# Table of Contents

**State/Territory Name:** **New York**

**State Plan Amendment (SPA) #:** **24-0023**

This file contains the following documents in the order listed:

# NY - Submission Package - NY2024MS0002O - (NY-24-0023) - Health Homes



DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Division of Program Operations
601 E. 12th St., Room 355
Kansas City, MO 64106

## Center for Medicaid & CHIP Services

June 27, 2024

Amir Bassiri
Medicaid Director
Department of Health
99 Washington Ave.
Albany, NY 12210

Re: Approval of State Plan Amendment NY-24-0023 NYS Health Home Program

Dear Amir Bassiri,

On March 29, 2024, the Centers for Medicare and Medicaid Services (CMS) received New York State Plan Amendment (SPA) NY-24-0023 for NYS Health Home Program to update the fees of health home serving children care management and add an additional tiered fee for health homes serving children providing High Fidelity Wraparound (HFW) as an evidence-based care management service provided to children/youth referred and eligible for HFW within Health Homes Serving Children, by agencies designated by the New York State designation process.

We approve New York State Plan Amendment (SPA) NY-24-0023 with an effective date of January 01, 2024.

If you have any questions regarding this amendment, please contact Melvina Harrison at melvina.harrison@cms.hhs.gov

Sincerely,

James G. Scott

Director, Division of Program Operations

Center for Medicaid & CHIP Services

# NY - Submission Package - NY2024MS0002O - (NY-24-0023) - Health Homes



## Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | NY2024MS0002O | NY-24-0023 | NYS Health Home Program

CMS-10434 OMB 0938-1188

### Package Header

**Package ID** NY2024MS0002O
**SPA ID** NY-24-0023
**Submission Type** Official
**Initial Submission Date** 3/29/2024
**Approval Date** 06/27/2024
**Effective Date** N/A
**Superseded SPA ID** N/A

### State Information

**State/Territory Name:** New York
**Medicaid Agency Name:** Department of Health

### Submission Component

- (•) State Plan Amendment
- (•) Medicaid
- ( ) CHIP

# Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | NY2024MS0002O | NY-24-0023 | NYS Health Home Program

## Package Header

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**Submission Type** Official
**Initial Submission Date** 3/29/2024
**Approval Date** 06/27/2024
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## SPA ID and Effective Date

**SPA ID** NY-24-0023

| Reviewable Unit | Proposed Effective Date | Superseded SPA ID |
|---|---|---|
| Health Homes Intro | 1/1/2024 | NY-23-0061 |
| Health Homes Population and Enrollment Criteria | 1/1/2024 | NY-21-0026 |
| Health Homes Providers | 1/1/2024 | NY-20-0034 |
| Health Homes Payment Methodologies | 1/1/2024 | NY-23-0061 |

# Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | NY2024MS0002O | NY-24-0023 | NYS Health Home Program

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**Effective Date** N/A
**Superseded SPA ID** N/A

## Executive Summary

**Summary Description Including Goals and Objectives** The Department of Health proposes to amend the Title XIX (Medicaid) State Plan Amendment for non-institutional services to comply with enacted statutory provisions. The changes proposed in the State Plan Amendment seek to update the fees of Health Home Serving Children care management and add an additional tiered fee for Health Homes Serving Children providing High Fidelity Wraparound (HFW) as an evidence-based care management service provided to children/youth referred and eligible for High Fidelity Wraparound within Health Homes Serving Children, by agencies designated by the New York State designation process.

## Federal Budget Impact and Statute/Regulation Citation

**Federal Budget Impact**

| | Federal Fiscal Year | Amount |
|---|---|---|
| First | 2024 | $1112831 |
| Second | 2025 | $1483775 |

**Federal Statute / Regulation Citation**

1945 of the Social Security Act

**Supporting documentation of budget impact is uploaded (optional).**

| Name | Date Created | |
|---|---|---|
| Fiscal Calculations (24-0023) | 3/13/2024 2:56 PM EDT | |
| Original Submission-HCFA (24-0023)( | 3/13/2024 3:58 PM EDT | |

# Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | NY2024MS0002O | NY-24-0023 | NYS Health Home Program

## Package Header

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| **Package ID** | NY2024MS0002O | **SPA ID** | NY-24-0023 |
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| **Approval Date** | 06/27/2024 | **Effective Date** | N/A |
| **Superseded SPA ID** | N/A | | |

## Governor's Office Review

- (•) No comment
- ( ) Comments received
- ( ) No response within 45 days
- ( ) Other

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. 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 range from 1 hour to 80 hours per response (see below), 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 7/1/2024 10:39 AM EDT*

# NY - Submission Package - NY2024MS0002O - (NY-24-0023) - Health Homes



## Health Homes Intro

MEDICAID | Medicaid State Plan | Health Homes | NY2024MS0002O | NY-24-0023 | NYS Health Home Program

CMS-10434 OMB 0938-1188

### Package Header

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|---|---|---|---|
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| **Approval Date** | 06/27/2024 | **Effective Date** | 1/1/2024 |
| **Superseded SPA ID** | NY-23-0061<br>System-Derived | | |

### 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**

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan Amendment for non-institutional services to comply with enacted statutory provisions. The changes proposed in the State Plan Amendment seek to update the fees of care management for Health Homes that service children/youth and add an additional tiered fee for Health Homes designated by the New York State designation process that serve children who meet High Fidelity Wraparound (HFW) eligibility criteria.

### General Assurances

- [x] The state provides assurance that eligible individuals will be given a free choice of Health Homes providers.
- [x] The states 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 FMAP for Health Homes services shall be 90% for the first eight fiscal quarters from the effective date of the SPA. After the first eight quarters, expenditures will be claimed at the regular matching rate.
- [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.
- [x] The state provides assurance that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.



*This view was generated on 7/1/2024 10:39 AM EDT*

# NY - Submission Package - NY2024MS0002O - (NY-24-0023) - Health Homes



## Health Homes Population and Enrollment Criteria

MEDICAID | Medicaid State Plan | Health Homes | NY2024MS0002O | NY-24-0023 | NYS Health Home Program

CMS-10434 OMB 0938-1188

### Package Header

**Package ID** NY2024MS0002O
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**Superseded SPA ID** NY-21-0026
System-Derived

### Categories of Individuals and Populations Provided Health Home Services

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

☑ Categorically Needy (Mandatory and Options for Coverage) Eligibility Groups

☑ Medically Needy Eligibility Groups

Mandatory Medically Needy

☑ Medically Needy Pregnant Women

☑ Medically Needy Children under Age 18

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

**Families and Adults**

☑ Medically Needy Children Age 18 through 20

☑ Medically Needy Parents and Other Caretaker Relatives

**Aged, Blind and Disabled**

☑ Medically Needy Aged, Blind or Disabled

☑ Medically Needy Blind or Disabled Individuals Eligible in 1973

# Health Homes Population and Enrollment Criteria

MEDICAID | Medicaid State Plan | Health Homes | NY2024MS0002O | NY-24-0023 | NYS Health Home Program

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System-Derived

## Population Criteria

**The state elects to offer Health Homes services to individuals with:**

☑ Two or more chronic conditions

**Specify the conditions included:**

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

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

☑ One chronic condition and the risk of developing another

**Specify the conditions included:**

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

| Name | Description |
|---|---|
| HIV/AIDS | see description below |
| One Serious Mental illness | see description below |
| SED/Complex Trauma | see description below |
| Sickle Cell Disease | see description below |

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

HIV, Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED) and complex trauma are each single qualifying conditions for which NYS was approved. Providers do not need to document a risk of developing another condition in these cases.
New York's Medicaid program serves over 5 million enrollees with a broad array of health care needs and challenges. While many Medicaid enrollees are relatively healthy and access practitioners to obtain episodic and preventive health care, the Medicaid program also has several population groups who have complex medical, behavioral, and long term care needs that drive a high volume of high cost services including inpatient and long term institutional care.

Of the 5.4M Medicaid enrollees who access services on a fee for service or

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

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

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

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

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

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

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

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

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

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

Major Category: Respiratory Disease
3M Clinical Risk Group (3M CRGs) Category
1. Asthma
2. Chronic Obstructive Pulmonary Disease

Major Category: Other
3M Clinical Risk Group (3M CRGs) Category
1. Other Chronic Disease -conditions listed above as well as other specific diagnoses of the population.

Description of population selection criteria

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

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

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

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

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

☑ One serious and persistent mental health condition

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

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

# Health Homes Population and Enrollment Criteria

MEDICAID | Medicaid State Plan | Health Homes | NY2024MS0002O | NY-24-0023 | NYS Health Home Program

## Package Header

| | | | |
|---|---|---|---|
| **Package ID** | NY2024MS0002O | **SPA ID** | NY-24-0023 |
| **Submission Type** | Official | **Initial Submission Date** | 3/29/2024 |
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| **Superseded SPA ID** | NY-21-0026 | | |
| | System-Derived | | |

## 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:**

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

Individuals in receipt of High Fidelity Wraparound care management through Health Homes will be children/youth who meet the following criteria:
1) Have a functional impairment in the home, school, or community as measured by the Children and Adolescent Needs and Strengths (CANS-NY) assessment,
2) Be Health Home (HH) Enrolled/Eligible through SED or 2 MH diagnoses, AND
3) Be a child/youth involved with two or more systems.
In addition, the child/youth must meet service utilization criteria which demonstrates their level of need for intensive care management services. Services include, but are not limited to, out-of-home inpatient or residential services, crisis and emergency services, intensive treatment programs, or services restricted to high-need populations.

Children/youth identified through the various child system of care providers, the local county department of mental health Single Point of Access (SPOAs) who have direct connections to mental health providers, schools, hospitals, and psychiatric centers, and the Health Home care management agencies will identify potential members and will receive referrals for Health Home care management services inclusive of High Fidelity Wrap.

Children/youth entering the Health Home program who meet high needs/high risk criteria above for mental health will be screened for the potential of HFW.

☑ The state provides assurance that it will clearly communicate the 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 their rights to choose or change Health Homes providers or to elect not to receive the benefit.

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



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# NY - Submission Package - NY2024MS0002O - (NY-24-0023) - Health Homes



## Health Homes Providers

MEDICAID | Medicaid State Plan | Health Homes | NY2024MS0002O | NY-24-0023 | NYS Health Home Program

CMS-10434 OMB 0938-1188

### Package Header

**Package ID** NY2024MS0002O
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System-Derived

**SPA ID** NY-24-0023
**Initial Submission Date** 3/29/2024
**Effective Date** 1/1/2024

### 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 |

# Health Homes Providers

MEDICAID | Medicaid State Plan | Health Homes | NY2024MS0002O | NY-24-0023 | NYS Health Home Program

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**Initial Submission Date** 3/29/2024

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**Superseded SPA ID** NY-20-0034

System-Derived

- [ ] Teams of Health Care Professionals
- [ ] Health Teams

# Health Homes Providers

MEDICAID | Medicaid State Plan | Health Homes | NY2024MS0002O | NY-24-0023 | NYS Health Home Program

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

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

A single care management record will be agreed to and shared by all team professionals and case reviews will be conducted on a regular basis. The care manager will be responsible for overall management and coordination of the enrolee's care plan which will include both medical/behavioral health and social service needs and goals.

In order to ensure the delivery of quality health home services, the State will provide educational opportunities for health home providers, such as webinars, regional meetings and/ or learning collaboratives to foster shared learning, information sharing and problem solving. Educational opportunities will be provided to support the provision of timely, comprehensive, high-quality health homes services that are whole person focused and that integrate medical, behavioral health and other needed supports and social services. The State will maintain a highly collaborative and coordinated working relationship with individual health home providers through frequent communication and feedback. Learning activities and technical assistance will also support providers of health home services to address the following health home functional components:

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

The Department of Health in partnership with the Office of Mental Health and the Office of Addiction Services and Supports 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.

Health Home care management agencies must be designated by New York State to offer High Fidelity Wraparound. Agencies must demonstrate and detail their understanding, commitment, and experience with the key qualifications necessary to effectively implement HFW and agree to remain in compliance throughout implementation.

HFW care managers must complete the required State certification in the HFW model. HFW care managers must also meet the Health Home Serving Children staff qualifications.

High Fidelity Wraparound caseloads will not exceed 1:12

## 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**

High Fidelity Wraparound certification training consists of self-paced and trainer-led instruction, peer learning collaboratives, and skills clinics. The certification training is completed over the course of 16 weeks with the skills and knowledge presented divided across the four phases of HFW. In addition to training, care managers are required to attend one coaching session per month for twelve months to receive full certification. Provisional certification is awarded to care managers following the successful completion of all training modules offered in the initial eight-week training period and two coaching calls. A care manager may begin implementing HFW with youth and families once provisional certification is achieved.

High Fidelity Wraparound Supervisory Certification is attained after successfully completing the initial 16-week care manager certification training and completing an additional HFW Supervision training module. This module consists of self-paced and trainer-led courses and is completed over the course of 6 weeks. In addition to care manager and supervisor training, supervisors are required to attend one coaching session per month for twelve months to receive full certification.

NYS has established a dynamic data collection and analysis process to monitor the delivery and outcomes related to HFW.

## 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 health care costs, specifically preventable hospital admissions/readmissions and avoidable emergency room visits; providing timely post discharge follow-up, and improving patient outcomes by addressing primary medical, specialist and behavioral
health care through direct provision, or through contractual arrangements with appropriate service providers, of
comprehensive, integrated services.

General Qualifications

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

2.Health home providers can either directly provide, or subcontract for the provision of, health home services. The health home provider remains responsible for all health home program requirements, including services performed by the subcontractor.

3.Care coordination and integration of health care services will be provided to all health home enrollees by an
interdisciplinary team of providers, where each individual's care is under the direction of a dedicated care manager who is accountable for assuring access to medical and behavioral health care services and community social supports as defined in the enrollee care plan.

4.Hospitals that are part of a health home network must have procedures in place for referring any eligible individual with chronic conditions who seek or need treatment in a hospital emergency department to a DOH designated health home provider.

5.Health home providers must demonstrate their ability to perform each of the eleven CMS health home core functional components. (Refer to section iii. Provider Infrastructure) Including:

i.processes used to perform these functions;
ii.processes and timeframes used to assure service delivery takes place in the described manner; and
iii.description of multifaceted health home service interventions that will be provided to promote patient engagement, participation in their plan of care and that ensures patients appropriate access to the continuum of physical and behavioral health care and social services.

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

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

I. Comprehensive Care Management

Policies and procedures are in place to create, document, execute and update an individualized, patient centered plan of care for each individual.
1a. A comprehensive health assessment that identifies medical, mental health, chemical dependency and social service needs is developed.
1b. The individual's plan of care integrates the continuum of medical, behavioral health services, rehabilitative, long term care and social service needs and clearly identifies the primary care physician/nurse practitioner, specialist(s), behavioral health care provider(s), care manager and other providers directly involved in the

individual's care.
1c.The individual (or their guardian) play a central and active role in the development and execution of their plan of care and should agree with the goals, interventions and time frames contained in the plan.
1d. The individual's plan of care clearly identifies primary, specialty, behavioral health and community networks and supports that address their needs.
1e. The individual's plan of care clearly identifies family members and other supports involved in the patient's care. Family and other supports are included in the plan and execution of care as requested by the individual.
1f. The individual's plan of care clearly identifies goals and timeframes for improving the patient's health and health care status and the interventions that will produce this effect.
1g. The individual's plan of care must included outreach and engagement activities that will support engaging patients in care and promoting continuity of care.
1h. The individual's plan of care includes periodic reassessment of the individual needs and clearly identifies the patient's progress in meeting goals and changes in the plan of care based on changes in patient's need.

II. Care Coordination and Health Promotion

2a. The health home provider is accountable for engaging and retaining health home enrollees in care; coordinating and arranging for the provision of services; supporting adherence to treatment recommendations; and monitoring and evaluating a patient's needs, including prevention, wellness, medical, specialist and behavioral health treatment, care transitions, and social and community services where appropriate through the
creation of an individual plan of care.
2b. The health home provider will assign each individual a dedicated care manager who is responsible for overall
management of the patient's care plan. The health home care manager is clearly identified in the patient record. Each individual enrolled with a health home will have one dedicated care manager who has overall responsibility and accountability for coordinating all aspects of the individual's care. The individual cannot be enrolled in more than one care management program funded by the Medicaid program.
2c. The health home provider must describe the relationship and communication between the dedicated care manager and the treating clinicians that assure that the care manager can discuss with clinicians on an as needed basis, changes in patient condition that may necessitate treatment change (i.e., written orders and/or
prescriptions).
2d. The health home provider must define how patient care will be directed when conflicting treatment is being provided.
2e. The health home provider has policies, procedures and accountabilities (contractual agreements) to support
effective collaborations between primary care, specialist and behavioral health providers, evidence-based referrals and follow-up and consultations that clearly define roles and responsibilities.
2f. The health home provider supports continuity of care and health promotion through the development of a treatment relationship with the individual and the interdisciplinary team of providers.
2g. The health home provider supports care coordination and facilitates collaboration through the establishment of regular case review meetings, including all members of the interdisciplinary team on a schedule determined by the health home provider. The health home provider has the option of utilizing technology conferencing tools including audio, video and /or web deployed solutions when security protocols and precautions are in place to protect PHI.
2h. The health home provider ensures 24 hours/seven days a week availability to a care manager to provide information and emergency consultation services.
2i. The health home provider will ensure the availability of priority appointments for health home enrollees to medical and behavioral health care services within their health home provider network to avoid unnecessary, inappropriate utilization of emergency room and inpatient hospital services.
2j. The health home provider promotes evidence based wellness and prevention by linking health home enrollees with resources for smoking cessation, diabetes, asthma, hypertension, self help recovery resources, and other services based on individual needs and preferences.
2k. The health home provider has a system to track and share patient information and care needs across providers and to monitor patient outcomes and initiate changes in care, as necessary, to address patient need.

III. Comprehensive Transitional Care

3a. The health home provider has a system in place with hospitals and residential/rehabilitation facilities in their network to provide the health home prompt notification of an individual's admission and/or discharge to/from an emergency room, inpatient, or residential/rehabilitation setting.
3b. The health home provider has policies and procedures in place with local practitioners, health facilities including emergency rooms, hospitals, and residential/rehabilitation settings, providers and community-based services to help ensure coordinated, safe transitions in care for its patients who require transfers in the site of care.
3c. The health home provider utilizes HIT as feasible to facilitate interdisciplinary collaboration among all providers, the patient, family, care givers, and local supports.
3d. The health home provider has a systematic follow-up protocol in place to assure timely access to follow-up care post discharge that includes at a minimum receipt of a summary care record from the discharging entity, medication reconciliation, timely scheduled appointments at recommended outpatient providers, care manager verification with outpatient provider that the patient attended the appointment, and a plan to outreach and 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 patients' knowledge about their disease, engagement and self management capabilities, and to improve adherence to prescribed treatment.
4d. The health home provider discusses advance directives with enrollees and their families or caregivers.
4e. The health home provider communicates and shares information with individuals and their families and other caregivers with appropriate consideration for language, literacy and cultural preferences.
4f. The health home provider gives the patient access to care plans and options for accessing clinical information.

V. Referral to Community and Social Support Services

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

preferences and contribute to achieving the patient's goals.

VI. Use of Health Information Technology to Link Services

Health home providers will make use of available HIT and accesses data through the regional health information organization (RHIOs)/Qualified Entities (QE) to conduct these processes as feasible, to comply with the initial standards cited in items 6a.-6d for implementation of health homes. In order to be approved as health home provider, applicants must provide a plan to achieve the final standards cited in items 6e.-6i. within eighteen (18) months of program initiation.
Initial Standards
6a. Health home provider has structured information systems, policies, procedures and practices to create, document, execute, and update a plan of care for every patient.
6b. Health home provider has a systematic process to follow-up on tests, treatments, services and, and referrals which is incorporated into the patient's plan of care.
6c. Health home provider has a health record system which allows the patient's health information and plan of care to be accessible to the interdisciplinary team of providers and which allows for population management and identification of gaps in care including preventive services.
6d. Health home provider makes use of available HIT and accesses data through the RHIO/QE to conduct these processes, as feasible.
Final Standards
6e. Health home provider has structured interoperable health information technology systems, policies, procedures and practices to support the creation, documentation, execution, and ongoing management of a plan of care for every patient.
6f. Health home provider uses an electronic health record system that qualifies under the Meaningful Use provisions of the HITECH Act, which allows the patient's health information and plan of care to be accessible to the interdisciplinary team of providers. If the provider does not currently have such a system, they will provide a plan for when and how they will implement it.
6g. Health home provider will be required to comply with the current and future version of the Statewide Policy Guidance (http://health.ny.gov/technology/statewide_policy_guidance.htm) which includes common information policies, standards and technical approaches governing health information exchange.
6h. Health home provider commits to joining regional health information networks or qualified health IT entities for data exchange and includes a commitment to share information with all providers participating in a care plan. RHIOs/QE provides policy and technical services required for health information exchange through the Statewide Health Information Network of New York (SHIN-NY).
6i. Health home provider supports the use of evidence based clinical decision making tools, consensus guidelines, and best practices to achieve optimal outcomes and cost avoidance. One example of such a tool is PSYCKES.

VII. Quality Measures Reporting to State

7a. The health home provider has the capability of sharing information with other providers and collecting and reporting specific quality measures as required by NYS and CMS.
7b. The health home provider is accountable for reducing avoidable health care costs specifically preventable hospital admissions/readmissions and avoidable emergency room visits; providing timely post discharge follow up, and improving patient outcomes as measured by NYS and CMS required quality measures.

| Name | Date Created | |
|---|---|---|
| No items available | | |

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# NY - Submission Package - NY2024MS0002O - (NY-24-0023) - Health Homes



## Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | NY2024MS0002O | NY-24-0023 | NYS Health Home Program

CMS-10434 OMB 0938-1188

### Package Header

**Package ID** NY2024MS0002O
**SPA ID** NY-24-0023
**Submission Type** Official
**Initial Submission Date** 3/29/2024
**Approval Date** 06/27/2024
**Effective Date** 1/1/2024
**Superseded SPA ID** NY-23-0061
System-Derived

### Payment Methodology

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

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

MEDICAID | Medicaid State Plan | Health Homes | NY2024MS0002O | NY-24-0023 | NYS Health Home Program

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System-Derived

**SPA ID** NY-24-0023

**Initial Submission Date** 3/29/2024

**Effective Date** 1/1/2024

## 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

**Effective Date**

4/1/2023

**Website where rates are displayed**

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/billing/index.htm

# Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | NY2024MS0002O | NY-24-0023 | NYS Health Home Program

## Package Header

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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, 2017 can be found at:
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_rates_eective_october_2017.xlsx

State Health Home Rates and Rate Codes Effective May 1, 2018 can be found at:
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_rates_eective_october_2017.xlsx

State Health Home Rates and Rate Codes Effective October 1, 2018 can be found at:
https://health.ny.gov/health_care/medicaid/program/medicaid_health_homes/billing/docs/hh_rates_effective_october_2018

.xlsx

State Health Home Rates and Rate Codes Effective July 1, 2020, can be found at: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/billing/hh_rates_effective_july_2020.htm

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.

Effective July 1, 2020, the PMPM for case finding will be reduced to $0 as indicated in the State Health Home Rates and Rate Codes posted to the State's website as indicated 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 active care management PMPM. Once a patient has consented to received services and been assigned a care manager and is enrolled in the health home program the active care management PMPM may be billed. 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 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 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 |

July1, 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 |

Effective October,1, 2022, Children's Health Homes may receive an assessment fee to ensure that any child who may be eligible for Home and Community-Based Services (HCBS) under the Children's Waiver, demonstration or State Plan authority will be eligible
to receive a timely HCBS assessment under the Health Home program. The HH HCBS assessment fee will compensate the HH for the costs associated with conduct of:
• Evaluation and/or re-evaluation of HCBS level of care;
• Assessment and/or reassessment of the need for HCBS;
• Inclusion of all aspects of an HCBS Plan of Care in the HH's Comprehensive Care Plan.
This fee will be paid in addition to the PMPM calculated above and is contingent upon the Health Home completing a timely and
complete assessment.

Effective January 1, 2024, a per member per month (PMPM) care management fee was developed separately for the Health Home members eligible for High Fidelity Wraparound due to an increased need for case management services based on severity of conditions. The fee is based on modeling estimated enrollment, staff salaries, benefits, non-personnel costs, overhead, and administrative costs that is based on region under High Fidelity Wraparound based on the caseload assumptions.

Separate rates are developed for the children’s High Fidelity Wraparound services. State Health Home Rates and Rate Codes Effective January 1, 2024 can be found at:
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/billing/index.htm

# Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | NY2024MS0002O | NY-24-0023 | NYS Health Home Program

## Package Header

| | | | |
|---|---|---|---|
| **Package ID** | NY2024MS0002O | **SPA ID** | NY-24-0023 |
| **Submission Type** | Official | **Initial Submission Date** | 3/29/2024 |
| **Approval Date** | 06/27/2024 | **Effective Date** | 1/1/2024 |
| **Superseded SPA ID** | NY-23-0061 | | |
| | 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.

☑ 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 | |
|---|---|---|
| Authorizing Provisions (24-0023)(CMS 3-29-24) | 3/13/2024 2:48 PM EDT | |
| Original Submission Letter (24-0023) (CMS 3-29-24) | 3/13/2024 2:52 PM EDT | |
| SFQ_s (24-0023)( CMS 3-29-24) | 3/13/2024 2:53 PM EDT | |
| Summary (CMS 3-29-24) | 3/13/2024 2:54 PM EDT | |



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