

Table of Contents

State/Territory Name: New York

State Plan Amendment (SPA) #: 17-0025

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) Approved SPA Pages w/ CMS 179 Form (MacPro)

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
New York Regional Office
26 Federal Plaza, Room 37-100
New York, NY 10278



DIVISION OF MEDICAID AND CHILDREN'S HEALTH OPERATIONS

April 9, 2018

Donna Frescatore
Medicaid Director, Deputy Commissioner
Office of Health Insurance Programs
NYS Department of Health
One Commerce Plaza, Suite 1211
Albany, New York 12210

Dear Ms. Frescatore:

Re: Approval of State Plan Amendment 17-0025

The Centers for Medicare & Medicaid Services (CMS) has completed its review of New York's State Plan Amendment (SPA) Transmittal Number 17-0025, New York State (NYS) Care Coordination Organization/Health Homes (CCO/HHs) Serving Individuals with Intellectual/Developmental Disabilities (I/DD). This SPA implements Health Homes as authorized under Section 2703 of the Patient Protection and Affordable Care Act (1945 of the Social Security Act). Individuals eligible to receive Health Home services include those with I/DD. This SPA establishes requirements for NYS CCO/HHs Serving I/DD Program, including establishing eligible I/DD Health Homes chronic conditions; transitioning Medicaid Service Coordination (MSC) and Plan of Care Support Services (PCSS) to Health Homes; establishing per member per month rates for Health Homes designated to serve members with I/DD; defining CCO/HHs core requirements, including Health Information Technology (HIT) requirements; establishing the processes for referring Medicaid members to CCO/HHs; and defining the requirements for providers to be eligible to be designated as CCO/HHs. The SPA also authorizes the statewide enrollment of individuals with eligible I/DD conditions into designated CCO/HHs.

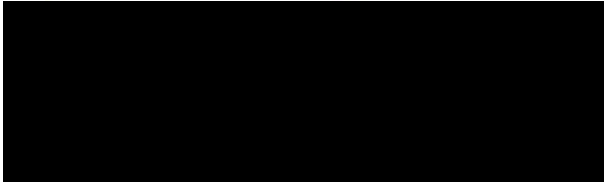
We approve New York's State Plan Amendment (SPA) Transmittal No. 17-0025 on April 9, 2018 with an effective date of July 1, 2018. Enclosed is a copy of the approved pages for incorporation into the New York State plan.

In accordance with the statutory provisions at Section 1945 (c) (1) of the Social Security Act, for payments made to health home providers under this amendment, during the first eight fiscal quarters that the SPA is in effect, July 1, 2018 through June 30, 2020 the federal medical assistance percentage (FMAP) rate applicable to such payments shall be equal to 90 percent. The FMAP rate for payments made to health home providers will return to the state's published

FMAP rate on July 1, 2020. The Form CMS-64 has a designated category of service Line 43 for states to report health home services expenditures for enrollees with chronic conditions.

Please share with your staff my appreciation for their time and effort throughout this process. If you have any questions regarding this Health Home State Plan Amendment, please contact Christopher Semidey at (212) 616-2328 or Christopher.Semidey@cms.hhs.gov.

Sincerely,



Michael Melendez, LMSW
Associate Regional Administrator

cc:

Christopher Semidey
Dominique Mathurin
Joanne Hounsell
Robert Weaver
Adam Goldman
Nicole McKnight
Ricardo Holligan
Lana Earle
Kate Marlay
Lauren Porter
Priscilla Smith

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: 04/09/2018

Head of Agency: Jason Helgeson

Title/Dept : Medicaid Director

Address 1: 99 Washington Ave.

Address 2:

City : Albany

State: NY

Zip: 12210

MACPro Package ID: NY2017MS00100

SPA ID: NY-17-0025

Subject

Notice of Approval

Dear Jason Helgeson

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-17-0025

Reviewable Unit	Effective Date
Health Homes Intro	7/1/2018
Health Homes Geographic Limitations	7/1/2018
Health Homes Population and Enrollment Criteria	7/1/2018
Health Homes Providers	7/1/2018
Health Homes Service Delivery Systems	7/1/2018
Health Homes Payment Methodologies	7/1/2018
Health Homes Services	7/1/2018
Health Homes Monitoring, Quality Measurement and Evaluation	7/1/2018

For payments made to Health Homes providers under this new Health Homes Program submission package a medical assistance percentage (FMAP) rate of 90% applies to such payments for the period 7/1/2018 to 6/30/2020.

90% FFP for eight quarters.

Sincerely,


Alissa M. DeBoy

Mrs.

Approval Documentation

Name	Date Created	Type
No items available		

Package Information

Package ID	NY2017MS00100	Submission Type	Official
Program Name	NYS CCO/HHs Serving Individuals with I/DD	State	NY
SPA ID	NY-17-0025	Region	New York, NY
Version Number	3	Package Status	Approved
Submitted By	Regina Deyette	Submission Date	3/1/2018
Package Disposition		Approval Date	4/9/2018 11:09 AM EDT
Priority Code	P2		

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | NY2017MS00100 | NY-17-0025 | NYS CCO/HHs Serving Individuals with I/DD

Not Started

In Progress

Complete

Package Header

Package ID	NY2017MS00100	SPA ID	NY-17-0025
Submission Type	Official	Initial Submission Date	3/1/2018
Approval Date	4/9/2018	Effective Date	N/A
Superseded SPA ID	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-17-0025

Reviewable Unit	Proposed Effective Date	Superseded SPA ID
Health Homes Intro	7/1/2018	
Health Homes Geographic Limitations	7/1/2018	
Health Homes Population and Enrollment Criteria	7/1/2018	
Health Homes Providers	7/1/2018	
Health Homes Service Delivery Systems	7/1/2018	
Health Homes Payment Methodologies	7/1/2018	
Health Homes Services	7/1/2018	
Health Homes Monitoring, Quality Measurement and Evaluation	7/1/2018	

Executive Summary

Summary Description Including Goals and Objectives The New York State Department of Health (DOH), in collaboration with the New York State Office for People With Developmental Disabilities (OPWDD), is seeking a new Health Home State Plan, effective July 1, 2018, to create and authorize Health Home care management for individuals with intellectual and/or developmental disabilities (I/DD). The goal of establishing Health Homes to serve the I/DD population is to provide a strong, stable, person-centered approach to holistic service planning and coordination required to ensure the delivery of quality care that is integrated and supports the needs of individuals with I/DD chronic conditions. The Health Home program authorized under this State Plan shall be known as the NYS Care Coordination Organizations/Health Homes (CCO/HHs) Serving Individuals with Intellectual and Developmental Disabilities (I/DD) Program (NYS CCO/HHs Serving I/DD) and Health Homes authorized under this State Plan shall be known as Care Coordination Organizations/Health Homes (CCO/HHs). As described in more detail, this SPA will establish requirements for the NYS CCO/HHs Serving I/DD Program, including establishing eligible I/DD Health Home chronic conditions; transitioning Medicaid Service Coordination (MSC) and Plan of Care Support Services (PCSS) to Health Homes; establishing per member per month rates for Health Homes designated to serve members with I/DD; defining CCO/HHs core requirements, including Health Information Technology (HIT) requirements; establishing the processes for referring Medicaid members to CCO/HHs; and defining the requirements for providers to be eligible to be designated as CCO/HHs. The State Plan authorizes the statewide enrollment of individuals with eligible Developmental Disability conditions in designated CCO/HHs.

Dependency Description

Description of any dependencies between this submission package and any other submission package undergoing review The expansion of Health Homes to serve the I/DD population is part of the State's Medicaid Redesign plan to, effective July 1, 2018, transition the 1915(c) OPWDD Comprehensive Waiver #NY.0238 to the 1115 Waiver and transition Medicaid Service Coordination and Plan of Care Supports, now provided for members eligible for the 1915(c) Comprehensive Waiver, to Health Homes.

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	\$25912379
Second	2019	\$104763868

	Federal Fiscal Year	Amount
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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.

Submission - Public Comment

MEDICAID | Medicaid State Plan | Health Homes | NY2017MS00100 | NY-17-0025 | NYS CCO/HHs Serving Individuals with I/DD

Not Started	In Progress	Complete
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Package Header

Package ID NY2017MS00100	SPA ID NY-17-0025
Submission Type Official	Initial Submission Date 3/1/2018
Approval Date 4/9/2018	Effective Date N/A
Superseded SPA ID N/A	

Name of Health Homes Program

NYS CCO/HHs Serving Individuals with I/DD



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

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

Indicate how public comment was solicited:

- 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
Response to Public comment 10 6 17 Final	2/26/2018 9:28 AM EST	
June 14 2017 FPN hh opwdd	2/26/2018 9:28 AM EST	

Upload with this application a written summary of public comments received (optional)

Name	Date Created	Type
No items available		

Indicate the key issues raised during the public comment period (optional)

- Access
- Quality
- Cost
- Payment methodology
- Eligibility
- Benefits
- Service delivery
- Other issue

Submission - Tribal Input

MEDICAID | Medicaid State Plan | Health Homes | NY2017MS00100 | NY-17-0025 | NYS CCO/HHs Serving Individuals with I/DD

Not Started

In Progress

Complete

Package Header

Package ID NY2017MS00100	SPA ID NY-17-0025
Submission Type Official	Initial Submission Date 3/1/2018
Approval Date 4/9/2018	Effective Date N/A
Superseded SPA ID N/A	

Name of Health Homes Program

NYS CCO/HHs Serving Individuals with I/DD

One or more Indian health programs or Urban Indian Organizations furnish health care services in this state

- Yes
 No

This state plan amendment is likely to have a direct effect on Indians, Indian health programs or Urban Indian Organizations

- Yes
 No

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

There is one federally recognized tribe in NYS that operates an agency that delivers both targeted case management

services and Home and Community Based Waiver services (HCBS) to members of the Tribe. In accordance with the CMS-approved transition plan to address conflict of interest, this case management/HCBS agency will be designated to provide both care management and HCBS services based on the need for culturally competent care for tribes' members. Indian Health Programs and Urban Indian Organizations will be encouraged, but not required, to participate in health home delivery as a care management agency or network provider.

- 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:
10/2/2017	tribal consultation sent, 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:
10/2/2017	tribal consultation sent, 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
Tribal 2 (17-0025)	3/1/2018 12:38 PM EST	

Name	Date Created	Type
		
Tribal 3 (17-0025)	3/1/2018 12:38 PM EST	
Tribal 4 (17-0025)	3/1/2018 12:38 PM EST	
Tribal 1 (17-0025)	3/1/2018 12:44 PM EST	
Tribal 6 (17-0025)	3/1/2018 12:44 PM EST	
Tribal 5 (17-0025)	3/1/2018 12:44 PM EST	

1 - 6 of 6

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 | NY2017MS00100 | NY-17-0025 | NYS CCO/HHs Serving Individuals with I/DD

Not Started

In Progress

Complete

Package Header

Package ID NY2017MS00100	SPA ID NY-17-0025
Submission Type Official	Initial Submission Date 3/1/2018
Approval Date 4/9/2018	Effective Date N/A
Superseded SPA ID N/A	

SAMHSA Consultation

Name of Health Homes Program

NYS CCO/HHs Serving Individuals with I/DD

- 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

7/20/2017

Health Homes Intro

MEDICAID | Medicaid State Plan | Health Homes | NY2017MS00100 | NY-17-0025 | NYS CCO/HHs Serving Individuals with I/DD

Not Started

In Progress

Complete

Package Header

Package ID	NY2017MS00100	SPA ID	NY-17-0025
Submission Type	Official	Initial Submission Date	3/1/2018
Approval Date	4/9/2018	Effective Date	7/1/2018
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 CCO/HHs Serving Individuals with I/DD

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

The New York State Department of Health (DOH), in collaboration with the New York State Office for People With Developmental Disabilities (OPWDD), is seeking a new Health Home State Plan, effective July 1, 2018, to create and authorize Health Home care management for individuals with intellectual and/or developmental disabilities (I/DD). The goal of establishing Health Homes to serve the I/DD population is to provide a strong, stable, person-centered approach to holistic service planning and coordination required to ensure the delivery of quality care that is integrated and supports the needs of individuals with I/DD chronic conditions. The Health Home program authorized under this State Plan shall be known as the NYS Care Coordination Organizations/Health Homes (CCO/HHs) Serving Individuals with Intellectual and Developmental Disabilities (I/DD) Program (NYS CCO/HHs Serving I/DD) and Health Homes authorized under this State Plan shall be known as Care Coordination Organizations/Health Homes (CCO/HHs). As described in more detail, this SPA will establish requirements for the NYS CCO/HHs Serving I/DD Program, including establishing eligible I/DD Health Home chronic conditions; transitioning Medicaid Service Coordination (MSC) and Plan of Care Support Services (PCSS) to Health Homes; establishing per member per month rates for Health Homes designated to serve members with I/DD; defining CCO/HHs core requirements, including Health Information Technology (HIT) requirements; establishing the processes for referring Medicaid members to CCO/HHs; and defining the requirements for providers to be eligible to be designated as CCO/HHs. The State Plan authorizes the statewide enrollment of individuals with eligible Developmental Disability conditions in designated CCO/HHs.

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 Geographic Limitations

MEDICAID | Medicaid State Plan | Health Homes | NY2017MS00100 | NY-17-0025 | NYS CCO/HHs Serving Individuals with I/DD

Not Started

In Progress

Complete

Package Header

Package ID	NY2017MS00100	SPA ID	NY-17-0025
Submission Type	Official	Initial Submission Date	3/1/2018
Approval Date	4/9/2018	Effective Date	7/1/2018
Superseded SPA ID	N/A		

- Health Homes services will be available statewide

- Health Homes services will be limited to the following geographic areas
- Health Homes services will be provided in a geographic phased-in approach

Health Homes Population and Enrollment Criteria

MEDICAID | Medicaid State Plan | Health Homes | NY2017MS00100 | NY-17-0025 | NYS CCO/HHs Serving Individuals with I/DD

Not Started

In Progress

Complete

Package Header

Package ID NY2017MS00100	SPA ID NY-17-0025
Submission Type Official	Initial Submission Date 3/1/2018
Approval Date 4/9/2018	Effective Date 7/1/2018
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
- 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
Developmental Disability	See description below

Specify the criteria for at risk of developing another chronic condition

The chronic conditions defined in the major Developmental Disability Category, which result in functional limitations that constitute a substantial handicap as defined by New York State Mental Hygiene Law Section 1.03(22) and as determined by the New York State Office for People With Developmental Disabilities (OPWDD) or its designee, are each single qualifying conditions for which an individual is at risk for developing another chronic condition, and may be enrolled in the Care Coordination Organization/Health Homes Serving Individuals with Intellectual and Developmental Disabilities Program. Information based on research shows that individuals with developmental disabilities often are at greater risk for other chronic conditions. Recently completed survey results from National Core Indicator (NCI) surveys demonstrate high levels of co-morbidity of anxiety disorders (23%), mood disorders (32%), or mental illness or psychiatric diagnoses (9%). The National Association on Dual Diagnosis indicates that 30-35% of individuals with I/DD have a comorbid mental health condition. A number of medical conditions are also common to persons with I/DD, such as epilepsy, obesity, and chronic pain. For example, the US Centers for Disease Control and Prevention identified that children with autism have much higher than expected rates of all the medical conditions studied, including: eczema, allergies, asthma, ear and respiratory infections, gastrointestinal problems, severe headaches, migraines, and seizures (Kohane et al., 2012).

Major Category: Developmental Disability Category

1. Intellectual Disability
2. Cerebral Palsy
3. Epilepsy
4. Neurological Impairment
5. Familial Dysautonomia
6. Prader-Willi Syndrome
7. Autism

New York's Medicaid program serves approximately 98,000 individuals who will meet the CCO/HHs eligibility criteria described above. These members are currently enrolled in the 1915(c) OPWDD Comprehensive Waiver #NY.0238 or are eligible for Home and Community Based Services (HCBS) and receive Medicaid Service Coordination. The 1915(c) OPWDD Comprehensive Waiver will transition to the 1115 Waiver and Medicaid Service Coordination will transition to, and be provided by CCO/HHs. CCO/HHs will affiliate with currently existing agencies that now provide Medicaid Service Coordination for the first year of operation, and the person may choose to enroll in this CCO/HHs or select a different, available option.

The presence of substantial functional limitations in everyday social and practical skills of daily living is what distinguishes a developmental disability as defined in MHL 1.03(22) from simply having a diagnosis of a disorder first evident in childhood or during the developmental period. Certain conditions, such as autism or cerebral palsy, are evident and may be diagnosed at birth or during early childhood but these diagnoses do not always result in the individual demonstrating substantial limitations in adaptive functioning. To demonstrate the presence of a developmental disability, the individual must have the diagnosed developmental disorder, along with substantial functional limitations evident prior to age 22.

Medicaid members with one condition in the Developmental Disability Category and who do not meet the functional limitations criteria for the Care Coordination Organization/Health Homes Serving Individuals with Intellectual and Developmental Disabilities Program, and a second chronic condition of serious mental illness, serious emotional disturbance, HIV, complex trauma or in the Major Categories of Alcohol and Substance Abuse 3M CRG Category, Mental Health 3M CRG Category, Cardiovascular Disease 3M CRG Category, Metabolic Disease 3M CRG, Respiratory Disease 3M CRG Category, or Other 3M

CRG Category may be enrolled in the New York State Health Home Program.

Description of population to be served

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 chronic condition criteria. New York will offer CCO/HHs services to individuals with one of the chronic conditions defined in the Developmental Disability Category, which result in functional limitations that constitute a substantial handicap as defined by New York State Mental Hygiene Law Section 1.03(22) and as determined by the New York State Office for People With Developmental Disabilities (OPWDD) or its designee.

Medicaid members with one condition in the Developmental Disability Category and who do not meet the functional limitations criteria for the Care Coordination Organization/Health Home Serving Individuals with Intellectual and Developmental Disabilities Program, and a second chronic condition of serious mental illness, serious emotional disturbance, HIV, complex trauma or in the Major Categories of Alcohol and Substance Abuse 3M CRG Category, Mental Health 3M CRG Category, Cardiovascular Disease 3M CRG Category, Metabolic Disease 3M CRG, Respiratory Disease 3M CRG Category, or Other 3M CRG Category may be enrolled in the New York State Health Home Program that serves children under 21 and/or adults.

One serious and persistent mental health 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

The primary mechanism for referral to Health Homes for individuals in the developmental disability category will be OPWDD, through its Developmental Disability Regional Offices (DDROs) or designee. OPWDD's DDROs are well connected to area schools, health care providers and other governmental and non-governmental social service providers and will make referrals to CCO/HHs that can meet their individual needs. DDRO referrals will consider the region the member lives and the connectivity of providers, including the current MSC and PCSS who are transitioning to CCO/HH and who are serving individuals who are transitioning to CCO/HH, that serve the eligible person to the designated CCO/HH. All designated CCO/HHs may also directly receive referrals from the community, including providers and managed care plans. Individuals will be given the options to choose another health home or opt out of enrollment into a CCO/HH.

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

Name	Date Created	Type
CCO_HH Enrollment Models Work Flows Attachment C 1.25.18	2/27/2018 1:34 PM EST	
CCO Intro Letter to Individuals FINAL on Letterhead	3/27/2018 2:21 PM EDT	

Health Homes Providers

MEDICAID | Medicaid State Plan | Health Homes | NY2017MS00100 | NY-17-0025 | NYS CCO/HHs Serving Individuals with I/DD

Not Started

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Complete

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Types of Health Homes Providers

Designated Providers

Indicate the Health Homes Designated Providers the state includes in its program and the provider qualifications and standards

- Physicians
- Clinical Practices or Clinical Group Practices
- Rural Health Clinics
- Community Health Centers
- Community Mental Health Centers
- Home Health Agencies
- Case Management Agencies
- Community/Behavioral Health Agencies
- Federally Qualified Health Centers (FQHC)
- Other (Specify)

Provider Type	Description
Designated Providers as described section 1945 (h)(5)	Please see text below

Teams of Health Care Professionals

Health Teams

Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Home Services

New York's CCO/HH provider infrastructure will include designated providers working with interdisciplinary teams as described below. CCO/HHs will be required to meet the standards and requirements included in the State Plan and other State issued guidance and requirements for delivering care management contemplated by the health home model.

The NYS Medicaid program plans to certify CCO/HHs that build on current relationships with providers that have experience in working with the individuals with I/DD and understand their needs and can build and leverage inter-disciplinary team to develop CCO/HH integrated life plans. Applicant CCO/HH providers will be required to meet State defined CCO/HH requirements that assure access to primary, specialty, behavioral health care and developmental disability services that support the integration and coordination of all care for I/DD individuals eligible and enrolled in a designated CCO/HH. New York State Law provides the Commissioners of 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, developmental disability services, and mental health certification requirements for health homes. As provided by State defined CCO/HH requirements, approved CCO/HHs will directly provide, or contract for, health home services to individuals determined by OPWDD, or its designee, to have one of the conditions in the Developmental Disability Major Category and the defined functional limitations. To meet this goal, it is expected that CCO/HH providers will develop health home networks with primary, medical, specialty and mental health, developmental

disability providers, substance abuse service providers, community based organizations, managed care plans and others to provide enrollees access to needed services.

NYS Medicaid providers eligible to become CCO/HHs include managed care plans, hospitals, medical, mental and chemical dependency treatment teams, primary care practitioner practices, PCMHs, FQHCs, designated home health care agencies and any other Medicaid enrolled provider that meets CCO/HH provider standards. The CCO/HH provider standards contained here in generally reflect (but tailored where necessary to meet the needs of the I/DD population) the standards applicable to the NYS Health Home Program.

The NYS CCO/HHs program will use inter-disciplinary teams of medical, mental health, developmental disability, 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, developmental disability, including community-based crisis prevention and response services and social services in accordance with a single life plan. Optional team members may include nutritionists/dietitians, pharmacists, peer specialists and other representatives as appropriate to meet the enrollee needs (housing representatives, entitlement, employment). All members of the team will be responsible for reporting back to the care manager on the individual's status, treatment options, actions taken and outcomes as a result of those interventions. All members of the team will also be responsible for ensuring that care is person centered, culturally competent and linguistically capable.

A single life plan will be agreed to and shared by all team professionals and case reviews will be conducted on a regular basis. Care management services, including monitoring and updating the life plan, are on-going services, and will be responsive to a person's needs. Formal reviews are conducted at least twice per-year, with at least one of these reviews occurring at a face-to-face meeting. Reviews may be more frequent if requested by the person or if required based on a change in person's or caretakers need /status.

The CCO/HH has policies and procedures in place to ensure the CCO/HH develops life plans that meet State requirements and guidance, including HIT requirements. The CCO/HH care manager will be responsible for overall management and coordination of the enrollee's care plan which will include both medical/behavioral health, developmental disability services, community supports and social service needs and reflects the goals of the individual and their family and/or representative. For individuals transitioning from MSC or PCSS, as described in the State's Transition Plan, the person's care plan for the 1915 (c) Waiver (called the Individualized Service Plan or ISP) will remain in effect until the time that the person's ISP is due for review. The IDT will be convened and the person and family will participate in the establishment of a new Life Plan that will include the person's authorized HCBS – unless the person is requesting a change in service or there is another need for a change. During the interim period between July 1, 2018 and the initiation of the Life Plan, the Care Management Checklist will ensure all parties are informed of the newly expanded scope of services available to the person.

To ensure the delivery of quality health home services, the State will provide educational opportunities for CCO/HH providers, such as webinars, regional meetings and/or learning collaboratives to foster shared learning, information sharing and problem solving. Educational opportunities will be provided to support the provision of timely comprehensive, high-quality health home services that are whole person focused and that integrate medical, behavioral health, developmental disabilities services and other needed supports and social services. The State will maintain a highly collaborative and coordinated working relationship with individual CCO/HH providers through frequent communication and feedback. Learning activities and technical assistance will also support providers of health home services to address the following health home functional components:

Supports for Health Homes Providers

Describe the methods by which the state will support providers of Health Homes services in addressing the following components

1. Provide quality-driven, cost-effective, culturally appropriate, and person- and family- centered Health Homes services
2. Coordinate and provide access to high quality health care services informed by evidence-based clinical practice guidelines
3. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders
4. Coordinate and provide access to mental health and substance abuse services
5. Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care
6. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families
7. Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services
8. Coordinate and provide access to long-term care supports and services
9. Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services
10. Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate
11. Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level

Description

The Department of Health in partnership with the Office for People With Developmental Disabilities will closely monitor CCO/HH providers to ensure that health home services are being provided that meet the NYS Health Home provider standards and CMS' health home core functional requirements. Oversight activities will include, but not be limited to: medical chart and care management record reviews, site audits, team composition analysis, and review of types and number of contacts.

Other Health Homes Provider Standards

The state's requirements and expectations for Health Homes providers are as follows

The state's minimum requirements and expectations for CCO/HH providers are as follows: Under New York State's approach to health home implementation, a CCO/HH provider is the central point for directing individual-centered care for individuals with I/DD. The CCO/HH is accountable for reducing avoidable healthcare costs, specifically preventable hospital admissions/readmissions and avoidable emergency room visits; and providing timely post discharge follow-up. The CCO/HH is responsible for maintaining and promoting quality of life with a focus on community living options, and improving individual outcomes by addressing primary medical, specialist and behavioral health care to individuals with intellectual and developmental disabilities through direct provision, or through arrangements with appropriate service providers of comprehensive integrated services.

General Qualifications

1. CCO/HH providers/plans must be enrolled (or be eligible for enrollment) in the NYS Medicaid program and agree to comply with all Medicaid program requirements and CCO/HH standards, requirements and guidance issued by the State.
2. CCO/HH providers can either directly provide, or subcontract for the provision of CCO/HH services, as provided by CCO/HH requirements. The CCO/HH remains responsible for all health home program requirements, including services performed by the subcontractor.
3. Care coordination and integration of health care services will be provided to all CCO/HH enrollees by an interdisciplinary team of providers where an individual's care is under the direction of a dedicated care manager who is accountable for assuring access to medical and behavioral health care services, community social supports and developmental disability services as defined in the enrollee care plan.
4. Hospitals that are part of a health home network must have procedures in place for referring any eligible individual with chronic conditions who seeks or needs treatment in a hospital emergency department to any DOH designated health home provider.
5. CCO/HH providers must demonstrate their ability to perform each of the eleven CMS health home core functional components. (Refer to section iii Provider Infrastructure) including:
 - i. processes used to perform these functions.
 - ii. processes and timeframes used to assure service delivery takes place in the described manner, and
 - iii. description of multifaceted health home service interventions that will be provided to promote individual engagement. Participation in their life plan ensures individuals appropriate access to the continuum of physical and behavioral health care, developmental disability services, and social services.
6. CCO/HH providers must meet the following core health home requirements in the manner described below, and in accordance with applicable State standards and requirements. CCO/HH providers must provide written documentation that clearly demonstrates how the requirements are being met.

Please note whenever family is stated, when applicable, the term is interchangeable with representative.

I. Comprehensive Care Management

Policies and procedures are in place to create, document, execute and update an individualized, person centered life plan for an individual.

- 1a. A comprehensive health assessment that identifies medical, mental health, chemical dependency, developmental disability and social service needs is developed.
- 1b. The individual's life plan integrates the continuum of medical, behavioral health services, rehabilitative, long term care, developmental disability services and social service needs and clearly identifies the primary care physician/nurse practitioner, specialist(s), behavioral health care provider(s), developmental disability providers, care manager and other providers directly involved in the individual's care.
- 1c. The individual's (or their guardian) play a central and active role in the development and execution of their life plan and should agree with the goals, interventions and time frames contained in the plan.
- 1d. The individual's life plan clearly identifies primary, specialty, behavioral health, developmental disability and community networks and supports that address their needs.
- 1e. The individual's life plan clearly identifies family members and other supports involved in the individual's care. Family and other supports are included in the plan and execution of care as requested by the individual.
- 1f. The individual's life plan clearly identifies goals and timeframes for improving the individual's health and health care status, independence and community integration and the interventions that will produce this effect.
- 1g. The individual's life plan must include outreach and engagement activities that will support engaging individuals in care and promoting continuity of care
- 1h. The individual's life plan includes periodic reassessment of the individual's needs and clearly identifies the individual's progress in meeting goals and changes in the life plan based on changes in individual's need.

II. Care Coordination and Health Promotion

- 2a. The CCO/HH provider is accountable for engaging and retaining CCO/HH enrollees in care coordinating and arranging for the provision of services, supporting adherence to treatment recommendations and monitoring and evaluating an individual's needs, including prevention, wellness, medical, specialist and behavioral health treatment care transitions, developmental disability services, long term supports and services, and social and community services where appropriate through the creation of an individual life plan.
- 2b. The CCO/HH provider will assign an individual a dedicated care manager who is responsible for overall management of the individual's life plan. The CCO/HH will ensure the dedicated care manager meets the qualifications (education and experience) established by the State for serving adults and children in the CCO/HH. The CCO/HH care manager is clearly identified in the individual record. Individuals enrolled with a CCO/HH will have one dedicated care manager who has overall responsibility and accountability for coordinating all aspects of the individual's care. The individual cannot be enrolled in more than one care management program funded by the Medicaid program. The CCO/HH dedicated care manager will work with the interdisciplinary team, that will be comprised of the individual, and/or their family and/or their representative, and the providers that comprise the integrated services included in the person-centered care plan (called a life plan). It is the care manager's responsibility to communicate with providers on the IDT, as needed, to ensure that the Life Plan comports with the providers/IDT's assessment of the person's needs.
- 2c. The CCO/HH provider must describe the relationship and communication between the dedicated care manager and the treating clinicians that assure that the care manager can discuss with clinicians on an as needed basis, changes in individual condition that may necessitate treatment change (i.e. written orders and/or prescriptions) update.
- 2d. The CCO/HH provider must define how individual care will be directed when conflicting treatment is being provided.
- 2e. The CCO/HH provider has policies and procedures and accountabilities (i.e., through agreements) to support effective collaborations between primary care, specialist, behavioral health and developmental disability providers, evidence-based referrals and follow-up and consultations that clearly define roles and responsibilities.
- 2f. The CCO/HH provider supports continuity of care and health promotion through the development of a treatment relationship with the individual and the interdisciplinary team of providers.
- 2g. The CCO/HH provider supports care coordination and facilitates collaboration through the establishment of regular case review meetings (i.e., person-centered life plan review), including all members of the interdisciplinary team on a schedule determined by the CCO/HH provider

and member. The CCO/HH provider has 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.

2h. The CCO/HH provider ensures 24 hours/seven days a week availability to a care manager to provide information and emergency consultation services.

2i. The CCO/HH provider will ensure timely access to appointments for CCO/HH enrollees to medical and behavioral health care services within their CCO/HH provider network to avoid unnecessary, inappropriate utilization of emergency room and inpatient hospital services.

2j. The CCO/HH provider promotes evidence based wellness and prevention by linking CCO/HH enrollees with resources for smoking cessation, Diabetes, asthma, hypertension, self-help recovery resources, and other services based on individual needs and preferences.

2k. The CCO/HH provider has a system to track individual information and care needs across providers and to monitor individual outcomes and initiate changes in care as necessary, to address individual need.

III. Comprehensive Transitional Care

3a. The CCO/HH provider has a system in place with hospitals and residential rehabilitation facilities in their network to provide the CCO/HH prompt notification of an individual's admission and/or discharge to/from an emergency room, inpatient, or residential/rehabilitation setting.

3b. The CCO/HH provider has policies and procedures in place to support individuals experiencing transitions from school to adult services, life changes (employment, retirement, other life events), or when an individual is electing to transition to a new CCO/HH provider or to a new Care Manager within the same CCO/HH.

3 c. The CCO/HH provider has policies and procedures in place with local practitioners, health facilities, including emergency rooms, hospitals, and residential/rehabilitation settings, providers and community-based services to help ensure coordinated, safe transitions in care for its individuals who require transfers in the site of care.

3d. The CCO/HH provider utilizes HIT as feasible to facilitate interdisciplinary collaboration among all providers, the individual, family and/or representative, and local supports.

3e. The CCO/HH provider has 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, timely scheduled appointments at recommended out-patient providers, care manager verification with the out-patient provider that the individual attended the appointment, and a plan to outreach and reengage the individual in care if the appointment was missed.

IV. Individual and Family Support

4a. The enrollee's life plan reflects the individual's and or their family and/or representative's preferences, education and support self-direction, self-help recovery, and other resources as appropriate.

4b. The life plan is accessible to the individual and their family and/or representative based on the enrollee's preference.

4c. The CCO/HH provider utilizes peer supports, support groups and self-care programs to increase the enrollee's knowledge about their disease, engagement and self-management capabilities, and to improve adherence to prescribed treatment.

4d. The CCO/HH provider discusses advance directives with the enrollee and their family and/or representative.

4e. The CCO/HH provider communicates and shares information with the enrollee and their family and/or representative with appropriate consideration for language, literacy and cultural preferences.

4f. The CCO/HH provider gives the enrollee access to their life plan and options for accessing clinical information.

V. Referral to Community and Social Support Services

5a. The CCO/HH provider identifies available community-based resources and actively manages appropriate referrals, access, engagement, follow-up and coordination of services.

5b. The CCO/HH provider has policies, procedures and accountabilities (i.e., through agreements) to support effective collaborations with community-based resources, which clearly defines roles and responsibilities.

5c. The life plan should include community-based and other social support services as well as healthcare, long term supports, services and developmental disability services that respond to the individual's needs and preferences and contribute to achieving the individual's goals.

VI. Use of Health Information Technology to Link Services

To the extent possible CCO/HH providers will be encouraged to utilize regional health information organizations or qualified entities to access individual data and to develop partnerships that maximize the use of HIT across providers. CCO/HH providers will be encouraged to utilize HIT, as feasible, to create, document, execute and update a life plan for every enrollee that is accessible to the interdisciplinary team of providers. CCO/HH providers will also be encouraged to utilize HIT as feasible to process and follow up on appointments, individual testing, treatments, community based services and provider referrals.

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 CCO/HHs that are consistent with NYS' Operational Plan for Health Information Technology and Exchange approved by CMS. Health home providers will make use of available HIT and access data through the regional health information organization (RHIOs)/Qualified Entities (QE) to conduct these processes as feasible to comply with the initial standards cited in items 6a.-6d for implementation of a CCO/HHs. To be designated as a CCO/HH provider, applicants must provide a plan to achieve the final standards cited in items 6e.-6i within no more than six months of the date the State designated CCO/HH is authorized to begin operations.

Initial Standards

6a. The CCO/HH provider has structured information systems, policies, procedures and practices to create, document, execute and update a life plan for every enrollee

6b. The CCO/HH provider has a systematic process to follow-up on tests, treatments, services and referrals which are incorporated into the enrollee's life plan

6c. The CCO/HH provider has a health record system which allows the individual's health information and life plan to be accessible to the interdisciplinary team or providers and which allows for population management and identification of gaps in care including preventive services.

6d. The CCO/HH provider makes use of available HIT and accesses data through the RHIO/QE to conduct these processes as feasible.

Final Standards

6e. The CCO/HH provider has structured interoperable health information technology systems, policies, procedures and practices to support the creation, documentation, execution and ongoing management of a life plan for every enrollee.

6f. The CCO/HH provider uses an electronic health record system that qualifies under the Meaningful Use provisions of the HITECH Act which allows the enrollee's health information and life plan to be accessible to the interdisciplinary team of providers. If the CCO/HH provider does not currently have such a system they will provide a plan for when and how they will implement it.

6g. The CCO/HH provider will be required to comply with the current and future version of the Statewide Policy Guidance

(https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/shinny.htm) which includes common information policies, standards and technical approaches governing health information exchange.

6h. The CCO/HH provider commits to joining regional health information networks or qualified health IT entities for data exchange and includes a commitment to share information with all providers participating in a care plan. RHIOs/QE provides policy and technical services required for health information exchange through the Statewide Health Information Network of New York (SHIN-NY).

6i. The CCO/HH supports the use of evidence based clinical decision-making tools, consensus guidelines, and best practices to achieve optimal outcomes and cost avoidance.

VII. Quality Measures Reporting to State

7a. The CCO/HH provider has the capability of sharing information with other providers and collecting and reporting specific quality measures as required by NYS and CMS.

7b. The CCO/HH provider is accountable for reducing avoidable healthcare costs specifically preventable hospital admissions/readmissions and avoidable emergency room visits, providing timely post discharge follow-up, and improving individual outcomes as measured by NYS and CMS required quality measures.

Name	Date Created	Type
No items available		

Health Homes Service Delivery Systems

MEDICAID | Medicaid State Plan | Health Homes | NY2017MS00100 | NY-17-0025 | NYS CCO/HHs Serving Individuals with I/DD

Not Started

In Progress

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Identify the service delivery system(s) that will be used for individuals receiving Health Homes services

- Fee for Service
- PCCM
- Risk Based Managed Care
- Other Service Delivery System

Describe if the providers in this other delivery system will be a designated provider or part of the Team of health care professionals and how payment will be delivered to these providers

Providers in this other delivery system will be part of the team of health care professionals. NYS CCO/HHs will use interdisciplinary teams of medical, mental health, chemical dependency treatment providers, developmental disability services 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 life plan. Conflict free case management standards, including firewalls for agencies that may provide Health Home care management, ensure there are avenues to integrate service delivery and avoid duplication of payments for services. Billing rate codes and systems will ensure there are no duplicate claims across Health Homes.

Managed Care Considerations

It is the intention of the State to coordinate and pay for CCO/HH services through health plans. CCO/HH rates paid through the health plans may be at State set rates for a period of time. Until such time as the State determines CCO/HH services will be paid through the health plans, CCO/HH payments will be billed directly to the State.

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 CCO/HH payments. The delivery design and payment methodology will not result in any duplication of payment between the CCO/HH and managed care.

- The managed care plan is not required to provide services that would duplicate the CMS reimbursed CCO/HH services for members participating in the State's CCO/HHs Serving I/DD Program.
- The managed care plan will be informed of members assigned to a CCO/HH or will assign its members to a CCO/HH for health home services. Plans will need to expand their network to include CCO/HHs to ensure appropriate access.
- The managed care plans will need to have signed administrative service agreements
- The managed care plan will be required to inform either the individual's Health Home or the State of any individual admission or discharge of a CCO/HHs member that the plan learns of through its individual admission initial authorization and concurrent review processes as soon as possible to promote appropriate follow-up and coordination of services
- The managed care plan will assist State designated CCO/HH providers in the network with coordinating access to data.as needed.
- The managed care plans will, as appropriate, assist with the collection of required care management and individual experience of care data from State designated CCO/HH providers in its network.

As the State implements future phases of the plan to transition the I/DD population to managed care, a new managed care contract appendix will be created and address the requirements of the CCO/HHs I/DD Program.

The State provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review.

Name	Date Created	Type
No items available		

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | NY2017MS00100 | NY-17-0025 | NYS CCO/HHs Serving Individuals with I/DD

Not Started

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Package ID	NY2017MS00100	SPA ID	NY-17-0025
Submission Type	Official	Initial Submission Date	3/1/2018
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Payment Methodology

The State's Health Homes payment methodology will contain the following features

- Fee for Service
- Individual Rates Per Service
- Per Member, Per Month Rates
- Fee for Service Rates based on

- Severity of each individual's chronic conditions
- Capabilities of the team of health care professionals, designated provider, or health team
- Other

Describe below

see text box below regarding rates.

- Comprehensive Methodology Included in the Plan
- Incentive Payment Reimbursement

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided see text below

- PCCM (description included in Service Delivery section)
- Risk Based Managed Care (description included in Service Delivery section)
- 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

Effective Date

Jul 1, 2018

Website where rates are displayed

https://health.ny.gov/health_care/medicaid/program/medicaid_health_homes/idd/index.htm

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.

Care Management Fee

CCO/HH providers that meet State and federal standards will be paid a per member per month care management fee that is based on region, assessment data, residential status and other functional indicators. A unit of service will be defined as a billable unit per service month. To be reimbursed for a billable unit of service per month, CCO/HH providers must, at a minimum, provide active care management by providing at least one of the core health home services per month. Once an individual has been assigned a care manager and is enrolled in the CCO/HHs program, the active care management per member per month (PMPM) may be billed. Care managers must maintain the CCO/HHs consent forms and document all services provided to the member in the member's life plan. Upon enrollment in the program, Care Managers will attest in the State system the individual's consent to enroll in Health Homes. The CCO will maintain the consent form electronically within the individual's record in the Care

Coordination system.

As described in the attachment CCO/HH Rate Setting Methodology, the care management PMPM will include four rate tiers. The rate tier of an individual is determined by region, the intensity of care coordination required to serve the individual and the residential/living setting of the individual. For enrollees who are new to the OPWDD service delivery system, there will be a separate tiered CCO/HH care management PMPM that may be billed for the first month of enrollment in CCO/HH for individuals who have never received a Medicaid-funded long-term service. The separate tiered rate includes costs related to preparing an initial life plan; an initial Medicaid application, if needed; and gathering documentation and records to support the I/DD diagnosis, that such I/DD condition results in substantial handicap and the individual's ability to function normally in society and level of care determination. The PMPM rate tiers are calculated based on total costs relating to the care manager (salary, fringe benefits, non-personal services, capital and administration costs) and, for each tier, caseload assumptions. The State will periodically review the CCO/HH payments in conjunction with Department of Labor salary data to ensure that the Health Home rates are sufficient to ensure quality services. In addition, based on operating experience, the State will make adjustments, as appropriate, to the PMPM.

Medicaid Service Coordinators (MSC) and Plan of Care Support Services (PCSS)

CCO/HH MSC and PCSS agencies that provide care management to individuals with developmental disabilities under the State Plan that convert to a CCO/HH or become part of a CCO/HHs will be paid the care management PMPMs described above.

All payment policies have been developed to assure that there is no duplication of payment for CCO/HH services.

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 achieved 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 governmental and private providers. All of the above payment policies have been developed to assure that there is no duplication of payment for health home services.

- 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 | NY2017MS00100 | NY-17-0025 | NYS CCO/HHs Serving Individuals with I/DD

Not Started

In Progress

Complete

Package Header

Package ID	NY2017MS00100	SPA ID	NY-17-0025
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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 individual-centered care plan, referred to as a life plan, will be required for all CCO/HH enrollees. CCO/HHs will be required to have policies and procedures in place to create, document, execute and update an individualized life plan that meet all standards and requirements prescribed by the State. The life plan will be developed based on the information obtained from a comprehensive health risk assessment and tools used to identify the enrollee's physical, mental health, chemical dependency, long term supports and services, developmental disability services and social service needs. The individualized life plan will be required to include and integrate the individual's medical and behavioral health services, rehabilitative, long term care, developmental disability services, and social service needs as applicable. The life plan will be required to clearly identify the primary care physician/nurse practitioner, specialist(s), behavioral health care provider(s), developmental disability service provider(s), care manager and other providers directly involved in the individuals care. The individual's life plan

must also identify community networks and supports that will be utilized to address their needs. Goals and timeframes for improving the individual's health and wellness, their overall health care status and the interventions that will produce this effect, must also be included in the life plan. Life plans must also reflect activities and actions that ensure to the extent possible individuals live and receive services in the most integrated settings; have meaningful and productive community participation, including paid employment; and accommodating people's needs as they change;

develop meaningful relationships with friends, family, and others in their lives, including the option of participating in the self-advocacy association, and mentoring program; and experience personal health, safety and growth.

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 life plan, and that they agree with the goals, interventions and time frames contained in the life plan. Family members and other supports involved in the individual's care should be identified and included in the life plan and execution of care as requested by the individual. An individual's life plan will be reviewed continuously based upon his/her needs with formal reviews conducted at least bi-annually. In addition, an individual's life plan may be reviewed and revised at any time if requested by the individual or family.

Care management services, including monitoring and updating the life plan, are on-going services, and will be responsive and updated based on the person's needs. The life plan will include periodic reassessments of the individual's needs and goals and clearly identify the individual's progress in meeting goals. A person's needs will be formally assessed on an annual basis or more frequently, as needed, based on a change in the person's needs (for example, following a hospitalization, change or loss of caregiver, loss or change in functional status, etc.) or if requested by the individual or family. The life plan is required to be accessible to the individual and his/her family/representative with appropriate consideration for language and literacy, either electronically and/or via mail, based on the individual's preference.

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 (HIT) by CCO/HHs 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 CCO/health home, as feasible. NY anticipates that a portion of CCO/HH providers may not utilize HIT in their current programs. All providers will be encouraged to utilize regional health information organizations (RHIOs) or a qualified entity to access individual data and to develop partnerships that maximize the use of HIT across providers (e.g., hospitals). Applicants must provide a plan to demonstrate how the final HIT standards will be achieved within no more than six months of the date the State designated CCO/HH is authorized to begin operations. CCO/HH providers will be encouraged to utilize HIT as feasible to create, document, execute and update a life plan for every individual that is accessible to the interdisciplinary team of providers. CCO/HH providers will also be encouraged to utilize HIT as feasible to process and follow up on individual 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
- Licensed Complementary and alternative Medicine Practitioners
- Dieticians
- Nutritionists
- Other (specify)

Provider Type	Description
Interdisciplinary teams	

Provider Type	Description
	<p>NYS CCO/HHs will use interdisciplinary teams of medical, mental health, chemical dependency treatment providers, developmental disability services 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 life plan.</p>

Care Coordination

Definition

The CCO/HH provider will be accountable for engaging and retaining CCO/HH 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 life plan will identify all services necessary to meet goals needed for care management of the enrollee such as prevention, wellness, medical treatment by specialists and behavioral health providers, developmental disability services, transition of care from provider to provider, and social and community services where appropriate.

To fulfill the care coordination requirements, the CCO/HH provider will assign each individual enrollee one dedicated care manager who is responsible for overall management of the enrollee's life plan. The enrollee's CCO/HH care manager will be clearly identified in the individual record and will have overall responsibility and accountability for coordinating all aspects of the individual's care. The CCO/HH will be responsible for assuring that communication will be fostered between the dedicated care manager and treating clinicians to discuss as needed enrollee's care needs, conflicting treatments, change in condition, change in guardian or family and/or representative status, which may necessitate treatment change (i.e., written orders and/or prescriptions) or other changes in the life plan.

The CCO/HH provider will be required to develop and have policies, procedures and accountabilities (i.e., through agreements), in place, to support and define the roles and responsibilities for effective collaboration between primary care, specialist, behavioral health providers, developmental disability providers and community-based organizations. The CCO/HH provider's 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 CCO/HH 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 CCO/HH provider will be required to develop and utilize a system to track and share individual information and care needs across providers, monitor individual outcomes, and initiate changes in care as necessary to address individual need.

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

CCO/HH providers will be encouraged to utilize RHIOs or a qualified entity to access individual data and to develop partnerships that maximize the use of HIT across providers (e.g. hospitals). CCO/HH providers will utilize HIT as feasible to create, document and execute and update a life plan for every individual that is accessible to the interdisciplinary team of providers. CCO/HH providers will also be encouraged to utilize HIT as feasible to monitor individual outcomes, initiate changes in care and follow up on individual 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
- Licensed Complementary and alternative Medicine Practitioners
- Dieticians
- Nutritionists

Other (specify)

Provider Type	Description
Interdisciplinary teams	NYS CCO/HHs will use interdisciplinary teams of medical, mental health, chemical dependency treatment providers, developmental disability 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 life plan.

Health Promotion

Definition

Health promotion begins for eligible CCO/HH enrollees with the commencement of engagement activities. Each of these engagement functions will include aspects of comprehensive care management, care coordination, and referral to community and social support services. All activities are built around the notion of linkages to care that address all clinical and non-clinical care needs of an individual and health promotion.

At the point of initiation of CCO/HH services, the care manager and individual and family will review the "Initiating Health Home Services: Care Manager Checklist." This document outlines the Core Health Home Services and ensures that the care manager, and the individual and family understand the new, expanded service options. The CCO/HH 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 care manager will review any immediate needs and begin the process of comprehensive assessment and development of the life plan with the full involvement of the member/family and the IDT. The CCO/HH will help educate and engage an individual in making decisions that promote his/her maximum independent living skills and lifestyle choices that achieve the following goals: good health, pro-active management of chronic conditions, early identification of risk factors, and appropriate screening for emerging health problems. CCO/HHs should ensure that materials are adapted to the individual's comprehension level, and Care Managers will provide the support necessary for the individual to understand and implement care coordination and health promotion practices. The CCO/HH provider will promote evidence based wellness and prevention by linking 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 individual 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

CCO/HH providers will be encouraged to utilize RHIOs or a qualified entity to access individual data and to develop partnerships that maximize the use of HIT across providers (e.g., Hospitals). The CCO/HH providers will utilize HIT as feasible to promote, link, manage and follow up on enrollee health promotion activities.

Scope of service

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
Interdisciplinary teams	NYS CCO/HHs will use interdisciplinary teams of medical, mental health, chemical dependency treatment providers, developmental disability 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 life plan.

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. Comprehensive transitional care will also be provided when the individual is transitioning between levels of care (including but not limited to hospital, nursing facility, Intermediate Care Facility (ICF), or rehabilitation facility, and community-based residences, including, but not limited to, Individual Residential Alternative (IRA), community based group home, family or self-care. To accomplish this, the CCO/HH provider will be required to develop and have a system in place with hospitals and residential/rehabilitation facilities and other providers in their network to provide the CCO/HH care manager prompt notification of an enrollee's admission and/or discharge to/from an emergency room, an inpatient facility, or residential rehabilitation setting. Comprehensive transitional care will also include care planning for individuals with I/DD transitioning from school to adult services, life changes (employment, retirement, other life events). The CCO/HH 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 individuals who require transfer to/from sites of care. The CCO/HH 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 providers. The CCO/HH provider 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 individuals 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

CCO/HH providers will be encouraged to utilize RHIOs or a qualified entity to access individual data and to develop partnerships that maximize the use of HIT across providers (e.g., hospitals). The CCO/HH provider will utilize HIT as feasible to communicate with health facilities and to facilitate interdisciplinary collaboration among all providers, the individual, family and/or representatives, 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
Interdisciplinary teams	NYS CCO/HHs will use interdisciplinary teams of medical, mental health, chemical dependency treatment providers, developmental disability 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 life plan.

Individual and Family Support (which includes authorized representatives)

Definition

Individual and family support includes coordinating of information and services to support enrollees and enrollees' family and/or representative to maintain and promote quality of life, with a focus on community living options. CCO/HHs will provide access and linkages to supports to individuals and families including providing education and guidance in support of self-advocacy; providing family and/or representative counseling or training, including promotion of skills to provide specific treatment regimens to help the individual improve function, obtaining information about the individual's disability or conditions, and assistance to navigate the service system; identifying resources to assist individuals and family members in acquiring, retaining, and improving self-help, socialization and adaptive skills; and providing information and assistance in accessing services such as: self-help services, peer support services, housing, transportation; and respite services.

The individual's life plan will reflect and incorporate the individual and family and/or representative preferences, education and support for self-management, self-help recovery, and other resources as appropriate. The provider will share and make accessible to the enrollee, their families or other representatives (based on the individual's preferences), the individualized life plan by presenting options for accessing the enrollee's clinical information.

Peer supports, support groups, and self-care programs will also be utilized by the CCO/HH provider to increase the individual's and family and/or representative's 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/or representative, information on advance directives to allow them to make informed end-of-life decisions ahead of time.

The CCO/HH provider will ensure that all communication and information shared with the enrollee, the enrollee's family and/or representative 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

CCO/HH providers will be encouraged to utilize RHIOs or a qualified entity to access individual data and to develop partnerships that maximize the use of HIT across providers (e.g., hospitals). The CCO/HH provider will utilize HIT as feasible to provide the individual 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
Interdisciplinary teams	NYS CCO/HHs will use interdisciplinary teams of medical, mental health, chemical dependency treatment providers, developmental disability 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 life plan.

Referral to Community and Social Support Services

Definition

The CCO/HH provide information and assistance to engage and refer enrollees and enrollee support members (including family members and/or representatives and others as determined by the enrollee) to community based resources, that can help meet the needs identified on the enrollee's life plan. The CCO/HH will work to include activities that connect and monitor individual's community activities and opportunities, develop relationships with others, and foster independence and integration, including employment in the individual's life plan.

The CCO/HH 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 CCO/HH provider has policies, procedures and accountabilities (i.e., through agreements) to support effective collaboration with community based resources that clearly define the roles and responsibilities of the participants. The State expects, and as part of readiness reviews and ongoing monitoring, will require the CCO/HH to continuously develop agreements with providers that will be a part of the interdisciplinary team that will provide and implement the services included in the life plan.

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

The State has directed hospitals to develop and have policies and procedures in place for referring eligible individuals who seek or need treatment in hospital emergency departments to designated Health Home providers. Hospitals are also required to submit written attestations confirming compliance with referral procedures and requirements and to submit, as may be directed, such policies and procedures to the State.

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

CCO/HH providers will be encouraged to utilize RHIOs or a qualified entity to access individual data and to develop partnerships that maximize the use of HIT across providers (e.g. hospitals). The CCO/HHs 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
- 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
Interdisciplinary teams	NYS CCO/HHS health homes will use interdisciplinary teams of medical, mental health, chemical dependency treatment providers, developmental disability 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 life plan.

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

The primary mechanism for referral to Health Homes for individuals in the developmental disability category will be OPWDD, through its Developmental Disability Regional Offices (DDROs) or designee. OPWDD's DDROs are well connected to area schools, health care providers and other governmental and non-governmental social service providers and will make referrals to CCO/HHs that can meet their individual needs. DDRO referrals will consider the region the member lives in and the connectivity of providers, including the current MSC and PCSS who are transitioning to CCO/HHs and who are serving individuals who are transitioning to CCO/HHs, that serve the eligible person to the designated CCO/HH. All designated CCO/HHs may also directly receive referrals from the community, including providers and managed care plans. Individuals will be given the options to choose another health home or opt out of enrollment into a CCO/HH. If an individual opts not to receive CCO/HH services, the individual will be eligible for enrollment in Basic HCBS Plan Support. The purpose of the Basic HCBS Plan Support is to maintain a person's care plan that is primarily focused on HCBS, and maintain Medicaid eligibility.

Name	Date Created	Type
CCO_HH Enrollment Models Work Flows Attachment C 1.25.18	2/1/2018 12:31 PM EST	

Health Homes Monitoring, Quality Measurement and Evaluation

MEDICAID | Medicaid State Plan | Health Homes | NY2017MS00100 | NY-17-0025 | NYS CCO/HHs Serving Individuals with I/DD

Not Started

In Progress

Complete

Package Header

Package ID	NY2017MS00100	SPA ID	NY-17-0025
Submission Type	Official	Initial Submission Date	3/1/2018
Approval Date	4/9/2018	Effective Date	7/1/2018
Superseded SPA ID	N/A		

Monitoring

Describe the state's methodology for calculating cost saving (and report cost savings annually in Quality Measure Report). Include savings that result from improved coordination of care and chronic disease management achieved through the Health Homes Program, including data sources and measurement specifications, as well as any savings associated with dual eligibles, and if Medicare data was available to the state to utilize in arriving at its cost-savings estimates

The State will report on required New York State quality measures and CMS required quality measures in the same manner as required under the New York State Health Home Program. NYS will monitor cost savings from CCO/HHs through measures or preventable events, including potentially preventable readmissions (PPR), and potentially preventable emergency room visits (PPV). NYS will compare total costs of care for enrollees in health homes, including all services costs, health home costs and managed care capitation (where applicable) to similar cohorts that are not receiving Health Home services.

Describe how the state will use health information technology in providing Health Homes services and to improve service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider)

To facilitate the use of health information technology by CCO/HHs to improve service delivery and coordination across the care continuum. NY has developed initial and final HIT standards. Providers must meet the initial HIT standards to implement a CCO/HH. In addition, applicants must provide a plan to demonstrate how the final HIT standards will be achieved within no more than six months of the date the State designated CCO/HH is authorized to begin operations.

The initial standards require CCO/HHs to make use of available HIT for the following processes, as feasible:

1. Have a structured information systems, policies, procedures and practices to create, document, execute and update a plan or care for every individual
2. Have a systematic process to follow-up on tests, treatments, services and referrals which is incorporated into the individual's life plan :
3. Have a health record system which allows the individual health information and life plan to be accessible to the interdisciplinary team of providers and allow for population management and identification of gaps in care including preventive services: and
4. Make use of available HIT and access members' data through the RHIO or QE to conduct all processes

The final standards require CCO/HHs providers to use HIT for the following:

1. Have structured interoperable health information technology systems, policies, procedures and practices to support the creation, documentation, execution and ongoing management of a life plan for every individual;
2. Utilize an electronic health record system that qualifies under the Meaningful Use provisions or the HITECH Act that allows the individuals' health Information and life plan to be accessible to the interdisciplinary team of providers. If the provider does not currently have such a system, they will have to provide a plan for when and how they will implement it. Health home providers will comply with all current and future versions of the Statewide Policy Guidance https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/shinny.htm which includes common information policies, standards and technical approaches governing health information exchange;
3. Join regional health information networks or qualified health IT entities for data exchange and make a commitment to share information with all providers participating in a care plan. Regional Health Information Organization /Qualified Entities will be provided policy and technical services required for health information exchange through the Statewide Health Information Network of New York (SHIN-NY); and
4. Support the use of evidence based clinical decision- making tools, consensus guidelines and best practices to achieve optimal outcomes and cost avoidance.

NY CCO/HHs will be encouraged to use wireless technology as available to improve coordination and management or care and enrollee individual adherence to recommendations made by their provider. This may include the use of cell phones, peripheral monitoring devices, and access individual care management records.

Quality Measurement and Evaluation

- The state provides assurance that all Health Homes providers report to the state on all applicable quality measures as a condition of receiving payment from the state
- The state provides assurance that it will identify measureable goals for its Health Homes model and intervention and also identify quality measures related to each goal to measure its success in achieving the goals
- The state provides assurance that it will report to CMS information submitted by Health Homes providers to inform evaluations, as well as Reports to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS
- The state provides assurance that it will track avoidable hospital readmissions and report annually in the Quality Measures report

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