions in adulthood.

Enrollees in the complex trauma category will be identified for referral to Health Homes by various entities, including child welfare systems (i.e., foster care and local departments of social services), health and behavioral health care providers, and other systems (e.g., education) that impact children.

Enrollees in the behavioral health category have been identified through claims and encounter data analysis as having received mental health or substance abuse services and/or having select mental health diagnoses. These enrollees often have co-morbid chronic, medical conditions. In addition, based on experience in working with this population, many of these enrollees have social issues, such as lack of permanent housing, that take priority to these individuals over their health care conditions. Enrollees in the chronic medical condition category have been identified through claims and encounter data analysis as having two or three chronic medical conditions.

One serious and persistent mental health condition

Specify the criteria for a serious and persistent mental health condition

The guidance on complex trauma draws upon the domains within the definition of serious emotional disturbance (SED). While there may be similarities in the condition(s) and symptoms that arise in either complex trauma or SED, the therapeutic approaches associated with the same diagnoses may vary significantly when the symptoms arising from traumatic experiences are identified as such. Trauma experts indicate that with complex trauma, the clinical diagnoses may be more severe and typically present as comorbidities or multiple diagnoses. 1. Definition of Complex Trauma a. The term complex trauma incorporates at least:

- i. Infants/children/or adolescents' exposure to multiple traumatic events, often of an invasive, interpersonal nature, and
- ii. the wide ranging long-term impact of this exposure. b. Nature of the traumatic events: i. often is severe and pervasive, such as abuse or profound neglect ii. usually begins early in life iii. can be disruptive of the child's development and the formation of a healthy sense of self (with self-regulatory, executive functioning, self-perceptions, etc.) iv. often occur in the context of the child's relationship with a caregiver, and v. can interfere with the child's ability to form a secure attachment bond, which is considered a prerequisite for healthy social-emotional functioning. c. Many aspects of a child's healthy physical and mental development rely on this secure attachment, a primary source of safety and stability. d. Wide-ranging, long-term adverse effects can include impairments in i. physiological responses and related neurodevelopment ii. emotional responses iii. cognitive processes including the ability to think, learn, and concentrate iv. impulse control and other self-regulating behavior v. self-image, and vi. relationships with others and vii. dissociation. Effective October 1, 2016 complex trauma and SED will each be a single qualifying condition.

Enrollment of Participants

Participation in a Health Homes is voluntary. Indicate the method the state will use to enroll eligible Medicaid individuals into a Health Home

- Opt-In to Health Homes provider
- Referral and assignment to Health Homes provider with opt-out
- Other (describe)

Describe the process used

Individuals eligible for health home services will be identified by the State. Individuals will be assigned to a health home provider based on existing relationships with health care providers or health care delivery system relationships, geography, and/or other qualifying conditions. Individuals will be enrolled into an appropriate health home and be given the option to choose another health home when available, or opt out of enrollment in a health home. Individuals will be notified by U.S. mail of their health home enrollment. The notification letter will identify the assigned health home, and provide the individual's option to select a health home or opt out from

receiving health home services with in a designated time period, and briefly describe health home services. The State will provide health home providers a roster of assigned enrollees and current demographic information to facilitate outreach and engagement.

Individuals that are under 21 years of age, including those for which consent to enroll in a health home will be provided by a parent or guardian, will be referred to health homes by health homes, care managers, managed care plans and other providers and entities, including local departments of social services, and local government units. Referrals will be processed for assignment, and such assignments will take into account existing relationships with health care providers or health care delivery system relationships, geography, and/or qualifying condition. Such individuals/parents/guardians will be given the option to choose another health home when available, or opt out of enrollment of a health home.

The state provides assurance that it will clearly communicate the individual's right to opt out of the Health Homes benefit or to change Health Homes providers at any time and agrees to submit to CMS a copy of any letter or communication used to inform the individuals of the Health Homes benefit and their rights to choose or change Health Homes providers or to elect not to receive the benefit

Alternative models of payment, other than Fee for Service or PMPM payments (describe below)

Agency Rates

Describe the rates used

- FFS Rates included in plan
- Comprehensive methodology included in plan
- The agency rates are set as of the following date and are effective for services provided on or after that date

Rate Development

Provide a comprehensive description in the SPA of the manner in which rates were set

1. In the SPA please provide the cost data and assumptions that were used to develop each of the rates
2. Please identify the reimbursable unit(s) of service
3. Please describe the minimum level of activities that the state agency requires for providers to receive payment per the defined unit
4. Please describe the state's standards and process required for service documentation, and
5. Please describe in the SPA the procedures for reviewing and rebasing the rates, including
 - the frequency with which the state will review the rates, and
 - the factors that will be reviewed by the state in order to understand if the rates are economic and efficient and sufficient to ensure quality services.

Comprehensive Description Provide a comprehensive description of the rate-setting policies the State will use to establish Health Homes provider reimbursement fee for service or PMPM rates. Explain how the methodology is consistent with the goals of efficiency, economy, and quality of care. Within your description, please explain: the reimbursable unit(s) of service, the cost assumptions and other relevant factors used to determine the payment amounts, the minimum level of activities that the State agency requires for providers to receive payment per the defined unit, and the State's standards and process required for service documentation.

Provider Type

NYS Medicaid providers eligible to become health homes include managed care plans; hospitals; medical, mental and chemical dependency treatment clinics; primary care practitioner practices; PCMHs; FQHCs; Targeted Case Management (TCM) providers; certified home health care agencies and any other Medicaid enrolled providers that meet health home provider standards.

Care Management Fee:

Health Homes meeting State and Federal standards will be paid a per member per month care management fee that is adjusted based on region and case mix method for adults, or the Child and Adolescent Needs and Strength Assessment of New York (CANS-NY) for children age 0 through 20). The total cost relating to a care manager (salary, fringe benefits, non-personal services, capital and administration costs) in conjunction with caseload assumptions were used to develop the Health Home rates. The state periodically reviews the Health Home payments in conjunction with Department of Labor salary data to ensure that the Health Home rates are sufficient to ensure quality services.

Effective May 1, 2018, the per member per month care management fee for adults will be based on region and case mix defined by populations as indicated below. Health Home rates for children will continue to be determined by an algorithm applied to the CANS-NY assessment. The risk adjusted payments will allow providers to receive a diverse population of patients and assign patients to various levels of care management intensity without having to meet preset standards for contact counts. Providers will be able to respond to and adjust the intensity and frequency of intervention based on patient's current condition and needs (from tracking to high touch). All rates will be published on the DOH website. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers. Rates for Health Home services to children are effective October 1, 2016 and apply to services furnished on and after October 1, 2016 through September 30, 2018. Rates for Health Home services furnished to other populations are effective as noted below and apply to services furnished on and after such dates.

State Health Home Rates and Rate Codes Effective October 1, 2017 can be found at:
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_rates_effective_october_2017.xlsx

State Health Home Rates and Rate Codes Effective May 1, 2018 can be found at:
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_rates_effective_october_2017.xlsx

Population Case Mix Definitions for Health Home Adult Rates

Health Home Plus/Care Management Rates include adults with active AOT order or expired AOT order within last year; adults stepping down from State PC and ACT; Health and Recovery Plan (HARP) members that meet high risk criteria (recent incarceration, homelessness, multiple hospital admissions, etc.); and members identified at the discretion of the Medicaid Managed Care Plan or state designated entity for adults not currently enrolled in a Medicaid Managed Care Plan.

Health Home High Risk/Need Care Management Rates, include adults that are HARP enrolled members not included in the Health Home Plus/Care Management; any adult member meeting high risk criteria based on the high, medium and low, Clinical and Functional Assessment; and members identified at the discretion of the Medicaid Managed Care Plan or state designated entity for adults not currently enrolled in a Medicaid Managed Care Plan.

Transition Rates, Health Home Plus/Care Management or High Risk /High Need Care Management Rates.

Health Home Services Adult Home Transition Rates apply to individuals, under the terms of a Stipulation and Order of Settlement between the U.S. Department of Justice and New York State, that are Adult Home Residents with serious mental illness (SMI) that are required to transition from Adult Homes located in New York City to the community.

The care management fee will be paid in two increments based on whether a patient was in 1) the case finding group or 2) the active care management group. Effective October 1, 2017, the case finding group will receive a PMPM for two consecutive months after a patient has been assigned or referred to the health home. The consecutive second month must be documented by a face-to-face contact. Two additional months of the case finding PMPM may be billed with a rolling 12 month period. A consecutive month billing must be documented with a face-to-face contact. This PMPM is intended to cover the cost of outreach and engagement.

A unit of service will be defined as a billable unit per service month. In order to be reimbursed for a billable unit of service per month health home providers must, at a minimum, provide one of the core health home services per month. The monthly payment will be paid via the case finding and active care management PMPM. To bill the active case management fee, the patient must have: consented to receive services, been assigned to a care manager and be enrolled in the health home program. Care managers must document all services provided to the member in the member's care plan.

Managed Care Considerations:

Similar to the NY patient centered Medical Home program, it is the intention of the State to coordinate and pay for health home services through health plans but at State set rates for the service. The State will address any existing care management resources in the current plan premium for health home enrollees under CMS guidelines (bring this resource out of the capitation and create federal matching for those resources under the health home payment). Plans will pay health home providers State set rates when providers are contracted to provide all health home services. In the case where the plan does a portion of the health home service (e.g. telephonic post discharge tracking) and downstream providers do a separate portion (e.g. face to face care management) the plan will then split the State generated PMPM proportional to the contracted effort.

The Medicaid/FHP Model Contract will be modified at the next scheduled amendment to include language similar to that outlined below which will address any duplication of payment between the MCO capitation payments and health home payments. The delivery design and payment methodology will not result in any duplication of payment between Health Homes and managed care.

- The managed care plan is not required to provide services that would duplicate the CMS reimbursed Health Home services for members participating in the State's Health Home program.
- The managed care organization will be informed of members assigned to a Health Home or will assign its members to a Health Home for health home services. Plans may need to expand their networks to include additional State designated health home providers to ensure appropriate access.
- Plans will need to have signed contracts including clearly established responsibilities with the provider based health homes.
- The managed care plan will be required to inform either the individual's Health Home or the State of any inpatient admission or discharge of a Health Home member that the plan learns of through its inpatient admission initial authorization and concurrent review processes as soon as possible to promote appropriate follow-up and coordination of services.
- Plans will assist State designated Health Home providers in their network with coordinating access to data, as needed.
- Plans will, as appropriate, assist with the collection of required care management and patient experience of care data from State designated Health Home providers in its' network.

The State has a health home advisory committee of providers and managed care plans through which any issues with payment would be raised and addressed. Directions have been given to health plans to match health home payment to providers based on relative health home care management effort. Further information on specific construction on health home rates includes specific administration compensation to guide rate differential construct.

Targeted Case Management (TCM) Conversion Considerations:

The State envisions that eventually all targeted case management programs operating in New York will convert to or become part of health homes, and these providers will require time to meet State and Federal health home standards. The State will allow TCM providers that can meet health home standards to convert to health homes or join with larger health homes. TCM providers that convert to health homes will be governed under NYS Health Home Provider Qualification Standards, not TCM standards. The payment method will be designed to transition all existing TCM capacity from the current rates to the new Health Home payment structure. Effective January 1, 2015 TCM programs for adults will be paid their existing TCM rates until November 30, 2016. Effective October 1, 2016 through September 30, 2018 TCM programs for children will be paid a transitional rate that is as financially equivalent as practicable to their current rate.

Health Home care management services may be provided to children that are eligible and enrolled in both the Early Intervention Program and Health Home, and will meet and fulfill the requirements of the ongoing service coordination required to be provided to children enrolled in the Early Intervention Program.

All payments will be made under the health home payment detailed above in the care management fee section if they convert to or become part of a health home. Effective October 1, 2017, the case finding PMPM will be paid under the provisions described in the care management fee section.

Assurances

The State provides assurance that it will ensure non-duplication of payment for services similar to Health Homes services that are offered/covered under a different statutory authority, such as 1915(c) waivers or targeted case management.

Describe below how non-duplication of payment will be All rates are published on the DOH website. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both government and private payers. Approval Date: 03/23/2018 Effective Date: 10/01/2017

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achieved that there is no duplication of payment for health home services.
http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/rate_information.htm.

- The State meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), 1902(a)(30)(A), and 1903 with respect to non-payment for provider-preventable conditions.
- The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule, unless otherwise described above.
- The State provides assurance that it shall reimburse providers directly, except when there are employment or contractual arrangements consistent with section 1902(a)(32).

Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | NY2017MH0006O | NY-17-0053 | NYS Health Home Program

Not Started

In Progress

Complete

Package Header

Package ID	NY2017MH0006O	SPA ID	NY-17-0053
Submission Type	Official	Initial Submission Date	12/26/2017
Approval Date	3/24/2018	Effective Date	10/1/2017
Superseded SPA ID	NY-16-0034		
	System-Derived		

Service Definitions

Provide the state's definitions of the following Health Homes services and the specific activities performed under each service

Comprehensive Care Management

Definition

A comprehensive individualized patient centered care plan will be required for all health home enrollees. The care plan will be developed based on the information obtained from a comprehensive health risk assessment used to identify the enrollee's physical, mental health, chemical dependency and social service needs. The individualized care plan will be required to include and integrate the individual's medical and behavioral health services, rehabilitative, long term care, social service needs, as applicable. The care plan will be required to clearly identify the primary care physician/nurse practitioner, specialist(s), behavioral health care provider(s), care manager and other providers directly involved in the individual's care. The individual's plan of care must also identify community networks and supports that will be utilized to address their needs. Goals and timeframes for improving the patient's health, their overall health care status and the interventions that will produce this effect must also be included in the plan of care.

The care manager will be required to make sure that the individual (or their guardian) plays a central and active part in the development and execution of their plan of care, and that they are in agreement with the goals, interventions and time frames contained in the plan. Family members and other supports involved in the patient's care should be identified and included in the plan and execution of care as requested by the individual.

The care plan must also include outreach and engagement activities which will support engaging the patient in their own care and promote continuity of care. In addition, the plan of care will include periodic reassessment of the individual's needs and goals and clearly identify the patient's progress in meeting goals. Changes in the plan of care will be made based on changes in patient need.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

To facilitate the use of health information technology by health homes to improve service delivery and coordination across the care continuum, NY has developed initial and final HIT standards. Providers must meet the initial HIT standard to implement a health home, as feasible. NY anticipates that a portion of health home providers may not utilize HIT in their current programs. These providers will be encouraged to utilize regional health information organizations (RHIOs) or a qualified entity to access patient data and to develop partnerships that maximize the use of HIT across providers (i.e. hospitals, TCMS). Applicants must provide a plan in order to achieve the final HIT standards within eighteen months of program initiation in order to be approved as a health home provider. Health home providers will be encouraged to utilize HIT as feasible to create, document and execute and update a plan of care for every patient that is accessible to the interdisciplinary team of providers. Health home providers will also be encouraged to utilize HIT as feasible to process and follow up on patient testing, treatments, services and referrals.

Scope of service

The service can be provided by the following provider types

- Behavioral Health Professionals or Specialists
- Nurse Practitioner
- Nurse Care Coordinators
- Nurses
- Medical Specialists
- Physicians
- Physician's Assistants

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- Pharmacists
- Social Workers
- Doctors of Chiropractic
- Licensed Complementary and alternative Medicine Practitioners
- Dieticians
- Nutritionists
- Other (specify)

Provider Type	Description
Multidisciplinary teams	NY health homes will use multidisciplinary teams of medical, mental health, chemical dependency treatment providers, social workers, nurses and other care providers led by a dedicated care manager who will assure that enrollees receive needed medical, behavioral, and social services in accordance with a single plan of care.

Care Coordination

Definition

The health home provider will be accountable for engaging and retaining health home enrollees in care, as well as coordinating and arranging for the provision of services, supporting adherence to treatment recommendations, and monitoring and evaluating the enrollee's needs. The individualized plan of care will identify all the services necessary to meet goals needed for care management of the enrollee such as prevention, wellness, medical treatment by specialists and behavioral health providers, transition of care from provider to provider, and social and community services where appropriate.

In order to fulfill the care coordination requirements, the health home provider will assign each individual enrollee one dedicated care manager who is responsible for overall management of the enrollee's plan of care. The enrollee's health home care manager will be clearly identified in the patient record and will have overall responsibility and accountability for coordinating all aspects of the individual's care. The health home provider will be responsible to assure that communication will be fostered between the dedicated care manager and treating clinicians to discuss as needed care needs, conflicting treatments, change in condition, etc. which may necessitate treatment change (i.e., written orders and/or prescriptions).

The health home provider will be required to develop and have policies, procedures and accountabilities (contractual agreements) in place, to support and define the roles and responsibilities for effective collaboration between primary care, specialist, behavioral health providers and community-based organizations. The health home providers policies and procedures will direct and incorporate successful collaboration through use of evidence-based referrals, follow-up consultations, and regular, scheduled case review meetings with all members of the interdisciplinary team. The health home provider will have the option of utilizing technology conferencing tools including audio, video and /or web deployed solutions when security protocols and precautions are in place to protect PHI to support care management/coordination activities.

The health home provider will be required to develop and utilize a system to track and share patient information and care needs across providers, monitor patient outcomes, and initiate changes in care as necessary to address patient need.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

Health home providers will be encouraged to utilize RHIOs or a qualified entity to access patient data and to develop partnerships that maximize the use of HIT across providers (i.e. hospitals, TCMS). Health home providers will utilize HIT as feasible to create, document and execute and update a plan of care for every patient that is accessible to the interdisciplinary team of providers. Health home providers will also be encouraged to utilize HIT as feasible to monitor patient outcomes, initiate changes in care and follow up on patient testing, treatments, services and referrals.

Scope of service

The service can be provided by the following provider types

- Behavioral Health Professionals or Specialists
- Nurse Practitioner
- Nurse Care Coordinators
- Nurses
- Medical Specialists
- Physicians
- Physician's Assistants
- Pharmacists
- Social Workers
- Doctors of Chiropractic

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- Licensed Complementary and alternative Medicine Practitioners
- Dieticians
- Nutritionists
- Other (specify)

Provider Type	Description
multidisciplinary teams	NY health homes will use multidisciplinary teams of medical, mental health, chemical dependency treatment providers, social workers, nurses and other care providers led by a dedicated care manager who will assure that enrollees receive needed medical, behavioral, and social services in accordance with a single plan of care.

Health Promotion

Definition

Health promotion begins for eligible health home enrollees with the commencement of outreach and engagement activities. NYS' health home plan for outreach and engagement will require a health home provider to actively seek to engage patients in care by phone, letter, HIT and community "in reach" and outreach. Each of these outreach and engagement functions will all include aspects of comprehensive care management, care coordination, and referral to community and social support services. All of the activities are built around the notion of linkages to care that address all of the clinical and non-clinical care needs of an individual and health promotion. The health home provider will support continuity of care and health promotion through the development of a treatment relationship with the individual and the interdisciplinary team of providers. The health home provider will promote evidence based wellness and prevention by linking health home enrollees with resources for smoking cessation, diabetes, asthma, hypertension, self-help recovery resources, and other services based on individual needs and preferences. Health promotion activities will be utilized to promote patient education and self management of their chronic condition.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

Health home providers will be encouraged to utilize RHIOs or a qualified entity to access patient data and to develop partnerships that maximize the use of HIT across providers (i.e. hospitals, TCMs). The health home providers will utilize HIT as feasible to promote, link, manage and follow up on enrollee health promotion activities.

Scope of service

The service can be provided by the following provider types

- Behavioral Health Professionals or Specialists
- Nurse Practitioner
- Nurse Care Coordinators
- Nurses
- Medical Specialists
- Physicians
- Physician's Assistants
- Pharmacists
- Social Workers
- Doctors of Chiropractic
- Licensed Complementary and alternative Medicine Practitioners
- Dieticians
- Nutritionists
- Other (specify)

Provider Type	Description
multidisciplinary teams	NY health homes will use multidisciplinary teams of medical, mental health, chemical dependency treatment providers, social workers, nurses and other care providers led by a dedicated care manager who will assure that enrollees receive needed medical, behavioral, and social services in accordance with a single plan of care.

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Comprehensive Transitional Care from Inpatient to Other Settings (including appropriate follow-up)

Definition

Comprehensive transitional care will be provided to prevent enrollee avoidable readmission after discharge from an inpatient facility (hospital, rehabilitative, psychiatric, skilled nursing or treatment facility) and to ensure proper and timely follow up care. To accomplish this, the health home provider will be required to develop and have a system in place with hospitals and residential/rehabilitation facilities in their network to provide the health home care manager prompt notification of an enrollee's admission and/or discharge to/from an emergency room, inpatient, or residential/rehabilitation setting.

The health home provider will also have policies and procedures in place with local practitioners, health facilities including emergency rooms, hospitals, and residential/rehabilitation settings, providers and community-based services to ensure coordinated, and safe transition in care for its patients who require transfer to/from sites of care.

The health home provider will be required to develop and have a systematic follow-up protocol in place to assure timely access to follow-up care post discharge that includes at a minimum receipt of a summary care record from the discharging entity, medication reconciliation, and a plan for timely scheduled appointments at recommended outpatient providers.

The health home care manager will be an active participant in all phases of care transition: including: discharge planning and follow-up to assure that enrollees received follow up care and services and re-engagement of patients who have become lost to care.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

Health home providers will be encouraged to utilize RHIOs or a qualified entity to access patient data and to develop partnerships that maximize the use of HIT across providers (i.e. hospitals, TCMS). The health home provider will utilize HIT as feasible to communicate with health facilities and to facilitate interdisciplinary collaboration among all providers, the patient, family, care givers and local supports.

Scope of service

The service can be provided by the following provider types

- Behavioral Health Professionals or Specialists
- Nurse Practitioner
- Nurse Care Coordinators
- Nurses
- Medical Specialists
- Physicians
- Physician's Assistants
- Pharmacists
- Social Workers
- Doctors of Chiropractic
- Licensed Complementary and alternative Medicine Practitioners
- Dieticians
- Nutritionists
- Other (specify)

Provider Type	Description
multidisciplinary teams	NY health homes will use multidisciplinary teams of medical, mental health, chemical dependency treatment providers, social workers, nurses and other care providers led by a dedicated care manager who will assure that enrollees receive needed medical, behavioral, and social services in accordance with a single plan of care.

Individual and Family Support (which includes authorized representatives)

Definition

The patient's individualized plan of care will reflect and incorporate the patient and family or caregiver preferences, education and support for self-management; self help recovery, and other resources as appropriate. The provider will share and make assessable to the enrollee, their families or other caregivers (based on the individual's preferences), the individualized plan of care by presenting options for accessing the enrollee's clinical information.

Peer supports, support groups, and self-care programs will be utilized by the health home provider to increase patients' and caregivers knowledge about the individual's disease(s), promote the enrollee's engagement and self management capabilities, and help the enrollee improve adherence to their prescribed treatment. The provider will discuss and provide the enrollee, the enrollee's family and care givers, information on advance directives in order to allow them to make informed end-of-life decisions ahead of time.

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The health home provider will ensure that all communication and information shared with the enrollee, the enrollee's family and caregivers is language, literacy and culturally appropriate so it can be understood.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

Health home providers will be encouraged to utilize RHIOs or a qualified entity to access patient data and to develop partnerships that maximize the use of HIT across providers (i.e. hospitals, TCMS). The health home provider will utilize HIT as feasible to provide the patient access to care plans and options for accessing clinical information.

Scope of service

The service can be provided by the following provider types

- Behavioral Health Professionals or Specialists
- Nurse Practitioner
- Nurse Care Coordinators
- Nurses
- Medical Specialists
- Physicians
- Physician's Assistants
- Pharmacists
- Social Workers
- Doctors of Chiropractic
- Licensed Complementary and alternative Medicine Practitioners
- Dieticians
- Nutritionists
- Other (specify)

Provider Type	Description
multidisciplinary teams	NY health homes will use multidisciplinary teams of medical, mental health, chemical dependency treatment providers, social workers, nurses and other care providers led by a dedicated care manager who will assure that enrollees receive needed medical, behavioral, and social services in accordance with a single plan of care.

Referral to Community and Social Support Services

Definition

The health home provider will identify available community-based resources and actively manage appropriate referrals, access to care, engagement with other community and social supports, coordinate services and follow-up post engagement with services. To accomplish this, the health home provider will develop policies, procedures and accountabilities (through contractual agreements) to support effective collaboration with community-based resources, that clearly define the roles and responsibilities of the participants.

The plan of care will include community-based and other social support services, appropriate and ancillary healthcare services that address and respond to the patient's needs and preferences, and contribute to achieving the patient's goals.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

Health home providers will be encouraged to utilize RHIOs or a qualified entity to access patient data and to develop partnerships that maximize the use of HIT across providers (i.e. hospitals, TCMS). The health home providers will utilize HIT as feasible to initiate, manage and follow up on community-based and other social service referrals.

Scope of service

The service can be provided by the following provider types

- Behavioral Health Professionals or Specialists
- Nurse Practitioner
- Nurse Care Coordinators

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- Nurses
- Medical Specialists
- Physicians
- Physician's Assistants
- Pharmacists
- Social Workers
- Doctors of Chiropractic
- Licensed Complementary and alternative Medicine Practitioners
- Dieticians
- Nutritionists
- Other (specify)

Provider Type	Description
multidisciplinary teams	NY health homes will use multidisciplinary teams of medical, mental health, chemical dependency treatment providers, social workers, nurses and other care providers led by a dedicated care manager who will assure that enrollees receive needed medical, behavioral, and social services in accordance with a single plan of care.

Health Homes Patient Flow

Describe the patient flow through the state's Health Homes system. Submit with the state plan amendment flow-charts of the typical process a Health Homes individual would encounter

See NY Health Home Patient flow chart below