



Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

Mr. Frank Walsh
Chief Budget Examiner
Division of the Budget
Health Unit
State Capitol
Albany, New York 12224

AUG 02 2017

Dear Mr. Walsh:

Enclosed for your review and assistance in obtaining the Governor's approval is submittal #17-0053, which is an amendment to this Department's State Plan under Title XIX (Medicaid).

This amendment proposes to revise the State Plan to modify the outreach and engagement process of the Health Home program.

To assist in your review of this submittal, enclosed are copies of the submittal of amendment #17-0053 and the fiscal analysis. We are requesting an October 1, 2017 effective date.

If you or your staff have any questions or need further assistance, please do not hesitate to contact Regina Deyette of my staff at (518) 473-3658.

Sincerely,

Jason A. Helgerson
Medicaid Director
Office of Health Insurance Programs

Enclosures

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 17-0053	2. STATE New York
FOR: HEALTH CARE FINANCING ADMINISTRATION		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 October 1, 2017	
5. TYPE OF PLAN MATERIAL <i>(Check One)</i> : <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT <i>(Separate Transmittal for each amendment)</i>			
6. FEDERAL STATUTE/REGULATION CITATION: §1902(a) of the Social Security Act and 42 CFR 447		7. FEDERAL BUDGET IMPACT: <i>(in thousands)</i> a. FFY 10/01/17-09/30/18 \$ (15,000.00) b. FFY 10/01/18-09/30/19 \$ (10,000.00)	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 3.1-H		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT <i>(If Applicable)</i> : Attachment 3.1-H	
10. SUBJECT OF AMENDMENT: Health Home Outreach Restructure (50% FMAP)			
11. GOVERNOR'S REVIEW <i>(Check One)</i> : <input checked="" type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: New York State Department of Health Bureau of Federal Relations & Provider Assessments 99 Washington Ave – One Commerce Plaza Suite 1432 Albany, NY 12210	
13. TYPED NAME: Jason A. Helgeson			
14. TITLE: Medicaid Director 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:			

Appendix I
2017 Title XIX State Plan
Fourth Quarter Amendment
Amended SPA Pages

SPA ID NY-17-0053

Reviewable Unit	Proposed Effective Date
Health Homes Intro	10/1/2017
Health Homes Population and Enrollment Criteria	10/1/2016
Health Homes Geographic Limitations	10/1/2016
Health Homes Services	10/1/2016
Health Homes Providers	10/1/2016
Health Homes Service Delivery Systems	10/1/2016
Health Homes Payment Methodologies	10/1/2017
Health Homes Monitoring Quality Measurement and Evaluation	10/1/2016

Executive Summary**Summary Description Including Goals and Objectives**

See executive summary within the intro

Dependency Description

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

Disaster-Related Submission

This submission is related to a disaster

- Yes
 No

Federal Budget Impact and Statute/Regulation Citation**Federal Budget Impact**

	Federal Fiscal Year	Amount
First	2018	[\$15,000,000.00]
Second	2019	[\$10,000,000.00]

Federal Statute/Regulation Citation

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

Governor's Office Review

- No comment
 Comments received

7.19.17 v4Records/Submission Packages

NY- Submission Package- NY2016MH00020- (NY-17-0053)

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Submission -Summary

MEDICAID- Health Homes- NYS Health Home Program NY- 2016

CMS-10434 OMB 0938-1188

Not Started

In Progress

Complete

Package Header

Package ID NY2016MH00020

SPA ID NY-17-0053

Submission Type Official - Review 1

Initial Submission Date 9/29/2016

Approval Date

Effective Date 10/1/2017

Superseded SPA 16-0034

ID

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State Information

State/Territory Name New York

Medicaid Agency Name Department of Health

Submission Component

State Plan Amendment

Medicaid

CHIP

Submission Type

Official Submission Package

Draft Submission Package

Allow this official package to be viewable by other states?

Yes

No

Key Contacts

Name

Title

Phone Number

Email Address

Gallagher, Regina NYS Medicaid State Plan Coordinator

(518)473-3658

regina.gallagher@health.ny.gov

SPA ID and Effective Date

Records/Submission Packages

NY- Submission Package- NY2016MH00020- (NY-17-0053)

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Submission -Medicaid State Plan

MEDICAID- Health Homes- NYS Health Home Program NY- 2016

CMS-10434 OMB 0938-1188

Not Started

In Progress

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Package Header

Package ID	NY2016MH00020	SPA ID	NY-17-0053
Submission Type	Official - Review 1	Initial Submission Date	9/29/2016
Approval Date		Effective Date	10/1/2017
Superseded SPA ID	16-0034		

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Submission - Medicaid State Plan

The submission includes the following

Benefits

Health Homes Program

Create new Health Homes program

Amend existing Health Homes program

Terminate existing Health Homes program

Create new program from blank form

Copy from existing Health Homes program

Name of Health Homes Program: NYS Health Home Program

Records/Submission Packages

NY- Submission Package- NY2016MH00020- (NY-17-0053)

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Submission – Public Comment

MEDICAID- Health Homes- NYS Health Home Program NY- 2016

CMS-10434 OMB 0938-1188

Not Started

In Progress

Complete

Package Header

Package ID	NY2016MH00020	SPA ID	NY-16-0034
Submission Type	Official - Review 1	Initial Submission Date	9/29/2016
Approval Date	12/22/2016	Effective Date	N/A
Superseded SPA	N/A		
ID			

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Name of Health Homes Program NYS Health Home Program

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

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

Indicate how the public notice was issued and public comment was solicited

- Newspaper Announcement
- Publication in states administrative record in accordance with the administrative procedure requirements **Date of Publication June 14, 2017**
- Email to Electronic Mailing List or Similar
- Mechanism Website Notice
- Public Hearing or Meeting
- Other Method

Upload copies of public notices and other documents used

Name	Date Created	Type
NYS Register (8-17-16)	9/13/2016 8::22AM EDT	
NYS Register (8-31-16)	9/13/2016 8::22AM EDT	

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

Name	Date Created	Type
------	--------------	------

No items available

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

- Access
- Quality
- Cost
- Payment methodology
- Eligibility
- Benefits
- Service Delivery
- Other Issue

Records/Submission Packages

NY- Submission Package- NY2016MH00020- (NY-17-0053)

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Submission –Tribal Input

MEDICAID- Health Homes- NYS Health Home Program NY- 2016

CMS-10434 OMB 0938-1188

Not Started

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Package Header

Package ID	NY2016MH00020	SPA ID	NY-16-0034
Submission Type	Official - Review I	Initial Submission Date	9/29/2016
Approval Date	12/22/2016	Effective Date	N/A
Superseded SPA ID	N/A		

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Name of Health Homes Program NYS Health Home Program

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

- Yes
- No

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

- Yes
- No

Explain why this SPA is not likely to have a direct effect on Indians, Indian Health Programs or Urban Indian Organizations - It extends health home legacy rates.

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

The state has not solicited advice from Indian Health Programs and/or Urban Indian Organizations prior to submission of this SPA

Complete the following Information regarding any tribal consultation conducted with respect to this submission

Tribal consultation was conducted in the following manner

Indian Health Programs

Name of Program	Date of consultation	Method/location of consultation
Health Clinic	9/2/2016	tribal consultation sent, no comment rec'vd

Urban Indian Organizations

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

Indian Tribes

Name of Tribe	Date of consultation	Method/Location of consultation
Cayuga Nation	9/2/2016	tribal consultation sent, no comment rec'vd
Oneida Indian Nation	9/2/2016	tribal consultation sent, no comment rec'vd
Onondaga Nation	9/2/2016	tribal consultation sent, no comment rec'vd
Seneca Nation of Indians	9/2/2016	tribal consultation sent, no comment rec'vd
Shinnecock Indian Nation Tribal Office	9/2/2016	tribal consultation sent, no comment rec'vd
St Regis Mohawk Tribe	9/2/2016	tribal consultation sent, no comment rec'vd
Tonawanda Seneca Nation Tribe	9/2/2016	tribal consultation sent, no comment rec'vd
Tuscarora Indian Nation	9/2/2016	tribal consultation sent, no comment rec'vd
Ukechang Indian Territory	9/2/2016	tribal consultation sent, no comment rec'vd

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

Name	Date Created	Type
Tribal 1	9/13/2016 8:51AM EDT	
Tribal 2	9/13/2016 8:51AM EDT	
Tribal 3	9/13/2016 8:51AM EDT	
Tribal 4	9/13/2016 8:54AM EDT	
Tribal 5	9/13/2016 8:54AM EDT	

Indicate the key issues raised (optional)

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

Records/Submission Packages

NY- Submission Package- NY2016MH00020- (NY-17-0053)

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Submission – SAMHSA Consultation

MEDICAID- Health Homes- NYS Health Home Program NY- 2016

CMS-10434 OMB 0938-1188

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Package Header

Package ID NY2016MH00020

SPA ID NY-16-0034

Submission Type Official - Review 1

Initial Submission Date 9/29/2016

Approval Date 12/22/2016

Effective Date N/A

Superseded SPA N/A

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Name of Health Homes Program NYS Health Home Program

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

Date of consultation
11/20/14

Records/Submission Packages

NY- Submission Package- NY2016MH00020- (NY-17-0053)

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Health Homes Intro

MEDICAID- Health Homes- NYS Health Home Program NY- 2016

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Superseded SPA ID 16-0034

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Program Authority

1945 of the Social Security Act

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

Name of Health Homes Program NYS Health Home Program

Executive Summary

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

Summary description including goals and objectives

New state plan amendment supersedes transmittal# 16-0034

Transmittal# 17-0053 Outreach and Engagement Restructuring

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

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

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

Effective October 1, 2017, the purpose of this State Plan Amendment is to modify the outreach and engagement process of the Health Home program, and to delete a technical inaccuracy related to the assessment fee for the CANS-NY applicable to children.

Amendment change is located in MACPro Unit 7, Health Homes Payment Methodologies p. 33 and 34

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

Part III: As requested by SAMHSA the definition of Complex Trauma has been amended to include "dissociation."

This change can be found in Unit 2, Health Homes Population and Enrollment Criteria p. 14.

General Assurances

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

Records/Submission Packages

NY- Submission Package- NY2016MH00020- (NY-16-0053)

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Health Homes Population and Enrollment Criteria

MEDICAID- Health Homes- NYS Health Home Program NY- 2016

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Not Started

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Package Header

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Submission Type Official - Review 1

Initial Submission Date 9/29/2016

Approval Date 12/22/2016

Effective Date 10/1/2016

Superseded SPA N/A

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Categories of Individuals and Populations Provided Health Homes Services

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

Categorically Needy (Mandatory and Options for Coverage) Eligibility Groups

Medically Needy Eligibility Groups

Mandatory Medically Needy

Medically Needy Pregnant Women

Medically Needy Children under Age 18

Optional Medically Needy (select the groups included in the population)

Families and Adults

Medically Needy Children Age 18 through 20

Medically Needy Parents and Other Caretaker Relatives

Aged, Blind and Disabled

Medically Needy Aged, Blind, Disabled

Medically Needy Blind, Disabled Individuals Eligible in 1973

Population Criteria

The State elects to offer Health Homes services to individuals with

Two or more chronic conditions

Specify the conditions included

Mental Health Condition

Substance Use Disorder

Asthma

Diabetes

- Heart Disease
- BMI over 25
- Other (specify)

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

One chronic condition and the risk of developing another

Specify the conditions included

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

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

Specify the criteria for at risk of developing another chronic condition

HIV, Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED) and complex trauma are each single qualifying conditions for which NYS was approved.

Providers do not need to document a risk of developing another condition in these cases.

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

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

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

To facilitate the use of health information technology by health homes to improve service delivery and coordination across the care continuum, NY has developed initial and final HIT standards for health homes that are consistent with NYS' Operational Plan for Health Information Technology and Exchange approved by CMS. Providers must meet initial HIT standards to implement a health home. Furthermore, applicants must provide a plan to achieve the final standards within eighteen months of program 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 that is for every patient. Health home providers will also be encouraged to utilize HIT as feasible to process and follow up on patient testing, treatments, community based services and provider referrals.

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

Major Category: Alcohol and Substance Abuse 3M Clinical Risk Group (3M CRGs) Category

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

Major Category: Mental Health 3M Clinical Risk Group (3M CRGs) Category

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

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

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

Major Category: HIV/AIDS 3M Clinical Risk Group (3M CRGs) Category

1. HIV Disease

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

1. Chronic Renal Failure
2. Diabetes

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

1. Asthma
2. Chronic Obstructive Pulmonary Disease

Major Category: Other 3M Clinical Risk Group (3M CRGs) Category

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

Description of population selection criteria

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

Enrollees in the behavioral health category have been identified through claims and encounter data analysis as having received mental health 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.

Complex trauma exposure in childhood has been shown to impair brain development and the ability to learn and develop social and emotional skills during childhood, consequently increasing the risks of developing serious or chronic diseases in adolescence and adulthood. Children who have experienced complex trauma and who are not old enough to have experienced long-term impacts are uniquely vulnerable. Childhood exposure to child maltreatment, including emotional abuse and neglect, exposure to violence, sexual and physical abuse are often traumatic

events that continue to be distressing for children even after the maltreatment has ceased, with negative physical, behavioral, and/or psychological effects on the children. Since child maltreatment occurs in the context of the child's relationship with a caregiver, the child's ability to form secure attachment bonds, sense of safety and stability, are disrupted. Without timely and effective intervention during childhood, a growing body of research shows that a child's experience of these events (simultaneous or sequential maltreatment) can create wide-ranging and lasting adverse effects on developmental functioning, and physical, social, emotional or spiritual well-being. Enrolling children who are experiencing complex trauma in Health Homes will work to prevent, while an individual is still in childhood, the development of other more complex chronic conditions in adulthood.

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

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

One serious and persistent mental health condition

Specify the criteria for a serious and persistent mental health condition

The guidance on complex trauma draws upon the domains within the definition of serious emotional disturbance. While there may be similarities in the condition(s) and symptoms that arise in either complex trauma or SED, the therapeutic approaches associated with the same diagnoses may vary significantly when the symptoms arising from traumatic experiences are identified as such. Trauma experts indicate that with complex trauma, the clinical diagnoses may be more severe and typically present as co-morbidities or multiple diagnoses. 1. Definition of Complex Trauma a. the term complex trauma incorporates at least: i. infants/children/or adolescents' exposure to multiple traumatic events, often of an invasive, interpersonal nature and ii. The wide ranging long-term impact of this exposure b. Nature of the traumatic events: i. often is severe and pervasive, such as abuse or profound neglect ii. usually begins early in life iii. Can be disruptive of the child's development and the formation of a healthy sense of self (with self-regulatory, executive functioning, self-perceptions, etc.) iv. often occur in the context of the child's relationship with a caregiver and v. can interfere with the child's ability to form a secure attachment bond which is considered a prerequisite for healthy social-emotional functioning. c. Many aspects of a child's healthy physical and mental development rely on this secure attachment, a primary source of safety and stability d. wide-ranging, long-term adverse effects can include impairments in i. physiological responses and related neurodevelopment, ii. emotional responses, iii. cognitive processes including the ability to think, learn and concentrate iv. Impulse control and other self-regulating behavior, v. self-image vi. relationships with others and vii. dissociation. Effective October, 1 2016 complex trauma and SED will each be a single qualifying condition.

Enrollment of Participant

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

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

Describe the process used

Individuals eligible for health home services will be identified by the State. Individuals will be assigned to a health home provider based on existing relationships with health care providers or health care delivery system relationships, geography, and/or other qualifying 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 within a designated time period and briefly describe health home services. The State would provide health home providers a roster of assigned enrollees and current demographic information to facilitate outreach and engagement.

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

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

Name	Date Created	Type
NY Health Home Brochure	9/14/2016	10:08 AM EDT

Records/Submission Packages

NY- Submission Package- NY2016MH00020- (NY-17-0053)

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Health Homes Geographic Limitations

MEDICAID- Health Homes- NYS Health Home Program NY- 2016

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Superseded SPA N/A

ID

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

Records/Submission Packages

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Health Homes Services

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Service Definitions

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

Comprehensive Care Management Definition

Definition

A comprehensive individualized patient center 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 or care.

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

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

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

To facilitate the use of health information technology by health homes to improve service delivery and coordination across the care continuum, NY has developed initial and final HIT standards. Providers must meet the initial HIT standard to implement a health home, as feasible. NY

anticipates that a portion of health home providers may not utilize HIT in their current programs. These providers will be encouraged to utilize regional health information organizations (RHIO's) 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 providers. Health home providers will be encouraged to utilize HIT as feasible to create, document and execute and update a plan of care for every patient that is accessible to the interdisciplinary team of providers. Health home providers will also be encouraged to utilize HIT as feasible to process and follow up on patient testing, treatments, services and referrals.

Scope of service

The service can be provided by the following provider types

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

Provider Type

Multidisciplinary teams

Description

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

Care Coordination

Definition

The health home provider will be accountable for engaging and retaining health home enrollees in care, as well as coordinating and arranging for the provision of services, supporting adherence to treatment recommendations, and monitoring and evaluating the enrollee's needs. The individualized plan of care will identify all of 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.

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

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

Scope of Service

The service can be provided by the following provider types

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

Provider Type

Multidisciplinary teams

Description

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

Health Promotion

Definition

Health promotion begins for eligible healthhome 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 include aspects of comprehensive care management, care coordination, and referral to community and social support services. All of the activities are built around the notion of linkages to care that address all of the clinical and non-clinical care needs of an individual and health promotion. The health home provider will support continuity of care and health promotion through the development of a treatment relationship with the individual and the interdisciplinary team of providers. The health home provider will promote evidence based wellness and prevention by linking health home enrollees with resources for smoking cessation, diabetes, asthma, hypertension, self-help recovery resources, and other services based on individual needs and preferences. Health promotion activities will be utilized to promote patient education and self-management of their chronic condition.

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

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

Scope of service

The service can be provided by the following provider types

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

Provider Type

Multidisciplinary teams

Description

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.

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

Definition

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

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

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

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

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

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

Scope of service

The service can be provided by the following provider types

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

Provider Type**Description**

Multidisciplinary teams

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

Individual and Family Support (which includes authorized representatives)**Definition**

The patient's individualized plan of care will reflect and incorporate the patient and family or caregiver preferences, education and support for self-management, self-help recovery, and other resources as appropriate. The provider will share and make accessible 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 caregivers, 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.

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

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

Scope of service**The service can be provided by the following provider types**

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

Provider Type

Multidisciplinary teams

Description

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

Referral to Community and Social Support Services**Definition**

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

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

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

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

Scope of service**The service can be provided by the following provider types**

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

Provider Type

Multidisciplinary teams

Description

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

Health Homes Patient Flow

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

See NY Health Home Patient flow chart below

Name	Date Created	Type
NY Health Home Patient Flow Charts	9/19/2016 3:56 PM EDT	

Records/Submission Packages

NY- Submission Package- NY2016MH00020- (NY-17-0053)

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Health Homes Providers

MEDICAID- Health Homes- NYS Health Home Program NY- 2016

CMS-10434 OMB 0938-1188

Not Started

In Progress

Complete

Package Header

Package ID	NY2016MH00020	SPA ID	NY-16-0034
Submission Type	Official - Review 1	Initial Submission Date	9/29/2016
Approval Date	12/22/2016	Effective Date	10/1/2016
Superseded SPA ID	N/A		

[View implementation Guide](#)

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Types of Health Homes Providers

Designated Providers

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

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

Provider Type

Description

Designated Providers as described in section 1945 (h)(5)

Please see text below

Teams of Health Care Professionals

Health Teams

Provider Infrastructure

Describe the Infrastructure of provider arrangements for Health Home Services

New York's 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 teams, 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/dietitians, 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 homes 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.

Supports for Health Homes Providers

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

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

Description

Other Health Homes Provider Standards

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

The state's minimum requirements and expectations for Health Home providers are as follows: 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 healthcare 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 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 include 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's 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 and procedures and accountabilities (contractual agreements) to support effective collaborations between primary care, specialist and behavioral health, 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 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 on 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 reengage 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 patient's 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, 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 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 or 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 healthcare 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.

Name

Date Created

Type

No items available

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NY- Submission Package- NY2016MH00020- (NY-17-0053)

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Health Homes Service Delivery Systems

MEDICAID- Health Homes- NYS Health Home Program NY- 2016

CMS-10434 OMB 0938-1188

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Package Header

Package ID	NY2016MH00020	SPA ID	NY-16-0034
Submission Type	Official - Review 1	Initial Submission Date	9/29/2016
Approval Date	12/22/2016	Effective Date	10/1/2016
Superseded SPA	N/A		

ID

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

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

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

Managed Care Considerations

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

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

Name	Date Created	Type
Unit 8 – Material on Quality Measures from previously approved I5-20 SPA	9/9/2016 3:43 PM EDT	
Unit 8 – Material on Monitoring omitted from MMDLY p. 54	9/14/2016 9:40 AM EDT	

Records/Submission Packages

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Health Homes Payment Methodologies

MEDICAID- Health Homes- NYS Health Home Program NY- 2016

CMS-10434 OMB 0938-1188

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In Progress

Complete

Package Header

Package ID	NY2016MH00020	SPA ID	NY-17-0053
Submission Type	Official - Review 1	Initial Submission Date	9/29/2016
Approval Date		Effective Date	10/1/2017
Superseded SPA ID	16-0034		

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Payment Methodology

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

Fee for Service

Individual/Rates Per Service

Per Member, Per Month Rates

Fee for Service Rates based on

Severity of each individual's chronic conditions

Capabilities of the team of health care professionals, designated provider, or health team.

Other (Describe Below)

See text box below regarding rates.

Comprehensive Methodology Included in the Plan

Incentive Payment Reimbursement

Describe any variations in payment based on provider qualification individual care needs, or the intensity of the services provided

See text below

- PCCM (description included in Service Delivery section)
- Risk Based Managed Care (description included in Service Delivery section)
- Alternative models of payment other than Fee for Service or PMPM payments (describe below)

Agency Rates

Describe the rates used

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

Rate Development

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

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

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

Provider Type

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

Care Management Fee

Health Homes meeting State and federal standards will be paid a per member per month care management fee that is adjusted based on region and case mix (from 3M Clinical Risk Groups (CRG) method for adults or the Child and Adolescent Needs and Strength Assessment of New York (CANS-NY) for children age 0 through 20. This fee will eventually be adjusted by (after the data is available) patient functional status. [Until such time as the behavioral health benefit is moved to managed care the fee will include a fee for conducting the CANS-NY assessment.] Effective October 1, 2017, or on the first day of the calendar month following any month in which the State has determined providers and managed care plans billing systems are in place, the per member per month care management fee for adults will be based on region and case mix. The State will provide managed care plans and providers with at least 30 days notice of the implementation of such fees for adults. The risk adjusted payments will allow providers to receive a diverse population of patients and assign patients to various levels of care management intensity without having to meet present standards for contact counts. Providers will be able to respond to and adjust the intensity and frequency of intervention based on patient's current condition and needs (from tracking to high touch). All rates will be published on the DOH website. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers. Rates for Health Home services to children are effective October 1, 2016 and apply to services furnished on and after October 1, 2016 through September

30, 2018. Rates for Health Home services furnished to other populations are set October 1, 2016 and apply to services furnished on and after that date. State Health Home rates may be found at:

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/rate_information.htm

The care management fee will be paid in two increments based on whether a patient was in 1) the case finding group or 2) the active care management group. Effective October 1, 2017, the case finding group will receive a PMPM [that is a reduced percentage (80%) of the active care management PMPM through November 30, 2016. On December 1, 2016, the case finding fee will be set at \$135. The case finding PMPM will be available] for two [the three] months after a patient has been assigned or referred to the health home. [Then, nothing can be billed for that patient for the next three months. Following this interval, case finding can be billed for another three months while outreach and engagement is attempted once again.] The Medicaid Managed Care Organization, or Health Home for a member not enrolled in a Managed Care Organization, may extend approval to bill the case finding fee for a period not to exceed an additional two months. This PMPM is intended to cover the cost of outreach and engagement.

Effective August 1, 2014, the per member per month care management fee will be adjusted by a temporary rate add-on to distribute the annual amounts authorized under the State's Medicaid Redesign Team (MRT) Waiver and as shown below.

August 1, 2014 to March 31, 2015: \$80 million

April 1, 2015 to December 31, 2015: \$66.7 million

January 1, 2016 to December 31, 2016: \$43.9 million

(SEE TABLE LOCATED UNDER SECTION ON NON-DUPLICATION OF PAYMENT. MOVED DUE TO SPACE CONSTRAINTS)

The temporary rate add-on will be paid to State designated Health Homes. Funds received through this rate add-on must be used to support costs related to one or more of the following authorized purposes: 1) Member engagement and promotion of Health Homes, 2) Workforce training and retraining, 3) Health information technology (HIT) and clinical connectivity and 4) Joint governance technical assistance.

Each Health Home will be required to submit semi-annual reports documenting how the funds were used in accordance with the four authorized purposes. Semi-annual reports shall be submitted until such time as it is verified that all funds have been used in accordance with authorized purposes. Funds that are not disbursed in accordance with authorized purposes will be recouped by the Department within 90 days of such finding.

A unit of service will be defined as a billable unit per service month. In order to be reimbursed for a billable unit of service per month health home providers must at a minimum, provide one of the core health home services per month. The monthly payment will be paid via the case finding and active care management PMPM. 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.

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

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

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

The State has a health home advisory committee of providers and managed care plans through which any issues with payment would be raised and addressed. Directions have been given to health plans to match health home payment to providers based on relative health home care

management effort. Further information on specific construction on health home rates includes specific administration compensation to guide rate differential construct

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

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

All payments will be made under the health home payment detailed above in the care management fee section if they convert to or become part of a health home. This existing TCM rate will be paid for both case finding and active care management. The case finding PMPM will be available for the three months after a patient has been assigned to a health home. Then, nothing can be billed for that patient for the next three months. Following this interval, case finding can be billed for another three months while outreach and engagement is attempted once again. This rate would be paid for both case finding and active care management

New York State's 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. All of the above payment policies have been developed to assure that there is no duplication of payment for health homes services.

CIDP information has been moved to non-duplication of payment for similar services section.

Assurances

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

Describe below how non-duplication of payment will be achieved

All rates are published on the DOH website. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers. All of the above payment policies have been developed to assure that there is no duplication of payment for health home services. http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/rate_information.htm

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.

HEALTH HOME DEVELOPMENT RATE ADD ON SCHEDULE FROM PREVIOUS SECTION PLACED HERE DUE TO SPACE CONSTRAINTS:

Payments will be applicable to claims with dates of service on and after August 1, 2014 and will be paid beginning March 2015 and quarterly thereafter as shown below. The rate add-on for each period will be calculated by dividing the authorized payment amount by total number of claims for such period.

Rate add on applied to claims with the following dates of payment	Rate Add-on Payment Date	Amount of Payment authorized under waiver
8/1/14 to 2/28/15	March 2015	\$80 million
3/1/15 to 5/31/15	June 2015	\$22.2 million
6/1/15 to 8/31/15	September 2015	\$22.2 million
9/1/15 to 11/30/15	December 2015	\$22.3 million
12/1/15 to 2/29/16	March 2016	\$10.9 million
3/1/16 to 5/31/16	June 2016	\$10.9 million
6/1/16 to 8/31/16	September 2016	\$10.9 million
9/1/16 to 11/30/16	December 2016	\$11.2 million

The State meets the requirements of 42 CFR Part 447, Subpart A and sections 1902(a)(4), 1902(a)(6), 1902(a)(30)(A), and 1903 with respect to non-payment of provider-preventable conditions.

The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule unless otherwise described above.

The State provides assurance that it shall reimburse providers directly, except when there are employment or contractual arrangements consistent with section 1902(a)(32).

Records/Submission Packages

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Health Homes Monitoring, Quality Measurement and Evaluation

MEDICAID- Health Homes- NYS Health Home Program NY- 2016

CMS-10434 OMB 0938-1188

Not Started

In Progress

Complete

Package Header

Package ID NY2016MH00020

SPA ID NY-16-0034

Submission Type Official - Review 1

Initial Submission Date 9/29/2016

Approval Date 12/22/2016

Effective Date 10/1/2016

Superseded SPA ID N/A

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Monitoring

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

NYS will monitor cost savings from health homes through measures or 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.

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

To facilitate the use of health information technology by 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 or care for every patient
2. Have a systematic process to follow-up on tests, treatments, services and referrals which is incorporated into the patient's plan or 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
3. Is required to make use of available HIT and access members' data through the RHIO or OE 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 or the HITECH Act that allows the patients' 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 to 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.

Quality Measurement and Evaluation

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

Health Homes Intro

MEDICAID | Medicaid State Plan | Health Homes | NY2017MH0006D | NYS Health Home Program

CMS-10434 OMB 0938-1188

Package Header

Package ID	NY2017MH0006D	SPA ID	N/A
Submission Type	Draft	Initial Submission Date	N/A
Approval Date	N/A	Effective Date	10/1/2017
Superseded SPA ID	NY-16-0034		

Program Authority

1945 of the Social Security Act

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

Name of Health Homes Program

NYS Health Home Program

Executive Summary

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

Summary description including goals and objectives:

New state plan amendment.

Supersedes transmittal # 16-0034

Transmittal # 17-0053 Outreach and Engagement Restructuring

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

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

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

Effective October 1, 2017, the purpose of this State Plan Amendment is to modify the outreach and engagement process of the Health Home program, and to delete a technical inaccuracy related to the assessment fee for the CANS-NY application to children. Amendment change located in MACPRO Unit 7, Health Home Payment Methodologies

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

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

General Assurances

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

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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Health Homes Population and Enrollment Criteria

MEDICAID | Medicaid State Plan | Health Homes | NY2017MH0006D | NYS Health Home Program

CMS-10434 OMB 0938-1188

100% Complete	In Progress	Complete
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Package Header

Package ID	NY2017MH0006D	SPA ID	N/A
Submission Type	Draft	Initial Submission Date	N/A
Approval Date	N/A	Effective Date	10/1/2016
Superseded SPA ID	NY-16-0034		

Categories of Individuals and Populations Provided Health Homes Services

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

- Categorically Needy (Mandatory and Options for Coverage) Eligibility Groups
- Medically Needy Eligibility Groups
 - Mandatory Medically Needy
 - Medically Needy Pregnant Women
 - Medically Needy Children under Age 18
 - Optional Medically Needy (select the groups included in the population)
 - Families and Adults**
 - Medically Needy Children Age 18 through 20
 - Medically Needy Parents and Other Caretaker Relatives
 - Aged, Blind and Disabled**
 - Medically Needy Aged, Blind or Disabled
 - Medically Needy Blind or Disabled Individuals Eligible in 1973

Population Criteria

The state elects to offer Health Homes services to individuals with

- Two or more chronic conditions
 - Specify the conditions included**
 - Mental Health Condition
 - Substance Use Disorder
 - Asthma
 - Diabetes
 - Heart Disease
 - BMI over 25
 - Other (specify)
- | Name | Description |
|-------------|---|
| BMI over 25 | BMI is defined as, at or above 25 for adults, and BMI at or above the 85 percentile for children. |
- One chronic condition and the risk of developing another
 - Specify the conditions included**

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

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

Specify the criteria for at risk of developing another chronic condition

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

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

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

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

To facilitate the use of health information technology by health homes to improve service delivery and coordination across the care continuum, NY has developed initial and final HIT standards for health homes that are consistent with NYS' Operational Plan for Health Information Technology and Exchange approved by

CMS. Providers must meet initial HIT standards to implement a health home. Furthermore, applicants must provide a plan to achieve the final standards within eighteen months of program 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.

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

Major Category: Alcohol and Substance Abuse

3M Clinical Risk Group (3M CRGs) Category

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

Major Category: Mental Health

3M Clinical Risk Group (3M CRGs) Category

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

Major Category: Cardiovascular Disease

3M Clinical Risk Group (3M CRGs) Category

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

Major Category: HIV/AIDS

3M Clinical Risk Group (3M CRGs) Category

1. HIV Disease

Major Category: Metabolic Disease

3M Clinical Risk Group (3M CRGs) Category

1. Chronic Renal Failure
2. Diabetes

Major Category: Respiratory Disease

3M Clinical Risk Group (3M CRGs) Category

1. Asthma
2. Chronic Obstructive Pulmonary Disease

Major Category: Other

3M Clinical Risk Group (3M CRGs) Category

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

Description of population selection criteria

The target population to receive health home services under this amendment includes categorically needy and medically needy

beneficiaries served by Medicaid managed care or fee for service and Medicare/Medicaid dual eligible beneficiaries who meet health home selection criteria. NY will offer Health Home Services to individuals with two or more chronic conditions, individuals with HIV/AIDS, individuals with one serious mental illness, individuals with SED, and individuals with complex trauma.

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

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

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

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

One serious and persistent mental health condition

Specify the criteria for a serious and persistent mental health condition

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

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | NY2017MH0006D | NYS Health Home Program

CMS-10434 OMB 0938-1188

Package Header

Package ID NY2017MH0006D	SPA ID N/A
Submission Type Draft	Initial Submission Date N/A
Approval Date N/A	Effective Date 10/1/2017
Superseded SPA ID NY-16-0034	

Payment Methodology

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

- Fee for Service
 - Individual Rates Per Service
 - Per Member, Per Month Rates
 - Fee for Service Rates based on
 - Severity of each individual's chronic conditions
 - Capabilities of the team of health care professionals, designated provider, or health team
 - Other
- Describe below**
see text box below regarding rates

- Comprehensive Methodology Included in the Plan
- Incentive Payment Reimbursement

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

- PCCM (description included In Service Delivery section)
- Risk Based Managed Care (description included In Service Delivery section)
- Alternative models of payment, other than Fee for Service or PMPM payments (describe below)

Agency Rates

Describe the rates used

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

Rate Development

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

- In the SPA please provide the cost data and assumptions that were used to develop each of the rates
- Please identify the reimbursable unit(s) of service

- 3. Please describe the minimum level of activities that the state agency requires for providers to receive payment per the defined unit
- 4. Please describe the state's standards and process required for service documentation, and
- 5. Please describe in the SPA the procedures for reviewing and rebasing the rates, including
 - the frequency with which the state will review the rates, and
 - the factors that will be reviewed by the state in order to understand if the rates are economic and efficient and sufficient to ensure quality services.

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

Provider Type

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

Care Management Fee:

Health Homes meeting State and federal standards will be paid a per member per month care management fee that is adjusted based on region and case mix (from 3M Clinical Risk Groups (CRG) method for adults, or the Child and Adolescent Needs and Strength Assessment of New York (CANS-NY) for children age 0 through 20). This fee will eventually be adjusted by (after the data is available) patient functional status. Effective October 1, 2017, or on the first day of the calendar month following any month in which the State has determined providers and managed care plans billing systems are in place, the per member per month care management fee for adults will be based on region and case mix. The State will provide managed care plans and providers with at least 30 days notice of the implementation of such fees for adults. The risk adjusted payments will allow providers to receive a diverse population of patients and assign patients to various levels of care management intensity without having to meet preset standards for contact counts. Providers will be able to respond to and adjust the intensity and frequency of intervention based on patient's current condition and needs (from tracking to high touch). All rates will be published on the DOH website. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers. Rates for Health Home services to children are effective October 1, 2016 and apply to services furnished on and after October 1, 2016 through September 30, 2018. Rates for Health Home services furnished to other populations are set October 1, 2016 and apply to services furnished on and after that date.



State Health Home rates may be found at:
http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/rate_information.htm

The care management fee will be paid in two increments based on whether a patient was in 1) the case finding group or 2) the active care management group. Effective October 1, 2017, the case finding group will receive a PMPM for two months after a patient has been assigned or referred to the health home. The Medicaid Managed Care Organization, or Health Home for a member not enrolled in a Managed Care Organization, may extend approval to bill the case finding fee for a period not to exceed an additional two months. This PMPM is intended to cover the cost of outreach and engagement.



Effective August 1, 2014, the per member per month care management fee will be adjusted by a temporary rate add-on to distribute the annual amounts authorized under the State's Medicaid Redesign Team (MRT) Waiver and as shown below.

- August 1, 2014 to March 31, 2015: \$80 million
- April 1, 2015 to December 31, 2015: \$66.7 million
- January 1, 2016 to December 31, 2016: \$43.9 million

(SEE TABLE LOCATED UNDER SECTION ON NON-DUPLICATION OF PAYMENT. MOVED DUE TO SPACE CONSTRAINTS)

The temporary rate add on will be paid to State designated Health Homes. Funds received through this rate add-on must be used to support costs related to one or more of the following authorized purposes: 1) Member engagement and promotion of Health Homes, 2) Workforce training and retraining, 3) Health information technology (HIT) and clinical connectivity, and 4) Joint governance technical assistance.

Each Health Home will be required to submit semi-annual reports documenting how the funds were used in accordance with the four authorized purposes. Semi-annual reports shall be submitted until such time as it is verified that all funds have been used in accordance with authorized purposes. Funds that are not disbursed in accordance with authorized purposes will be recouped by the Department within 90 days of

such finding.

A unit of service will be defined as a billable unit per service month. In order to be reimbursed for a billable unit of service per month health home providers must, at a minimum, provide one of the core health home services per month. The monthly payment will be paid via the case finding and active care management PMPM. 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.

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

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

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

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

Targeted Case Management (TCM) 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, and these providers will require time to meet State and Federal health home standards. The State will allow TCM providers that can meet health home standards to convert to health homes or join with larger health homes. TCM providers that convert to health homes will be governed under NYS Health Home Provider Qualification Standards, not TCM standards. The payment method will be designed to transition all existing TCM capacity from the current rates to the new Health Home payment structure. Effective January 1, 2015 TCM programs for adults will be paid their existing TCM rates until [August 31, 2016] November 30, 2016 . Effective October 1, 2016 through September 30, 2018 TCM programs for children will be paid a transitional rate that is as financially equivalent as practicable to their current rate.

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

All payments will be made under the health home payment detailed above in the care management fee section if they convert to or become part of a health home. This existing TCM rate will be paid for both case finding and active care management. The case finding PMPM will be available for the three months after a patient has been assigned to a health home. Then, nothing can be billed for that patient for the next three months. Following this interval, case finding can be billed for another three months while outreach and engagement is attempted once again. This rate would be paid for both case finding and active care management.

New York State's 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. All of the above payment policies have been developed to assure that there is no duplication of payment for health homes services.

CIDP information has been moved to non-duplication of payment for similar services section.

Assurances

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

Describe below how non-duplication of payment will be achieved All rates are published on the DOH website. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers. All of the above payment policies have been developed to assure that there is no duplication of payment for health home services. http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/rate_information.htm.

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.

HEALTH HOME DEVELOPMENT RATE ADD ON SCHEDULE FROM PREVIOUS SECTION PLACED HERE DUE TO SPACE CONSTRAINTS:

Payments will be applicable to claims with dates of service on and after August 1, 2014 and will be paid beginning March 2015, and quarterly thereafter as shown below. The rate add-on for each period will be calculated by dividing the authorized payment amount by total number of claims for such period.

Rate add on applied to claims with the following dates of payment	Rate Add-on Payment Date	Amount of Payment Authorized Under the Waiver
8/1/14 to 2/28/15	March 2015	\$80 million
3/1/15 to 5/31/15	June 2015	\$22.2 million
6/1/15 to 8/31/15	September 2015	\$22.2 million
9/1/15 to 11/30/15	December 2015	\$22.3 million
12/1/15 to 2/29/16	March 2016	\$10.9 million
3/1/16 to 5/31/16	June 2016	\$10.9 million
6/1/16 to 8/31/16	September 2016	\$10.9 million
9/1/16 to 11/30/16	December 2016	\$11.2 million

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

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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Appendix II
2017 Title XIX State Plan
Fourth Quarter Amendment
Summary

SUMMARY
SPA # 17-0053

The purpose of this State Plan Amendment is to modify the outreach and engagement process of the Health Home program. Effective on or after October 1, 2017, the care management fee will be paid in two increments based on whether a patient was in 1) the case finding group or 2) the active care management group. The case finding group will receive a PMPM for two months after a patient has been assigned or referred to the health home. The Medicaid Managed Care Organization, or Health Home for a member not enrolled in a Managed Care Organization, may extend approval to bill the case finding fee for a period not to exceed an additional two months. This PMPM is intended to cover the cost of outreach and engagement. In addition, no earlier than October 1, 2017, the per member per month care management fee for adults will be modified to be based on region and case mix.

Appendix III
2017 Title XIX State Plan
Fourth Quarter Amendment
Authorizing Provisions

As of 06/28/2017 12:32PM , the Laws database is current through
2017 Chapters 1-48, 55-59

Social Services

§ 365-1. 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. Such additional amounts may be paid with state funds only if federal financial participation for such payments is unavailable.

2-a. Up to fifteen million dollars in state funding may be used to fund health home infrastructure development. Such funds shall be used to develop enhanced systems to support Health Home operations including assignments, workflow, and transmission of data. Funding will also be disbursed pursuant to a formula established by the commissioner to be designated health homes. Such formula may consider prior access to similar funding opportunities, geographic and demographic factors, including the population served, and prevalence of qualifying conditions, connectivity to providers, and other criteria as established by the commissioner.

2-b. The commissioner is authorized to make lump sum payments or adjust rates of payment to providers up to a gross amount of five million dollars, to establish coordination between the health homes and the criminal justice system and for the integration of information of health homes with state and local correctional facilities, to the extent permitted by law. Such rate adjustments may be made to health homes participating in a criminal justice pilot program with the purpose of enrolling incarcerated individuals with serious mental illness, two or more chronic conditions, including substance abuse disorders, or HIV/AIDS, into such health home. Health homes receiving funds under this subdivision shall be required to document and demonstrate the effective use of funds distributed herein.

2-c. The commissioner is authorized to make grants up to a gross amount of one million dollars for certified application counselors and assistants to facilitate the enrollment of persons in high risk populations, including but not limited to persons with mental health and/or substance abuse conditions that have been recently discharged or are pending release from state and local correctional facilities. Funds allocated for certified application counselors and assistants shall be expended through a request for proposal process.

offered an option of at least two providers of health home services, to the extent practicable.

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-1 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 multipayer 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:

3. Until such time as the commissioner obtains necessary waivers and/or approvals of the federal social security act, Medicaid enrollees assigned to providers of health home services will be allowed to opt out of such services. In addition, upon enrollment, an enrollee shall be

Appendix IV
2017 Title XIX State Plan
Fourth Quarter Amendment
Public Notice

- ESG U.S. equity strategies using the Russell 3000, Russell 1000 or S&P 500 as their primary benchmark will be considered. Strategies with an extreme style bias, sector focus or small cap orientation will not be considered.

The RFP process for both the Opportunistic Growth and ESG options is open to evaluating mutual funds, CIT's, or other daily valued, daily liquid pooled vehicles that are funded and able to accept NYSDC participant assets. Separate accounts and unfunded commingled vehicles will not be considered for these RFPs.

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 non-institutional services. The following changes are proposed:

The following clarification to the April 29, 2015, notice provision to revise provisions of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services related to the expansion of behavioral health services provided to individuals under the age of 21 years to add the following six new services will take effect on or after July 1, 2018.

- Crisis Intervention
- Other Licensed Providers
- Community Psychiatric Supports and Treatment
- Psychosocial Rehabilitative Supports
- Family Peer Support Services, and
- Youth Peer Support and Training

The public is invited to review and comment on this proposed State Plan Amendment, a copy of which will be available for public review on the Department's website at http://www.health.ny.gov/regulations/state_plans/status.

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

For further information and to review and comment, please contact:
Department of Health, Division of Finance and Rate Setting, 99 Washington Ave., One Commerce Plaza, Suite 1432, Albany, NY 12210, spa_inquiries@health.ny.gov

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 non-institutional services. The following changes are proposed:

Effective on or after October 1, 2017, the Commissioner of Health will amend the State Plan for Health Home services to reduce the per member per month (pmpm) "outreach" payment for members in the case finding group that have been assigned to a Health Home from \$135 (pmpm) to a rate no less than \$100. In addition, the billing cycles applicable to outreach will be modified, and may include limiting payments for outreach to two consecutive months and requiring a face-to-face meeting in the second month.

The public is invited to review and comment on this proposed State Plan Amendment, a copy of which will be available for public review on the Department's website at http://www.health.ny.gov/regulations/state_plans/status.

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For further information and to review and comment, please contact:
Department of Health, Division of Finance and Rate Setting, 99 Washington Ave., One Commerce Plaza, Suite 1432, Albany, NY 12210, spa_inquiries@health.ny.gov

PUBLIC NOTICE

Department of Health

The New York State Department of Health is submitting a request to the federal Centers for Medicare and Medicaid Services (CMS) to amend New York State's Medicaid Section 1115 Medicaid Redesign Team (MRT) Waiver.

Beginning no earlier than January 1, 2018, New York is seeking approval with this demonstration amendment to:

- Expand the 1115 benefit package to include those OPWDD Medicaid services targeted for individuals with intellectual and developmental disabilities not previously included in the waiver benefit package.

- Transition coverage under the Office for People with Developmental Disabilities (OPWDD) 1915(c) Comprehensive Home and Community Based Services (HCBS) waiver to the 1115 demonstration.

- Remove the exemption from mandatory enrollment into Medicaid Managed Care (MMC) for Medicaid eligible persons who have an intellectual and/or developmental disability (IDD) as defined in Mental Hygiene Law 1.03, unless the individual is otherwise excluded from enrollment, i.e., available comprehensive Third Party Health Insurance and/or Medicare. Individuals who have an intellectual and/or

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For further information and to review and comment, please contact:
Department of Health, Bureau of Federal Relations & Provider Assessments, 99 Washington Ave., One Commerce Plaza, Suite 1460, Albany, NY 12210, spa_inquiries@health.ny.gov

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 institutional temporary rate adjustments to providers that are undergoing a closure, merger, consolidation, acquisition or restructuring themselves or other health care providers. These payments are authorized by § 2826 of the New York Public Health Law.

This notice provides for a temporary rate adjustment with an aggregate payment amounts totaling up to \$10,001,000 annually, for the period April 1, 2017 through March 31, 2019. These payments will be made to the following approved providers: A.O Fox Memorial Hospital, Adirondack Medical Center, Alice Hyde Hospital Association, Auburn Memorial Hospital, Bassett Hospital of Schoharie County- Cobleskill Reg, Brooks Memorial Hospital, Canton-Potsdam Hospital, Carthage Area Hospital, Catskill Regional Hospital – Sullivan, Catskill Regional Medical Center-Hermann Div, Cayuga Medical Center-Ithaca, Champlain Valley Physicians HMC, Chenango Memorial Hospital, Claxton Hepburn Hospital, Clifton-Fine Hospital, Columbia Memorial Hospital, Community Memorial Hospital, Corning Hospital, Cortland Memorial Hospital, Cuba Memorial Hospital, Delaware Valley Hospital, Elizabethtown Community Hospital, Ellenville Community Hospital, Gouverneur Hospital, Ira Davenport Memorial Hospital, Jones Memorial Hospital, Lewis County General Hospital, Little Falls Hospital, Margaretville Memorial Hospital, Mary Imogene Bassett Hospital, Massena Memorial Hospital, Medina Memorial Hospital, Moses-Ludington Hospital, Nathan Littauer Hospital, Northern Dutchess Hospital, Noyes Memorial Hospital, O'Connor Hospital, Olean General Hospital – Main, Oneida City Hospital, Oswego Hospital, River Hospital, Samaritan Medical Center, Schuyler Hospital, Soldiers and Sailors Memorial Hospital, St. James Mercy Hospital, TLC Health Network, Tri Town Regional, Westfield Memorial Hospital, Wyoming County Community Hospital, WCA Hospital, United Memorial Medical Center, St. Mary's Healthcare.

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.

Copies of the proposed State Plan Amendments will be on file in each local (county) social services district and available for public review.

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Staten Island, New York 10301

For further information and to review and comment, please contact:
Department of Health, Division of Finance and Rate Setting, 99 Washington Ave., One Commerce Plaza, Suite 1460, Albany, NY 12210, spa_inquiries@health.ny.gov

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 non-institutional services. The following changes are proposed:

The following is a clarification to the June 14, 2017 noticed provision which proposed to reduce the per member per month (pmpm) "outreach" payment for members in the case finding group that have been assigned to a Health Home. This notice clarifies that the proposed State Plan Amendment will also simplify and modify the Health Home services per member per month care management fee to be based on region and case mix that will be defined by type of population served.

The public is invited to review and comment on this proposed State Plan Amendment, a copy of which will be available for public review on the Department's website at http://www.health.ny.gov/regulations/state_plans/status.

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

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

Department of Health, Division of Finance and Rate Setting, 99 Washington Ave., One Commerce Plaza, Suite 1432, Albany, NY 12210, spa_inquiries@health.ny.gov

PUBLIC NOTICE

Monroe County, New York

Notice of Final Request for Proposals (RFP)

Notice is Hereby Given, That Sealed Proposals are Sought and Requested by the County of Monroe, New York for the Performance of the Following Contract, According to Terms of the Final RFP:

Proposal for the Operation and Maintenance of the Monroe County Resource Recovery Facility and Transfer Station

Monroe County is soliciting proposals for the Operation and Maintenance of the County Resource Recovery Facility and Transfer Station. These operations include the receiving, processing, marketing and/or disposal associated with solid waste, industrial, commercial & institutional waste, construction & demolition debris, waste tires, and organics that are collected by private and public haulers. Prospective Respondents must offer a proposal that will meet the scope of services, qualifications and general description of work activities identified in this Request for Proposals (RFP).

A draft RFP was issued on February 17, 2017 pursuant to the provisions of New York General Municipal Law (NY GML) § 120-w. All comments and questions regarding the draft RFP from prospective Respondents and the public were incorporated as appropriate into the final RFP, or filed with the final RFP, as set forth in the RFP document.

The final RFP will be released on July 28, 2017 in accordance with the timeline and regulations set forth in New York General Municipal Law (NY GML) § 120-w. The final RFP will be available for download from the Monroe County website, at <http://www.monroecounty.gov/bid/rfps>. Individuals must register through the Monroe County website to obtain the PDF version of the final RFP. In addition, the final RFP will be on file at the Monroe County Clerk's Office, 39 W. Main St., Rm. 101, Rochester, NY, 14614, and at the Central Library of Rochester and Monroe County, 115 S. Ave., Rochester, NY, 14604.

Monroe County is soliciting proposals by 3:00 PM EST on October 27, 2017. Any verbal or other communication sent or made to anyone other than to the RFP Coordinator will not be considered and may be cause for rejection of the Respondent's proposal. Respondents' proposals are due to the RFP Coordinator in accordance with the timeline and proposal requirements listed in the final RFP at the Monroe County Division of Purchasing and Central Services, 39 W. Main St., Rm. 200, Rochester, NY, 14614.

PUBLIC NOTICE

Department of State

A meeting of the New York State Board of Real Estate Appraisal will be held on September 28, 2017 at 1:00 p.m. at the Department of State, 99 Washington Ave., Rm. 505, Albany; 65 Court St., Rm. 208, Buffalo; and 123 William St., Rm. 231, New York City.

Should you wish to attend or require further information, please contact Sharon Charland, Board Coordinator, at sharon.charland@dos.ny.gov or (518) 473-2733.

PUBLIC NOTICE

Department of State

Proclamation

Revoking Limited Liability Partnerships

WHEREAS, Article 8-B of the Partnership Law, requires registered limited liability partnerships and New York registered foreign limited liability partnerships to furnish the Department of State with a statement every five years updating specified information, and **WHEREAS**, the following registered limited liability partnerships and New York registered foreign limited liability partnerships have not furnished the department with the required statement, and **WHEREAS**, such registered limited liability partnerships and New

York registered foreign limited liability partnerships have been provided with 60 days notice of this action;

NOW, THEREFORE, I, Rossana Rosado, Secretary of State of the State of New York, do declare and proclaim that the registrations of the following registered limited liability partnerships are hereby revoked and the status of the following New York foreign limited liability partnerships are hereby revoked pursuant to the provisions of Article 8-B of the Partnership Law, as amended:

DOMESTIC REGISTERED LIMITED LIABILITY PARTNERSHIPS

A

ACTIVE CARE CHIROPRACTIC, LLP (12)
ALBANY PHYSICAL THERAPY ASSOCIATES L.L.P. (06)
ALBER & LOGLISCI LLP (05)
ALL CITY PODIATRY, LLP (12)
AMP MEDICAL DIAGNOSTICS LLP (07)
ARCHITECTURE FOR RADIOLOGY LLP (96)
ARNOLD J. HODES & COMPANY CERTIFIED PUBLIC ACCOUNTANTS, L.L. (95)
ASHER GAUGHRAN LLP (06)
ATHARI & NIXON, LLP (04)

B

BAKER, NELSON & WILLIAMS, LLP (96)
BARILE LAW LLP (12)
BAUER AND COLABELLA, LLP (12)
BELAIR & EVANS LLP (96)
BERNSTONE AND GRIECO, LLP (01)
BPLG RUNOFF LLP (12)

C

CAMA & CAMA, LLP (12)
CHARLES E. BINDER & HARRY J. BINDER - ATTORNEYS AT LAW, LLP (11)
COGNITIVE AND BEHAVIORAL CONSULTANTS LLP (04)
COLTHIRST & WALKER, LLP (04)
CONDE & GLASER L.L.P. (12)
COOPER, PAROFF & COOK., LLP (12)
CORNING EMERGENCY PHYSICIANS ASSOCIATES, RLLP (01)
COSMETIC DENTAL ASSOCIATES, LLP (01)
CROWE DEEGAN LLP (01)

D

D&F ASSOCIATES, LLP (04)
DANZIGER AND MANGOLD LLP (06)
DEFOREST GLOBAL PARTNERS LLP (11)
DELL & LITTLE, LLP (96)
DENNIS GROSS, MD, LLP (99)
DESIMONE, AVILES, SHORTER & OXAMENDI LLP (01)
DEUTSCH, METZ & DEUTSCH, LLP (94)
DEVEREAUX AND ASSOCIATES, LLP (05)
DEVITO ZSUFFA LLP (05)
DIGIACOMO & DETOMMASI, L.L.P. (97)
DOLCE AND GOLD, LLP (11)
DOLOBOFF, NADLER & UPBIN LLP (11)

E

EAST ORANGE PSYCHIATRIC ASSOCIATES, LLP (06)
EDWARDS & EDWARDS L.L.P. (12)
EICHLER BERGSMAN & CO., LLP (94)
EMDIN & RUSSELL, LLP (01)
EMERY, CELLI, BRINCKERHOFF & ABADY LLP (97)

F

FAGA SAVINO, LLP (05)

Appendix V
2017 Title XIX State Plan
Fourth Quarter Amendment
Responses to Standard Funding Questions

NON-INSTITUTIONAL SERVICES
State Plan Amendment #17-0053

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 3.1-H 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: Health Home payments are not subject to UPL requirements.

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.

ACA Assurances:

1. **Maintenance of Effort (MOE).** Under section 1902(gg) of the Social Security Act (the Act), as amended by the Affordable Care Act, as a condition of receiving any Federal payments under the Medicaid program during the MOE period indicated below, the State shall not have in effect any eligibility standards, methodologies, or procedures in its Medicaid program which are more restrictive than such eligibility provisions as in effect in its Medicaid program on March 10, 2010.

MOE Period.

- **Begins on:** March 10, 2010, and
- **Ends on:** The date the Secretary of the Federal Department of Health and Human Services determines an Exchange established by a State under the provisions of section 1311 of the Affordable Care Act is fully operational.

Response: This SPA complies with the conditions of the MOE provision of section 1902(gg) of the Act for continued funding under the Medicaid program.

2. **Section 1905(y) and (z) of the Act provides for increased FMAPs for expenditures made on or after January 1, 2014 for individuals determined eligible under section 1902(a)(10)(A)(i)(VIII) of the Act. Under section 1905(cc) of the Act, the increased FMAP under sections 1905(y) and (z) would not be available for States that require local political subdivisions to contribute amounts toward the non-Federal share of the State's expenditures at a greater percentage than would have been required on December 31, 2009.**

Prior to January 1, 2014 States may potentially require contributions by local political subdivisions toward the non-Federal share of the States' expenditures at percentages greater than were required on December 31, 2009. However, because of the provisions of section 1905(cc) of the Act, it is important to determine and document/flag any SPAs/State plans which have such greater percentages prior to the January 1, 2014 date in order to anticipate potential violations and/or appropriate corrective actions by the States and the Federal government.

Response: This SPA would [] / would not [] violate these provisions, if they remained in effect on or after January 1, 2014.

3. Please indicate whether the State is currently in conformance with the requirements of section 1902(a)(37) of the Act regarding prompt payment of claims.

Response: The State does comply with the requirements of section 1902(a)(37) of the Act regarding prompt payment of claims.

Tribal Assurance:

Section 1902(a)(73) of the Social Security Act the Act requires a State in which one or more Indian Health Programs or Urban Indian Organizations furnish health care services to establish a process for the State Medicaid agency to seek advice on a regular ongoing basis from designees of Indian health programs whether operated by the Indian Health Service HIS Tribes or Tribal organizations under the Indian Self Determination and Education Assistance Act ISDEAA or Urban Indian Organizations under the Indian Health Care Improvement Act.

IHCIA Section 2107(e)(I) of the Act was also amended to apply these requirements to the Children's Health Insurance Program CHIP. Consultation is required concerning Medicaid and CHIP matters having a direct impact on Indian health programs and Urban Indian organizations.

- a) Please describe the process the State uses to seek advice on a regular ongoing basis from federally recognized tribes Indian Health Programs and Urban Indian Organizations on matters related to Medicaid and CHIP programs and for consultation on State Plan Amendments waiver proposals waiver extensions waiver amendments waiver renewals and proposals for demonstration projects prior to submission to CMS.**
- b) Please include information about the frequency inclusiveness and process for seeking such advice.**
- c) Please describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment when it occurred and who was involved.**

Response: Tribal consultation was performed in accordance with the State's tribal consultation policy as approved in SPA 11-06, and documentation of such is included with this submission. To date, no feedback has been received from any tribal representative in response to the proposed change in this SPA.

