NY- Submission Package- NY-17-0025

Request System Help

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Submission -Summary

MEDICAID- Health Homes- NYS Health Home Program

Not Started In Progress Complete

Package Header

Package ID **SPA ID**

Submission Type Official - Review 1 **Initial Submission Date**

Approval Date **Effective Date** July 1, 2018

Superseded SPA ID 16-0034

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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

SPA ID and Effective Date

SPA ID NY-17-0025

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

Executive Summary

Summary Description Including Goals and Objectives

The New York State Department of Health (DOH), in collaboration with the New York State Office for People With Developmental Disabilities (OPWDD), is working to expand the Health Home program to serve individuals with intellectual and/or developmental disabilities (I/DD). The amendments to the Health Home State Plan included herein expand Health Home eligibility criteria to include Developmental Disability chronic conditions as defined in this SPA, and establish per member per month rates for Health Homes certified to serve members with I/DD. Enrollment of individuals with eligible Developmental Disability conditions in Health Homes is anticipated to begin July 2018, and may be phased in regionally. The State is seeking 90/10 Federal/State match for eight quarters following the implementation of the new Health Home Developmental Disability chronic conditions in each region.

The expansion of Health Home to serve the I/DD population is part of the State's Medicaid Redesign plan to transition the 1915(c) OPWDD Comprehensive Waiver #NY.0238 to the 1115 Waiver, transition Medicaid Service Coordination to Health Home and transition the OPWDD I/DD population to managed care.

Dependency Description

Description of any dependencies between this submission package and any other submission package undergoing review

The expansion of Health Home to serve the I/DD population is part of the State's Medicaid Redesign plan to transition the 1915(c) OPWDD Comprehensive Waiver #NY.0238 to the 1115 Waiver, transition Medicaid Service Coordination to Health Home and transition the OPWDD I/DD population to managed care.

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	
Second	

Federal Statute/Regulation Citation

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

Governor's Office Review

☒ No comment

☐ **Comments received**

Records/Submission Packages

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Submission -Medicaid State Plan

MEDICAID- Health Homes- NYS Health Home Program

Not Started In Progress Complete

Package Header

Package ID **SPA ID**

Submission Type **Initial Submission Date**

Approval Date **Effective Date**

Superseded SPA ID N/A

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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

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Submission – Public Comment

MEDICAID- Health Homes- NYS Health Home Program

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Package ID **SPA ID**

Submission Type Official - Review 1 **Initial Submission Date**

Approval Date **Effective Date** N/A

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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

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

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Submission –Tribal Input

MEDICAID- Health Homes- NYS Health Home Program

Not Started In Progress Complete

Package Header

Package ID **SPA ID**

Submission Type **Initial Submission Date**

Approval Date **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 -

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

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

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

Complete the following Information regarding any 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		

☐ **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		
Oneida Indian Nation		
Onondaga Nation		
Seneca Nation of Indians		
Shinnecock Indian Nation Tribal Office		
St Regis Mohawk Tribe		
Tonawanda Seneca Nation Tribe		
Tuscarora Indian Nation		
Ukechang Indian Territory		

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		
Tribal 2		
Tribal 3		
Tribal 4		
Tribal 5		

Indicate the key issues raised (optional)

☐ **Access**

☐Quality

☐Cost

☐Payment methodology

☐Eligibility

☐Benefits

☐Service delivery

☐Other issue

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Submission – SAMHSA Consultation

MEDICAID- Health Homes- NYS Health Home Program

Not Started In Progress Complete

Package Header

Package ID **SPA ID**

Submission Type **Initial Submission Date**

Approval Date **Effective Date** N/A

Superseded SPA ID

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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
7/20/17

Records/Submission Packages

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Health Homes Intro

MEDICAID- Health Homes- NYS Health Home Program

Not Started In Progress Complete

Package Header

Package ID **SPA ID**

Submission Type **Initial Submission Date** TBD

Approval Date **Effective Date**

Superseded SPA ID N/A

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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

The New York State Department of Health (DOH), in collaboration with the New York State Office for People With Developmental Disabilities (OPWDD), is working to expand the Health Home program to serve individuals with intellectual and/or developmental disabilities (I/DD). The amendments to the Health Home State Plan included herein expand Health Home eligibility criteria to include Developmental Disability chronic conditions as defined in the SPA, and establish per member per month rates for Health Homes certified to serve members with I/DD. Enrollment of individuals with eligible Developmental Disability conditions in Health Homes is anticipated to begin July 2018, and may be phased in regionally. The State is seeking 90/10 Federal/State match for eight quarters following the implementation of the new Health Home Developmental Disability chronic conditions in each region.

Health Homes that are certified to serve the individuals with intellectual and/or developmental disabilities and that meet State and federal standards will be paid a per member per month care management fee that is based on assessment data and residential status. Rates for Health

Homes certified to serve individuals with intellectual and/or developmental disabilities will be established for the first month of enrollment and for each month of enrollment thereafter. Individuals enrolled in Health Homes certified to serve individuals with intellectual and/or developmental disabilities will not be subject to a case finding PMPM.

For the twenty-four months beginning from the effective date the State authorizes Health Homes, located in a region or regions, which are certified to serve individuals with intellectual and developmental disabilities to begin to enroll individuals with eligible DD chronic conditions, the per member per month case management fee will include a rate add on for initial infrastructure and governance costs associated with the implementation Health Homes certified to serve individuals with intellectual and developmental disabilities.

General Assurances

☒ **The state provides assurance that eligible individuals will be given a free choice of Health Homes providers.**

☒ **The state 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 such assurance from the effective date the State authorizes Health Homes, located in a region or regions, which are certified to serve members with intellectual and developmental disabilities to begin to enroll members with eligible DD chronic conditions, the FMAP for Health Home services shall be 90% for the first eight fiscal quarters from such effective date. Such effective date shall begin on the first day of a month, and the State will notify CMS at least 30 days prior to such effective date and identify the authorized regions.

☒ **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

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Health Homes Population and Enrollment Criteria

MEDICAID- Health Homes- NYS Health Home Program

Not Started In Progress Complete

Package Header

Package ID **SPA ID**

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Approval Date **Effective Date**

Superseded SPA ID 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.
Developmental Disability	See description below

☒ 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
Developmental Disability	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 and the chronic conditions defined in the developmental disabilities category (resulting in functional limitations that constitute a substantial handicap as defined by New York State Mental Hygiene Law Section 1.03(22) and determined by the New York State Office for People With Developmental Disabilities (OPWDD) or its designee) are each single qualifying conditions for which NYS is ~~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. In addition, approximately 100,000 (including dual eligibles) have been identified as having a developmental disability, as defined in New York State Mental Hygiene Law section 1.03(22). These high cost/high need enrollees are categorized into four groups representing enrollees with intellectual and/or developmental 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. Health homes may be certified to specialize in serving adults, children age 0 through 20, and/or individuals with I/DD. Applicant health home providers will be required to meet State defined health home requirements that assure access to primary, specialty, behavioral health care and developmental disability services 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, developmental disability 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, developmental disability 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 toutilize 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 and the developmental disabilities 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.

Major Category: Developmental Disability Category

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

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, individuals with complex trauma, or individuals with one of the developmental disabilities in the developmental disability category of chronic conditions and which results in functional limitations that constitute a substantial handicap as defined by New York State Mental Hygiene Law Section 1.03(22) and determined by the New York State Office for People With Developmental Disabilities (OPWDD) or its designee. New York will also offer Health Home services to individuals with one developmental disability in the developmental disability category of chronic conditions as defined by the State and another chronic condition. Such individuals may be enrolled in Health Homes certified to serve children or adults, as appropriate for their needs. 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.

The primary mechanism for referral to Health Homes for individuals in the developmental disability category will be OPWDD, through its Developmental Disability Regional Offices (DDROs) or designee. OPWDD's DDROs are well connected to area schools, health care providers and other governmental and non-governmental social service providers and will make referrals to Health Homes that can meet their individual needs. Referrals will consider the region where a member lives and the connectivity of providers that serve the eligible person to the certified Health Homes. All certified Health Homes may also directly receive referrals from the community, including providers and managed care plans and will ensure the individual is referred to a certified Health Home that can meet their individual needs.

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 diagnosis. 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, sell-perceptions, etc.) iv. often occur in the context or the child's relationship with a caregiver and v. can interfere with the child's ability to form a secure attachment bond which is considered a prerequisite for healthy social-emotional functioning. c. Many aspects of a child's healthy physical and mental development rely on this secure attachment, a primary source of safety and stability d. wide-ranging, long-term adverse effects can include impairments in i. physiological responses and related neurodevelopment, ii. emotional responses, iii. cognitive processes including the ability to think, learn and concentrate iv. Impulse control and other self-regulating behavior, v. self-image and vi. relationships with others. Effective October, 1 2016 complex trauma and SED will each be a single qualifying condition.

Enrollment of Participants

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

☐ **Opt-In to Health Homes provider**

☒ **Referral and assignment to Health Homes provider with opt-out**

☐ **Other (describe)**

Describe the process used

Individuals eligible for health home services may ~~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, developmental disability regional offices (DDROs) 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 primary mechanism for referral to Health Homes for individuals in the developmental disability category will be OPWDD, through its Developmental Disability Regional Offices (DDROs) or designee. OPWDD's DDROs are well connected to area schools, health care providers and other governmental and non-governmental social service providers. Referrals will consider the region where a member lives and the connectivity of providers that serve the eligible person to the certified Health Homes. Health Homes may also directly receive referrals from the community, including providers and managed care plans. All certified Health Homes may also directly receive referrals from the community, including providers and managed care plans and will ensure the individual is referred to a certified Health Home that can meet their individual needs. Individuals will be given the option to choose another health home when available or opt out of enrollment into 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-17-0025) Follow

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Health Homes Geographic Limitations

MEDICAID- Health Homes- NYS Health Home Program NY-

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Package Header

Package ID **SPA ID**

Submission Type **Initial Submission Date**

Approval Date **Effective Date**

Superseded SPA ID N/A

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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

NY- Submission Package- Follow

Request System Help

-All Reviewable Units

Health Homes Services

MEDICAID- Health Homes- NYS Health Home Program NY-

Not Started In Progress Complete

Package Header

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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-centered care plan will be required for all health home enrollees. The care plan will be developed based on the information obtained from a comprehensive health risk assessment used to identify the enrollee's physical, mental health, chemical dependency, long term supports and services, developmental disability services 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, developmental disability services, and 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), developmental disability service provider(s), care manager and other providers directly involved in the individuals 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**

☐**Dieticians**

☐**Nutritionists**

☒**Other (specify)**

Provider Type	Description
Multidisciplinary teams	NY health homes will use multidisciplinary teams of medical, mental health, chemical dependency treatment providers, developmental disability services providers, social workers, nurses and other care providers led by a dedicated care manager who will assure that enrollees receive needed medical, behavioral, and social services in accordance with a single 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, developmental disability services, 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, developmental disability providers and community-based organizations. The health home provider's policies and procedures will direct and

incorporate successful collaboration through use of evidence-based referrals, follow-up consultations, and regular, scheduled case review meetings with all members of the interdisciplinary team. The 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 requiredto 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 toutilize 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	Description
Multidisciplinary teams	NY health homes will use multidisciplinary teams of medical, mental health, chemical dependency treatment providers, developmental disability providers, social workers, nurses and other care providers led by a dedicated care manager who will assure that enrollees receive needed medical, behavioral, and social services in accordance with a single plan of care.

Health Promotion

Definition

Health promotion begins for eligible health home enrollees with the commencement of outreach and engagement activities. NYS' health home plan for outreach and engagement will require a health home provider to actively seek to engage patients in care by phone, letter, HIT and community "in reach" and outreach. Each of these outreach and engagement functions will 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 basedwellness and prevention by linking health home enrollees with resources for smoking cessation, diabetes, asthma, hypertension, self- help recovery resources, and other services based on individual needs and preferences. Health promotion activities will be utilized to promote patient education and self-management of their chronic condition.

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

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

Scope of service

The service can be provided by the following provider types

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

Provider Type	Description
Multidisciplinary teams	NY health homes will use multidisciplinary teams of medical, mental health, chemical dependency treatment providers, developmental disability providers, social workers, nurses and other care providers led by a dedicated care manager who will assure that enrollees receive needed medical, behavioral, and social services in accordance with a single 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 todevelop 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 requiredto 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 toutilize 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, developmental disability providers, social workers, nurses and other care providers led by a dedicated care manager who will assure that enrollees receive needed medical, behavioral, and social services in accordance with a single 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 caregiver's knowledge about the individual's disease(s), promote the enrollee's engagement and self-management capabilities, and help the enrollee improve adherence to their prescribed treatment. The provider will discuss and provide the enrollee, the enrollee's family and 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**
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- ☐ **Social Workers**
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- ☐ **Licensed Complementary and alternative Medicine Practitioners**
- ☐ **Dieticians**
- ☐ **Nutritionists**

☒Other (specify)

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

Request System Help

Health Homes Providers

MEDICAID- Health Homes- NYS Health Home Program

Not Started In Progress Complete

Package Header

Package ID **SPA ID**

Submission Type **Initial Submission Date**

Approval Date **Effective Date**

Superseded SPA ID N/A

View implementation Guide

View All Responses

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, developmental disability and social services in a coordinated and integrated manner.

NY health homes will use multidisciplinary teams of medical, mental health, developmental disability, chemical dependency treatment providers, social workers, nurses and other care providers led by a dedicated care manager who will assure that enrollees receive needed medical, behavioral, developmental disability, including community-based crisis prevention and response services and social services in accordance with a single plan of care. Optional team members may include nutritionists/dieticians, pharmacists, outreach workers, including peer specialists and other representatives as appropriate to meet the enrollee needs (housing representatives, entitlement, employment). All members of the team will be responsible for reporting back to the care manager on patient status, treatment options, actions taken and outcomes as a result of those interventions. All members of the team will also be responsible for ensuring that care is person centered, culturally competent and linguistically capable.

A single care management record willbe 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, developmental disability 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, developmental disabilities services 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 heath 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, Office for Children and Family Services and the Office for People With Developmental Disabilities 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, as provided by Health Home standards and requirements. 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 providedto 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 and developmental disability services as defined in the enrollee care plan.

4. Hospitals that are part of a health home network must have procedures in place for referring any eligible individual with chronic conditions who 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, developmental disability services, 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, developmental disability 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, developmental disability services and social service needs and clearly identifies the primary care physician/nurse practitioner, specialist(s), behavioral health care provider(s), developmental disability providers, care manager and other providers directly involved inthe 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, developmental disability 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, independence and community integration 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, developmental disability services, long term supports and services, 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) update.

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 and developmental disability providers, evidence-based referrals and follow-up and consultations that clearly define roles and responsibilities.

2f.The health home provider supports continuity of care and health promotion through the development of a treatment relationship with the individual and the interdisciplinary team of providers.

2g.The health home provider supports care coordination and facilitates collaboration through the establishment of regular case review meetings, including all members of the interdisciplinary team on a schedule determined by the health home provider and member. 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 dearly define roles and responsibilities.

5c.The plan of care should include community-based and other social support services as well as healthcare, long term supports, services and developmental disability services that respond to the 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://www.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	

Records/Submission Packages

NY- Submission Package- Follow

Request System Help

-All Reviewable Units

Health Homes Service Delivery Systems

MEDICAID- Health Homes- NYS Health Home Program

Not Started In Progress Complete

Package Header

Package ID **SPA ID**

Submission Type **Initial Submission Date**

Approval Date **Effective Date**

Superseded SPA ID N/A

View implementation Guide

View All Responses

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 15-20 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

NY- Submission Package- Follow

Request System Help

-All Reviewable Units

Health Homes Payment Methodologies

MEDICAID- Health Homes- NYS Health Home Program NY-

Not Started In Progress Complete

Package Header

Package ID **SPA ID**

Submission Type **Initial Submission Date**

Approval Date **Effective Date**

Superseded SPA ID N/A

View implementation Guide

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 thedefined 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 that are certified to serve adults and meet~~ing~~ 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. This fee will eventually be adjusted by (after the data is available) patient functional status. Health homes that are certified to serve children (age 0 through 20) and meet State and Federal standards will be paid a per member per month care management fee that is adjusted based, 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. Health Homes that are certified to serve the individuals with intellectual and/or developmental disabilities and meeting State and federal standards will be paid a per member per month care management fee that is based on assessment data, residential status and other functional indicators. Rates for Health Homes certified to serve individuals with intellectual and/or developmental disabilities will be established for the first month of enrollment and for each month of enrollment thereafter. 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. Rates for Health Home certified to serve individuals with intellectual and/or developmental disabilities may be phased in regionally but will begin no earlier than July 1, 2018.

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

This care management fee will be paid in two increments based on whether a patient is in 1) the case finding group or 2) the active care management group. The case finding group will receive a PMPM that is a reduced percentage (80%) 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 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 PMPM is intended to cover the cost of outreach and engagement. Patients with developmental disabilities and enrolled in Health Homes certified to serve individuals with intellectual and/or developmental disabilities will not be subject to a case finding PMPM.

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, 2014to March 31, 2015:$80 million

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

January 1, 2016to 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 folbwing 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.

For the twenty-four months beginning from the effective date the State authorizes Health Homes, located in a region or regions, which are certified to serve individuals with intellectual and developmental disabilities to begin to enroll individuals with eligible DD chronic conditions, the per member per month case management fee will include a rate add on for initial infrastructure and governance costs associated with the implementation Health Homes certified to serve individuals with intellectual and developmental disabilities. Health Homes must use the to

support costs related to one or more of the purposes identified above, and are subject to the reporting requirements and recoupment provisions provided above.

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. TCM providers, including Medicaid Service Coordinators (MSC) that provide care management to individuals with developmental disabilities will transition to Health Home care management and will be paid the care management fee described above for individuals with developmental disabilities.

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

NY- Submission Package- Follow

Request System Help

-All Reviewable Units

Health Homes Monitoring, Quality Measurement and Evaluation

MEDICAID- Health Homes- NYS Health Home Program

Not Started In Progress Complete

Package Header

Package ID	SPA ID
Submission Type	Initial Submission Date
Approval Date	Effective Date
Superseded SPA ID N/A	

View implementation Guide

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

4. Is required to make use of available HIT and access members' data through the RHIO or QE to conduct all processes as feasible

The final standards require health home provider to use HIT for the following:

1. Have structured interoperable health information technology systems, policies, procedures and practices to support the creation, documentation, execution and ongoing management of a plan of care for every patient;

2. Utilize an electronic health record system that qualifies under the Meaningful Use provisions 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://www.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 or care and patient adherence to recommendations made by their provider. This may include the use of cell phones, peripheral monitoring devices, and access patient care management records, as feasible

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

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

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 measurable 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.**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL **FOR: HEALTH CARE FINANCING ADMINISTRATION**	1. TRANSMITTAL NUMBER: **17-0025**	2. STATE **New York**
	3. PROGRAM IDENTIFICATION: **TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)**	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE **July 1, 2018**	

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

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

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

6. FEDERAL STATUTE/REGULATION CITATION: **1902(a) of the Social Security Act and 42 CFR 447**	7. FEDERAL BUDGET IMPACT: **(in thousands)** **a. FFY 10/01/17-09/30/18 $ 41,174.10** **b. FFY 10/01/18-09/30/19 $ 166,377.51**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **MacPro Portal SPA – Attachment 3.1-H**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **MacPro Portal SPA – Attachment 3.1-H**

10. SUBJECT OF AMENDMENT:
Health Home IDD
(FMAP = 90%)

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:	16. RETURN TO: **New York State Department of Health** **Division of Finance & Rate Setting** **99 Washington Ave – One Commerce Plaza** **Suite 1432** **Albany, NY 12210**
13. TYPED NAME: **Jason A. Helgerson**	
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:

Fiscal Calculations

SPA # 17-0025
Description: IDD Health Home
Effective Date: 7/1/2018
Source: DOH (SPA Unit/Program)
Date Modified: 8/31/2017 16:58

				FFY 3 7/1/18 - 9/30/18	FFY 12 10/1/18 - 9/30/19
New CCO Spend					
			Gross Amount	70,544,773	284,988,941
			Monthly Amount	23,514,924	23,749,078
	FMAP				
Federal Share					
Year 1	90.00%	7/1/18 - 9/30/18	3 months	63,490,296	
Year 2	90.00%	10/1/18 - 9/30/19	12 months		256,490,047
			Total	63,490,296	256,490,047
Non-Federal Share					
Year 1	10.00%	7/1/18 - 9/30/18	3 months	7,054,477	
Year 2	10.00%	10/1/18 - 9/30/19	12 months		28,498,894
			Total	7,054,477	28,498,894
			Total	70,544,773	284,988,941
Remove Historical MSC					
			Gross Amount	-44,632,395	-180,225,073
			Monthly Amount	-14,877,465	-15,018,756
	FMAP				
Federal Share					
Year 1	50.00%	7/1/18 - 9/30/18	3 months	-22,316,197	
Year 2	50.00%	10/1/18 - 9/30/19	12 months		-90,112,537
			Total	-22,316,197	-90,112,537
Non-Federal Share					
Year 1	50.00%	7/1/18 - 9/30/18	3 months	-22,316,197	
Year 2	50.00%	10/1/18 - 9/30/19	12 months		-90,112,537
			Total	-22,316,197	-90,112,537
			Total	-44,632,395	-180,225,073
Total					
			Gross Amount	25,912,379	104,763,868
			Monthly Amount	8,637,460	8,730,322
	FMAP				
Federal Share					
Year 1	Varies	7/1/18 - 9/30/18	3 months	41,174,099	
Year 2	Varies	10/1/18 - 9/30/19	12 months		166,377,510
			Total	41,174,099	166,377,510
Non-Federal Share					
Year 1	Varies	7/1/18 - 9/30/18	3 months	-15,261,720	
Year 2	Varies	10/1/18 - 9/30/19	12 months		-61,613,642
			Total	-15,261,720	-61,613,642
			Total	25,912,379	104,763,868

developmental disability under the demonstration who have access to Comprehensive Third Party Health Insurance or Medicare will remain in Fee For Service (FFS) Medicaid until these exclusions from MMC enrollment are removed.

Additional information concerning the MRT Plan and any amendment requests can be obtained by writing to: Department of Health, Office of Health Insurance Programs, Corning Tower (OCP Suite 720), Waiver Management Unit, Albany, NY 12237 or by e-mail: 1115waivers@health.state.ny.us.

Written comments concerning the amendment will be accepted at the above address for a period of thirty (30) days from the date of this notice.

MRT Plan information is also available to the public on-line at http://www.health.ny.gov/health_care/ medicaid/redesign/medicaid_waiver_1115.htm

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 related to Health Homes. The following changes are proposed:

Effective on or after January 1, 2018 the Commissioner of Health, in consultation with the Commissioner of the Office for People With Developmental Disabilities (OPWDD), will amend the State Plan for Health Home services to prioritize and phase in the enrollment of individuals with intellectual and/or developmental disabilities (I/DD) into Health Homes. Proposed State Plan Amendments include amending the Health Home eligibility chronic condition criteria to include new qualifying intellectual and/or developmental disabilities and establishing per member, per month Health Home rates for I/DD members that are based on a needs assessment. The State will be seeking an enhanced federal match of 90% for the new I/DD qualifying Health Home chronic conditions.

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

Oneida-Herkimer Solid Waste Authority

Oneida-Herkimer Solid Waste Authority is soliciting proposals from administrative service agencies relating to trust service, administration and/or funding of a Deferred Compensation Plan for the employees of the Oneida-Herkimer Solid Waste Authority. They must meet the requirements of section 457 of the Internal Revenue Code and Section 5 of the State Finance Law, including all rules and regulations issued pursuant thereto.

A copy of the proposal questionnaire may be obtained from: Oneida-Herkimer Solid Waste Authority, Patrick J. Donovan, Comptroller, 1600 Genesee St., Utica, NY 13502, or patd@ohswa.org

All proposals must be received no later than 30 days from the date of publication in the New York State Register.

PUBLIC NOTICE

Department of State
Notice of Routine Program Change
Town of Huron
Local Waterfront Revitalization Program

PURSUANT to 15 CFR 923.84(b), the New York State Department of State (DOS) has submitted a routine program change to the federal Office of Coastal Management (OCM). The change to the New York State Coastal Management Program (CMP) covered by this request is the incorporation of the Town of Huron Local Waterfront Revitalization Program (LWRP) into the State's CMP.

A major component of the State's CMP is the provision that local governments be allowed to prepare Local Waterfront Revitalization Programs, which further detail and make geographically specific the State's coastal policies. Each LWRP is reviewed for consistency with the State's CMP and approved if it meets the guidelines established in the State CMP and Article 42 of the NYS Executive Law.

The Town of Huron LWRP is a long-term management program for the Town's waterfront resources along Sodus Bay, Lake Ontario, East Bay, and Port Bay, prepared under the provisions of Article 42 of the Executive Law and its implementing regulations. The LWRP revises the inland alignment of the coastal boundary by incorporating land acquired for preservation purposes located south and west of Shaker Tract Road. The LWRP includes comprehensive text and graphics describing the existing land uses and controls in the Town of Huron, including the Building Law that was amended in 2011 to implement the New York State Uniform Fire Prevention and Building Code and its standards, the Septic Law that was amended in 2013 to supplement and expand the local requirements for septic system maintenance and upgrades, the Land Development Regulations and Public Works Requirements Law adopted in 2005 to replace the Subdivision Regulations adopted in 1969, the local Coastal Erosion Hazard Area Law adopted in 2002 to regulate new construction or placement of structures in order to ensure that they are located a safe distance from areas of active erosion and the impacts of coastal storms, the Dock and Moorings Law adopted in 2005 to regulate the placement, construction and use of docks, piers, boathouses, boat hoists, and other structures or moorings in public waterways, and the LWRP Consistency Review Law adopted in 2016 to establish the legal framework for the review of direct and indirect Town actions with the waterfront revitalization area covered by the LWRP.

The draft LWRP was circulated by the New York State Department of State to potentially affected State, federal, and regional agencies during a review period from April 23, 2014 to June 26, 2014. Following this review period, the Department of State coordinated responses to comments received with the Town of Huron, and revised the draft LWRP where necessary. The Town of Huron LWRP was adopted by resolution by the Town of Huron Town Board on April 18, 2016, and approved by the New York State Secretary of State on May 15, 2017.

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 assistors 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 assistors shall be expended through a request for proposal process.

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

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-l of this title on entities participating in demonstration projects established pursuant to such section, the commissioner is authorized to allow such entities which meet the requirements of this section to provide health home services.

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

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

(b) meet the standards established pursuant to subdivision one of this section for providing and receiving payment for health home services; provided, however, that an entity meeting the standards established pursuant to subdivision one of this section shall not be required to be an integrated service provider pursuant to this subdivision.

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

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

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

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

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

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

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

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

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

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

9. The contract entered into by the commissioner of health prior to January first, two thousand thirteen pursuant to subdivision eight of this section may be amended or modified without the need for a competitive bid or request for proposal process, and without regard to the provisions of sections one hundred twelve and one hundred sixty-three of the state finance law, section one hundred forty-two of the economic development law, or any other provision of law, excepting the responsible vendor requirements of the state finance law, including, but not limited to, sections one hundred sixty-three and one hundred thirty-nine-k of the state finance law, to allow the purchase of additional personnel and services, subject to available funding, for the limited purpose of assisting the department of health with implementing the Balancing Incentive Program, the Fully Integrated Duals Advantage Program, the Vital Access Provider Program, the Medicaid waiver amendment associated with the public hospital transformation, the addition of behavioral health services as a managed care plan benefit, the delivery system reform incentive payment plan, activities to facilitate the transition of vulnerable populations to managed care and/or any workgroups required to be established by the chapter of the laws of two thousand thirteen that added this subdivision. The department is authorized to extend such contract for a period of one year, without a competitive bid or request for proposal process, upon determination that the existing contractor is qualified to continue to provide such services; provided, however, that the department of health shall submit a request for applications for such contract during the time period specified in this subdivision and may terminate the contract identified herein prior to expiration of the extension authorized by this subdivision.

Mental Hygiene

§ 1.03 Definitions.

When used in this chapter, unless otherwise expressly stated or unless the context otherwise requires:

1. "Department" means the department of mental hygiene of the state of New York. Except as used in article five of this chapter, the term "department" shall hereafter refer to an office of the department created by section 5.01 of this chapter.

2. "Commissioner" means the commissioner of mental health, the commissioner of developmental disabilities and the commissioner of alcoholism and substance abuse services as used in this chapter. Any power or duty heretofore assigned to the commissioner of mental hygiene or to the department of mental hygiene pursuant to this chapter shall hereafter be assigned to the commissioner of mental health in the case of facilities, programs, or services for individuals with mental illness, to the commissioner of developmental disabilities in the case of facilities, programs, or services for individuals with developmental disabilities, to the commissioner of alcoholism and substance abuse services in the case of facilities, programs, or services for alcoholism, alcohol abuse, substance abuse, substance dependence, and chemical dependence in accordance with the provisions of titles D and E of this chapter.

3. "Mental disability" means mental illness, intellectual disability, developmental disability, alcoholism, substance dependence, or chemical dependence.

4. "Services for persons with a mental disability" means examination, diagnosis, care, treatment, rehabilitation, supports, habilitation or training of the mentally disabled.

5. "Provider of services" means an individual, association, corporation, partnership, limited liability company, or public or private agency, other than an agency or department of the state, which provides services for persons with a mental disability. It shall not include any part of a hospital as defined in article twenty-eight of the public health law which is not being operated for the purpose of providing services for the mentally disabled. No provider of services shall be subject to the regulation or control of the department or one of its offices except as such regulation or control is provided for by other provisions of this chapter.

6. "Facility" means any place in which services for the mentally disabled are provided and includes but is not limited to a psychiatric center, developmental center, institute, clinic, ward, institution, or building, except that in the case of a hospital as defined in article twenty-eight of the public health law it shall mean only a ward, wing, unit, or part thereof which is operated for the purpose of providing services for the mentally disabled. It shall not include a place where the services rendered consist solely of non-residential services for the mentally disabled which are exempt from the requirement for an operating certificate under article sixteen, thirty-one or thirty-two of this chapter, nor shall it include domestic care and comfort to a person in the home.

7. "Department facility" means a facility within one of the offices of the department.

8. "Examining physician" means a physician licensed to practice medicine in the state of New York.

9. "Certified psychologist" means a person who has been certified and

registered to practice psychology in the state of New York pursuant to the education law.

* 10. "Hospital" means the in-patient services of a psychiatric center under the jurisdiction of the office of mental health or other psychiatric in-patient facility in the department, a psychiatric in-patient facility maintained by a political subdivision of the state for the care or treatment of the mentally ill, a ward, wing, unit, or other part of a hospital, as defined in article twenty-eight of the public health law, operated as a part of such hospital for the purpose of providing services for the mentally ill pursuant to an operating certificate issued by the commissioner of mental health, a comprehensive psychiatric emergency program which has been issued an operating certificate by such commissioner, or other facility providing in-patient care or treatment of the mentally ill which has been issued an operating certificate by such commissioner.

* NB Effective until July 1, 2020

* 10. "Hospital" means the in-patient services of a psychiatric center under the jurisdiction of the office of mental health or other psychiatric in-patient facility in the department, a psychiatric in-patient facility maintained by a political subdivision of the state for the care or treatment of the mentally ill, a ward, wing, unit, or other part of a hospital, as defined in article twenty-eight of the public health law, operated as a part of such hospital for the purpose of providing services for the mentally ill pursuant to an operating certificate issued by the commissioner of mental health, or other facility providing in-patient care or treatment of the mentally ill which has been issued an operating certificate by such commissioner.

* NB Effective July 1, 2020

11. "School" means the in-patient service of a developmental center or other residential facility for individuals with developmental disabilities under the jurisdiction of the office for people with developmental disabilities or a facility for the residential care, treatment, training, or education of individuals with developmental disabilities which has been issued an operating certificate by the commissioner of developmental disabilities.

12. "Alcoholic beverages" means alcoholic spirits, liquors, wines, beer, and every liquid or fluid containing alcohol, which is capable of being consumed by human beings and produces intoxication in any form or in any degree.

13. "Alcoholism" means a chronic illness in which the ingestion of alcohol usually results in the further compulsive ingestion of alcohol beyond the control of the sick person to a degree which impairs normal functioning.

14. "Alcoholic" means any person who is afflicted with the illness of alcoholism.

15. "Recovered alcoholic" means a person with a history of alcoholism whose course of conduct over a sufficient period of time reasonably justifies a determination that the person's capacity to function normally within his social and economic environment is not, and is not likely to be, destroyed or impaired by alcohol.

16. "Alcohol abuse" means any use of alcohol which interferes with the health, social or economic functioning of the individual or of society.

17. "Alcoholism facility" means an in-patient facility in the department designated by the commissioner of alcoholism and substance abuse services as suitable for the care and treatment of alcoholics or an in-patient facility which has been approved by such commissioner as suitable for the care and treatment of persons suffering from alcoholism

and which has been issued an operating certificate by such commissioner.

18. "Alcoholism programs", "treatment facilities", and "services" mean programs, treatment facilities, and services provided to persons suffering from alcoholism, alcohol abusers, and significant others.

19. "Significant other" means a relative, close friend, associate or individual otherwise concerned with the welfare of a person suffering from alcohol and/or substance abuse when that individual is directly affected by the person's alcoholism and/or substance abuse.

20. "Mental illness" means an affliction with a mental disease or mental condition which is manifested by a disorder or disturbance in behavior, feeling, thinking, or judgment to such an extent that the person afflicted requires care, treatment and rehabilitation.

22. "Developmental disability" means a disability of a person which:

(a) (1) is attributable to intellectual disability, cerebral palsy, epilepsy, neurological impairment, familial dysautonomia, Prader-Willi syndrome or autism;

(2) is attributable to any other condition of a person found to be closely related to intellectual disability because such condition results in similar impairment of general intellectual functioning or adaptive behavior to that of intellectually disabled persons or requires treatment and services similar to those required for such person; or

(3) is attributable to dyslexia resulting from a disability described in subparagraph one or two of this paragraph;

(b) originates before such person attains age twenty-two;

(c) has continued or can be expected to continue indefinitely; and

(d) constitutes a substantial handicap to such person's ability to function normally in society.

23. "Patient" means a person receiving services for the mentally disabled at a facility. It includes a resident at a school.

24. "Informal caregiver" means the family member, friends, neighbors, or other natural person who normally provides the daily care or supervision of a mentally disabled person. Such informal caregiver may, but need not reside in the same household as the mentally disabled person.

25. "Chemical abuse" means the use of alcohol and/or one or more substances to the extent that there is impairment of normal development or functioning due to such use in one or more of the major life areas including but not limited to the social, emotional, familial, educational, vocational, or physical. The term "chemical abuse" shall mean and include alcohol and/or substance abuse.

26. "Infant" or "minor" means a person who has not attained the age of eighteen years.

27. "Aftercare services" means services for persons no longer receiving in-patient services for the mentally disabled and may include, but shall not be limited to, medical care, including psychiatric care, and vocational and social rehabilitation.

28. "Community residence" means any facility operated by or subject to licensure by the office of mental health or the office for people with developmental disabilities which provides a supervised residence or residential respite services for individuals with mental disabilities and a homelike environment and room, board and responsible supervision for the habilitation or rehabilitation of individuals with mental disabilities as part of an overall service delivery system. A community residence shall include an intermediate care facility with fourteen or fewer residents that has been approved pursuant to law, and a community residential facility as that term is used in section 41.36 of this chapter. Such term does not include family care homes.

28-a. "Supervised living facility" means a community residence providing responsible supervisory staff on-site twenty-four hours per day for the purpose of enabling residents to live as independently as possible.

28-b. "Supportive living facility" means a community residence providing practice in independent living under supervision but not providing staff on-site on a twenty-four hour per day basis.

29. "Release" means the termination of a patient's in-patient care at a school, hospital, or alcoholism facility.

30. "Conditional release" means release subject to the right of the school, hospital, or alcoholism facility to return the patient to in-patient care pursuant to the conditions set forth in section 29.15 of this chapter.

31. "Discharge" means release and the termination of any right to retain or treat the patient on an in-patient basis. The discharge of such a patient shall not preclude the patient from receiving necessary services on other than an in-patient basis nor shall it preclude subsequent readmission as an in-patient if made in accordance with article nine, fifteen, or twenty-two of this chapter.

32. "Conference" means the New York state conference of local mental hygiene directors as established pursuant to section 41.10 of this chapter.

33. "Residential treatment facility for children and youth" shall mean an inpatient psychiatric facility which provides active treatment under the direction of a physician for individuals who are under twenty-one years of age, provided that a person who, during the course of treatment, attains the age of twenty-one may continue to receive services in a residential treatment facility for children and youth until he or she reaches the age of twenty-two. The term "residential treatment facility for children and youth" does not apply to the children's psychiatric centers described in section 7.17 of this chapter or to facilities specifically licensed by the office of mental health as children's hospitals. Residential treatment facilities for children and youth are a sub-class of the class of facilities defined to be "hospitals" in subdivision ten of this section.

34. "Authorized agency" shall have the meaning defined in section three hundred seventy-one of the social services law.

35. "Social services official" shall have the meaning defined in section two of the social services law.

36. "Residential care center for adults" means a facility which provides long term residential care and support services to mentally ill adults, provides case management and medication management services, and assists residents in securing clinical, vocational and social services necessary to enable the resident to continue to live in the community. No residential care center for adults established after September first, nineteen hundred eighty-six shall have more than one hundred fifty residents. A residential care center for adults is not an adult care facility subject to licensure by the department of social services, nor is it an inpatient treatment facility.

* 37. "Comprehensive psychiatric emergency program" means a program which is licensed by the office of mental health to provide a full range of psychiatric emergency services within a defined geographic area to persons who are believed to be mentally ill and in need of such services, and which shall include crisis intervention services, crisis outreach services, crisis residence services, extended observation beds, and triage and referral services, as such terms are defined in section 31.27 of this chapter.

* NB Repealed July 1, 2020

38. "Alcoholism community residence" means any facility licensed or operated by the office of alcoholism and substance abuse services which provides a supervised residence for persons suffering from alcoholism or alcohol abuse and a homelike environment, including room, board and responsible supervision for the rehabilitation of such persons as part of an overall service delivery system.

* 39. "Substance" shall mean:

(i) any controlled substance listed in section thirty-three hundred six of the public health law;

(ii) any substance listed in section thirty-three hundred eighty of the public health law;

(iii) any substance, except alcohol and tobacco, as listed in the published rules of the office which has been certified to the commissioner by the commissioner of health as having the capability of causing physical and/or psychological dependence. Notice of a proposed rule listing any such substance shall be given to the speaker of the assembly and the temporary president of the senate. The commissioner shall consider the advice and recommendations of the legislature and shall hold a public hearing prior to listing any substance in its published rules.

* NB There are 2 sub 39's

* 39. "Employee assistance program" means a confidential program designed to assist employees and their families, through identification, motivation referral, and follow-up, with problems that may interfere with the employees' ability to perform on the job effectively, efficiently and safely. Such problems include alcohol and substance abuse problems, emotional, marital, family, and other personal problems.

* NB There are 2 sub 39's

40. "Substance abuse" shall mean the repeated use of one or more substances, as defined in this section, except when such substance is used in accordance with a lawful prescription.

41. "Substance dependence" shall mean the physical or psychological reliance upon a substance as defined in this section, arising from substance abuse or arising from the lawful use of any such substance for the sole purpose of alleviating such a physical or psychological reliance.

42. "Substance abuse program" shall mean any public or private person, corporation, partnership, agency, either profit or non-profit, or state or municipal government which provides substance abuse services, in either a residential or ambulatory setting, to persons who are substance abusers, substance dependent, in need of services to avoid becoming substance abusers, substance dependent or to significant others. Any person or entity providing such services as a minor part of a general health or counseling unit subject to regulations promulgated by the commissioner and other appropriate agencies shall not be considered a substance abuse program.

43. "Substance abuse services" shall include services to inhibit the onset of substance abuse or substance dependence; to address the social dysfunction, medical problems and other disabilities associated with substance abuse or substance dependence, and to rehabilitate persons suffering from substance abuse or dependence.

44. "Chemical dependence" means the repeated use of alcohol and/or one or more substances to the extent that there is evidence of physical or psychological reliance on alcohol and/or substances, the existence of physical withdrawal symptoms from alcohol and/or one or more substances, a pattern of compulsive use, and impairment of normal development or

functioning due to such use in one or more of the major life areas including but not limited to the social, emotional, familial, educational, vocational, and physical. Unless otherwise provided, for the purposes of this chapter, the term "chemical dependence" shall mean and include alcoholism and/or substance dependence.

45. "Alcohol, substance abuse, and chemical dependence prevention" shall mean strategies and approaches, primary and secondary, to prevent the onset or reduce the incidence of use and abuse of alcohol and/or substances.

46. "Record" of a patient or client shall consist of admission, transfer or retention papers and orders, and accompanying data required by this article and the regulations of the commissioner.

47. "Director of community services" shall mean the director of community services for the mentally disabled appointed pursuant to this chapter.

48. "Practitioner" shall mean a physician, dentist, podiatrist, veterinarian, scientific investigator, or other person licensed, or otherwise permitted to dispense, administer or conduct research with respect to a controlled substance in the course of a licensed professional practice or research licensed pursuant to this article. Such person shall be deemed a "practitioner" only as to such substances, or conduct relating to such substances, as is permitted by his license, permit or otherwise permitted by law.

49. "Prescription" shall mean an official New York state prescription, a written prescription or an oral prescription.

50. "Controlled substance" shall mean the definition of "controlled substance" as contained in section thirty-three hundred two of the public health law.

52. "Persons with serious mental illness" means individuals who meet criteria established by the commissioner of mental health, which shall include persons who are in psychiatric crisis, or persons who have a designated diagnosis of mental illness under the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders and whose severity and duration of mental illness results in substantial functional disability. Persons with serious mental illness shall include children and adolescents with serious emotional disturbances.

53. "Children and adolescents with serious emotional disturbances" means individuals under eighteen years of age who meet criteria established by the commissioner of mental health, which shall include children and adolescents who are in psychiatric crisis, or children and adolescents who have a designated diagnosis of mental illness under the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders and whose severity and duration of mental illness results in substantial functional disability.

54. "Compulsive gambling" means an impulse control disorder, as defined by the most recent edition of the diagnostic and statistical manual of mental disorders (DSM), published by the American Psychiatric Association.

55. "Chemical dependence services" shall mean examination, evaluation, diagnosis, care, treatment, rehabilitation, or training of persons suffering from alcohol and/or substance abuse and/or dependence and significant others. Unless otherwise provided, for the purposes of this chapter, the term "chemical dependence services" shall mean and include alcoholism and/or substance abuse services.

56. "Substance use disorder" means the misuse of, dependence on, or addiction to alcohol and/or legal or illegal drugs leading to effects that are detrimental to the individual's physical and mental health, or

the welfare of others and shall include alcoholism, alcohol abuse, substance abuse, substance dependence, chemical abuse, and/or chemical dependence.

57. "Substance use disorder services" shall mean and include examination, evaluation, diagnosis, care, treatment, rehabilitation, or training of persons with substance use disorders and their families or significant others.

58. "Behavioral health services" means examination, diagnosis, care, treatment, rehabilitation, or training for persons with mental illness, substance use disorder, or compulsive gambling disorder.

NON-INSTITUTIONAL SERVICES
State Plan Amendment #17-0025

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**

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

   Response: The rate methodology included in the State Plan for health home services is a per member per month (PMPM) case management fee adjusted by region and case mix (from clinic risk group (CRG) methodology). This fee will eventually be adjusted by the patient functional status. We are unaware of any requirement under current federal law or regulation that limits individual provider's payments to their actual costs.

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.

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.

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: This 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.