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**State/Territory Name: New York**

**State Plan Amendment (SPA) #: 19-0007**

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) Submission Form
- 3) Approved SPA Reviewable Units



DIVISION OF MEDICAID AND CHILDREN'S HEALTH OPERATION

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DMCHO: MT NY SPA 19-0007 Approval

January 16, 2019

Donna Frescatore  
Medicaid Director  
Office of Health Insurance Programs  
New York State Department of Health  
One Commerce Plaza, Suite 1211  
Albany, NY 12210

RE: NY SPA #19-0007

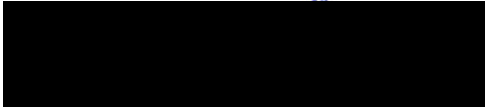
Dear Ms. Frescatore:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of New York State Plan Amendment (SPA) Transmittal Number 19-0007. Effective January 1, 2019, this amendment establishes transitional Children's Health Home rates for 1915(c) SED and B2H providers.

Enclosed are copies of the approved pages for incorporation into the New York State plan.

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 Maria Tabakov of this office. Ms. Tabakov may be reached at (212) 616-2503.

Sincerely,

  
Ricardo Holligan  
Acting Associate Regional Administrator  
Division of Medicaid and Children's Health Operations

cc: J.Hounsell  
R.Weaver  
S.Rhoades  
R.Deyette

## Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | NY2018MS0008O | NY-19-0007 | NYS Health Home Program

### Package Header

<b>Package ID</b>	NY2018MS0008O	<b>SPA ID</b>	NY-19-0007
<b>Submission Type</b>	Official	<b>Initial Submission Date</b>	12/31/2018
<b>Approval Date</b>	1/16/2019	<b>Effective Date</b>	N/A
<b>Superseded SPA ID</b>	N/A		

### State Information

**State/Territory Name:** New York

**Medicaid Agency Name:** Department of Health

### Submission Component

- State Plan Amendment
- Medicaid
- CHIP

## Submission - Summary

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<b>Superseded SPA ID</b>	N/A		

### SPA ID and Effective Date

**SPA ID** NY-19-0007

Reviewable Unit	Proposed Effective Date	Superseded SPA ID
Health Homes Payment Methodologies	1/1/2019	NY-18-0051

## Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | NY2018MS00080 | NY-19-0007 | NYS Health Home Program

### Package Header

<b>Package ID</b>	NY2018MS00080	<b>SPA ID</b>	NY-19-0007
<b>Submission Type</b>	Official	<b>Initial Submission Date</b>	12/31/2018
<b>Approval Date</b>	1/16/2019	<b>Effective Date</b>	N/A
<b>Superseded SPA ID</b>	N/A		

### Executive Summary

**Summary Description Including Goals and Objectives** Effective January 1, 2019, the State will provide transitional health home payments to a transitioning provider who will be providing Health Home care management services to a child and who is currently providing Health Care Integration (HCI) or Individualized Care Coordination (ICC) under the current approved 1915c Waiver. Those providers will be entitled to bill the transition rate for up to 2 years. A transitional rate will only be allowed to be billed if there is a corresponding Health Home enrolled child with the appropriate documented Health Home required core service(s) provided to bill the Health Home acuity rate. During this period from January 1, 2019 through December 31, 2020, the provider would continue to bill for the Health Home rate.

### Federal Budget Impact and Statute/Regulation Citation


#### Federal Budget Impact

	Federal Fiscal Year	Amount
First	2019	\$38926
Second	2020	\$43976

#### Federal Statute / Regulation Citation

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

Supporting documentation of budget impact is uploaded (optional).

Name	Date Created	
<a href="#">Fiscal Calculations (19-0007) (11-08-18)</a>	11/8/2018 2:02 PM EST	

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### Governor's Office Review

- No comment
- Comments received
- No response within 45 days
- Other

# Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | NY2018MS00080 | NY-19-0007 | NYS Health Home Program

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	System-Derived		

## Payment Methodology

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

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

**Describe below**

see text box below regarding rates

- Comprehensive Methodology Included in the Plan
- Incentive Payment Reimbursement

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

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

# Health Homes Payment Methodologies

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## Agency Rates

### Describe the rates used

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



# Health Homes Payment Methodologies

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	System-Derived		

## Rate Development

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

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

**Comprehensive Description** 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 providers that meet health home provider standards.

#### Care Management Fee:

Health Homes meeting State and Federal standards will be paid a per member per month care management fee that is adjusted based on region and case mix method for adults, or the Child and Adolescent Needs and Strength Assessment of New York (CANS-NY) for children age 0 through 20). The total cost relating to a care manager (salary, fringe benefits, non-personal services, capital and administration costs) in conjunction with caseload assumptions were used to develop the Health Home rates. The state periodically reviews the Health Home payments in conjunction with Department of Labor salary data to ensure that the Health Home rates are sufficient to ensure quality services.

Effective May 1, 2018, the per member per month care management fee for adults will be based on region and case mix defined by populations as indicated below. Health Home rates for children will continue to be determined by an algorithm applied to the CANS-NY assessment. 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.

For dates of service beginning June 1, 2018 through December 31, 2018, the per member per month care management fee for Health Homes that are, as of June 1, 2018, designated to serve children only, or designated to serve children in 43 counties and adults and children in one county, shall be adjusted to provide \$4 million in payments to supplement care management fees. The supplemental payments shall be paid no later than March 31, 2019 and will be allocated proportionately among such Health Homes based on services provided between June 1, 2018 and December 1, 2018. The supplement shall be a lump sum payments.

Rates for Health Home services furnished to other populations are effective as noted below and apply to services furnished on and after such dates.

State Health Home Rates and Rate Codes Effective October 1, 2018 can be found at:

[https://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_health\\_homes/billing/docs/hh\\_rates\\_effective\\_october\\_2017.pdf](https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/billing/docs/hh_rates_effective_october_2017.pdf)

#### Population Case Mix Definitions for Health Home Adult Rates

Health Home Plus/Care Management Rates include adults with active AOT order or expired AOT order within last year; adults stepping down from State PC and ACT; Health and Recovery Plan (HARP) members that meet high risk criteria (recent incarceration, homelessness, multiple hospital admissions, etc.); and members identified at the discretion of the Medicaid Managed Care Plan or state designated entity for adults not currently enrolled in a Medicaid Managed Care Plan.

Health Home High Risk/Need Care Management Rates, include adults that are HARP enrolled members not included in the Health Home Plus/Care Management; any adult member meeting high risk criteria based on the high, medium and low,

Clinical and Functional Assessment; and members identified at the discretion of the Medicaid Managed Care Plan or state designated entity for adults not currently enrolled in a Medicaid Managed Care Plan.

Health Home Care Management Rates, include all other adults not meeting criteria for Health Home Services Adult Home Transition Rates, Health Home Plus/Care Management or High Risk /High Need Care Management Rates.

Health Home Services Adult Home Transition Rates apply to individuals, under the terms of a Stipulation and Order of Settlement between the U.S. Department of Justice and New York State, that are Adult Home Residents with serious mental illness (SMI) that are required to transition from Adult Homes located in New York City to the community.

The care management fee will be paid in two increments based on whether a patient was in 1) the case finding group or 2) the active care management group. Effective October 1, 2017, the case finding group will receive a PMPM for two consecutive months after a patient has been assigned or referred to the health home. The consecutive second month must be documented by a face-to-face contact. Two additional months of the case finding PMPM may be billed with a rolling 12 month period. Effective October 1, 2018, the PMPM will be reduced as indicated in the State Health Home Rates and Rate Codes posted to the State's website as indicated above. This PMPM is intended to cover the cost of outreach and engagement.

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. To bill the active case management fee, the patient must have: consented to receive services, been assigned to a care manager and be enrolled in the health home program. Care managers must document all services provided to the member in the member's care plan.

#### 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 (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 has been modified to include language similar to that outlined below which addresses any duplication of payment between the MCO capitation payments and health home payments. The delivery design and payment methodology will not result in any duplication of payment between Health Homes and managed care.

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

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

#### Targeted Case Management (TCM) Conversion Considerations:

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

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

All payments will be made under the health home payment detailed above in the care management fee section if they convert to or become part of a health home. Effective October 1, 2017, the case finding PMPM will be paid under the provisions described in the care management fee section.

#### Children's Transitional Rates

Providers delivering Individualized Care Coordination (ICC) under the 1915c SED or Health Care Integration (HCI) under the

1915c B2H waivers, who shall provide Health Home Care Management services in accordance with this section effective on January 1, 2019, shall be eligible for a transition rate add-on for two years to enable providers to transition to Health Home rates. Health Home Care Management Services eligible for the transition rate add-on shall be limited to services provided to the number of children such providers served as of December 31, 2018. Services provided to a greater number of children than such providers served as of December 31, 2018 shall be reimbursed the Health Home rate without the add-on. The transition methodology is set forth in the transitional rate chart.

Children's Health Home Transition Rates

January 1, 2019 through June 30, 2019

Health Home	Add-On			Transitional Rate				
	Upstate	Downstate		Upstate	Downstate	Upstate	Downstate	
1869: Low	\$225.00	\$240.00	7926: SED (L)	\$948.00	\$992.00	SED (L)	\$1,173.00	\$1,232.00
1870: Medium	\$450.00	\$479.00	7925: SED (M)	\$723.00	\$753.00	SED (M)	\$1,173.00	\$1,232.00
1871: High	\$750.00	\$799.00	7924: SED (H)	\$423.00	\$433.00	SED (H)	\$1,173.00	\$1,232.00

July 1, 2019 through December 31, 2019

Health Home	Add-On			Transitional Rate				
	Upstate	Downstate		Upstate	Downstate	Upstate	Downstate	
1869: Low	\$225.00	\$240.00	7926: SED (L)	\$711.00	\$744.00	SED (L)	\$936.00	\$984.00
1870: Medium	\$450.00	\$479.00	7925: SED (M)	\$542.00	\$565.00	SED (M)	\$992.00	\$1,044.00
1871: High	\$750.00	\$799.00	7924: SED (H)	\$317.00	\$325.00	SED (H)	\$1,067.00	\$1,124.00

January 1, 2020 through June 30, 2020

Health Home	Add-On			Transitional Rate				
	Upstate	Downstate		Upstate	Downstate	Upstate	Downstate	
1869: Low	\$225.00	\$240.00	7926: SED (L)	\$474.00	\$496.00	SED (L)	\$699.00	\$736.00
1870: Medium	\$450.00	\$479.00	7925: SED (M)	\$362.00	\$377.00	SED (M)	\$812.00	\$856.00
1871: High	\$750.00	\$799.00	7924: SED (H)	\$212.00	\$217.00	SED (H)	\$962.00	\$1,016.00

July 1, 2020 through December 31, 2020

Health Home	Add-On			Transitional Rate				
	Upstate	Downstate		Upstate	Downstate	Upstate	Downstate	
1869: Low	\$225.00	\$240.00	7926: SED (L)	\$237.00	\$248.00	SED (L)	\$462.00	\$488.00
1870: Medium	\$450.00	\$479.00	7925: SED (M)	\$181.00	\$188.00	SED (M)	\$631.00	\$667.00
1871: High	\$750.00	\$799.00	7924: SED (H)	\$106.00	\$108.00	SED (H)	\$856.00	\$907.00

January 1, 2019 through June 30, 2019

Health Home	Add-On			Transitional Rate				
	Upstate	Downstate		Upstate	Downstate	Upstate	Downstate	
1869: Low	\$225.00	\$240.00	8002: B2H (L)	\$925.00	\$960.00	B2H (L)	\$1,150.00	\$1,200.00
1870: Medium	\$450.00	\$479.00	8001: B2H (M)	\$700.00	\$721.00	B2H (M)	\$1,150.00	\$1,200.00
1871: High	\$750.00	\$799.00	8000: B2H (H)	\$400.00	\$401.00	B2H (H)	\$1,150.00	\$1,200.00

July 1, 2019 through December 31, 2019

Health Home	Add-On			Transitional Rate				
	Upstate	Downstate		Upstate	Downstate	Upstate	Downstate	
1869: Low	\$225.00	\$240.00	8002: B2H (L)	\$694.00	\$720.00	B2H (L)	\$919.00	\$960.00
1870: Medium	\$450.00	\$479.00	8001: B2H (M)	\$525.00	\$541.00	B2H (M)	\$975.00	\$1,020.00
1871: High	\$750.00	\$799.00	8000: B2H (H)	\$300.00	\$301.00	B2H (H)	\$1,050.00	\$1,100.00

January 1, 2020 through June 30, 2020

Health Home	Add-On			Transitional Rate				
	Upstate	Downstate		Upstate	Downstate	Upstate	Downstate	
1869: Low	\$225.00	\$240.00	8002: B2H (L)	\$463.00	\$480.00	B2H (L)	\$688.00	\$720.00
1870: Medium	\$450.00	\$479.00	8001: B2H (M)	\$350.00	\$361.00	B2H (M)	\$800.00	\$840.00
1871: High	\$750.00	\$799.00	8000: B2H (H)	\$200.00	\$201.00	B2H (H)	\$950.00	\$1,000.00

July 1, 2020 through December 31, 2020

Health Home	Add-On			Transitional Rate				
	Upstate	Downstate		Upstate	Downstate	Upstate	Downstate	
1869: Low	\$225.00	\$240.00	8002: B2H (L)	\$231.00	\$240.00	B2H (L)	\$456.00	\$480.00
1870: Medium	\$450.00	\$479.00	8001: B2H (M)	\$175.00	\$180.00	B2H (M)	\$625.00	\$659.00
1871: High	\$750.00	\$799.00	8000: B2H (H)	\$100.00	\$100.00	B2H (H)	\$850.00	\$899.00

# Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | NY2018MS00080 | NY-19-0007 | NYS Health Home Program

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	System-Derived		

## 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](http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/rate_information.htm).

- The state has developed payment methodologies and rates that are consistent with section 1902(a)(30)(A).
- The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule, unless otherwise described above.
- The State provides assurance that it shall reimburse providers directly, except when there are employment or contractual arrangements consistent with section 1902(a)(32).

## Optional Supporting Material Upload

Name	Date Created	
Standard Funding Questions (19-0007) (1-9-19)	1/9/2019 12:34 PM EST	

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

*This view was generated on 1/23/2019 1:45 PM EST*