NY - Submission Package - NY2026MS0001O - (NY-26-0029) - Health Homes

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Financial Management Group
230 South Dearborn Street
Chicago, IL 60604

Center for Medicaid & CHIP Services

September 16, 2026

Amir Bassiri
Acting Medicaid Director
Department of Health
99 Washington Ave.
Albany, NY 12210

Re: Approval of State Plan Amendment NY-26-0029 NYS Health Home Program

Dear Director Bassiri,

On June 30, 2026, the Centers for Medicare and Medicaid Services (CMS) received New York State Plan Amendment (SPA) NY-26-0029 for NYS Health Home Program which proposes a 2.7% rate increase to existing per member per month (PMPM) case management fees for adults in the state-defined Health Homes+ (HH+) level of need.

We approve New York State Plan Amendment (SPA) NY-26-0029 with an effective date(s) of April 1, 2026. April 01, 2026.

If you have any questions regarding this amendment, please contact Jerica Bennett at 410-786-1167 or jerica.bennett@cms.hhs.gov.

Sincerely,

Todd McMillion

Director, Division of Reimbursement Review

Center for Medicaid & CHIP Services

NY - Submission Package - NY2026MS0001O - (NY-26-0029) - Health Homes

CMS-10434 OMB 0938-1188

Package Information

Package ID	NY2026MS0001O	**Submission Type**	Official
Program Name	NYS Health Home Program	**State**	NY
SPA ID	NY-26-0029	**Region**	New York, NY
Version Number	1	**Package Status**	Approved
Submitted By	Jennifer Yungandreas	**Submission Date**	6/30/2026
Package Disposition		**Approval Date**	9/16/2026 9:57 AM EDT

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | NY2026MS0001O | NY-26-0029 | NYS Health Home Program

Package Header

Package ID	NY2026MS0001O	**SPA ID**	NY-26-0029
Submission Type	Official	**Initial Submission Date**	6/30/2026
Approval Date	09/16/2026	**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Superseded SPA ID	N/A		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 - Summary

MEDICAID | Medicaid State Plan | Health Homes | NY2026MS0001O | NY-26-0029 | NYS Health Home Program

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Superseded SPA ID N/A

SPA ID and Effective Date

SPA ID NY-26-0029

Reviewable Unit	Proposed Effective Date	Superseded SPA ID
1945 Health Home Intro	4/1/2026	NY-25-0047
1945 Health Home Payment Methodologies	4/1/2026	NY-25-0047

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | NY2026MS0001O | NY-26-0029 | NYS Health Home Program

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Effective Date N/A
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Executive Summary

Summary Description Including Goals and Objectives SUMMARY
SPA #26-0029

This State Plan Amendment proposes to amend the Title XIX (Medicaid) State Plan for non-institutional services to comply with enacted statutory provisions.

Chapter 57 of the Laws of 2026, Part P of the SFY26/27 Enacted Budget outlines a 2.7% Targeted Inflationary Increase (TII) in eligible Health Home rates for those Health Home members that meet the risk and acuity criteria for Health Home Plus and for those Heath Home members that meet the risk and acuity criteria for Health Home Plus and are receiving Assisted Outpatient Treatment (AOT).

Federal Budget Impact and Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First	2026	$178256
Second	2027	$356513

Federal Statute / Regulation Citation

Section 1945 of the Social Security Act.

Supporting documentation of budget impact is uploaded (optional).

Name	Date Created	
Fiscal Calculations (26-0029) (6-1-26)	6/30/2026 11:41 AM EDT	
Summary (26-0029) (6-1-26)	6/30/2026 11:41 AM EDT	
Authorizing Provisions (26-0029) (6-1-26)	6/30/2026 11:41 AM EDT	

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | NY2026MS0001O | NY-26-0029 | NYS Health Home Program

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Superseded SPA ID	N/A		

Governor's Office Review

- (•) No comment
- ( ) Comments received
- ( ) No response within 45 days
- ( ) Other

Submission - Medicaid State Plan

MEDICAID | Medicaid State Plan | Health Homes | NY2026MS0001O | NY-26-0029 | NYS Health Home Program

CMS-10434 OMB 0938-1188

The submission includes the following:

- [ ] Administration
- [ ] Eligibility
- [x] Benefits and Payments
  - [x] 1945 Health Home Program

Do not use "Create New 1945 Health Home Program" to amend an existing 1945 Health Home program. Instead, use "Amend existing 1945 Health Home program," below.

- ( ) Create new 1945 Health Home program
- (•) Amend existing 1945 Health Home program
- ( ) Terminate existing 1945 Health Home program

NYS Health Home Program

1945 Health Home SPA - Reviewable Units

Only select Reviewable Units to include in the package which you intend to change.

*

	Reviewable Unit Name	Included in Another Submission Package	Source Type
[x]	1945 Health Home Intro	( )	APPROVED
[ ]	Health Homes Geographic Limitations	( )	APPROVED
[ ]	Health Homes Population and Enrollment Criteria	( )	APPROVED
[ ]	Health Homes Providers	( )	APPROVED
[ ]	Health Homes Service Delivery Systems	( )	APPROVED
[x]	1945 Health Home Payment Methodologies	( )	APPROVED
[ ]	Health Homes Services	( )	APPROVED
[ ]	Health Homes Monitoring, Quality Measurement and Evaluation	( )	APPROVED

1 – 8 of 8

- [ ] 1945A Health Home Program

Submission - Public Notice/Process

MEDICAID | Medicaid State Plan | Health Homes | NY2026MS0001O | NY-26-0029 | NYS Health Home Program

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Name of 1945 Health Home Program

NYS Health Home Program

☑ Public notice was provided due to proposed changes in methods and standards for setting payment rates for services, pursuant to 42 CFR 447.205.

Upload copies of public notices and other documents used

Name	Date Created	
FPN-NYS Register (03-25-2026)	4/8/2026 1:10 PM EDT	
FPN-2026-2027 Executive Budget Clarifier for DOS (6-26-26)	6/30/2026 11:45 AM EDT	

Submission - Tribal Input

MEDICAID | Medicaid State Plan | Health Homes | NY2026MS0001O | NY-26-0029 | NYS Health Home Program

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Name of 1945 Health Home Program:

NYS Health Home Program

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, as described in the state consultation plan.

- (•) Yes
- ( ) No

[x] The state has solicited advice from Indian Health Programs and/or Urban Indian Organizations, as required by section 1902(a)(73) of the Social Security Act, and in accordance with the state consultation plan, 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:

[x] All Indian Health Programs

Date of solicitation/consultation:	Method of solicitation/consultation:
6/9/2026	paper mailing/electronic mail

[ ] 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:

[x] All Indian Tribes

Date of consultation:	Method of consultation:
6/9/2026	paper mailing/electronic mail.

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	
Tribal Consultation Summary (26-0029)(6-9-26)	6/30/2026 11:48 AM EDT	

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 | NY2026MS0001O | NY-26-0029 | NYS Health Home Program

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Superseded SPA ID N/A

SAMHSA Consultation

Name of 1945 Health Home Program

NYS Health Home Program

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

Date of consultation
1/1/2014

1945 Health Home Intro

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Superseded SPA ID	NY-25-0047		
	User-Entered		

Program Authority

1945 of the Social Security Act

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

Name of 1945 Health Home Program

NYS Health Home Program

Executive Summary

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

This State Plan Amendment proposes to amend the Title XIX (Medicaid) State Plan for non-institutional services to comply with enacted statutory provisions.

Chapter 57 of the Laws of 2026, Part P of the SFY26/27 Enacted Budget outlines a 2.7% Targeted Inflationary Increase (TII) in eligible Health Home rates for those Health Home members that meet the risk and acuity criteria for Health Home Plus and for those Heath Home members that meet the risk and acuity criteria for Health Home Plus and are receiving Assisted Outpatient Treatment (AOT).

General Assurances

- ☑ The state provides assurance that eligible individuals will be given a free choice of Health Home providers.
- ☑ The states provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Home 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 Home providers.
- ☑ The state provides assurance that FMAP for 1945 Health Home 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 home 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.

1945 Health Home Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | NY2026MS0001O | NY-26-0029 | NYS Health Home Program

Package Header

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Payment Methodology

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

- [x] Fee for Service
  - [ ] Individual Rates Per Service
  - [x] Per Member, Per Month Rates
    - [x] Fee for Service Rates based on
      - [x] Severity of each individual's chronic conditions
      - [ ] Capabilities of the team of health care professionals, designated provider, or health team
      - [x] 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)

1945 Health Home Payment Methodologies

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Superseded SPA ID NY-25-0047
User-Entered

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

4/1/2026

Website where rates are displayed

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/billing/hh_rates.htm

1945 Health Home Payment Methodologies

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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

Provider Types

NYS Medicaid providers eligible to become Health Homes (HHs) include: Medicaid Managed Care Plans (MMCPs); hospitals; medical, mental, and chemical dependency treatment clinics; primary care practitioner practices; PCMHs; Federally Qualified Health Centers (FQHCs); Targeted Case Management (TCM) providers; Certified Home Healthcare Agencies (CHHAs), and any other Medicaid enrolled providers that meet HH provider standards.

Care Management (CM) Fees

HHs meeting State and Federal standards are paid a per member per month (PMPM) CM fee that is adjusted based on region and case mix method for Health Homes Serving Adults (HHSA) class members; or the Child and Adolescent Needs and Strength Assessment of New York (CANS-NY) for Health Homes Serving Children (HHSC) (age 0 through 20). The total costs relating to a care manager (salary, fringe benefits, non-personal services, capital and administration costs), in conjunction with caseload assumptions, are used to develop the HHCM fees. The State periodically reviews HH claims data in conjunction with Department of Labor salary data to ensure that the fees are sufficient to ensure quality services. Except as otherwise noted in the plan, State developed fee schedules are the same for both governmental and private providers.

All current/pending HHSC, HHSA, and HH+ fees are published on the DOH website:
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/billing/docs/hh_rates.pdf

All historical HHSC, HHSA, and HH+ fees are published on the DOH website:
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/archive/historical.htm

A unit of service will be defined as a billable unit per service month. In order to be reimbursed for a billable unit of service per month HH providers must, at a minimum, provide one of the core HH services per month. The monthly payment will be paid via the active CM PMPM. Once a patient has consented to receive services, has been assigned a care manager, and is enrolled in the HH program; the active CM PMPM may be billed. Care managers must document all services provided to the member in the member's care plan.

Population Case Mix Definitions for Health Homes Serving Adults (HHSA) Class Members

Health Home Plus (HH+) class CM includes adults with an active AOT order or expired AOT order within the last year; adults stepping down from State Psychiatric Care (PC) and Assertive Community Treatment (ACT); Health and Recovery Plan (HARP) members that meet high risk criteria (recent incarceration, homelessness, multiple hospital admissions, etc.); and members identified at the discretion of the MMCP or State designated entity for adults not currently enrolled in a MMCP.

HHSA High Risk/High Need class CM includes adults that are Health and Recovery Plan (HARP) enrolled members not included in HH+ CM; any adult member meeting high risk criteria based on the high, medium and low Clinical and Functional Assessment; and members identified at the discretion of the MMCP or State designated entity for adults not currently enrolled in a MMCP.

HHSA Home Transition class includes adults who, under the terms of a Stipulation and Order of Settlement between the U.S. Department of Justice and New York State, are Adult Home Residents with serious mental illness (SMI) who are required to transition from Adult Homes located in New York City to the community.

HHSA class CM includes all other adults not meeting the criteria for HH+ CM, High Risk/High Need CM, or HHSA Home Transition.

Managed Care (MC) Considerations

Similar to the NY patient centered Medical Home program, it is the intention of the State to coordinate and pay for HH services through MMCPs, but at State set fees for the service. The State will address any existing CM resources in the current plan premium for HH enrollees under CMS guidelines (bring this resource out of the capitation and create federal

matching for those resources under the HH payment). MMCPs will pay HH providers State set fees when providers are contracted to provide all HH services. In cases where the MMCP performs a portion of the HH service (e.g. telephonic post discharge tracking) and downstream providers perform a separate portion (e.g. face to face CM), the MMCP will split the State generated PMPM proportional to the contracted effort.

The Medicaid/FHP Model Contract has been modified to include language similar to that outlined below which addresses any duplication of payment between the Managed Care Organization (MCO) capitation payments and HH payments. The delivery design and payment methodology will not result in any duplication of payment between HHs and managed care.

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

The State has a HH advisory committee of providers and MMCPs through which any issues with payment should be raised and addressed. Directions have been given to MMCPs to match HH payment to providers based on relative HHCM effort. Further information on specific construction on HH payments includes specific administration compensation to guide rate differential construct.

Effective January 1, 2012 the State envisions that eventually all Targeted Case Management (TCM) programs operating in New York will convert to or become part of HHs, and these providers will require time to meet State and Federal HH standards. The State will allow TCM providers that can meet HH standards to convert to HHs or join with larger HHs. TCM providers that convert to HHs will be governed under NYS HH Provider Qualification Standards, not TCM standards. The payment method will be designed to transition all existing TCM capacity from the current rates to the new HH fee payment structure.

HHCM services may be provided to children that are eligible and enrolled in both the Early Intervention (EI) and HHSC programs and will meet and fulfill the requirements of the ongoing service coordination required to be provided to children enrolled in the EI program.

All payments will be made under the HH payment detailed above in the CM Fee section if they convert to or become part of a HH.

Effective December 1, 2016 risk adjusted payments (high, medium, low acuity levels) for all Health Home member classes allow providers to service a diverse population of patients and assign patients to various levels of CM intensity without having to meet preset standards for contact counts. Providers are able to respond to and adjust the intensity and frequency of intervention based on a patient’s current condition and needs (from tracking to high touch).

Effective June 1, 2018 the PMPM CM fee for HHs that are designated HHSC only, or designated HHSC in 43 counties and both HHSA and HHSC in 1 county, shall receive an additional $4 million in payments to supplement CM fees. The supplemental payments shall be lump sum payments paid no later than March 31, 2019 and will be allocated proportionately among such HHs based on services provided between June 1, 2018 and December 1, 2018.

Effective January 1, 2019 Providers delivering Individualized Care Coordination (ICC) under the 1915c SED or Health Care Integration (HCI) under the 1915c B2H waivers, who shall provide HHCM services in accordance with this section shall be eligible for a transition fee add-on for two years to enable providers to transition to HHSC fees. HHSC CM services eligible for the transition fee add-on shall be limited to services provided to the number of children such providers served as of December 31, 2018. Services provided to a greater number of children than such providers served as of December 31, 2018 shall be reimbursed the HHSC fee without the add-on.

Effective October,1, 2022 HHSC may receive an assessment fee to ensure that any child who may be eligible for Home and Community-Based Services (HCBS) under the Consolidated Children's Waiver or State Plan authority will be eligible to receive a timely HCBS assessment under the HH program. The HHSC HCBS assessment fee will compensate the HH for the costs associated with conduct of:

- Evaluation and/or re-evaluation of HCBS level of care;
- Assessment and/or reassessment of the need for HCBS;
- Inclusion of all aspects of an HCBS Plan of Care in the HH's Comprehensive Care Plan.

This fee will be paid in addition to the CM PMPM and is contingent upon the HH completing a timely and complete assessment.

Effective January 1, 2024 a PMPM CM fee was developed separately for HHSC designated by the NYS designation process and providing High Fidelity Wraparound (HFW). The fee is based on modeling estimated enrollment, staff salaries, benefits, non-personnel costs, overhead, and administrative costs that is based on region under HFW based on caseload assumptions. Separate projections and fees are developed for this population of most vulnerable children who meet the following conditions to be part of this service:

SED diagnosis as well as additional criteria, namely that the child or youth is:

- Between 6 and 21 years of age;
- Has a functional impairment in the home, school, or community as measured by the CANS-NY system;
- Is HH enrolled/eligible through SED or has 2 mental health (MH) diagnoses;
- Is involved with two or more systems;
- Has a history of service utilization with out-of-home residential or inpatient services, crisis and emergency services, intensive treatment programs or represents high needs populations.

Effective April 1, 2024 a supplemental PMPM CM fee was developed for the HHSA designated by the NYS designation process and providing HH+ CM to members who are receiving HH+ CM due to an Assisted Outpatient Treatment (AOT) Order.

Effective April 1, 2025 a 2.6% Targeted Inflationary Increase (TII) is applied to the CM fees for those HH members that meet the risk and acuity criteria for HH+ and for those members that meet the risk and acuity criteria for HH+ and are receiving AOT as per the SFY 2026 enacted budget.

Effective April 1, 2026 a 2.7% TII is applied to the CM fees for those HH members that meet the risk and acuity criteria for HH+ and for those members that meet the risk and acuity criteria for HH+ and are receiving AOT as per the SFY 2027 enacted budget.

1945 Health Home Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | NY2026MS0001O | NY-26-0029 | NYS Health Home Program

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Assurances

☑ The State provides assurance that it will ensure non-duplication of payment for services similar to Health Home 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.

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/billing/docs/hh_rates.pdf

☑ The state has developed payment methodologies and rates that are consistent with section 1902(a)(30)(A).

☑ 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).

Optional Supporting Material Upload

Name	Date Created	
2026 NI Rate SFQs (26-0029) (6-1-26)	6/30/2026 11:50 AM EDT	

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

This view was generated on 9/16/2026 10:05 AM EDT