NEW YORK
state department of
HEALTH

Nirav R. Shah, M.D., M.P.H.
Commissioner

Sue Kelly
Executive Deputy Commissioner

Electronically Submitted:
November 8, 2011

Mr. Michael Melendez
Associate Regional Administrator
Department of Health & Human Services
Centers for Medicare & Medicaid Services
New York Regional Office
Division of Medicaid and Children's Health Operations
26 Federal Plaza - Room 37-100 North
New York, New York 10278

RE: SPA #11-56
Non-Institutional Services

Dear Mr. Melendez:

The State requests approval of the enclosed amendment #11-56 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective January 1, 2012 (Appendix I). This amendment is being submitted based on enacted legislation. A summary of the plan amendment is provided in Appendix II.

The State of New York reimburses these services through the use of rates that are consistent with and promote efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area as required by §1902(a)(30) of the Social Security Act and 42 CFR §447.204.

Copies of pertinent sections of proposed State statute are enclosed for your information (Appendix III). A copy of the public notice for this plan amendment, which was given in the New York State Register on March 30, 2011, and a copy of a clarifying public notice, which will be published in the New York State Register on November 9, 2011, are also enclosed for your information (Appendix IV). In addition, responses to the five standard funding questions and the standard access questions are also enclosed (Appendix V and VI, respectively).

If you have any questions regarding this State Plan submission, please do not hesitate to contact John E. Ulberg, Jr., Director, Division of Health Care Financing at (518) 474-6350.

Sincerely,

Jason A. Helgerson
Medicaid Director
Deputy Commissioner
Office of Health Insurance Programs

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER: **#11-56**	2. STATE **New York**
	3. PROGRAM IDENTIFICATION: **TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)**	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE **January 1, 2012**	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: **Section 1902(a) of the Social Security Act, and 42 CFR 447**	7. FEDERAL BUDGET IMPACT: a. FFY **01/01/12-09/30/12 $533,332** b. FFY **10/01/12-09/30/13 ($2,185,890)**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 3.1-H: Pages 1 through 26**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

10. SUBJECT OF AMENDMENT:
Implement Health Home for High-Cost, High-Need Enrollees
FMAP = 90% for Health Homes

11. GOVERNOR'S REVIEW *(Check One)*:
☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:	16. RETURN TO: **New York State Department of Health** **Corning Tower** **Empire State Plaza** **Albany, New York 12237**
13. TYPED NAME: **Jason A. Helgerson**	
14. TITLE: **Medicaid Director & Deputy Commissioner Department of Health**	
15. DATE SUBMITTED:	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED:
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL:	20. SIGNATURE OF REGIONAL OFFICIAL:
21. TYPED NAME:	22. TITLE:

23. REMARKS:

FORM HCFA-179 (07-92)

Appendix I
2011 Title XIX State Plan
Second Quarter Amendment
Non-Institutional Services
Amended SPA Pages

Id: NEW YORK
State: New York
Health Home Services

Effective Date-
January 1, 2012

SPA includes both
Categorically Needy and
Medically Needy
Beneficiaries- check box

3.1 - A: Categorically Needy View

Attachment 3.1-H
Page
Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Care Services: Categorically Needy

Health Home Services

How are Health Home Services Provided to the Medically Needy?

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

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

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

Individuals eligible for health home services will be identified by the State. Individuals will be assigned to a health home provider based on existing relationships with health care providers or health care delivery system relationships, geography, and/or qualifying condition. Individuals will be enrolled into an appropriate health home and be given the option to choose another health home when available, or opt out of enrollment in a health home. Individuals

will be notified by U.S. mail of their health home enrollment. The notification letter will identify the assigned health home, describe the individual's option to select another health home or opt-out from receiving health home services with in a designated time period, and briefly describe health home services. The State will provide health home providers a roster of assigned enrollees and current demographic information to facilitate outreach and engagement.

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

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

i. Geographic Limitations

If Targeted Geographic Basis:

New York's Health Homes will be conducted in the following counties:
Bronx
Brooklyn
Nassau
Monroe
Warren
Washington
Essex
Hamilton
Clinton
Franklin
St. Lawrence
Saratoga
Schenectady

ii. Population Criteria

The State elects to offer Health Home Services to individuals with:

☑ Two chronic conditions

☑ One chronic condition (HIV/AIDS) - and the risk of developing another

☑ One serious mental illness

From the list of conditions below:

☑ Mental Health Condition

☑ Substance Use Disorder

☑ Asthma

☑ Diabetes

☑ Heart Disease

☑ BMI over 25

☑ Other Chronic Conditions

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

Major Category: Alcohol and Substance Abuse
3M™ Clinical Risk Group (3M CRGs) Category
1. Alcohol Liver Disease
2. Chronic Alcohol Abuse
3. Cocaine Abuse
4. Drug Abuse – Cannabis/NOS/NEC
5. Substance Abuse
6. Opioid Abuse
7. Other Significant Drug Abuse

Major Category: Mental Health
3M™ Clinical Risk Group (3M CRGs) Category
1. Bi-Polar Disorder
2. Conduct, Impulse Control, and Other Disruptive Behavior Disorders
3. Dementing Disease
4. Depressive and Other Psychoses
5. Eating Disorder
6. Major Personality Disorders
7. Psychiatric Disease (Except Schizophrenia)
8. Schizophrenia

Major Category: Cardiovascular Disease
3M™ Clinical Risk Group (3M CRGs) Category
1. Advanced Coronary Artery Disease
2. Cerebrovascular Disease
3. Congestive Heart Failure
4. Hypertension
5. Peripheral Vascular Disease

Major Category: HIV/AIDS
3M™ Clinical Risk Group (3M CRGs) Category
1. HIV Disease

Major Category: Metabolic Disease
3M™ Clinical Risk Group (3M CRGs) Category
1. Chronic Renal Failure
2. Diabetes

Major Category: Respiratory Disease
3M™ Clinical Risk Group (3M CRGs) Category

1. Asthma
2. Chronic Obstructive Pulmonary Disease

Major Category: Other
3M™ Clinical Risk Group (3M CRGs) Category
1. Other Chronic Disease

Description of population selection criteria

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

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

iii. Provider Infrastructure

☑ Designated Providers as described in §Section 1945(h)(5)

New York's health home provider infrastructure will include designated providers working with multidisciplinary teams as described below. NYS Medicaid providers eligible to become health homes include managed care plans; hospitals; medical, mental and chemical dependency treatment clinics; primary care practitioner practices; PCMHs; FQHCs; Targeted Case Management (TCM) providers; certified home health care agencies and any other Medicaid enrolled provider that meet health home provider standards. To assure that NY health homes meet the proposed federal health home model of service delivery and NYS standards, health home provider qualification standards were developed. The standards were developed with input from a variety of stakeholders including hospitals, clinics, physicians, mental health experts, chemical dependency treatment experts and housing providers. Representatives from the Department of Health's Offices of Health Systems Management, Health IT Transformation, and the AIDS Institute and the NYS Offices of Mental Health and Alcoholism and Substance Abuse Services also participated in the development of these standards. The standards set the ground work for assuring that health home enrollees will receive appropriate, and timely access to medical, behavioral, and social services in a coordinated and integrated manner.

NY health homes will use multidisciplinary teams of medical, mental health, chemical dependency treatment providers, social workers, nurses and other care providers led by a dedicated care manager who will assure that enrollees receive needed medical, behavioral, and social services in accordance with a single plan of care. Optional team members may include nutritionists/dieticians, pharmacists, outreach workers including 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 patient 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 care management record will be agreed to and shared by all team professionals and case reviews will be conducted on a regular basis. The care manager will be responsible for overall management and coordination of the enrollee's care plan which will include both medical/behavioral health and social service needs and goals.

In order to ensure the delivery of quality health home services, the State will provide educational opportunities for health home 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 homes services that are whole person focused and that integrate medical, behavioral health and other needed supports and social services. The State will maintain a highly collaborative and coordinated working relationship with individual health home 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:

1. Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered health home 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; and
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.

The Department of Health in partnership with the Office of Mental Health and the Office of Alcoholism and Substance Abuse Services will closely monitor health home 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 review, site audits, team composition analysis, and review of types and number of contacts, etc.

☐ Team of Health Care Professionals as described in §section 1945(h)(6)

☐ Health Team as described in §section 1945(h)(7), via reference to §section 3502

iv. Service Definitions

Comprehensive Care Management

Service Definition

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

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

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

Ways Health IT Will Link

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

Care Coordination
Service Definition

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

In order to fulfill the care coordination requirements, the health home provider will assign each individual enrollee one dedicated care manager who is responsible for overall management of the enrollee's plan of care. The enrollee's health home care manager will be clearly identified in the patient record and will have overall responsibility and accountability for

coordinating all aspects of the individual's care. The health home provider will be responsible to assure that communication will be fostered between the dedicated care manager and treating clinicians to discuss as needed enrollee's care needs, conflicting treatments, change in condition, etc. which may necessitate treatment change (i.e., written orders and/or prescriptions).

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

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

Ways Health IT Will Link

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

Health Promotion
Service Definition

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

Ways Health IT Will Link

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

Comprehensive Transitional Care (including appropriate follow-up, from inpatient to other settings)

Service Definition

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

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

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

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

Ways Health IT Will Link

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

Individual and Family Support Services (including authorized representatives)
Service Definition

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

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

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

Ways Health IT Will Link

Health home providers will be encouraged to utilize RHIOs or a qualified entity to access patient data and to develop partnerships that maximize the use of HIT across providers (i.e.

hospitals, TCMs). The health home provider will utilize HIT as feasible to provide the patient access to care plans and options for accessing clinical information.

Referral to Community and Social Support Services
Service Definition

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

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

Ways Health IT Will Link

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

v. Provider Standards

Under New York State's approach to health home implementation, a health home provider is the central point for directing patient-centered care and is accountable for reducing avoidable health care costs, specifically preventable hospital admissions/readmissions and avoidable emergency room visits; providing timely post discharge follow-up, and improving patient outcomes by addressing primary medical, specialist and behavioral health care through direct provision, or through contractual arrangements with appropriate service providers, of comprehensive, integrated services.

General Qualifications

1. Health home providers/plans must be enrolled (or be eligible for enrollment) in the NYS Medicaid program and agree to comply with all Medicaid program requirements.

2. Health home providers can either directly provide, or subcontract for the provision of, health home services. The health home provider 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 health home enrollees by an interdisciplinary team of providers, where each 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 and community social supports 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 seek or need treatment in a hospital emergency department to a DOH designated health home provider.

5. Health home 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 patient engagement, participation in their plan of care and that ensures patients appropriate access to the continuum of physical and behavioral health care and social services.

6. Health home providers must meet the following core health home requirements in the manner described below. Health home providers must provide written documentation that clearly demonstrates how the requirements are being met.

* Please note whenever the individual/ patient /enrollee is stated when applicable, the term is interchangeable with guardian.

I. Comprehensive Care Management

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

II. Care Coordination and Health Promotion

2a. The health home provider is accountable for engaging and retaining health home enrollees in care; coordinating and arranging for the provision of services; supporting adherence to treatment recommendations; and monitoring and evaluating a patient's needs, including prevention, wellness, medical, specialist and behavioral health treatment, care transitions, and social and community services where appropriate through the creation of an individual plan of care.
2b. The health home provider will assign each individual a dedicated care manager who is responsible for overall management of the patient's care plan. The health home care manager is clearly identified in the patient record. Each individual enrolled with a health home 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.

2c. The health home 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 patient condition that may necessitate treatment change (i.e., written orders and/or prescriptions).
2d. The health home provider must define how patient care will be directed when conflicting treatment is being provided.
2e. The health home provider has policies, procedures and accountabilities (contractual agreements) to support effective collaborations between primary care, specialist and behavioral health providers, evidence-based referrals and follow-up and consultations that clearly define roles and responsibilities.
2f. The health home 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 health home provider supports care coordination and facilitates collaboration through the establishment of regular case review meetings, including all members of the interdisciplinary team on a schedule determined by the health home provider. The health home 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 health home provider ensures 24 hours/seven days a week availability to a care manager to provide information and emergency consultation services.
2i. The health home provider will ensure the availability of priority appointments for health home enrollees to medical and behavioral health care services within their health home provider network to avoid unnecessary, inappropriate utilization of emergency room and inpatient hospital services.
2j. The health home provider promotes evidence based wellness and prevention by linking health home enrollees with resources for smoking cessation, diabetes, asthma, hypertension, self help recovery resources, and other services based on individual needs and preferences.
2k. The health home provider has a system to track and share patient information and care needs across providers and to monitor patient outcomes and initiate changes in care, as necessary, to address patient need.

III. Comprehensive Transitional Care

3a. The health home provider has a system in place with hospitals and residential/rehabilitation facilities in their network to provide the health home prompt notification of an individual's admission and/or discharge to/from an emergency room, inpatient, or residential/rehabilitation setting.
3b. The health home 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 patients who require transfers in the site of care.
3c. The health home provider utilizes HIT as feasible to facilitate interdisciplinary collaboration among all providers, the patient, family, care givers, and local supports.
3d. The health home 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 outpatient providers, care manager verification with outpatient provider that the patient attended the appointment, and a plan to outreach and re-engage the patient in care if the appointment was missed.

IV. Patient and Family Support

4a. Patient's individualized plan of care reflects patient and family or caregiver preferences, education and support for self-management; self help recovery, and other resources as appropriate.
4b. Patient's individualized plan of care is accessible to the individual and their families or other caregivers based on the individual's preference.
4c. The health home provider utilizes peer supports, support groups and self-care programs to increase patients' knowledge about their disease, engagement and self management capabilities, and to improve adherence to prescribed treatment.
4d. The health home provider discusses advance directives with enrollees and their families or caregivers.
4e. The health home provider communicates and shares information with individuals and their families and other caregivers with appropriate consideration for language, literacy and cultural preferences.
4f. The health home provider gives the patient access to care plans and options for accessing clinical information.

V. Referral to Community and Social Support Services

5a. The health home provider identifies available community-based resources and actively manages appropriate referrals, access, engagement, follow-up and coordination of services.
5b. The health home provider has policies, procedures and accountabilities (contractual agreements) to support effective collaborations with community-based resources, which clearly define roles and responsibilities.
5c. The plan of care should include community-based and other social support services as well as healthcare services that respond to the patient's needs and preferences and contribute to achieving the patient's goals.

VI. Use of Health Information Technology to Link Services

Health home providers will make use of available HIT and accesses 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 health homes. In order to be approved as health home provider, applicants must provide a plan to achieve the final standards cited in items 6e.-6i. within eighteen (18) months of program initiation.
Initial Standards
6a. Health home provider has structured information systems, policies, procedures and practices to create, document, execute, and update a plan of care for every patient.
6b. Health home provider has a systematic process to follow-up on tests, treatments, services and, and referrals which is incorporated into the patient's plan of care.
6c. Health home provider has a health record system which allows the patient's health information and plan of care to be accessible to the interdisciplinary team of providers and which allows for population management and identification of gaps in care including preventive services.
6d. Health home provider makes use of available HIT and accesses data through the RHIO/QE to conduct these processes, as feasible.
Final Standards
6e. Health home provider has structured interoperable health information technology systems, policies, procedures and practices to support the creation, documentation, execution, and ongoing management of a plan of care for every patient.
6f. Health home provider uses an electronic health record system that qualifies under the Meaningful Use provisions of the HITECH Act, which allows the patient's health information and plan of care to be accessible to the interdisciplinary team of providers. If the provider does not currently have such a system, they will provide a plan for when and how they will implement it.

6g. Health home provider will be required to comply with the current and future version of the Statewide Policy Guidance (http://health.ny.gov/technology/statewide_policy_guidance.htm) which includes common information policies, standards and technical approaches governing health information exchange.
6h. Health home 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. Health home provider supports the use of evidence based clinical decision making tools, consensus guidelines, and best practices to achieve optimal outcomes and cost avoidance. One example of such a tool is PSYCKES.

VII. Quality Measures Reporting to State

7a. The health home 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 health home provider is accountable for reducing avoidable health care costs specifically preventable hospital admissions/readmissions and avoidable emergency room visits; providing timely post discharge follow-up, and improving patient outcomes as measured by NYS and CMS required quality measures.

vi. Assurances

☐ ☑ A. The State assures that hospitals participating under the State plan or a waiver of such plan will establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated providers.

☐ ☑B. The State 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.

☐ ☑C. The State will report to CMS information submitted by health home providers to inform the evaluation and Reports to Congress as described in section 2703(b) of the Affordable Care Act, and as described by CMS.

vii. Monitoring

A. Describe the State's methodology for tracking avoidable hospital readmissions, to include data sources and measure specifications.

NYS has been monitoring avoidable hospital readmissions since 2009, using 3M software called Potentially Preventable Readmissions (PPRs). This software incorporates clinical judgment to determine if the original admission and subsequent readmissions are clinically related. NYS calculates PPRs for all of Medicaid including fee for service and managed care. Using health home rosters, rates of PPRs can be calculated for health home participants as well as comparison groups.

B. Describe the State's methodology for calculating cost savings that result from improved chronic care coordination and management achieved through this program, to include data sources and measure specifications.

NYS will monitor cost savings from health homes through measures of preventable events, including PPRs, potentially preventable hospital admissions and potentially avoidable ER visits. These metrics are the same metrics for evaluation in section IX. Measures of preventable

hospitalizations and avoidable ER will be calculated for the entire Medicaid program. Similar to Section VII, A, NYS will use health home rosters to calculate potential cost savings for enrollees in health homes.

NYS will also compare total costs of care for enrollees in health homes, including all services costs, health home costs and managed care capitation to similar cohorts that are not receiving health home services.

C. Describe the State's proposal for using health information technology in providing health home services under this program and improving 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 health homes to improve service delivery and coordination across the care continuum, NY has developed initial and final HIT standards. Providers must meet the initial HIT standard to implement a health home. In addition, provider applicant must provide a plan in to achieve the final standards within eighteen months of program initiation in order to be approved as a health home provider.

The initial standards require health home providers 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 of care for every patient;
2. Have a systematic process to follow-up on tests, treatments, services and, and referrals which is incorporated into the patient's plan of care;
3. Have a health record system which allows the patient health information and plan of care 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. Is required to make use of available HIT and access members' data through the RHIO or QE to conduct all processes, as feasible.

The final standards require health home provider 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 plan of care for every patient;
2. Utilize an electronic health record system that qualifies under the Meaningful Use provisions of the HITECH Act that allows the patient's health information and plan of care 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 (http://health.ny.gov/technology/statewide_policy_guidance.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. For example, in New York the Office of Mental Health has a web and evidence based practices system, known as Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES), which

utilizes informatics to improve the quality of care, accountability, and cost-effectiveness of mental health prescribing practices in psychiatric centers.

NY health home providers will be encouraged to use wireless technology as available to improve coordination and management of care and patient adherence to recommendations made by their provider. This may include the use of cell phones, peripheral monitoring devices, and access patient care management records, as feasible.

To facilitate state reporting requirements to CMS, NY is working toward the development of a single portal to be used by health homes for submission of functional assessment and quality measure reporting to the State. Consideration is being given to also include a care management record, also accessed via the portal as an option for health home providers who currently do not have an electronic care management record system.

Significant investment has been made in New York's Health Information Infrastructure to ensure that medical information is in the hands of clinicians and New Yorkers to guide medical decisions and supports the delivery of coordinated, preventive, patient-centered and high quality care. Ongoing statewide evaluation designed to evaluate the impact of HIT on quality and outcomes of care is underway by the Office of Health Information Technology and Transformation.

3.1 - A: Categorically Needy View

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Care Services: Categorically Needy

viii. Quality Measures: Goal based Quality Measures

A. Goal 1: Reduce utilization associated with avoidable (preventable) inpatient stays

1. Clinical Outcomes

Measures	Data Source	Specifications	HIT Utilization
Ambulatory Care Sensitive Conditions **OR** Preventable Quality Indicators	Claims	(National Quality Measures Clearinghouse NQMC – Rosenthal) Ambulatory care sensitive conditions: age-standardized acute care hospitalization rate for conditions where appropriate ambulatory care prevents or reduces the need for admission to the hospital, (per 100,000 population) under age 75 years. The rate of acute care hospitalizations for ambulatory care sensitive conditions per 1,000 member years.	Acute care discharges will be identified from administrative claims. We will use data analytics to aggregate results by health homes and compare to peers. Information on performance will be shared with the health homes.
Plan- All Cause Readmission **OR** Potentially Preventable Readmissions	Claims	(HEDIS 2012 – Use of Services) For members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted	Acute care admissions occurring within 30 days of discharge from acute care inpatient stays will be identified using administrative data. We will use data analytics to determine aggregate results and the weight adjustments for

		probability of an acute readmission. The results are the average adjusted probability of readmission. The adjustment takes into account: Age/Gender, Surgery, Discharge Condition (CC), Comorbidities (HCCs), and Base Weight.	the predicted probability of readmission. The expected to observed ratios will be used to adjust the result and compare to the unadjusted overall readmission rates for health homes.

2. Experience of Care

Measures	Data Source	Specifications	HIT Utilization
NA	NA	NA	NA

3. Quality of Care

Measures	Data Source	Specifications	HIT Utilization
Care Transitions: Transition Record Transmitted to Health Care Professional	Claims (Denom.) Survey/EMR (Num.)	(National Quality Measures Clearinghouse) Percentage of patients who are discharged from an acute inpatient setting to home or any other site of care for whom a transition record (Diagnosis/problem list, medication list with OTC and allergies, identified follow up provider, cognitive status, and test results or pending results) was transmitted to the accepting facility or to the designated follow up provider within 24 hours of discharge.	Acute Care admissions will be determined from administrative claims. Health homes will audit a sample of inpatient and follow up provider records each quarter to determine transmission or transition records within 24 hours. Health homes will submit aggregated information at specified intervals. We will summarize data across health homes and share overall peer performance.

B. Goal 2: Reduce utilization associated with avoidable (preventable) emergency room visits

1. Clinical Outcomes

Measures	Data Source	Specifications	HIT Utilization
Ambulatory Care (ED Visits)	Claims	(HEDIS 2012 – Use of Services) The rate of ED visits per 1,000 member months. Data is reported by age categories.	Emergency Department visits will be identified from administrative claims. Results of aggregated rates will be shared with health homes including their results and benchmarking to the overall peer results.

2. Experience of Care

Measures	Data Source	Specifications	HIT Utilization
NA	NA	NA	NA

3. Quality of Care

Measures	Data Source	Specifications	HIT Utilization
NA	NA	NA	NA

C. Goal 3: Improve Outcomes for persons with Mental Illness and/or Substance Use Disorders

1. Clinical Outcomes

Measures	Data Source	Specifications	HIT Utilization
Mental Health Utilization	Claims	(HEDIS 2012 – Use of Services) The number and percentage of members receiving the following mental health services during the measurement year. • Any service • Inpatient • Intensive outpatient or partial hospitalization • Outpatient or ED	Mental health services will be identified by data analysis of administrative claims. Results of aggregated results will be shared with health homes including their results and benchmarking to the overall peer results.
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Claims	(HEDIS 2012 – Use of Services) This measures the percentage of adolescents and adults members with a new episode of alcohol or other drug (AOD) dependence who received the following: • Initiation - an inpatient admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of diagnosis Inpatient • Engagement - Initiation of AOD treatment and two or more inpatient admissions, outpatient visits, intensive outpatient encounters or partial hospitalizations with any AOD diagnosis within 30 days after the date of the Initiation encounter (inclusive). Multiple engagement visits may occur on the same day, but they must be with different providers in order to be counted.	New episodes of alcohol and other drug dependence and qualifying services will be identified by data analysis of administrative claims. Results of aggregated rates will be shared with health homes including their results and benchmarking to the overall peer results.
Follow Up After Hospitalization for Mental Illness	Claims	(HEDIS 2012 - Effectiveness of Care) Percentage of discharges for treatment of selected mental illness disorders who had an outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health provider within 7 days and within 30 days of discharge. In addition, 'retention' in services, defined as at least five qualifying visits (see above) with mental health providers within 90 days of discharge.	The transition of care HEDIS indicator is developed from treatment guidelines. The State's Office of Mental Health added quantification standards for retention to capture quality of ongoing care for a persistently severe mentally ill population targeted by NYS SPA for Health Home. The follow up visits will be identified from vendor data and claims. We will use data analytics to aggregate results by health home and compare to peers.
Follow up After Hospitalization	Claims	(New York State Specific) The percentage of discharges for specified alcohol and chemical	The transition of care is patterned after the HEDIS indicator for mental health. The State's Office

for Alcohol and Chemical Dependency Detoxification		dependency conditions that are followed up with visits with chemical treatment and other qualified providers within 7 days and within 30 days and who have ongoing visits within 90 days of the discharges.	of Alcohol and Substance Abuse Services added quantification standards for retention to capture quality of ongoing care for a chemically dependent population targeted By NYS SPA for Health Home. The follow up visits will be identified from vendor data and claims. We will use data analytics to aggregate results by health home and compare to peers.

2. Experience of Care

Measures	Data Source	Specifications	HIT Utilization
NA	NA	NA	NA

3. Quality of Care

Measures	Data Source	Specifications	HIT Utilization
Antidepressant Medication Management	Claims and Pharmacy	(HEDIS 2012 - Effectiveness of Care) Percentage of members who had a new diagnosis of depression and treated with an antidepressant medication who remained on the antidepressant for acute phase and recovery phase of treatment.	The medication adherence HEDIS indicators are developed from treatment guidelines. We will use data analytics with administrative claims data to calculate the results which will be shared with the health homes and will include benchmarks to peers.
Follow Up Care for Children Prescribed ADHD Medication	Claims and Pharmacy	(HEDIS 2012 - Effectiveness of Care) Percentage of children newly prescribed ADHD medication who had appropriate follow up in the initial 30 days and in the continuation and maintenance phase.	The medication adherence HEDIS indicators are developed from treatment guidelines. We will use data analytics with administrative claims data to calculate the results which will be shared with the health homes and will include benchmarks to peers.
Adherence to Antipsychotics for Individuals with Schizophrenia	Claims and Pharmacy	(RAND section 2701 ACA proposed measure) Percentage of patients with a schizophrenia diagnosis who received an antipsychotic medication that had a proportion of days covered (PDC) for antipsychotic medication greater than or equal to 0.8 during the measurement period.	This medication adherence indicator is based on the RAND measure and includes advice from the State's mental health agency to better reflect the standards of quality of care for a persistently severe mentally ill population targeted for Health Home. We will use data analytics with administrative claims data to calculate the results which will be shared with the health homes and will include benchmarks to peers.
Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder	Claims and Pharmacy	(RAND section 2701 ACA proposed measure) Percentage of patients with bipolar I disorder who received a mood stabilizer medication that had a proportion of days covered (PDC) for mood stabilizer medication greater than or equal to 0.8 during the measurement period.	This medication adherence indicator is based on the RAND measure and includes advice from the State's mental health agency to better reflect the standards of quality of care for a persistently severe mentally ill population targeted for Health Home. We will use data analytics with administrative claims data to

			calculate the results which will be shared with the health homes and will include benchmarks to peers.

D. Goal 4: Improve Disease-Related Care for Chronic Conditions

1. Clinical Outcomes

Measures	Data Source	Specifications	HIT Utilization
NA	NA	NA	NA

2. Experience of Care

Measures	Data Source	Specifications	HIT Utilization
NA	NA	NA	NA

3. Quality of Care

Measures	Data Source	Specifications	HIT Utilization
Use of Appropriate Medications for People with Asthma	Claims and Pharmacy	(HEDIS 2012 - Effectiveness of Care) Percentage of members who are identified with persistent asthma and who were appropriately prescribed preferred asthma medication.	The medication adherence HEDIS indicator is developed from treatment guidelines. We will use data analytics with administrative claims data to calculate the results which will be shared with the health homes and will include benchmarks to peers.
Medication Management for People With Asthma	Claims and Pharmacy	(HEDIS 2012 – Effectiveness of Care) The percentage of members who were identified as having persistent asthma and were dispensed appropriate medications in amounts to cover: 1) at least 50% of their treatment period and 2) at least 75% of their treatment period.	The medication adherence HEDIS indicator is developed from treatment guidelines. We will use data analytics with administrative claims data to calculate the results which will be shared with the health homes and will include benchmarks to peers.
Comprehensive Diabetes Care (HbA1c test and LDL-c test)	Claims, Pharmacy	(HEDIS 2012 - Effectiveness of Care) Percentage of members with diabetes who had at least one HbA1c test and at least one LDL-C test.	The service-related HEDIS indicators are developed from treatment guidelines. We will use data analytics with administrative claims data to calculate the results which will be shared with the health homes and will include benchmarks to peers.
Persistence of Beta-Blocker Treatment after Heart Attack	Claims and Pharmacy	(HEDIS 2012 - Effectiveness of Care) Percentage of members who were hospitalized and discharged alive with a diagnosis of AMI and who received persistent beta-blocker treatment for six months after discharge.	The medication adherence HEDIS indicators are developed from treatment guidelines. We will use data analytics with administrative claims data to calculate the results which will be shared with the health homes and will include benchmarks to peers.
Cholesterol Testing for Patients with Cardiovascular Conditions	Claims, Pharmacy	(HEDIS 2012 - Effectiveness of Care) Percentage of members who were discharged alive for AMI, CABG or PCI or who have a diagnosis of IVD and who had at	The service-related HEDIS indicators were developed from treatment guidelines. We will use data analytics with administrative claims data to calculate the results

		least one LDL-C screening.	which will be shared with the health homes and will include benchmarks to peers.
Comprehensive Care for People Living with HIV/AIDS	Claims and Pharmacy	(NYS Specific QARR 2010) Percentage of members living with HIV/AIDS who received the following services: (A) two outpatient visits with primary care with one visit in the first six months and one visit in the second six months, (B) viral load monitoring, and (C) Syphilis screening for all who 18 and older.	The service-related HEDIS indicators were developed from treatment guidelines. We will use data analytics with administrative claims data to calculate the results which will be shared with the health homes and will include benchmarks to peers.

E. Goal 5: Improve Preventive Care

1. Clinical Outcomes

Measures	Data Source	Specifications	HIT Utilization
NA	NA	NA	NA

2. Experience of Care

Measures	Data Source	Specifications	HIT Utilization
NA	NA	NA	NA

3. Quality of Care

Measures	Data Source	Specifications	HIT Utilization
Adult BMI Assessment	Medical Records (EMR)	(HEDIS 2012 – Effectiveness of Care) Percentage of members 18-74 years of age who had an outpatient visit and who had their body mass index (BMI) documented during the measurement year or the year prior to the measurement year	The preventive care HEDIS indicator was developed from preventive care guidelines. Health homes will audit a sample of EMRs or provider records each quarter to determine BMI calculation contained in the record within the measurement year or the year prior. Health homes will submit aggregated information at specified intervals. We will summarize data will be shared with the health homes and will include benchmarks to peers.
Screening for Clinical Depression and Follow-up Plan	Medical Records (EMR)	(National Quality Forum) Percentage of patients aged 18 years and older screened for clinical depression using a standardized tool AND follow-up documented.	Health homes will audit a sample of EMRs or provider records each quarter to determine screening for depression with a standardized tool and documentation of follow up if the tool results indicate positive findings. Health homes will submit aggregated information at specified intervals. We will summarize data across health homes and share overall peer performance.
Chlamydia Screening in Women	Claims and Pharmacy	(HEDIS 2012 - Effectiveness of Care) Percentage of women who were identified as sexually active and who had at least one test for Chlamydia.	The preventive care HEDIS indicator was developed from preventive care guidelines. We will use data analytics with administrative claims data to

			calculate the results which will be shared with the health homes and will include benchmarks to peers.
Colorectal Cancer Screening	Claims (administrative method only)	(HEDIS 2012 - Effectiveness of Care) Percentage of member 50 and older who had appropriate screening for colorectal cancer.	The preventive care HEDIS indicator was developed from preventive care guidelines. We will use data analytics with administrative claims data to calculate the results which will be shared with the health homes and will include benchmarks to peers.

viii. Quality Measures: Service Based Quality Measures- N/A

3.1 - A: Categorically Needy View

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Care Services: Categorically Needy

ix. Evaluations

A. Describe how the State will collect information from health home providers for purposes of determining the effect of this program on reducing the following (include the data source and frequency of data collection):

NYS plans on calculating all of these measures using existing resources, and sharing the results with each Health Home provider. Measures will be calculated minimally annually and possibly quarterly to monitor the effectiveness of each Health Home.

Evaluation				
Hospital Inpatient	Hospital Admissions	Claims and Encounters	Hospital Utilization and cost per member per month	Claims and Encounters
Emergency Room Visits	ER Visits	Claims and Encounters	ER Utilization and cost per member per month	Claims and Encounters
Skilled NH Admissions	NH Admissions	Claims and Encounters	Nursing Home Utilization and cost per member per month	Claims and Encounters

B. Describe how the State will collect information for purposes of informing the evaluations, which will ultimately determine the nature, extent and use of this program, as it pertains to the following:

New York will use a number of methods for collecting information for purposes of informing the evaluations. For evaluation data, NY will draw upon Medicaid records—enrollment, claims, encounter, pharmacy—as well as other state databases that record use of substance use disorder treatment (which include demographic and clinical characteristics as well as treatment utilization). Additionally, NY will work with CMS to develop a patient experience of care survey that draws from survey items included in CAHPS (Consumer Assessment of Healthcare Programs and Systems) and, potentially, behavioral health specific items from MHSIP (Mental Health Statistics Improvement Program). New York State has extensive experience adapting CAHPS to survey managed Medicaid and other populations. NY will also

work with academic partners to supplement these databases with data collection that informs program implementation.

New York will use quasi-experimental approaches to create comparison groups for the empirical items derived from administrative databases that are noted below (items i, ii, vi, & vii). We note that the analytical strategy will begin with descriptive examination of the Health Home population and the characteristics of individuals enrolled. The analysis will then increase in complexity to the level necessary to address questions of implementation effectiveness and impact on utilization and costs. Comparison groups will be devised using examination of historical utilization and costs of the eligible population and by statistical matching, which will use population databases to identify patients with similar demographic, geographic, and clinical characteristics as Health Home enrollees. For historical comparisons, NY will look at utilization patterns of the population of individuals who met the Health Home criteria prior to program implementation as well as utilization of Health Home clients in the year prior to enrollment. For purposes of creating statistically matched comparisons, NY will examine the feasibility of using propensity score methods by region from individuals meeting eligibility criteria but who were not recruited into the health homes due to staggered enrollment or variations in Health Home penetration within the eligible population. NY will also be able to compare across Health Home providers while adjusting for client characteristics. The statistical matching will be based on demographic characteristics, clinical complexity, and historical utilization patterns. The feasibility of other analytical strategies, such as instrumental variable, will be considered to adjust for bias associated with self-selection. NY will partner with state and academic researchers who have expertise in applying these health services research methods.

i. Hospital admission rates

NYS has been monitoring avoidable hospital readmissions for Medicaid populations since 2009 using 3M software called Potentially Preventable Readmissions (PPRs). This software has an algorithm for determining whether a readmission is plausibly connected to an initial admission. NY will calculate PPRs within 30 days of an initial inpatient discharge. For the avoidable readmission rate, we will calculate an overall rate with total counts of acute hospitalizations for the eligible chronic conditions in the denominator and a numerator with counts of PPRs. NY will calculate the rate across all conditions and also within condition (i.e., mental health condition, substance use disorder, asthma, diabetes, heart disease, HIV/AIDS, and hypertension).

As indicated above, NY will calculate historical avoidable readmission rates for comparison as well as compute rates for a statistically matched comparison group. We will also compare avoidable readmission rates across Health Home providers.

ii. Chronic disease management

Data on chronic disease management will be collected in two ways. First, we will examine how the Health Homes implement disease management across key chronic illness management functional components of our state Health Home qualification criteria. With the aid of state and academic partners, NY will work with stakeholders to assess the key functional components to include: 1) inclusion of preventive and health promotion services, 2) coordination of care between primary care, specialty providers and community supports, 3) emphasis on collaborative patient decision making and teaching of disease self-management, 4) structuring of care to ensure ongoing monitoring and follow-up care, 5) facilitation of evidence based practice, and 6) use of clinical information systems to facilitate tracking of care as well as integration between providers. NY will modify standardized assessment tools as well as use qualitative interviews with HH administrative staff and providers to determine the implementation of these functional components. Additionally, the patient Experience of Care measure will provide information on self-management support from the health home.

Second, NY will conduct cohort analyses as part of the evaluation focusing on groups at-risk to incur high costs.

iii. Coordination of care for individuals with chronic conditions

NYS will use claims, encounter, and pharmacy data to collect information on coordination of care. As indicated in the quality measures section of this SPA, NYS will use claims, encounter, and pharmacy data to collect information on post-inpatient discharge continuation of care (e.g., persistent beta-blocker treatment after hospitalization for AMI) or transition to another level of care (e.g., outpatient care following hospitalization for a behavioral health condition). This coordination of care measures will be compared to historical controls, to statistically matched comparison groups, and across Health Home providers.

In addition NY is considering the feasibility of more closely examining provider behavior through medical chart reviews, case record audits, team composition analysis, and key informant interviews. As part of this process we will carefully monitor the use of HIT as a primary modality to support coordination of care.

iv. Assessment of program implementation

Learning Collaboratives will be constituted with a group of early adopter providers of Health Homes to identify implementation challenges as well as potential solutions. Other data related to implementation including responses to the Health Home experiences of care survey and, if feasible, provider audits and surveys, and stakeholder interviews will be collected. All implementation data will be shared with the Health Home Advisory Group (comprised of state, provider, community, and academic members) and a compilation of lessons learned.

v. Processes and lessons learned

Learning Collaboratives will be constituted with a group of early adopter providers of Health Homes to identify implementation challenges as well as potential solutions. NYS will use the Health Home Advisory Group to monitor, comment, and make recommendations on implementation strategies that are working as well as those that are not. The group will use the Health Home functional components (see section iii. Provider Infrastructure) as well as the provider qualification criteria (see section v. Provider Standards) as guides in assessing program processes and outcome success. The Advisory Group will use information gathered through assessments of program implementation as well as from ongoing quality monitoring using administrative data to review program successes and failures.

vi. Assessment of quality improvements and clinical outcomes

As detailed in the quality measures section, NYS has identified an extensive list of quality and outcome measures that will be derived from administrative claims and encounter data. The quality measures are indicators of chronic illness management while the clinical outcome measures are indicators of poor disease management leading to high-cost treatment episodes. Ongoing assessments of these quality measures will be conducted at the levels of Health Home providers, region, and state-wide.

The endpoint evaluation will be designed as a quasi-experimental longitudinal study where endpoint outcomes will be patient-level indicators of poorly managed care of chronic conditions; indicators of stable engagement in guideline concordant care; and high-cost utilization of services. There are a number of clear indicators of poorly managed care across disorders: emergency department (ED) visits, hospital re-admissions, poor transition from inpatient to outpatient care, etc. In addition, we will attempt to define, where possible, more refined measures that are disease specific (e.g., repeated detox in substance abuse).

vii. Estimates of cost savings

NYS will work with state and academic partners to devise a sophisticated econometric analysis of the overall Health Home initiative as well as of each vendor. First, NYS will monitor costs

savings through by tracking high-cost forms of utilization (e.g., preventable hospitalizations, ED use, detoxification). Utilization of high cost events will be compared with historical rates as well as with statistically matched comparison groups as indicated above. Additionally, NYS will compare total costs of care for Health Home enrollees—including all services costs, health home costs and managed capitation—to statistically matched comparisons.

The econometric analyses will begin with descriptive statistics and increase in complexity to the minimal level necessary to address the question of cost savings. Analyses will focus on per member per month (PMPM) expenditures of enrollees compared to controls as described in this section's preamble. For regression analyses that examine changes in cost relative to controls, we employ longitudinal nested designs that account for serial correlation within person and within provider and region. Regression analyses will account for prior year costs by type of utilization (e.g., ED, inpatient, mental health), clinical complexity (e.g., PPR risk score), regional utilization characteristics, and demographic factors. Parameter estimates for Health Home participants will indicate differences in PMPM relative to controls while controlling for historical utilization patterns, regional practice variation, and individual demographic characteristics.

4.19 – B: Payment Methodology View
Attachment 4.19-B

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Care Services: Categorically Needy

Payment Methodology

Payment Type: Per Member Per Month

Provider Type
Description

☐ **Tiered? N/A**

Provider Type

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

Description

Care Management Fee:

Health Homes meeting State and federal standards will be paid a per member per month care management fee that is adjusted based on 1) region, 2) enrollment volume, 3) case mix (from 3M™ Clinical Risk Groups (CRG) method) and this fee will eventually be adjusted by (after the data is available) patient functional status. This risk-adjusted payment will allow providers to receive a diverse population of patients and assign patients to various levels of care management intensity without having to meet preset standards for contact counts. Providers will be able to respond to and adjust the intensity and frequency of intervention based on patient's current condition and needs (from tracking to high touch).

This care management fee will be paid in two increments based on whether a patient is in 1) the case finding group or 2) the active care management group. The case finding group will receive a PMPM that is a reduced percentage (perhaps 80 percent) of the active care management PMPM. The case finding PMPM is only available for the first few months (e.g.3-6) after a patient has been assigned to a given health home and this PMPM is intended to cover

the cost of outreach and engagement. Once a patient has been assigned a care manager and is enrolled in the health home program the active care management PMPM may be billed.

The active care management PMPM will be paid in two installments. The first installment maybe billed up front and the second installment will automatically be paid once the health home provider meets certain pre-set state quality metrics. In the first year, some percentage (perhaps 90 percent) of the PMPM will be paid up front and the remaining percentage (perhaps 10%) will be reserved against meeting the quality benchmarks.

Shared Savings:

If the State achieves overall savings from the implementation of this program, Health home providers will be eligible to participate in a shared savings pool. The pool will be developed at the end of the first year of health home operation and will consist of a percentage (perhaps 15 percent) of the documented State share savings derived from health home operation. The State will use a method to adjust savings for regression to the mean before setting up the pool. If the federal portion of savings becomes eligible for shared savings with providers then a portion of those savings will be included in the pool based on any federal conditions that may be applied to such savings. Under Federal rules, some shared savings incentive payments cannot exceed 105% of the aggregate payment for Medicaid services received.

Managed Care Considerations:

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

Targeted Case Management (TCM) and Chronic Illness Demonstration Projects (CIDPs) Conversion Considerations:

The State envisions that eventually all targeted case management programs operating in New York will convert to or become part of health homes. However, given that some of these providers will require time to meet State and Federal health home standards this conversion will take place over the next two years. The State will allow TCM providers that can meet health home standards to convert to health homes or join with larger health homes. The payment method will be designed to transition all existing TCM capacity from the current rates to the new Health Home payment structure. TCM programs will be paid their existing TCM rates for a period of one (1) year from the effective date of the SPA if they convert to or become part of a health home. Beginning with second year after the effective date of the SPA, these converted TCM programs or health homes affiliated with TCM programs will be paid for all patients under a blended methodology that will include a component of the TCM payment and the component of the new Health Home payment. In the third year we expect all payments will be made under the health home payment detailed above in the care management fee section.

Identical to fee for service, Health Plans will be required to pay TCM programs operating as health homes or health homes affiliated with TCM programs the State set TCM rate for current and new TCM assignees up to the TCM's historical capacity.

The State anticipates that most of the six CIDPs will convert to health homes. The CIDP providers are well positioned to become health homes and meet State and Federal health home standards. The CIDPs that convert to health homes will be paid at their existing CIDP rate for a period of one (1) year from the effective date of the SPA if they convert to health home for their existing patients. For new patients that may be assigned to a CIDP program that has converted to health home the State will pay the State set health home PMPM. At the beginning of the second year after the effective date of the SPA these converted programs will be paid for all patients under the State set health home PMPM. CIDPs that do not convert to health homes, if any, will end operations as CIDPs on March 29, 2012 when the contract with the State terminates.

New York States' health home services are set as of January 1, 2012 and are effective for services on or after that date. All rates will be published on the DOH website. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

Appendix II
2011 Title XIX State Plan
Second Quarter Amendment
Non-Institutional Services
Summary

SUMMARY
NYS SPA 11-56
Implement Health Home for High-Cost, High-Need Enrollees

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

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

The health home federal legislation will bring New York needed revenue to fund care coordination for Medicaid beneficiaries with chronic conditions. Health home services include comprehensive care management; health promotion; transitional care; including appropriate follow-up from inpatient to other settings; patient and family support; referral to community and social support services; and, use of health information technology to link services. T he health home legislation also provides New York's Medicaid program with new flexibility to make necessary program changes using Medicaid's existing health provider network that should reduce Medicaid costs while improving the care of Medicaid enrollees with chronic disease.

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

Health homes will be phased in statewide. Phase One will include the counties of: Bronx, Brooklyn, Nassau, Monroe, Warren, Washington, Essex, Hamilton, Saratoga, Clinton, Franklin, St. Lawrence, Schenectady.

Appendix III
2011 Title XIX State Plan
Second Quarter Amendment
Non-Institutional Services
Authorizing Provisions

SPA 11-56

S.2809-B/A-4009.B - Part H

§ 37. The social services law is amended by adding a new section 365-l to read as follows:

§ 365-l. Health homes. 1. Notwithstanding any law, rule or regulation to the contrary, the commissioner of health is authorized, in consultation with the commissioners of the office of mental health, office of alcoholism and substance abuse services, and office for people with developmental disabilities, to (a) establish, in accordance with applicable federal law and regulations, standards for the provision of health home services to Medicaid enrollees with chronic conditions, (b) establish payment methodologies for health home services based on factors including but not limited to the complexity of the conditions providers will be managing, the anticipated amount of patient contact needed to manage such conditions, and the health care cost savings realized by provision of health home services, (c) establish the criteria under which a Medicaid enrollee will be designated as being an eligible individual with chronic conditions for purposes of this program, (d) assign any Medicaid enrollee designated as an eligible individual with chronic conditions to a provider of health home services.

2. In addition to payments made for health home services pursuant to subdivision one of this section, the commissioner is authorized to pay additional amounts to providers of health home services that meet process or outcome standards specified by the commissioner.

3. Until such time as the commissioner obtains necessary waivers of the federal social security act, Medicaid enrollees assigned to providers of health home services will be allowed to opt out of such services.

4. Payments authorized pursuant to this section will be made with state funds only, to the extent that such funds are appropriated therefore, until such time as federal financial participation in the costs of such services is available.

5. The commissioner is authorized to submit amendments to the state plan for medical assistance and/or submit one or more applications for waivers of the federal social security act, to obtain federal financial participation in the costs of health home services provided pursuant to this section, and as provided in subdivision three of this section.

6. Notwithstanding any limitations imposed by section three hundred sixty-four-l of this title on entities participating in demonstration projects established pursuant to such section, the commissioner is authorized to allow such entities which meet the requirements of this section to provide health home services.

7. Notwithstanding any law, rule, or regulation to the contrary, the commissioners of the department of health, the office of mental health, the office for people with developmental disabilities, and the office of alcoholism and substance abuse services are authorized to jointly establish a single set of operating and reporting requirements and a single set of construction and survey requirements for entities that:

(a) can demonstrate experience in the delivery of health, and mental health and/or alcohol and substance abuse services and/or services to persons with developmental disabilities, and the capacity to offer integrated delivery of such services in each location approved by the commissioner; and

(b) meet the standards established pursuant to subdivision one of this section for providing and receiving payment for health home services; provided, however, that an entity meeting the standards established

pursuant to subdivision one of this section shall not be required to be an integrated service provider pursuant to this subdivision.

In establishing a single set of operating and reporting requirements and a single set of construction and survey requirements for entities described in this subdivision, the commissioners of the department of health, the office of mental health, the office for people with developmental disabilities, and the office of alcoholism and substance abuse services are authorized to waive any regulatory requirements as are necessary to avoid duplication of requirements and to allow the integrated delivery of services in a rational and efficient manner.

8. (a) The commissioner of health is authorized to contract with one or more entities to assist the state in implementing the provisions of this section. Such entity or entities shall be the same entity or entities chosen to assist in the implementation of the multipayor patient centered medical home program pursuant to section twenty-nine hundred fifty-nine-a of the public health law. Responsibilities of the contractor shall include but not be limited to: developing recommendations with respect to program policy, reimbursement, system requirements, reporting requirements, evaluation protocols, and provider and patient enrollment; providing technical assistance to potential medical home and health home providers; data collection; data sharing; program evaluation, and preparation of reports.

(b) Notwithstanding any inconsistent provision of sections one hundred twelve and one hundred sixty-three of the state finance law, or section one hundred forty-two of the economic development law, or any other law, the commissioner of health is authorized to enter into a contract or contracts under paragraph (a) of this subdivision without a competitive bid or request for proposal process, provided, however, that:

(i) The department of health shall post on its website, for a period of no less than thirty days:

(1) A description of the proposed services to be provided pursuant to the contract or contracts;

(2) The criteria for selection of a contractor or contractors;

(3) The period of time during which a prospective contractor may seek selection, which shall be no less than thirty days after such information is first posted on the website; and

(4) The manner by which a prospective contractor may seek such selection, which may include submission by electronic means;

(ii) All reasonable and responsive submissions that are received from prospective contractors in timely fashion shall be reviewed by the commissioner of health; and

(iii) The commissioner of health shall select such contractor or contractors that, in his or her discretion, are best suited to serve the purposes of this section.

Appendix IV
2011 Title XIX State Plan
Second Quarter Amendment
Non-Institutional Services
Public Notice

MISCELLANEOUS NOTICES/HEARINGS

Notice of Abandoned Property Received by the State Comptroller

Pursuant to provisions of the Abandoned Property Law and related laws, the Office of the State Comptroller receives unclaimed monies and other property deemed abandoned. A list of the names and last known addresses of the entitled owners of this abandoned property is maintained by the office in accordance with Section 1401 of the Abandoned Property Law. Interested parties may inquire if they appear on the Abandoned Property Listing by contacting the Office of Unclaimed Funds, Monday through Friday from 8:00 a.m. to 4:30 p.m., at:

1-800-221-9311
or visit our web site at:
www.osc.state.ny.us

Claims for abandoned property must be filed with the New York State Comptroller's Office of Unclaimed Funds as provided in Section 1406 of the Abandoned Property Law. For further information contact: Office of the State Comptroller, Office of Unclaimed Funds, 110 State St., Albany, NY 12236.

PUBLIC NOTICE
Department of Civil Service

PURSUANT to the Open Meetings Law, the New York State Civil Service Commission hereby gives public notice of the following:

Please take notice that the regular monthly meeting of the State Civil Service Commission for April 2011 will be conducted on April 14 commencing at 10:00 a.m. This meeting will be conducted at New York Network, Suite 146, South Concourse, Empire State Plaza, Albany, NY. Directions and parking information available at (www.nyn.suny.edu).

For further information, contact: Office of Commission Operations, Department of Civil Service, Alfred E. Smith State Office Bldg., Albany, NY 12239, (518) 473-6598

PUBLIC NOTICE
Department of Health

Pursuant to 42 CFR Section 447.205, the Department of Health hereby gives public notice of the following:

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for inpatient, long term care, and non-institutional services to comply with recently proposed statutory provisions. The following significant changes are proposed:

All Services

• Effective on and after April 1, 2011, no annual trend factor will be applied pursuant to the provisions of Public Health Law § 2807-c(10)(c) to rates of payment for hospital inpatient, residential health care facilities, certified home health agencies, personal care services, and adult day health care services provided to patients diagnosed with AIDS. This includes the elimination of the 2011 trend factor effective for rates of payment April 1, 2011, and thereafter. In addition, the Department is authorized to promulgate regulations, to be effective April 1, 2011, such that no annual trend factor may be applied to rates of payment by the Department of Health for assisted living program services, adult day health care services or personal care services provided in those local social services districts, including New York City, whose rates of payment for services is established by such social services districts pursuant to a rate-setting exemption granted by the Department. This includes the elimination of the 2011 trend factor effective for rates of payment April 1, 2011, and thereafter.

- Effective for dates of service April 1, 2011, through March 31, 2012, and each state fiscal year thereafter, all non-exempt Medicaid payments as referenced below will be uniformly reduced by two percent. Such reductions will be applied only if an alternative method that achieves at least $345 million in Medicaid state share savings annually is not implemented.

- Medicaid administration costs paid to local governments, contractors and other such entities will also be reduced in the same manner as described above.

- Payments exempt from the uniform reduction based on federal law prohibitions include, but are not limited to, the following:

• Federally Qualified Health Center services;

• Indian Health Services and services provided to Native Americans;

• Supplemental Medical Insurance - Part A and Part B;

• State Contribution for Prescription Drug Benefit (aka Medicare Part D payments);

• Any local share cap payment required by the Federal Medical Assistance Percentage (FMAP) increase legislation;

• Required payments related to the School Supportive Health Services Program and Preschool Supportive Health Services Program settlement agreement;

• Services provided to American citizen repatriates; and

• Hospice Services.

- Payments exempt from the uniform reduction based on being funded exclusively with federal and/or local funds include, but are not limited to, the following:

• Upper payment limit payments to non-state owned or operated governmental providers certified under Article 28 of the NYS Public Health Law;

• Certified public expenditure payments to the NYC Health and Hospital Corporation;

• Certain disproportionate share payments to non-state operated or owned governmental hospitals;

• Certain managed care payments pursuant to section 3-d of Part B of the Chapter 58 of the Laws of 2010; and

• Services provided to inmates of local correctional facilities.

- Payments pursuant to the mental hygiene law will be exempt from the reduction;

- Court orders and judgments; and

- Payments where applying the reduction would result in a lower FMAP as determined by the Commissioner of Health and the Director of the Budget will be exempt.

• Medicaid expenditures will be held to a year to year rate of growth spending cap which does not exceed the rolling average of the preceding 10 years of the medical component of the Consumer Price Index (CPI) as published by the United States Department of Labor, Bureau of Labor Statistics.

- The Director of the Budget and the Commissioner of Health will periodically assess known and projected Medicaid expenditures to determine whether the Medicaid growth spending cap appears to be pierced. The cap may be adjusted to account for any revision in State Financial Plan projections due to a change in the FMAP amount, provider based revenues, and beginning April 1, 2012, the operational costs of the medical indemnity fund. In the event it is determined that Medicaid expenditures exceed the Medicaid spending cap, after any adjustment to the cap if needed, the Director of the Division of the Budget and the Commissioner of Health will develop a Medicaid savings allocation plan to limit the Medicaid expenditures by the amount of the projected overspending. The savings allocation plan will be in compliance with the following guidelines:

• The plan must be in compliance with the federal law;

• It must comply with the State's current Medicaid plan, amendment, or new plan that may be submitted;

• Reductions must be made uniformly among category of service, to the extent practicable, except where it is determined by the Commissioner of Health that there are grounds for non-uniformity; and

• The exceptions to uniformity include but are not limited to: sustaining safety net services in underserved communities, to ensuring that the quality and access to care is maintained, and to avoiding administrative burden to Medicaid applicants and recipients or providers.

Medicaid expenditures will be reduced through the Medicaid savings allocation plan by the amount of projected overspending through actions including, but not limited to: modifying or suspending reimbursement methods such as fees, premium levels, and rates of payment; modifying or discontinuing Medicaid program benefits; seeking new waivers or waiver amendments.

Institutional Services

• For the state fiscal year beginning April 1, 2011 through March 31, 2012, continues specialty hospital adjustments for hospital inpatient services provided on and after April 1, 2011, to public general hospitals, other than those operated by the State of New York or the State University of New York, located in a city with a population of over one million and receiving reimbursement of up to $1.08 billion annually. Payments to eligible public general hospitals may be added to rates of payment or made as aggregate payments.

• Effective for periods on and after January 1, 2011, for purposes of calculating maximum disproportionate share (DSH) payment distributions for a rate year or part thereof, costs incurred of furnishing hospital services net of medical assistance payments, other than DSH payments, and payments by uninsured patients shall for the 2011 calendar year, be determined initially based on each hospital's submission of a fully completed 2008 DSH hospital data collection tool, which is required to be submitted to the Department, and shall be subsequently revised to reflect each hospital's submission of a fully completed 2009 DSH hospital data collection tool, which is required to be submitted to the Department.

- For calendar years on and after 2012, such initial determinations shall reflect submission of data as required by the Commissioner on a specific date. All such initial determinations shall subsequently be revised to reflect actual rate period data and statistics. Indigent care payments will be withheld in instances when a hospital has not submitted required information by the due dates, provided, however, that such payments shall be made upon submission of such required data.

- For purposes of eligibility to receive DSH payments for a rate year or part thereof, the hospital inpatient utilization rate shall be determined based on the base year statistics and costs incurred of furnishing hospital services determined in accordance with the established methodology that is consistent with all federal requirements.

• Extends through December 31, 2014, the authorization to distribute Indigent Care and High Need Indigent Care disproportionate share payments in accordance with the previously approved methodology.

• For state fiscal years beginning April 1, 2011, and for each state fiscal year thereafter, additional medical assistance payments for inpatient hospital services may be made to public general hospitals operated by the State of New York or the State University of New York, or by a county which shall not include a city with a population over one million, and those public general hospitals located in the counties of Westchester, Erie, or Nassau, up to one hundred percent (100%) of each such public hospital's medical assistance and uninsured patient losses after all other medical assistance, including disproportionate share payments to such general hospitals. Payments may be added to rates of payment or made as aggregate payments. Payments will be based initially on reported reconciled data from the base year two years prior to the payment year adjusted for authorized Medicaid rate changes and further reconciled to actual reported data from such payment year.

• Public general hospitals, other than those operated by the State of New York or the State University of New York, that are located in a city with a population of over one million may receive additional medical assistance DSH payments for inpatient hospital services for the state fiscal year beginning April 1, 2011 through March 31, 2012, and annually thereafter, in the amount of up to $120 million, as further increased by up to the maximum payment amounts permitted under sections 1923(f) and (g) of the federal Social Security Act, as determined by the Commissioner of Health after application of all other disproportionate share hospital payments. Payments may be added to rates of payment or made as aggregate payments. Payments will be based initially on reported reconciled data from the base year two years prior to the payment year adjusted for authorized Medicaid rate changes and further reconciled to actual reported data from such payment year.

• Extends current provisions to services on and after April 1, 2011, the reimbursable operating cost component for general hospital inpatient rates will be established with the 2006 final trend factor equal to the final Consumer Price Index (CPI) for all urban consumers less 0.25%.

• The State proposes to extend, effective April 1, 2011, and thereafter, certain cost containment initiatives that were enacted in Chapter 81 of the Laws of 1995 and extended by subsequent legislation. The extended provisions are as follows: (1) hospital capital costs shall exclude 44% of major moveable equipment costs; (2) elimination of reimbursement of staff housing operating and capital costs; and (3) budgeted capital inpatient costs of a general hospital applicable to the rate year shall be decreased to reflect the percentage amount by which the budgeted costs for capital related inpatient costs of the hospital for the base year two years prior to the rate year exceeded actual costs.

• Per federal requirements, the Commissioner of Health shall promulgate regulations effective July 1, 2011 that will deny Medicaid payment for costs incurred for hospital acquired conditions (HACs). The regulations promulgated by the Commissioner shall incorporate the listing of Medicaid HACs in the yet to be issued final federal rule.

• The Commissioner of Health shall promulgate regulations to incorporate quality related measures pertaining to potentially preventable conditions and complications, including, but not limited to, diseases or complications of care acquired in the hospital and injuries sustained in the hospital.

• Effective April 1, 2011, hospital inpatient rates of payment for cesarean deliveries will be limited to the average Medicaid payment for vaginal deliveries. All cesarean claims will be subject to an appeal process to determine if the services were medically necessary thus warranting the higher Medicaid payment.

• Effective April 1, 2011, the Department is proposing to expand the current Patient Centered Medical Home (PCMH) to more payers and incorporate several provisions to improve medical care. Two provisions result in a change in the methods by which Medicaid fee-for-service (FFS) reimburses Medicaid providers who are designated by the National Committee for Quality Assurance as patient centered medical homes: 1) testing new models of payment to high-volume Medicaid primary care medical home practices which incorporate risk-adjusted global payments with care management and pay-for-performance, and 2) improving the relationship of FFS Medicaid members to medical homes by creating medical home payments only for FFS members who have evidence of ongoing continuity relationship with provider/practice and providing more reliable care manage-

ment payments to those providers which are independent of specific visit types. These provisions require the following changes to Medicaid:

- New models of reimbursement to high-volume Medicaid providers will be tested which may incorporate risk-adjusted global payments and pay-for-performance. Risk-adjusted payment models will differentially reimburse providers based on their historical case mix. Pay-for-performance will provide enhanced reimbursement to providers who provide high-quality care (such as improved preventative screenings) and/or reduce unnecessary utilization (such as a reduction in admissions for ambulatory sensitive conditions) as defined by standardized measures of performance; and

- Eligible Medicaid fee-for-service recipients, who are currently receiving care from a certified PCMH provider, as determined by an attribution methodology developed by the Commissioner of Health, will be assigned to this PCMH provider. Medicaid FFS will reimburse PCMH providers a per member per month (PMPM) capitation payment for FFS recipients attributed to their practices to provide the necessary care coordination and disease management services.

• Effective April 1, 2011, for inpatient hospital services the commissioner may grant approval of temporary adjustments to Medicaid rates to provide assistance to accommodate additional patient services requirements resulting from the closure, merger or reconfiguration of other hospitals in the area. Such rate increases would enable the surviving hospital to cover costs, including but not limited to additional staff, service reconfiguration, transfer of medical residents to other programs, increased patient volume, and enhancing information technology (IT) systems.

• The institutional cost report shall no longer be required to be certified by an independent licensed public accountant effective with cost reports filed with the Department of Health for cost reporting years ending on or after December 31, 2010. Effective for the same time periods, the Department will have authority to audit such cost reports.

Long Term Care Services

• Effective for periods on and after July 1, 2011, Medicaid rates of payments for inpatient services provided by residential health care facilities (RHCF), which as of April 1, 2011, operate discrete units for treatment of residents with Huntington's disease, and shall be increased by a rate add-on. The aggregate amount of such rate add-ons for the periods July 1, 2011 through December 31, 2011 shall be $850,000 and for calendar year 2012 and each year thereafter, shall be $1.7 million. Such amounts shall be allocated to each eligible RHCF proportionally, based on the number of beds in each facility's discrete unit for treatment of Huntington's disease relative to the total number of such beds in all such units. Such rate add-ons shall be computed utilizing reported Medicaid days from certified cost reports as submitted to the Department for the calendar year period two years prior to the applicable rate year and, further, such rate add-ons shall not be subject to subsequent adjustment or reconciliation.

• For state fiscal years beginning April 1, 2011, and thereafter, continues additional payments to non-state government operated public residential health care facilities, including public residential health care facilities located in Nassau, Westchester, and Erie counties, but excluding public residential health care facilities operated by a town or city within a county, in aggregate amounts of up to $300 million. The amount allocated to each eligible public RHCF will be in accordance with the previously approved methodology. Payments to eligible RHCF's may be added to rates of payment or made as aggregate payments.

• Continues, effective for periods on or after April 1, 2011, the total reimbursable state assessment on each residential health care facility's gross receipts received from all patient care services and other operating income on a cash basis for inpatient or health-related services, including adult day service, but excluding gross receipts attributable to payments received pursuant to Title XVIII of the federal Social Security Act (Medicare), at six percent. The extent to which a facility is reimbursed for the additional cost of the assessment is dependent upon Medicaid volume of services.

• Continues, effective April 1, 2011, and thereafter, the provision that rates of payment for RHCFs shall not reflect trend factor projections or adjustments for the period April 1, 1996 through March 31, 1997.

• Extends current provisions to services on and after April 1, 2011, the reimbursable operating cost component for RHCFs rates will be established with the final 2006 trend factor equal to the final Consumer Price Index (CPI) for all urban consumers less 0.25%.

• Continues, effective April 1, 2011, and thereafter, long-term care Medicare maximization initiatives.

• Effective April 1, 2011, for inpatient services provided by residential health care facilities (RHCFs), the commissioner may grant approval of temporary adjustments to Medicaid rates to provide assistance to accommodate additional patient services requirements resulting from the closure, merger or reconfiguration of other providers in the area. Such rate increases would enable the surviving RHCF to cover costs, including but not limited to additional staff, service reconfiguration, transfer of medical residents to other programs, increased patient volume, and enhancing information technology (IT) systems.

• The regional pricing methodology previously approved to be effective July 1, 2011 for inpatient services provided by residential health care facilities is repealed and replaced with a Statewide pricing methodology to be effective July 1, 2011.

- The Statewide pricing methodology for the non-capital component of the rates of payment for inpatient services provided by residential health care facilities shall utilize allowable operating costs for a base year, as determined by the Commissioner of Health by regulation, and shall reflect:

• A direct statewide price component adjusted by a wage equalization factor and subject to a Medicaid-only case mix adjustment.

• An indirect statewide price component adjusted by a wage equalization factor; and

• A facility specific non-comparable component.

- The non-capital component of the rates for AIDS facilities or discrete AIDS units within facilities; discrete units for residents receiving care in a long-term inpatient rehabilitation program for traumatic brain injured persons; discrete units providing specialized programs for residents requiring behavioral interventions; discrete units for long-term ventilator dependent residents; and facilities or discrete units within facilities that provide extensive nursing, medical, psychological and counseling support services solely to children shall be established pursuant to regulations.

The Commissioner of Health may promulgate regulations to implement the provisions of the methodology and such regulations may also include, but not be limited to, provisions for rate adjustments or payment enhancements to facilitate the transition of facilities to the rate-setting methodology and for facilitating quality improvements in residential health care facilities.

• Effective April 1, 2011, the capital cost component of Medicaid rates of payment for services provided by residential health care facilities shall not include any payment factor for return on or return of equity or for residual reimbursement.

• Effective January 1, 2012, payments for reserved bed days for temporary hospitalizations, for Medicaid eligible residents aged 21 and older, shall only be made to a residential health care facility if at least fifty percent of the facility's residents eligible to participate in a Medicare managed care plan are enrolled in such a plan. Payments for these reserved bed days will be consistent with current methodology.

Non-Institutional Services

• For State fiscal years beginning April 1, 2011 through March 31, 2012, continues hospital outpatient payment adjustments that increase the operating cost components of rates of payment for hospital outpatient and emergency departments for public general hospitals other than those operated by the State of new York or the State University of New York, which are located in a city with a population of over one million. The eligibility criteria remain unchanged. The amount to be paid will be up to $287 million annually. Payments to eligible public general hospitals may be added to rates of payment or made as aggregate payments.

• Effective April 1, 2011, the Office of Mental Health, the Office of

Alcoholism and Substance Abuse Services, and the Office for People with Developmental Disabilities will each establish utilization standards or thresholds for their voluntary-operated clinics. These standards or thresholds will target excessive utilization and will be either patient-specific or provider-specific, at the option of the controlling State agency. The standards or thresholds will be established based on normative provider visit volume for the clinic type, as determined by the controlling State agency. The Commissioner of Health may promulgate regulations, including emergency regulations, to implement these standards.

• Effective April 1, 2011, claims submitted by clinics licensed under Article 28 of New York State Public Health Law will receive an enhanced Medicaid payment for federally designated family planning services.

• Effective for the period April 1, 2011 through March 31, 2012 and each state fiscal year thereafter, the Department of Health is authorized to make supplemental payments for services provided by physicians, nurse practitioners and physician assistants who participate in a plan for the management of clinical practice at the State University of New York. Fees for these professional services shall be increased by an amount equal to the average commercial or Medicare rate that would otherwise be received for such services rendered by physicians, nurse practitioners and physician assistants. Such included payments may be added to such professional fees or made as aggregate lump sum payments made to eligible clinical practice plans.

• Effective for the period April 1, 2011 through March 31, 2012 and each state fiscal year thereafter, the Department of Health is authorized to make supplemental payments for services provided by physicians, nurse practitioners and physician assistants who are employed by non-state operated public general hospitals operated by a public benefit corporation located in a city of more than one million persons or at a facility of such public benefit corporation as a member of a practice plan under contract to provide services to patients of such a public benefit corporation. Fees for these professional services shall be increased by an amount equal to the average commercial or Medicare rate that would otherwise be received for such services rendered by physicians, nurse practitioners and physician assistants, provided, however, that such supplemental fee payments shall not be available with regard to services provided at facilities participating in the Medicare Teaching Election Amendment. Such included payments may be added to such professional fees or made as aggregate lump sum payments.

• Effective April 1, 2011, hospitals that voluntarily reduce excess staffed bed capacity in favor of expanding the State's outpatient, clinic, and ambulatory surgery services capacity may request and receive a temporary rate enhancement under the ambulatory patient groups (APG) methodology.

• Extends current provisions to services on and after April 1, 2011, the reimbursable operating cost component for general hospital outpatient rates and adult day health care services provided by RHCFs rates will be established with the final 2006 trend factor equal to the final consumer price index (CPI) for all urban consumers less 0.25%.

• Continues, effective April 1, 2011, and thereafter, certain cost containment initiatives currently in effect for Medicaid rates of payments. These are as follows: diagnostic and treatment center and certified home health agency administrative and general cost reimbursement limits; home health care Medicare maximization initiatives; hospital outpatient and emergency department reimbursement reductions attributable to exclusion of 44% of major moveable equipment capital costs; and elimination of staff housing costs.

• The current authority to adjust Medicaid rates of payment for personal care services, provided in local social services districts which include a city with a population of over one million persons and distributed in accordance with memorandums of understanding entered into between the State and such local districts for purpose of supporting recruitment and retention of personal care service workers has been extended for the period April 1, 2011 through March 31, 2014. Payments for the periods April 1, 2011 through March 31, 2012; April 1, 2012 through March 31, 2013; and April 1, 2013 through March 31, 2014, shall not exceed, in the aggregate, $340 million for each applicable period.

• The current authority to adjust Medicaid rates of payment for personal care services, provided in local social services districts which shall not include a city with a population of over one million persons, for purpose of supporting recruitment and retention of personal care service workers has been extended for the period April 1, 2011 through March 31, 2014. Payments for the period April 1, 2011 through March 31, 2012; April 1, 2012 through March 31, 2013; and April 1, 2013 through March 31, 2014, shall not exceed, in the aggregate, $28.5 million for each applicable period.

• The current authority to adjust Medicaid rates of payment for certified home health agencies, AIDS home care programs, and hospice programs for purposes of supporting recruitment and retention of non-supervisory health care workers or any worker with direct patient care responsibility has been extended for the period April 1, 2011 through March 31, 2014. Payments shall not exceed in the aggregate, $100 million for each of the following periods: April 1, 2011 through March 31, 2012; April 1, 2012 through March 31, 2013; and April 1, 2013 through March 31, 2014, and shall be calculated in accordance with the previously approved methodology. Such adjustments to rates of payment shall be allocated proportionally based on each certified home health agency's, AIDS home care and hospice programs' home health aide or other direct care services total annual hours of service provided to Medicaid patients, as reported in each such agency's most recently available cost report as submitted to the Department. Payments made shall not be subject to subsequent adjustment or reconciliation.

• Effective April 1, 2011, for the period April 1, 2011 through June 30, 2011, medical assistance rates of payment to residential health care facilities and diagnostic treatment centers licensed under Article 28 of the Public Health Law for adult day health care services provided to registrants with acquired immunodeficiency syndrome (AIDS) or other human immunodeficiency virus (HIV) related illnesses, shall be increased by an aggregated amount of $1,867,000. Such amount shall be allocated proportionally among such providers based on the medical assistance visits reported by each provider in the most recently available cost reports, submitted to the Department by January 1, 2011. Such adjustments shall be included as adjustments to each provider's daily rate of payment for such services and shall not be subject to subsequent adjustment or reconciliation.

- Effective April 1, 2011, for the period April 1, 2011 through June 30, 2011, rates of payment to residential health care facilities and diagnostic treatment centers licensed under Article 28 of the Public Health Law for adult day health care services provided to registrants with acquired immunodeficiency syndrome (AIDS) or other human immunodeficiency virus (HIV) related illnesses, shall reflect an adjustment to such rates of payment in an aggregate amount of $236,000. Such adjustments shall be distributed proportionally as rate add-ons, based on each eligible provider's Medicaid visits as reported in such provider's most recently available cost report as submitted to the Department prior to January 1, 2011, and provided further, such adjustments shall not be subject to subsequent adjustment or reconciliation.

• Effective April 1, 2011 through March 31, 2012, Medicaid rates of payment for services provided by certified home health agencies (except for such services provided to children under eighteen years of age and other discrete groups as may be determined by the Commissioner of Health) shall reflect agency ceiling limitations. In the alternative, and at the discretion of the Commissioner, such ceilings may be applied to payments for such services.

- The agency ceilings shall be applied to payments or rates of payment for certified home health agency services as established by applicable regulations and shall be based on a blend of:

• an agency's 2009 average per patient Medicaid claims, weighted at a percentage as determined by the Commissioner; and

• the 2009 statewide average per patient Medicaid claims adjusted by a regional wage index factor and an agency patient case mix index, weighted at a percentage as determined by the Commissioner.

- An interim payment or rate of payment adjustment effective April 1, 2011 shall be applied to agencies with projected average per patient Medicaid claims, as determined by the Commissioner, to be over their

ceilings. Such agencies shall have their payments or rates of payment reduced to reflect the amount by which such claims exceed their ceilings.

- The ceiling limitations shall be subject to retroactive reconciliation and shall be based on a blend of:

• agency's 2009 average per patient Medicaid claims adjusted by the percentage of increase or decrease in such agency's patient case mix from the 2009 calendar year to the annual period April 1, 2011 through March 31, 2012, weighted at a percentage as determined by the Commissioner, and

• the 2009 statewide average per patient Medicaid claims adjusted by a regional wage index factor and the agency's patient case mix index for the annual period April 1, 2011 through March 31, 2012, weighted at a percentage as determined by the Commissioner.

- Such adjusted agency ceiling shall be compared to actual Medicaid paid claims for the period April 1, 2011 through March 31, 2012. In those instances when:

• An agency's actual per patient Medicaid claims are determined to exceed the agency's adjusted ceiling, the amount of such excess shall be due from each such agency to the State and may be recouped by the Department in a lump sum amount or through reductions in the Medicaid payments due to the agency.

• An interim payment or rate of payment adjustment was applied to an agency as described above, and such agency's actual per patient Medicaid claims are determined to be less than the agency's adjusted ceiling, the amount by which such Medicaid claims are less than the agency's adjusted ceiling shall be remitted to each such agency by the Department in a lump sum amount or through an increase in the Medicaid payments due to the agency.

- In determining case mix, each patient shall be classified using a system based on measures which may include, but not be limited to, clinical and functional measures, as reported on the federal Outcome and Assessment Information Set (OASIS), as may be amended.

- The Commissioner may require agencies to collect and submit any data, and may promulgate regulations to implement the agency ceilings.

- The payments or rate of payment adjustments described above shall not, as determined by the Commissioner, result in an aggregate annual decrease in Medicaid payments to providers in excess of $200 million.

• Effective April 1, 2012, Medicaid payments for services provided by Certified Home Health Agencies (CHHAs), except for such services provided to children under 18 years of age and other discrete groups, as may be determined by the Commissioner of Health, will be based on episodic payments.

- To determine such episodic payments, a statewide base price will be established for each 60-day episode of care and shall be adjusted by a regional wage index factor and an individual patient case mix index. Such episodic payments may be further adjusted for low utilization cases and to reflect a percentage limitation of the cost for high-utilization cases that exceed outlier thresholds of such payments.

- To achieve savings comparable to the prior state fiscal year, the initial 2012 base year episodic payments will be based on 2009 Medicaid paid claims, as determined by the Commissioner. Such base year adjustments shall be made not less frequently than every three years. However, base year episodic payments subsequent to 2012 will be based on a year determined by the Commissioner that will be subsequent to 2009. Such base year adjustments shall be made not less frequently than every three years.

- In determining case mix, each patient shall be classified using a system based on measures which may include, but not be limited to, clinical and functional measures as reported on the federal Outcome and Assessment Information Set (OASIS).

- The Commissioner may require agencies to collect and submit any data determined to be necessary.

• Effective April 1, 2011, Medicaid rates for services provided by certified home health agencies, or by an AIDS home care program shall not reflect a separate payment for home care nursing services provided to patients diagnosed with Acquired Immune Deficiency Syndrome (AIDS).

• Effective for the period October 1, 2011 through September 30, 2013, pursuant to Section 2703 of the Patient Protection and Affordable Care Act, payments will be made to Managed Long Term Care Plans that have been designated as Health Home providers serving individuals with chronic conditions to cover comprehensive care management, care coordination and health promotion, comprehensive transitional care, patient and family support, referral to community and social support services and the use of health information technology to link services.

• Effective April 1, 2011, the Department is proposing to expand the current Patient Centered Medical Home (PCMH) to more payers and incorporate several provisions to improve medical care. Two provisions result in a change in the methods by which Medicaid fee-for-service (FFS) reimburses Medicaid providers who are designated by the National Committee for Quality Assurance as patient centered medical homes: 1) testing new models of payment to high-volume Medicaid primary care medical home practices which incorporate risk-adjusted global payments with care management and pay-for-performance, and 2) improving the relationship of FFS Medicaid members to medical homes by creating medical home payments only for FFS members who have evidence of ongoing continuity relationship with provider/practice and providing more reliable care management payments to those providers which are independent of specific visit types. These provisions require the following changes to Medicaid.

- New models of reimbursement to high-volume Medicaid providers will be tested which may incorporate risk-adjusted global payments and pay-for-performance. Risk-adjusted payment models will differentially reimburse providers based on their historical case mix. Pay-for-performance will provide enhanced reimbursement to providers who provide high-quality care (such as improved preventative screenings) and/or reduce unnecessary utilization (such as a reduction in admissions for ambulatory sensitive conditions) as defined by standardized measures of performance; and

- Eligible Medicaid fee-for-service recipients, who are currently receiving care from a certified PCMH provider, as determined by an attribution methodology developed by the Commissioner of Health, will be assigned to this PCMH provider. Medicaid FFS will reimburse PCMH providers a per member per month (PMPM) capitation payment for FFS recipients attributed to their practices to provide the necessary care coordination and disease management services.

• Effective October 1, 2011, the Department of Health will update rates paid for Medicaid coverage for preschool and school supportive health services (SSHS). SSHS are provided to Medicaid-eligible students with disabilities in school districts, counties, and State supported § 4201 schools. Payment will be based on a certified public expenditure reimbursement methodology, based on a statistically valid cost study for all school supportive health services and transportation. SSHS are authorized under § 1903(c) of the Social Security Act and include: physical therapy, occupational therapy, speech therapy, psychological evaluations, psychological counseling, skilled nursing services, medical evaluations, medical specialist evaluations, audiological evaluations, and special transportation services.

• Effective April 1, 2011, the Medicaid program is authorized to establish Behavioral Health Organizations (BHOs) to manage behavioral health services. BHOs will be authorized to manage mental health and substance abuse services not currently included in the managed care benefit for Medicaid enrollees in managed care and to facilitate the integration of such services with other health services. The BHOs will also be authorized to manage all mental health and substance abuse services for Medicaid enrollees not in managed care. Behavioral health management will be provided through a streamlined procurement process resulting in contracts with regional behavioral health organizations that will have responsibility for authorizing appropriate care and services based on criteria established by the Offices of Mental Health (OMH) and Alcohol and Substance Abuse Services (OASAS). OMH and OASAS will also be authorized, by April 1, 2013 to jointly designate on a regional basis, a limited number of special needs plans and/or

integrated physical and behavioral health provider systems capable of managing the physical and behavioral health needs of Medicaid enrollees with significant behavioral health needs.

• Effective October 1, 2011, Medicaid will expand coverage of smoking cessation counseling services so that it is available to all Medicaid enrollees. Reimbursement for these services will be available to office based providers, hospital outpatient departments and free-standing diagnostic and treatment centers.

• Effective October 1, 2011 the Department of Health is proposing a change in co-payment policy for Medicaid recipients as permitted in the federal regulations on cost sharing, 42 CFR 447.50 through 447.62. Under this proposal the current copayments will be increased and some services previously exempt from co-payments will be subject to co-payments. The chart below summarizes the current and proposed co-payment structure.

MEDICAID CO-PAYMENTS CURRENT AND PROPOSED

SERVICE OR ITEM	CURRENT AMOUNT	PROPOSED AMOUNT
Clinic Visits	$3.00	$3.40
Brand Name Prescription	$3.00	$3.40
Generic Drug Prescription, and Preferred Brand Name Prescription Drugs	$1.00	$1.15
Over-the-counter Medications	$0.50	$0.60
Lab Tests	$0.50	$0.60
X-Rays	$1.00	$1.15
Medical Supplies	$1.00	$1.15
Overnight Hospital Stays	$25.00 on the last day	$30.00
Emergency Room (for non-emergency room services)	$3.00	$6.40
Additional Services Proposed for Copay		
Eye Glasses	$0.00	$1.15
Eye Exams	$0.00	$1.15
Dental Services	$0.00	$3.40
Audiologist	$0.00	$2.30
Physician Services	$0.00	$3.40
Nurse Practitioner	$0.00	$2.30
Occupational Therapist	$0.00	$2.30
Physical Therapist	$0.00	$3.40
Speech Pathologist	$0.00	$3.40
Annual (SFY) Maximum Limit	$200.00	$300.00

- Other provisions on co-payments as stated in the § 360-7.12 of New York State Social Services Law remain unchanged. The providers of such services may charge recipients the co-payments. However, providers may not deny services to recipients because of their inability to pay the co-payments.

- The following recipients are exempt from co-payments:

• Recipients younger than 21 years of age;

• Recipients who are pregnant;

• Residents of an adult care facility licensed by the New York State Department of Health (for pharmacy services only);

• Residents of a nursing home;

• Residents of an Intermediate Care Facility for the Developmentally Disabled (ICF/DD);

• Residents of an Office of Mental Health (OMH) or Office of People with Developmental Disabilities (OPWDD) certified Community Residence;

• Enrollees in a Comprehensive Medicaid Case Management (CMCM) or Service Coordination Program;

• Enrollees in an OMH or OMRDD Home and Community Based Services (HCBS) Waiver Program; and

• Enrollees in a Department of Health HCBS Waiver Program for Persons with Traumatic Brain Injury (TBI).

- The following services are exempt from co-payments:

• Emergency services;

• Family Planning;

• Drugs to treat mental illness; and

• Services provided through managed care plans.

• Physical therapy, occupational therapy, and speech-language pathology are federal optional Medicaid services. New York State Medicaid presently covers these rehabilitation services with no limits. In order to eliminate delivery of excessive and/or unnecessary services, effective October 1, 2011, the New York State Medicaid Program is establishing utilization limits for the provision of these rehabilitation services. Enrollees will be permitted to receive up to a maximum of 20 visits in a 12 month period each for physical therapy, occupational therapy, and speech-language pathology. The utilization limits will apply to services provided by practitioners in private practice settings as well as for services provided in Article 28 certified hospital outpatient departments and diagnostic and treatment centers (free-standing clinics). The service limits will not apply to services provided in hospital inpatient settings, skilled nursing facilities, or in facilities operated by the Office of Mental Health or the Office of Persons with Developmental Disabilities. Additionally, the utilization limits will not apply for services provided to Medicaid enrollees less than 21 years of age enrollees who are developmentally disabled or to enrollees with specified chronic medical/physical conditions.

• Federal rules allow states the option of reducing coinsurance amounts at their discretion. Effective October 1, 2011, the Department of Health will change the cost-sharing basis for Medicare Part B payments. Currently, New York State Medicaid reimburses practitioners the full or partial Medicare Part B coinsurance amount for enrollees who have both Medicare and Medicaid coverage (the dually-eligible). Medicaid reimburses the Medicare Part B coinsurance, regardless of whether or not the service is covered by Medicaid. Upon federal approval of the proposed state plan change, Medicaid will no longer reimburse practitioners for the Medicare Part B coinsurance for those services that are not covered for a Medicaid-only enrollee. Medicaid presently reimburses Article 28 certified clinics (hospital outpatient departments and diagnostic and treatment centers) the full Medicare Part B coinsurance amount. The full coinsurance is paid by Medicaid, even if the total Medicare and Medicaid payment to the provider exceeds the amount that Medicaid would have paid if the enrollee did not have both Medicare and Medicaid coverage. Under the new reimbursement policy, Medicaid will provide payment for the Medicare Part B coinsurance amount, but the total Medicare/Medicaid payment to the provider will not exceed the amount that the provider would have received if the patient had Medicaid-only coverage. Therefore, if the Medicare payment exceeds what Medicaid would have paid for the service, no coinsurance will be paid by Medicaid. Practitioners and clinics will be required to accept the total Medicare and Medicaid payment (if any) as full payment for services. They will be prohibited from billing the Medicaid recipient.

• Effective October 1, 2011, the Department of Health, in collaboration with the Office of Mental Health, the Office of Alcohol and Substance Abuse Services, and the Office for People with Developmental Disabilities, will be authorized to begin Medicaid coverage for health home services to high cost, high need enrollees. Health home services include comprehensive care coordination for medical and behavioral health services, health promotion, transitional care, including appropriate follow-up from inpatient to other settings, patient and family support, referral to community and social support services, and use of health information technology to link services.

- High risk patients will be assigned to provider networks meeting state and federal health home standards (on a mandatory or opt out basis) for the provision of health home services.

- These services will range from lower intensity patient tracking to higher intensity care/service management depending on patient needs.

The provision of coordinated, integrated physical and behavioral health services will be critical components of the health home program. Strong linkages to community resources will be a health home requirement. Use of peer supports will be explored to help enrollees in the community cope with their medical and behavioral health conditions. The Managed Addiction Treatment Program (MATS), which manages access to treatment for high cost, chemically dependent Medicaid enrollees, will be expanded. Health home payment will be based on a variety of reimbursement methodologies including care coordination fees, partial and shared risk. The focus of the program will be reducing avoidable hospitalizations, institutionalizations, ER visits, and improving health outcomes.

- Payment methodologies for health home services shall be based on factors including, but not limited to, complexity of conditions providers will be managing, the anticipated amount of patient contact needed to manage such conditions, and the health care cost savings realized by provision of health home services.

- The Commissioner of Health is authorized to pay additional amounts to providers of health home services that meet process or outcomes standards specified by the Commissioner.

- Through a collaborative effort, the Department of Health, with the Office of Mental Health, Office of Alcohol and Substance Abuse Services, and the Office for People with Developmental Disabilities, will streamline existing program requirements that create barriers to co-locating medical and behavioral health services in licensed facilities to support improved coordination and integration of care.

• Effective for dates of service on and after April 1, 2011, coverage for prescription footwear and footwear inserts and components for adults age 21 and over will be limited to diabetic footwear or when the footwear is attached to a lower limb orthotic brace. This will reduce overutilization of footwear. Effective for dates of service on and after May 1, 2011, the DOH will establish maximum fees for prescription footwear, inserts and components. The fees will be based on an average of industry costs of generically equivalent products.

• Effective for dates of service on and after April 1, 2011, coverage of enteral formula for adults age 21 and over will be limited to formula administered by feeding tube or formula for treatment of an inborn metabolic disease. This will preserve coverage for medical need and eliminate coverage of orally consumed formulas for adults who can obtain nutrients through other means.

• Effective for dates of service on and after April 1, 2011, coverage of compression and support stockings will be limited to treatment of open wounds or for use as a pregnancy support. Coverage of stockings will not be available for comfort or convenience.

• Effective on and after July 1, 2011, the Department will choose selected transportation providers to deliver all necessary transportation of Medicaid enrollees to and from dialysis, at a per trip fee arrived through a competitive bid process. The Department will choose one or more transportation providers in a defined community to deliver necessary transportation of Medicaid enrollees to and from dialysis treatment. The enrollee's freedom to choose a transportation provider will be restricted to the selected provider(s) in the community. Medicaid enrollee access to necessary transportation to dialysis treatment will not be impacted by this change.

Prescription Drugs

• Effective April 1, 2011, the following is proposed:

- For sole or multi-source brand name drugs the Estimated Acquisition Cost (EAC) is defined as Average Wholesale Price (AWP) minus seventeen (17) percent and the Average Acquisition Cost (AAC) will be incorporated into the prescription drug reimbursement methodology;

- The dispensing fees paid for generic drugs will be $3.50; and

- Specialized HIV pharmacy reimbursement rates will be discontinued and a pharmacy previously designated as a specialized HIV pharmacy will receive the same reimbursement as all other pharmacies.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to reform and other initiatives contained in the budget for state fiscal year 2011/2012 is $223 million; and the estimated annual net aggregate increase in gross Medicaid expenditures attributable to an extension of pertinent disproportionate share (DSH) and upper payment limit (UPL) payments for state fiscal year 2011/2012 is $1.9 billion.

Copies of the proposed state plan amendments will be on file in each local (county) social services district and available for public review.

For the New York City district, copies will be available at the following places:

New York County
250 Church Street
New York, New York 10018

Queens County, Queens Center
3220 Northern Boulevard
Long Island City, New York 11101

Kings County, Fulton Center
114 Willoughby Street
Brooklyn, New York 11201

Bronx County, Tremont Center
1916 Monterey Avenue
Bronx, New York 10457

Richmond County, Richmond Center
95 Central Avenue, St. George
Staten Island, New York 10301

The public is invited to review and comment on this proposed state plan amendment.

For further information and to review and comment, please contact: Department of Health, Bureau of HCRA Operations & Financial Analysis, Corning Tower Bldg., Rm. 984, Empire State Plaza, Albany, NY 12237, (518) 474-1673, (518) 473-8825 (FAX), e-mail: spa_inquires@health.state.ny.us

SALE OF FOREST PRODUCTS

Chenango Reforestation Area No. 1
Contract No. X008135

Pursuant to Section 9-0505 of the Environmental Conservation Law, the Department of Environmental Conservation hereby gives Public Notice for the following:

Sealed bids for 21 tons more or less red pine, 32.6 MBF more or less white ash, 23.6 MBF more or less black cherry, 15.2 MBF more or less red maple, 10.0 MBF more or less sugar maple, 0.3 MBF more or less yellow birch, 0.5 MBF more or less basswood, 0.1 MBF more or less aspen, 233 cords more or less firewood, located on Chenango Reforestation Area No. 1, Stands C-27, D-25 and D-28, will be accepted at the Department of Environmental Conservation, Contract Unit, 625 Broadway, 10th Fl., Albany, NY 12233-5027 until 11:00 a.m. on Thursday, April 7, 2011.

For further information, contact: Robert Slavicek, Supervising Forester, Department of Environmental Conservation, Division of Lands and Forests, Region 7, 2715 State Hwy. 80, Sherburne, NY 13460-4507, (607) 674-4036

SALE OF FOREST PRODUCTS

Lewis Reforestation Area No. 20
Contract No. X008125

Pursuant to Section 9-0505 of the Environmental Conservation Law, the Department of Environmental Conservation hereby gives Public Notice of the following:

To be published in New York State Register on November 9, 2011.

Public Notice
NYS Department of Health

Pursuant to 42 CFR Section 447.205, the Department of Health hereby gives public notice of the following:

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

Non-Institutional Services

The following clarifications are to the March 30, 2011 noticed provision for Health Home Services.

Effective January 1, 2012, the Department of Health, in collaboration with the Office of Mental Health, the Office for Alcohol and Substance Abuse Services, and the Office of People with Developmental Disabilities will be authorized to begin Medicaid coverage for Health Home Services to high-cost, high-need enrollees. The previous effective date was October 1, 2011.

Payment for Health Homes service will be a per-member, per-month (PMPM) care management fee that is adjusted based on 1) region, 2) enrollment volume, and 3) case mix (from 3M™ Clinical Risk Groups (CRG) method). This fee will eventually be adjusted by (after the data is available) patient functional status. As a result, reimbursement will be reflective of cost-associated adjustments in the intensity and frequency of intervention based on patient's current condition and needs (from tracking to high touch).

This care management fee will be paid in two increments based on whether a patient is in 1) the case finding group, or 2) the active care management group. The case finding group will receive a PMPM that is a reduced percentage (80 percent) of the active care management PMPM. The case finding PMPM is only available for up to the first three months after a patient has been assigned to a given Health Home, and this PMPM is intended to cover the cost of outreach and engagement. Once a patient has been assigned a care manager and is actively engaged in the Health Home program, the active care management PMPM may be billed.

The active care management PMPM will be paid in two installments. The first installment may be billed up front, and the second installment will automatically be paid once the Health Home provider meets certain pre-set state quality metrics. In the first year, a percentage (90 percent) of the PMPM will be paid up front and the remaining percentage (10 percent) will be reserved against meeting the quality benchmarks.

If the State achieves overall savings from the implementation of this program, Health Home providers will be eligible to participate in a shared savings pool. The pool will be developed at the end of the first year of health home operation and will consist of a percentage (15 percent) of the documented State share savings derived from Health Home operation. The State will use a method to adjust savings for regression to the mean before setting up the pool. If the federal portion of savings becomes eligible for shared savings with providers, then a portion of those savings will be included in the pool based on any federal conditions that may be applied to such savings. Under federal rules, some shared savings incentive payments cannot exceed 105 percent of the aggregate payment for Medicaid services received.

The estimated net aggregate decrease in gross Medicaid expenditures attributable to this initiative for the period January 1, 2012 through September 30, 2012 is $13.6 million and for the period October 1, 2012 through September 30, 2013 is $48.3 million.

The public is invited to review and comment on this proposed state plan amendment, copies of which will be available for public review on the Department's website at:

http://www.health.ny.gov/regulations/state_plans/status

In addition, copies of the proposed state plan amendment will be on file and available for public review in each local (county) social services district.

For the New York City district, copies will be available at the following places:

New York County
250 Church Street
New York, New York 10018

Queens County, Queens Center
3220 Northern Boulevard
Long Island City, New York 11101

Kings County, Fulton Center
114 Willoughby Street
Brooklyn, New York 11201

Bronx County, Tremont Center
1916 Monterey Avenue
Bronx, New York 10457

Richmond County, Richmond Center
95 Central Avenue, St. George
Staten Island, New York 10301

For further information and to review and comment, please contact:

New York State Department of Health
Bureau of HCRA Operations & Financial Analysis
Corning Tower Building, Rm. 984
Empire State Plaza
Albany, New York 12237
(518) 474-1673
(518) 473-8825 (FAX)
spa_inquiries@health.state.ny.us

Appendix V
2011 Title XIX State Plan
Second Quarter Amendment
Non-Institutional Services
Responses to Standard Funding Questions

NON-INSTITUTIONAL SERVICES
State Plan Amendment #11-56

CMS Standard Funding Questions

The following questions are being asked and should be answered in relation to all payments made to all providers reimbursed pursuant to a methodology described in Attachment 4.19-B of this SPA. For SPAs that provide for changes to payments for clinic or outpatient hospital services or for enhanced or supplemental payments to physician or other practitioners, the questions must be answered for all payments made under the state plan for such service.

1. **Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State plan. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.).**

   Response: Providers do retain the payments made pursuant to this amendment. However, this requirement in no way prohibits the public provider, including county providers, from reimbursing the sponsoring local government for appropriate expenses incurred by the local government on behalf of the public provider. The State does not regulate the financial relationships that exist between public health care providers and their sponsoring governments, which are extremely varied and complex. Local governments may provide direct and/or indirect monetary subsidies to their public providers to cover on-going unreimbursed operational expenses and assure achievement of their mission as primary safety net providers. Examples of appropriate expenses may include payments to the local government which include reimbursement for debt service paid on a provider's behalf, reimbursement for Medicare Part B premiums paid for a provider's retirees, reimbursement for contractually required health benefit fund payments made on a provider's behalf, and payment for overhead expenses as allocated per federal Office of Management and Budget Circular A-87 regarding Cost Principles for State, Local, and Indian Tribal Governments. The existence of such transfers should in no way negate the legitimacy of these facilities' Medicaid payments or result in reduced Medicaid federal financial participation for the State. This position was further supported by CMS in review and approval of SPA 07-07C when an on-site audit of these transactions for New

York City's Health and Hospitals Corporation was completed with satisfactory results.

2. **Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either through an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local governmental entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:**

   (i) a complete list of the names of entities transferring or certifying funds;
   (ii) the operational nature of the entity (state, county, city, other);
   (iii) the total amounts transferred or certified by each entity;
   (iv) clarify whether the certifying or transferring entity has general taxing authority: and,
   (v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

Response

Payments made to service providers under the provisions of this SPA are funded through a general appropriation received by the State agency that oversees medical assistance (Medicaid), which is the Department of Health. The source of the appropriation is the Local Assistance Account under the General Fund/Aid to Localities.

3. **Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.**

Response: The payments authorized for this provision are not supplemental or enhanced payments.

4. **For clinic or outpatient hospital services please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e., applicable to the current rate year) UPL demonstration.**

   Response: Based on guidance from CMS, the State and CMS staff will engage in discussions to develop a strategic plan to complete the UPL demonstration for 2011.

5. **Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?**

   Response: The rate methodology included in the State Plan for health home services is a per member per month (PMPM) care management fee adjusted by geographic region and case mix (from clinical risk group (CRP) methodology. This fee will eventually be adjusted by the patient functional status and potentially enrollment volume if necessitated by smaller rural applications. We are unaware of any requirement under current federal law or regulation that limits individual providers' payments to their actual costs.

Assurances:

1. **The State needs to verify it is in compliance with the provisions of Section 5006 of the Recovery Act concerning tribal consultations for the SPA, or an explanation why the provisions did not apply in this instance.**

   Response: The provision concerning tribal consultations does not apply to this SPA since Indian Health Programs in New York State do not provide health home services and, therefore, receive no Medicaid payments for such services. However, as a courtesy, a draft copy of this SPA was provided to all tribal organizations within New York State on September 27, 2011. To date, no feedback has been received from tribal representatives.

Appendix VI
2011 Title XIX State Plan
Second Quarter Amendment
Non-Institutional Services
Responses to Standard Access Questions

NON-INSTITUTIONAL SERVICES
State Plan Amendment #11-56

CMS Standard Access Questions

The following questions have been asked by CMS and are answered by the State in relation to all payments made to all providers under Attachment 4.19-B of the state plan.

1. **Specifically, how did the State determine that the Medicaid provider payments that will result from the change in this amendment are sufficient to comply with the requirements of 1902(a)(30)?**

   Response: This amendment seeks to improve patient outcomes and decrease inappropriate utilization of high-cost care and services, particularly for emergency department services for the chronically ill population. The initiative seeks to control inappropriate utilization of Medicaid services by providing health home services (care coordination) to facilitate the delivery of coordinated, integrated medical and behavioral health care to the behaviorally and medically chronically ill population. Coordinated care will shift the delivery of care from emergency room settings and facilitate access to more appropriate ambulatory care settings. This shift in care delivery will result in a net aggregate decrease in gross Medicaid expenditures (for the period January 1, 2012 through September 30, 2012) of $13.6 million; and (for the period October 1, 2012 through September 30, 2013) of $48.3 million. Health home service payments are consistent with efficiency, economy, and quality of care and will be sufficient to enlist enough providers so that care and services are available under the plan, at least to the extent that such care and services are available to the general population, in the geographic area.

2. **How does the State intend to monitor the impact of the new rates and implement a remedy should rates be insufficient to guarantee required access levels?**

   Response: The State has various ways to ensure that access levels in the Medicaid program are retained and is currently not aware of any access issues, particularly since there is excess bed capacity for both hospitals and nursing homes. Additionally, hospital and nursing home providers must notify and receive approval from the Department's Office of Health Systems Management (OHSM) in order to discontinue services. This Office monitors and considers such requests in the context of access as they approve/deny changes in services. Finally, providers cannot discriminate based on source of payment.

For providers that are not subject to an approval process, the State will continue to monitor provider complaint hotlines to identify geographic areas of concern and/or service type needs. If Medicaid beneficiaries begin to encounter access issues, the Department would expect to see a marked increase in complaints. These complaints will be identified and analyzed in light of the changes proposed in this State Plan Amendment.

Finally, the State ensures that there is sufficient provider capacity for Medicaid Managed Care plans as part of its process to approve managed care rates and plans. Should sufficient access to services be compromised, the State would be alerted and would take appropriate action to ensure retention of access to such services.

3. **How were providers, advocates and beneficiaries engaged in the discussion around rate modifications? What were their concerns and how did the State address these concerns?**

   Response: This change was enacted by the State Legislature as part of the negotiation of the 2011-12 Budget. The impact of this change was weighed in the context of the overall Budget in the State. The legislative process provides opportunities for all stakeholders to lobby their concerns, objections, or support for various legislative initiatives.

4. **What action(s) does the State plan to implement after the rate change takes place to counter any decrease to access if the rate decrease is found to prevent sufficient access to care?**

   Response: Should any essential community provider experience Medicaid or other revenue issues that would prevent access to needed community services, per usual practice, the State would meet with them to explore the situation and discuss possible solutions, if necessary.

5. **Is the State modifying anything else in the State Plan which will counterbalance any impact on access that may be caused by the decrease in rates (e.g. increasing scope of services that other provider types may provide or providing care in other settings)?**

   Response: Over the course of the past three years, the State has undertaken a massive reform initiative to better align reimbursement with care. When fully implemented in 2010-11, the initiative will invest over $600 million in the State's ambulatory care system (outpatient, ambulatory surgery, emergency department, clinic and physicians) to incentivize care in the most appropriate setting. The State has also increased its physician reimbursement schedule to resemble Medicare payments for similar services, thus ensuring continued access for Medicaid beneficiaries. Further, the State is implementing initiatives that will award $600 million annually, over five

years, to providers who promote efficiency and quality care through the Federal-State Health Reform Partnership(F-SHRP)/ NYS Healthcare Efficiency and Affordability Law (HEAL). While some of these initiatives are outside the scope of the State Plan, they represent some of the measures the State is taking to ensure quality care for the State's most vulnerable population.