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State/Territory Name: New York

State Plan Amendment (SPA) #:15-0020

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages

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

CENTERS FOR MEDICARE & MEDICAID SERVICES

DIVISION OF MEDICAID AND CHILDREN'S HEALTH OPERATIONS

DMCHO: JM

April 7, 2016

Jason Helgerson
Medicaid Director, Deputy Commissioner
Office of Health Insurance Programs
New York State Department of Health
Corning Tower (OCP – 1211)
Albany, New York 12237

RE: NY SPA #15-0020

Dear Mr. Helgerson:

The Centers for Medicare & Medicaid Services (CMS), New York Regional Office, has completed its review of New York State Plan Amendment (SPA) Transmittal Number 15-0020. Effective October 1, 2016, this amendment will add health home eligibility criteria for children.

This SPA is approved April 7, 2016, with an effective date of October 1, 2016. Enclosed are copies of the approved pages for incorporation into the New York State plan.

In accordance with the statutory provisions at Section 1945(c)(1) of the Social Security Act, for payments made to health home providers under this amendment, during the first eight fiscal quarters that the SPA is in effect, October 1, 2016 through September 30, 2018, the federal medical assistance percentage (FMAP) rate applicable to such payments shall be equal to 90 percent. The FMAP rate for payments made to health home providers will return to the state's published FMAP rate on October 1, 2018. The Form CMS-64 has a designated category of service Line 43 for States to report health home services expenditures for enrollees with chronic conditions.

Please share with your staff my appreciation for their time and effort throughout this process. If you have any questions regarding this State Plan Amendment, please contact John Montalto at John.Montalto@cms.hhs.gov or (212) 616-2326.

Sincerely,

[redacted]

Michael J. Melendez
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

Health Home State Plan Amendment

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

Transmittal Number: NY-15-0020 Supersedes Transmittal Number: NY-15-0002 Proposed Effective Date: Oct 1, 2016
Approval Date:
Attachment 3.1-H Page Number: 25

Submission Summary

Transmittal Number:
Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

NY-15-0020

Supersedes Transmittal Number:
Please enter the Supersedes Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

NY-15-0002

☑ **The State elects to implement the Health Homes State Plan option under Section 1945 of the Social Security Act.**

Name of Health Homes Program:

New York Health Home Services (Health Home Eligibility Criteria for Children)

State Information

State/Territory name:
New York
Medicaid agency:

New York State Department of Health

Authorized Submitter and Key Contacts

The authorized submitter contact for this submission package.

Name:

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The primary contact for this submission package.

Name:
Jason A. Helgerson
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Medicaid Director
Telephone number:

Email:

The secondary contact for this submission package.

Name:

Title:

Telephone number:

Email:

The tertiary contact for this submission package.

Name:

Title:

Telephone number:

Email:

Proposed Effective Date

10/01/2016 *(mm/dd/yyyy)*

Executive Summary

Summary description including goals and objectives:

Summary description including goals and objectives:
New state plan amendment.

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2016	$0.00
Second Year	2017	$68000000.00

Federal Statute/Regulation Citation

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

Governor's Office Review

- (●) **No comment.**
- ( ) **Comments received.**
  Describe:
- ( ) **No response within 45 days.**
- ( ) **Other.**
  Describe:

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Submission - Public Notice

Indicate whether public notice 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 public notice was solicited:

- [ ] **Newspaper Announcement**
- [x] **Publication in State's administrative record, in accordance with the administrative procedures requirements.**
  Date of Publication: 01/28/2015 *(mm/dd/yyyy)*
- [ ] **Email to Electronic Mailing List or Similar Mechanism.**
  Date of Email or other electronic notification: *(mm/dd/yyyy)*
  Description:

Website Notice

Select the type of website:

Website of the State Medicaid Agency or Responsible Agency

Date of Posting: (mm/dd/yyyy)

Website URL:

Website for State Regulations

Date of Posting: (mm/dd/yyyy)

Website URL:

Other

Public Hearing or Meeting

Other method

Indicate the key issues raised during the public notice period:(This information is optional)

Access

Summarize Comments

Summarize Response

Quality

Summarize Comments

Summarize Response

Cost

Summarize Comments

Summarize Response

Payment methodology

Summarize Comments

Summarize Response

Eligibility

Summarize Comments

Summarize Response

☐ **Benefits**

Summarize Comments

Summarize Response

☐ **Service Delivery**

Summarize Comments

Summarize Response

☐ **Other Issue**

Transmittal Number: NY-15-0020 Supersedes Transmittal Number: NY-15-0002 Proposed Effective Date: Oct 1, 2016 Approval Date:

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Submission - Tribal Input

☑ **One or more Indian health programs or Urban Indian Organizations furnish health care services in this State.**

☐ **This State Plan Amendment is likely to have a direct effect on Indians, Indian health programs or Urban Indian Organizations.**

☑ **The State has solicited advice from Tribal governments prior to submission of this State Plan Amendment.**

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

Tribal consultation was conducted in the following manner:

☑ **Indian Tribes**

Indian Tribes	☒
Name of Indian Tribe: Cayuga Nation Date of consultation: 04/20/2015 *(mm/dd/yyyy)* Method/Location of consultation: Tribal consultation sent; no comments received to date.	
Name of Indian Tribe: Oneida Indian Nation Date of consultation: 04/20/2015 *(mm/dd/yyyy)* Method/Location of consultation: Tribal consultation sent; no comments received to date.	
Name of Indian Tribe:	

Indian Tribes	☒
Onondaga Nation Date of consultation: 04/20/2015 (mm/dd/yyyy) Method/Location of consultation: Tribal consultation sent; no comments received to date.	
Name of Indian Tribe: Seneca Nation of Indians Date of consultation: 04/20/2015 (mm/dd/yyyy) Method/Location of consultation: Tribal consultation sent; no comments received to date.	
Name of Indian Tribe: Shinnecock Indian Nation Tribal Office Date of consultation: 04/20/2015 (mm/dd/yyyy) Method/Location of consultation: Tribal consultation sent; no comments received to date.	
Name of Indian Tribe: St. Regis Mohawk Tribe Date of consultation: 04/20/2015 (mm/dd/yyyy) Method/Location of consultation: Tribal consultation sent; no comments received to date.	
Name of Indian Tribe: Tonowanda Seneca Indian Nation Date of consultation: 04/20/2015 (mm/dd/yyyy) Method/Location of consultation: Tribal consultation sent; no comments received to date.	
Name of Indian Tribe: Tuscarora Indian Nation Date of consultation: 04/20/2015 (mm/dd/yyyy) Method/Location of consultation: Tribal consultation sent; no comments received to date.	
Name of Indian Tribe: Ukechaug Indian Territory Date of consultation: 04/20/2015 (mm/dd/yyyy) Method/Location of consultation:	

Indian Tribes	
Tribal consultation sent; no comments received to date.	

☑ **Indian Health Programs**

Indian Health Programs	
Name of Indian Health Programs: Health Clinic Date of consultation: 04/20/2015 (mm/dd/yyyy) Method/Location of consultation: Tribal consultation sent; no comments received to date.	

☑ **Urban Indian Organization**

Urban Indian Organizations	
Name of Urban Indian Organization: American Indian Community House Date of consultation: 04/20/2015 (mm/dd/yyyy) Method/Location of consultation: Tribal consultation sent; no comments received to date.	

Indicate the key issues raised in Indian consultative activities:

☐ **Access**

Summarize Comments

Summarize Response

☐ **Quality**

Summarize Comments

Summarize Response

☐ **Cost**

Summarize Comments

Summarize Response

☐ **Payment methodology**

Summarize Comments

Summarize Response

☐ **Eligibility**

Summarize Comments

Summarize Response

☐ **Benefits**

Summarize Comments

Summarize Response

☐ **Service delivery**

Summarize Comments

Summarize Response

☐ **Other Issue**

Transmittal Number: NY-15-0020 Supersedes Transmittal Number: NY-15-0002 Proposed Effective Date: Oct 1, 2016
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Submission - SAMHSA Consultation

☑ **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	☒
Date of consultation: 11/20/2014 *(mm/dd/yyyy)*	

Transmittal Number: NY-15-0020 Supersedes Transmittal Number: NY-15-0002 Proposed Effective Date: Oct 1, 2016
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Health Homes Population Criteria and Enrollment

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 Abuse Disorder**
☑ **Asthma**
☑ **Diabetes**
☑ **Heart Disease**
☑ **BMI over 25**

Other Chronic Conditions	☒

Additional description of other chronic conditions:

BMI is defined as, at or above 25 for adults, and BMI at or above the 85 percentile for children. In addition, in the absence of the radio button Other Chronic Conditions, the list of conditions above includes Other

☑ **One chronic condition and the risk of developing another**

Specify the conditions included:

☐ **Mental Health Condition**
☐ **Substance Abuse Disorder**
☐ **Asthma**
☐ **Diabetes**
☐ **Heart Disease**
☐ **BMI over 25**

Other Chronic Conditions	☒
HIV/AIDS	
One Serious Mental illness	
SED/Complex Trauma	

Specify the criteria for at risk of developing another chronic condition:

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

Additional description of other chronic conditions:

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

☑ **One or more serious and persistent mental health condition**

Specify the criteria for a serious and persistent mental health condition:

The guidance on complex trauma draws upon the domains within the definition of serious emotional disturbance(SED). While there may be similarities in the condition(s)and symptoms that arise in either

Geographic Limitations

☑ **Health Homes services will be available statewide**

Describe statewide geographical phase in/expansion. This should include dates and corresponding geographical areas that bring the program statewide.

January 1, 2012: counties Bronx, Brooklyn, Nassau, Warren, Washington, Essex, Hamilton, Clinton, Franklin and Schenectady

If no, specify the geographic limitations:

- **By county**
  Specify which counties:

- **By region**
  Specify which regions and the make-up of each region:

- **By city/municipality**
  Specify which cities/municipalities:

- **Other geographic area**
  Describe the area(s):

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**
  Describe the process used:

- (●) **Automatic Assignment with Opt-Out of Health Homes provider**
  Describe the process used:

  Individuals eligible for health home services will be identified by the State. Individuals will be assigned to a

  - [ ] **The State provides assurance that it will clearly communicate the opt-out option to all individuals assigned to a Health Home under an opt-out process and submit to CMS a copy of any letter or other communication used to inform such individuals of their right to choose.**

- **Other**
  Describe:

- [x] **The State provides assurance that eligible individuals will be given a free choice of Health Homes providers.**
- [x] **The State provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services.**
- [x] **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.**
- [x] **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. Enhanced FMAP may only be claimed for the first eight quarters after the effective date of a Health Homes State Plan Amendment that makes Health Home Services available to a new population, such as people in a particular geographic area or people with a particular chronic condition.**
- [x] **The State assures that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.**

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Health Homes Providers

Types of Health Homes Providers

- [x] **Designated Providers**

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

- [ ] **Physicians**

Describe the Provider Qualifications and Standards:

- [ ] **Clinical Practices or Clinical Group Practices**

Describe the Provider Qualifications and Standards:

- [ ] **Rural Health Clinics**

Describe the Provider Qualifications and Standards:

- [ ] **Community Health Centers**

Describe the Provider Qualifications and Standards:

- [ ] **Community Mental Health Centers**

Describe the Provider Qualifications and Standards:

- [ ] **Home Health Agencies**

Describe the Provider Qualifications and Standards:

☑ **Other providers that have been determined by the State and approved by the Secretary to be qualified as a health home provider:**

☐ **Case Management Agencies**

Describe the Provider Qualifications and Standards:

☐ **Community/Behavioral Health Agencies**

Describe the Provider Qualifications and Standards:

☐ **Federally Qualified Health Centers (FQHC)**

Describe the Provider Qualifications and Standards:

☑ **Other (Specify)**

Provider	
Name: Designated Providers as described in section 1945(h)(5) Provider Qualifications and Standards:	

☐ **Teams of Health Care Professionals**

Indicate the composition of the Health Homes Teams of Health Care Professionals the State includes in its program. For each type of provider indicate the required qualifications and standards:

☐ **Physicians**

Describe the Provider Qualifications and Standards:

☐ **Nurse Care Coordinators**

Describe the Provider Qualifications and Standards:

☐ **Nutritionists**

Describe the Provider Qualifications and Standards:

☐ **Social Workers**

Describe the Provider Qualifications and Standards:

☐ **Behavioral Health Professionals**

Describe the Provider Qualifications and Standards:

☐ **Other (Specify)**

☐ **Health Teams**

Indicate the composition of the Health Homes Health Team providers the State includes in its program, pursuant to Section 3502 of the Affordable Care Act, and provider qualifications and standards:

☐ **Medical Specialists**

Describe the Provider Qualifications and Standards:

☐ **Nurses**

Describe the Provider Qualifications and Standards:

☐ **Pharmacists**

Describe the Provider Qualifications and Standards:

☐ **Nutritionists**

Describe the Provider Qualifications and Standards:

☐ **Dieticians**

Describe the Provider Qualifications and Standards:

☐ **Social Workers**

Describe the Provider Qualifications and Standards:

☐ **Behavioral Health Specialists**

Describe the Provider Qualifications and Standards:

☐ **Doctors of Chiropractic**

Describe the Provider Qualifications and Standards:

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Describe the Provider Qualifications and Standards:

☐ **Physicians' Assistants**

Describe the Provider Qualifications and Standards:

Supports for Health Homes Providers

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

1. **Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered Health Homes services,**
2. **Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines,**
3. **Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders,**
4. **Coordinate and provide access to mental health and substance abuse services,**
5. **Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings,**

such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care,

6. **Coordinate and provide access to chronic disease management, including self-management support to individuals and their families,**
7. **Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services,**
8. **Coordinate and provide access to long-term care supports and services,**
9. **Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services:**
10. **Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate:**
11. **Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.**

Description:

Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Homes 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

Provider Standards

The State's minimum requirements and expectations for Health Homes 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 health care costs, specifically

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Health Homes Service Delivery Systems

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

- [x] **Fee for Service**
- [ ] **PCCM**
  - ( ) **PCCMs will not be a designated provider or part of a team of health care professionals. The State provides assurance that it will not duplicate payment between its Health Homes payments and PCCM payments.**
  - ( ) **The PCCMs will be a designated provider or part of a team of health care professionals.**
    The PCCM/Health Homes providers will be paid based on the following payment methodology outlined in the payment methods section:
    - [ ] **Fee for Service**
    - [ ] **Alternative Model of Payment (describe in Payment Methodology section)**
    - [ ] **Other**
      Description:

☐ **Requirements for the PCCM participating in a Health Homes as a designated provider or part of a team of health care professionals will be different from those of a regular PCCM.**

If yes, describe how requirements will be different:

☐ **Risk Based Managed Care**

○ **The Health Plans will not be a Designated Provider or part of a Team of Health Care Professionals. Indicate how duplication of payment for care coordination in the Health Plans' current capitation rate will be affected:**

☐ **The current capitation rate will be reduced.**

☐ **The State will impose additional contract requirements on the plans for Health Homes enrollees.**

Provide a summary of the contract language for the additional requirements:

☐ **Other**

Describe:

○ **The Health Plans will be a Designated Provider or part of a Team of Health Care Professionals.**

Provide a summary of the contract language that you intend to impose on the Health Plans in order to deliver the Health Homes services.

☐ **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.**

The State intends to include the Health Homes payments in the Health Plan capitation rate.

○ **Yes**

☐ **The State provides an assurance that at least annually, it will submit to the regional office as part of their capitated rate Actuarial certification a separate Health Homes section which outlines the following:**

- **Any program changes based on the inclusion of Health Homes services in the health plan benefits**
- **Estimates of, or actual (base) costs to provide Health Homes services (including detailed a description of the data used for the cost estimates)**
- **Assumptions on the expected utilization of Health Homes services and number of eligible beneficiaries (including detailed description of the data used for utilization estimates)**
- **Any risk adjustments made by plan that may be different than overall risk adjustments**
- **How the final capitation amount is determined in either a percent of the total capitation or an actual PMPM**

☐ **The State provides assurance that it will design a reporting system/mechanism to monitor the use of Health Homes services by the plan ensuring appropriate documentation of use of services.**

☐ **The State provides assurance that it will complete an annual assessment to determine if the payments delivered were sufficient to cover the costs to deliver the Health Homes services and provide for adjustments in the rates to compensate for any differences found.**

○ **No**

Indicate which payment methodology the State will use to pay its plans:

☐ **Fee for Service**

☐ **Alternative Model of Payment (describe in Payment Methodology section)**

☐ **Other**

Description:

☑ **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

☐ **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.**

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Health Homes Payment Methodologies

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

☑ **Fee for Service**

☑ **Fee for Service Rates based on:**

☐ **Severity of each individual's chronic conditions**

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

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

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

☐ **Other: Describe below.**

Provide a comprehensive description of the rate-setting policies the State will use to establish Health Homes provider reimbursement fee-for-service 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.

☑ **Per Member, Per Month Rates**

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;

☐ **Incentive payment reimbursement**

Provide a comprehensive description of incentive payment policies that the State will use to reimburse in addition to the unit base rates. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain: the incentives that will be reimbursed through the methodology, how the supplemental incentive payments are tied to the base rate activities, the criteria used to determine a provider's eligibility to receive the payment, the methodology used to determine the incentive payment amounts, and the frequency and timing through which the Medicaid agency will distribute the payments to providers.

☐ **PCCM Managed Care (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 PM/PM payments (describe below)**

☐ **Tiered Rates based on:**

☐ **Severity of each individual's chronic conditions**

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

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

☐ **Rate only reimbursement**

Provide a comprehensive description of the policies the State will use to establish Health Homes alternative models of payment. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain the nature of the payment, the activities and associated costs or other relevant factors used to determine the payment amount, any limiting criteria used to determine if a provider is eligible to receive the payment, and the frequency and timing through which the Medicaid agency will distribute the payments to providers.

Explain how the State will ensure non-duplication of payment for similar services that are offered through another method, such as 1915(c) waivers or targeted case management.

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

☑ **The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule**

☑ **The State provides assurance that it shall reimburse Health Homes providers directly, except when there are employment or contractual arrangements.**

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Submission - 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 eligibility groups**

Health Homes Services (1 of 2)

Category of Individuals
CN individuals

Service Definitions

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

Comprehensive Care Management

Definition:

A comprehensive individualized 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

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.

Scope of benefit/service

☐ **The benefit/service can only be provided by certain provider types.**

☐ **Behavioral Health Professionals or Specialists**

Description

☐ **Nurse Care Coordinators**

Description

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☐ **Other (specify):**

Name

Description

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

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,

Scope of benefit/service

☐ **The benefit/service can only be provided by certain provider types.**

☐ **Behavioral Health Professionals or Specialists**

Description

☐ **Nurse Care Coordinators**

Description

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☐ **Other (specify):**

Name

Description

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

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,

Scope of benefit/service

☐ **The benefit/service can only be provided by certain provider types.**

☐ **Behavioral Health Professionals or Specialists**

Description

☐ **Nurse Care Coordinators**

Description

☐ **Nurses**

Description

Medical Specialists

Description

Physicians

Description

Physicians' Assistants

Description

Pharmacists

Description

Social Workers

Description

Doctors of Chiropractic

Description

Licensed Complementary and Alternative Medicine Practitioners

Description

Dieticians

Description

Nutritionists

Description

Other (specify):

Name

Description

Health Homes Services (2 of 2)

Category of Individuals
CN individuals

Service Definitions

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

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

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,

Scope of benefit/service

☐ **The benefit/service can only be provided by certain provider types.**

☐ **Behavioral Health Professionals or Specialists**

Description

☐ **Nurse Care Coordinators**

Description

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☐ **Other (specify):**

Name

Description

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

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,

Scope of benefit/service

☐ **The benefit/service can only be provided by certain provider types.**

☐ **Behavioral Health Professionals or Specialists**

Description

☐ **Nurse Care Coordinators**

Description

☐ **Nurses**

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Description

☐ **Physicians' Assistants**

Description

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Description

☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☐ **Other (specify):**

Name

Description

Referral to community and social support services, if relevant

Definition:

The health provider will identify available community-based resources and actively manage appropriate referrals, access to care, engagement with other community and social supports,

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,

Scope of benefit/service

☐ **The benefit/service can only be provided by certain provider types.**

☐ **Behavioral Health Professionals or Specialists**

Description

☐ **Nurse Care Coordinators**

Description

☐ **Nurses**

Description

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☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☐ **Other (specify):**

Name

Description

Health Homes Patient Flow

Describe the patient flow through the State's Health Homes system. The State must submit to CMS flow-charts of the typical process a Health Homes individual would encounter:

Further information will be provided to CMS.

☑ **Medically Needy eligibility groups**

- ◉ **All Medically Needy eligibility groups receive the same benefits and services that are provided to Categorically Needy eligibility groups.**
- ○ **Different benefits and services than those provided to Categorically Needy eligibility groups are provided to some or all Medically Needy eligibility groups.**
  - ○ **All Medically Needy receive the same services.**
  - ○ **There is more than one benefit structure for Medically Needy eligibility groups.**

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Approval Date:
Attachment 3.1-H Page Number:

Health Homes Monitoring, Quality Measurement and Evaluation

Monitoring

Describe the State's methodology for tracking avoidable hospital readmissions, including data sources and measurement specifications:

NYS has been monitoring avoidable hospital readmissions since 2009, using 3M software called Potentially Preventable Readmissions (PPRs). This software incorporates clinical judgment to determine

Describe the State's methodology for calculating cost savings that result from improved coordination of care and chronic disease management achieved through the Health Homes program, including data sources and measurement specifications.

NYS will monitor cost savings from health homes through measures of preventable events, including PPRs, potentially preventable hospital admissions and potentially avoidable ER visits. These metrics are

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

Quality Measurement

☑ **The State provides assurance that it will require that all Health Homes providers report to the State on all applicable quality measures as a condition of receiving payment from the State.**

☐ **The State provides assurance that it will identify measureable goals for its Health Homes model and intervention and also identify quality measures related to each goal to measure its success in achieving the goals.**

States utilizing a health team provider arrangement must describe how they will align the quality measure reporting requirements within section 3502 of the Affordable Care Act and section 1945(g) of the Social Security Act. Describe how the State will do this:

Evaluations

☑ **The State provides assurance that it will report to CMS information submitted by Health Homes providers to inform the evaluation and Reports to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS.**

Describe how the State will collect information from Health Homes providers for purposes of determining the effect of the program on reducing the following:

Hospital Admissions

Measure:
1. Hospital Admissions

Measure Specification, including a description of the numerator and denominator.
Frequency of Data Collection
NYS plans on calculating all of these measures using existing resources, and sharing the

Data Sources:
1.Claims and Encounters

Frequency of Data Collection:
- ○ **Monthly**
- ○ **Quarterly**
- ○ **Annually**
- ○ **Continuously**
- ◉ **Other**

minimally annually and possibly quarterly

Measure:
1.Inpatient Utilization - General Hospital/Acute Care

Measure Specification, including a description of the numerator and denominator.
1. (HEDIS 2012 - Use of Services) The rate of utilization of acute inpatient care per 1,000 member months. Data is reported by age for categories: Medicine, Surgery, Maternity and

Data Sources:
1. Claims

Frequency of Data Collection:
- ○ **Monthly**
- ○ **Quarterly**
- ○ **Annually**
- ○ **Continuously**
- ◉ **Other**

minimally annually and possibly quarterly

Measure:
2. Hospital Utilization and cost per member per month

Measure Specification, including a description of the numerator and denominator.
Frequency of Data Collection
NYS plans on calculating all of these measures using existing resources, and sharing the

Data Sources:

2.Claims and Encounters

Frequency of Data Collection:

- Monthly
- Quarterly
- Annually
- Continuously
- Other

minimally annually and possibly quarterly

Emergency Room Visits

Measure:

1. ER visits

Measure Specification, including a description of the numerator and denominator.

Frequency of Data Collection
NYS plans on calculating all of these measures using existing resources, and sharing the

Data Sources:

1. Claims and Encounters

Frequency of Data Collection:

- Monthly
- Quarterly
- Annually
- Continuously
- Other

minimally annually and possibly quarterly

Measure:

1.Ambulatory Care (ED Visits)

Measure Specification, including a description of the numerator and denominator.

1.(HEDIS 2012 - Use of Services) The rate of ED visits per 1,000 member months. Data is reported by age categories.

Data Sources:

1.Claims

Frequency of Data Collection:

- Monthly
- Quarterly
- Annually
- Continuously
- Other

minimally annually and possibly quarterly

Measure:

2. ER utilization and costs per member per month

Measure Specification, including a description of the numerator and denominator.

Frequency of Data Collection
NYS plans on calculating all of these measures using existing resources, and sharing the

Data Sources:

2. Claims and Encounters

Frequency of Data Collection:

- Monthly
- Quarterly
- Annually
- Continuously
- Other

minimally annually and possibly quarterly

Skilled Nursing Facility Admissions

Measure:

1. Nursing Home Admissions

Measure Specification, including a description of the numerator and denominator.

Frequency of Data Collection
NYS plans on calculating all of these measures using existing resources, and sharing the

Data Sources:

1.Claims and Encounters

Frequency of Data Collection:

- Monthly
- Quarterly
- Annually
- Continuously
- Other

minimally annually and possibly quarterly

Measure:

2. Nursing Home Utilization and cost per member per month

Measure Specification, including a description of the numerator and denominator.

Frequency of Data Collection
NYS plans on calculating all of these measures using existing resources, and sharing the

Data Sources:

2.Claims and Encounters

Frequency of Data Collection:

- Monthly
- Quarterly
- Annually
- Continuously
- Other

minimally annually and possibly quarterly

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

Hospital Admission Rates

For a general description of how the State will collect information for purpose of informing the evaluations, which will ultimately determine the nature, extent and use of the program, as it pertains to all of the following, see

Chronic Disease Management

Data on chronic disease management will be collected in two ways. First, we will examine how the Health Homes implement disease management across key chronic illness management functional components of our state Health

Coordination of Care for Individuals with Chronic Conditions

NYS will use claims, encounter, and pharmacy data to collect information on coordination of care. As indicated in the quality measures section of this SPA, NYS will use claims, encounter, and pharmacy data to collect

Assessment of Program Implementation

Learning Collaboratives will be constituted with a group of early adopter providers of Health Homes to identify implementation challenges as well as potential solutions. Other data related to implementation including responses

Processes and Lessons Learned

Learning Collaboratives will be constituted with a group of early adopter providers of Health Homes to identify implementation challenges as well as potential solutions. NYS will use the Health Home Advisory Group to

Assessment of Quality Improvements and Clinical Outcomes

As detailed in the quality measures section, NYS has identified an extensive list of quality and outcome measures that will be derived from administrative claims and encounter data. The quality measures are indicators of chronic

Estimates of Cost Savings

☐ **The State will use the same method as that described in the Monitoring section.**

If no, describe how cost-savings will be estimated.

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

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PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 80 per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.