



Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, M.D., M.P.H.
Commissioner

JOHANNE E. MORNE, M.S.
Executive Deputy Commissioner

March 29, 2024

Payments and Coverage
James G. Scott, Director
Division of Program Operations
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

RE: SPA #24-0023
Non-Institutional Services

Dear Mr. Scott:

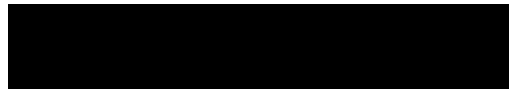
The State requests approval of the enclosed amendment #24-0023 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective January 1, 2024 (Appendix I). This amendment is being submitted based on enacted legislation. A summary of the plan amendment is provided in Appendix II.

The State of New York reimburses these services through the use of rates that are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area as required by § 1902(a)(30) of the Social Security Act and 42 CFR § 447.204.

A copy of pertinent sections of enacted legislation is enclosed for your information (Appendix III). A copy of the public notice of this plan amendment, which was given in the New York State Register on December 27, 2023, is also enclosed for your information (Appendix IV). In addition, responses to the five standard funding questions are also enclosed (Appendix V).

If you have any questions regarding this State Plan Amendment submission, please do not hesitate to contact Regina Deyette, Medicaid State Plan Coordinator, Division of Finance and Rate Setting, Office of Health Insurance Programs at (518) 473-3658.

Sincerely,



Amir Bassiri
Medicaid Director
Office of Health Insurance Programs

Enclosures

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

1. TRANSMITTAL NUMBER <u>2 4 — 0 0 2 3</u>	2. STATE <u>NY</u>
3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT <input checked="" type="radio"/> XIX <input type="radio"/> XXI	

TO: CENTER DIRECTOR CENTERS FOR MEDICAID & CHIP SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE <u>January 1, 2024</u>
5. FEDERAL STATUTE/REGULATION CITATION <u>§ 1945 of the Social Security Act</u>	6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars) a. FFY <u>01/01/24-09/30/24</u> \$ <u>1,112,831</u> b. FFY <u>10/01/24-09/30/25</u> \$ <u>1,483,775</u>
7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT <u>MACPro Portal SPA</u>	8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable) <u>MACPro Portal SPA</u>

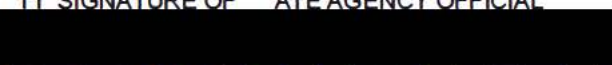
9. SUBJECT OF AMENDMENT

Health Home Serving Children High Fidelity Wrap and HHSC Rebasing

10. GOVERNOR'S REVIEW (Check One)

GOVERNOR'S OFFICE REPORTED NO COMMENT
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

OTHER, AS SPECIFIED:

11. SIGNATURE OF STATE AGENCY OFFICIAL 	15. RETURN TO New York State Department of Health Division of Finance and Rate Setting 99 Washington Ave – One Commerce Plaza Suite 1432 Albany, NY 12210
12. TYPED NAME <u>Amir Bassiri</u>	
13. TITLE <u>Medicaid Director</u>	
14. DATE SUBMITTED <u>March 29, 2024</u>	

FOR CMS USE ONLY

16. DATE RECEIVED	17. DATE APPROVED
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PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL	19. SIGNATURE OF APPROVING OFFICIAL
20. TYPED NAME OF APPROVING OFFICIAL	21. TITLE OF APPROVING OFFICIAL

22. REMARKS

Appendix I
2024 Title XIX State Plan
First Quarter Amendment
Amended SPA Pages

[Records](#) / [Submission Packages](#) [Your state](#)

NY - Submission Package - NY2024MS00020 - (NY-24-0023) - Health Homes

[Summary](#) [Reviewable Units](#) [News](#) [Related Actions](#)

CMS-10434 OMB 0938-1188

Package Information

Package ID	NY2024MS00020	Submission Type	Official
Program Name	NYS Health Home Program	State	NY
SPA ID	NY-24-0023	Region	New York, NY
Version Number	1	Package Status	Submitted
Submitted By	Michelle Levesque	Submission Date	3/29/2024
		Regulatory Clock	90 days remain
		Review Status	Review 1

Submission - Summary

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	/ 9/ 024
Approval Date	N/A	Effective Date	N/A
Superseded SPA ID	N/A		

Reviewable Unit Instructions

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 | NY2024MS00020 | NY-24-0023 | NYS Health Home Program

Package Header

Package ID NY2024MS00020	SPA ID NY-24-0023
Submission Type Official	Initial Submission Date 3/29/2024
Approval Date N/A	Effective Date N/A
Superseded SPA ID N/A	

Reviewable Unit Instructions

SPA ID and Effective Date

PA ID NY 4-00

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/ 0 4	NY 20 00 4
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

Package Header

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

Reviewable Unit Instructions

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

194 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 (4 002)	3/13/2024 2:56 PM EDT	

Submission - Summary

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

Reviewable Unit Instructions

Governor's Office Review

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

Submission - Medicaid State Plan

MEDICAID | Medicaid State Plan | Health Homes | NY2024MS00020 | NY-24-0023 | NYS Health Home Program

CMS 10434 OMB 0938 1188

The submission includes the following:

- Administration
- Eligibility
- Benefits and Payments
 - Health Homes Program

Do not use "Create New Health Homes Program" to amend an existing Health Homes program. Instead, use "Amend existing Health Homes program," below.

- Create new Health Homes program
- Amend existing Health Homes program
- Terminate existing Health Homes program

NY Health Home Program ▼

Health Homes SPA - Reviewable Units

Only select Reviewable Units to include in the package which you intend to change.

*

<input type="checkbox"/>	Reviewable Unit Name	Included in Another Source Type Submission Package
<input checked="" type="checkbox"/>	Health Homes Intro	(APPROVED
<input type="checkbox"/>	Health Homes Geographic Limitations	(APPROVED
<input checked="" type="checkbox"/>	Health Homes Population and Enrollment Criteria	(APPROVED
<input checked="" type="checkbox"/>	Health Homes Providers	(APPROVED
<input type="checkbox"/>	Health Homes Service Delivery Systems	(APPROVED
<input checked="" type="checkbox"/>	Health Homes Payment Methodologies	(APPROVED
<input type="checkbox"/>	Health Homes Services	(APPROVED
<input type="checkbox"/>	Health Homes Monitoring, Quality Measurement and Evaluation	(APPROVED

1 - 8 of 8

1945A Health Home Program

Submission - Public Notice/Process

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	/ 9/ 024
Approval Date	N/A	Effective Date	N/A
Superseded SPA ID	N/A		

Reviewable Unit Instructions

Name of Health Homes Program

NYS Health Home Program

Public notice was provided due to proposed changes in methods and standards for setting payment rates for services, pursuant to 42 CFR 447.205.

Upload copies of public notices and other documents used

Name	Date Created	
FPN NY Register (1 7)	/ 1/ 024 1 PM E T	

Submission - Tribal Input

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	/ 9/ 024
Approval Date	N/A	Effective Date	N/A
Superseded SPA ID	N/A		

Reviewable Unit Instructions

Name of Health Homes Program:

NYS Health Home Program

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

- Yes
- No

This state plan amendment is likely to have a direct effect on Indians, Indian Health Programs or Urban Indian Organizations, as described in the state consultation plan

- Yes
- No

The state has solicited advice from Indian Health Programs and/or Urban Indian Organizations as required by section 1902(a)(7) of the Social Security Act, and in accordance with the state consultation plan, prior to submission of this SPA.

Complete the following information regarding any solicitation of advice and/or tribal consultation conducted with respect to this submission:

Solicitation of advice and/or Tribal consultation was conducted in the following manner:

All Indian Health Programs

Date of solicitation/consultation	Method of solicitation/consultation
3/14/2024	paper mailing/electronic mail


All Urban Indian Organizations

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

All Indian Tribes

Date of consultation:	Method of consultation:
/14/ 024	paper mailing/electronic mail

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

Name	Date Created	
Tribal Consultation (24-0023) (Summary) (3-14-24)	3/14/2024 2:04 PM EDT	

Indicate the key issues raised (optional)

- Access
- Quality
- Cost
- Payment methodology
- Eligibility

- Benefits
- Service delivery
- Other issue

Submission - Other Comment

MEDICAID | Medicaid State Plan | Health Homes | NY2024MS00020 | NY 24 0023 | NYS Health Home Program

Package Header

Package ID NY20 4M 000 O	PA ID NY 4 00
Submission Type Official	Initial Submission Date 3/29/2024
Approval Date N/A	Effective Date N/A
Superseded SPA ID N/A	

Reviewable Unit Instructions

SAMHSA Consultation

Name of Health Homes Program

NY Health Home Program

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

Date of consultation
1/20/2014

Health Homes Intro

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	/ 9/ 024
Approval Date	N/A	Effective Date	1/1/2024
Superseded SPA ID	NY-23-0061		

System Der ved

Reviewable Unit Instructions

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

NY 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 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.

General Assurances

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

Health Homes Population and Enrollment Criteria

MEDICAID | Medicaid State Plan | Health Homes | NY2024MS00020 | NY-24-0023 | NYS Health Home Program

Package Header

Package ID	NY2024MS00020	SPA ID	NY-24-0023
Submission Type	Official	Initial Submission Date	1/9/24
Approval Date	N/A	Effective Date	1/1/2024
Superseded SPA ID	NY-21-0026		

System Derived

Reviewable Unit Instructions

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 1

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 197

Health Homes Population and Enrollment Criteria

MEDICAID | Medicaid State Plan | Health Homes | NY2024MS00020 | NY-24-0023 | NYS Health Home Program

Package Header

Package ID	NY2024MS00020	SPA ID	NY-24-0023
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Superseded SPA ID	NY-21-0026		
	System-Derived		

Reviewable Unit Instructions

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 erious Mental Illness (MI) and erious Emotional Disturbance (ED) 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 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/NO /NEC
5. Substance Abuse
6. Opioid Abuse
7. Other Significant Drug Abuse

Major Category: Mental Health

3M Clinical Risk Group (3M CRGs) Category

1. Bipolar 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)

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
 M Clinical Risk Group (M CRGs) Category
 1. Chronic Renal Failure
 2. Diabetes

Major Category: Respiratory Disease
 3M Clinical Risk Group (3M CRGs) Category
 1. Asthma
 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 | NY2024MS00020 | NY-24-0023 | NYS Health Home Program

Package Header

Package ID	NY2024MS00020	SPA ID	NY-24-0023
Submission Type	Official	Initial Submission Date	3/29/2024
Approval Date	N/A	Effective Date	1/1/ 0 4
Superseded SPA ID	NY-21-0026		
	System-Derived		

Reviewable Unit Instructions

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

One exception to the processes described above relates to beneficiaries for High Fidelity Wraparound (HFW) for this level of care coordination requires: the child/youth must meet each of the following factors: 1) Age 6-21, 2) A functional impairment in the home, school, or community as measured by the Children and Adolescent Needs and Strengths (CANS-NY), 3) Health Home (HH) Enrolled/Eligible through ED or MH diagnoses AND 4) The child/ youth is 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 (POAs) 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 serving Children 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	

Health Homes Providers

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	/ 9/ 024
Approval Date	N/A	Effective Date	1/1/2024
Superseded SPA ID	NY-20-0034		
	System Der ved		

Reviewable Unit Instructions

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

Package Header

Package ID	NY2024MS0002O	SPA ID	NY-24-0023
Submission Type	Official	Initial Submission Date	3/29/2024
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	System-Derived		

Reviewable Unit Instructions

- Teams of Health Care Professionals
- Health Teams

Health Homes Providers

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

Package Header

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Reviewable Unit Instructions

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 enrollee's care plan which will include both medical/behavioral health and social service needs and goals.

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

NY 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 include outreach and engagement activities that will support engaging patients in care and promoting continuity of care.
- 1h. The individual's plan of care includes periodic reassessment of the individual 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.
- b. 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

- a. 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

- a. 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		

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | NY2024MS00020 | NY-24-0023 | NYS Health Home Program

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	System Derived		

Reviewable Unit Instructions

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

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

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Reviewable Unit Instructions

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 h omes/billing/index.htm](https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/billing/index.htm)

Health Homes Payment Methodologies

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Reviewable Unit Instructions

Rate Development

Provide a comprehensive description in the PA 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;
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 (CAN -NY) for children age 0 through 0) 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 CAN -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 1 016

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

tate Health Home Rates and Rate Codes Effective October 1 01 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 00 the PMPM for case finding will be reduced to \$0 as indicated in the tate 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 CM 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 tate 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 tate 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 1 019 through December 1 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 0 0 through June 0 0 0

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 1 020 through December 1 20 0

Health Home	Add-On			Transitional Rate			
	Upstate	Downstate		Upstate	Downstate	Upstate	Downstate

Medicaid State Plan Print View

169 Low	\$22.00	\$40.00	002 B H (L)	\$1.00	\$40.00	B H (L)	\$46.00	\$40.00
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 Homes Serving Children designated by the NYS designation process and providing High Fidelity Wraparound. 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 projections and rates are developed for this population of most vulnerable children who meet the following conditions to be part of this service:

SED diagnosis as well as additional criteria, namely that the child or youth is:

- Between 6 and 21 years of age;
- Has a functional impairment in the home, school, or community as measured by the Children and Adolescent Needs and Strengths (CAN - NY)
- Is Health Home (HH) Enrolled/Eligible through SED or 2 MH diagnoses;
- Is involved with two or more systems;
- Has a history of service utilization with out-of-home residential or inpatient services, crisis and emergency services, intensive treatment programs or represent high needs populations.

Separate rates are developed for the children's High Fidelity Wraparound services for the Health Homes Serving Children 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 | NY2024MS00020 | NY-24-0023 | NYS Health Home Program

Package Header

Package ID	NY2024MS00020	SPA ID	NY-24-0023
Submission Type	Official	Initial Submission Date	3/29/2024
Approval Date	N/A	Effective Date	1/1/ 0 4
Superseded SPA ID	NY-23-0061		
	System-Derived		

Reviewable Unit Instructions

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 190 (a)()

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	
FQ s (4-00)(CM -29 4)	/1 / 024 5 PM EDT	
Summary (CMS 3-29-24)	3/13/2024 2:54 PM EDT	

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 submission 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, Attention PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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Appendix II
2024 Title XIX State Plan
First Quarter Amendment
Summary

SUMMARY
SPA #24-0023

This State Plan Amendment proposes to amend the Title XIX (Medicaid) for non-institutional services to comply with enacted statutory provisions 1945 of the Social Security Act. The changes proposed in the SPA seek to update the fees of the Health Home Serving Children care management and add an additional tiered fee for Health Home 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 Home Serving Children, by agencies designated by the New York State designation process.

Appendix III
2024 Title XIX State Plan
First Quarter Amendment
Authorizing Provisions

Compilation Of The Social Security Laws



STATE OPTION TO PROVIDE COORDINATED CARE THROUGH A HEALTH HOME FOR INDIVIDUALS WITH CHRONIC CONDITIONS^[412]

SEC. 1945. [42 U.S.C. 1396w-4] (a) IN GENERAL.—Notwithstanding section 1902(a)(1) (relating to statewideness), section 1902(a)(10)(B) (relating to comparability), and any other provision of this title for which the Secretary determines it is necessary to waive in order to implement this section, beginning January 1, 2011, a State, at its option as a State plan amendment, may provide for medical assistance under this title to eligible individuals with chronic conditions who select a designated provider (as described under subsection (h)(5)), a team of health care professionals (as described under subsection (h)(6)) operating with such a provider, or a health team (as described under subsection (h)(7)) as the individual's health home for purposes of providing the individual with health home services.

(b) HEALTH HOME QUALIFICATION STANDARDS.—The Secretary shall establish standards for qualification as a designated provider for the purpose of being eligible to be a health home for purposes of this section.

(c) PAYMENTS.—

(1) IN GENERAL.—A State shall provide a designated provider, a team of health care professionals operating with such a provider, or a health team with payments for the provision of health home services to each eligible individual with chronic conditions that selects such provider, team of health care professionals, or health team as the individual's health home. Payments made to a designated provider, a team of health care professionals operating with such a provider, or a health team for such services shall be treated as medical assistance for purposes of section 1903(a), except that, subject to paragraph (4), during the first 8 fiscal year quarters that the State plan amendment is in effect, the Federal medical assistance percentage applicable to such payments shall be equal to 90 percent.^[413]

(2) METHODOLOGY.—

(A) IN GENERAL.—The State shall specify in the State plan amendment the methodology the State will use for determining payment for the provision of health home services. Such methodology for determining payment—

(i) may be tiered to reflect, with respect to each eligible individual with chronic conditions provided such services by a designated provider, a team of health care professionals operating with such a provider, or a health team, as well as the severity or number of each such individual's chronic conditions or the specific capabilities of the provider, team of health care professionals, or health team; and

(ii) shall be established consistent with section 1902(a)(30)(A).

(B) ALTERNATE MODELS OF PAYMENT.—The methodology for determining payment for provision of health home services under this section shall not be limited to a per-member per-month basis and may provide

(as proposed by the State and subject to approval by the Secretary) for alternate models of payment.

(3) PLANNING GRANTS.—

(A) IN GENERAL.—Beginning January 1, 2011, the Secretary may award planning grants to States for purposes of developing a State plan amendment under this section. A planning grant awarded to a State under this paragraph shall remain available until expended.

(B) STATE CONTRIBUTION.—A State awarded a planning grant shall contribute an amount equal to the State percentage determined under section 1905(b) (without regard to section 5001 of Public Law 111–5) for each fiscal year for which the grant is awarded.

(C) LIMITATION.—The total amount of payments made to States under this paragraph shall not exceed \$25,000,000.

(4)[414] SPECIAL RULE RELATING TO SUBSTANCE USE DISORDER HEALTH HOMES.—

(A) IN GENERAL.—In the case of a State with an SUD-focused State plan amendment approved by the Secretary on or after October 1, 2018, the Secretary may, at the request of the State, extend the application of the Federal medical assistance percentage described in paragraph (1) to payments for the provision of health home services to SUD-eligible individuals under such State plan amendment, in addition to the first 8 fiscal year quarters the State plan amendment is in effect, for the subsequent 2 fiscal year quarters that the State plan amendment is in effect. Nothing in this section shall be construed as prohibiting a State with a State plan amendment that is approved under this section and that is not an SUD-focused State plan amendment from additionally having approved on or after such date an SUD-focused State plan amendment under this section, including for purposes of application of this paragraph.

(B) REPORT REQUIREMENTS.—In the case of a State with an SUD-focused State plan amendment for which the application of the Federal medical assistance percentage has been extended under subparagraph (A), such State shall, at the end of the period of such State plan amendment, submit to the Secretary a report on the following, with respect to SUD-eligible individuals provided health home services under such State plan amendment:

- (i) The quality of health care provided to such individuals, with a focus on outcomes relevant to the recovery of each such individual.
- (ii) The access of such individuals to health care.
- (iii) The total expenditures of such individuals for health care.

For purposes of this subparagraph, the Secretary shall specify all applicable measures for determining quality, access, and expenditures.

(C) BEST PRACTICES.—Not later than October 1, 2020, the Secretary shall make publicly available on the internet website of the Centers for Medicare & Medicaid Services best practices for designing and implementing an SUD-focused State plan amendment, based on the experiences of States that have State plan amendments approved under this section that include SUD-eligible individuals.

(D) DEFINITIONS.—For purposes of this paragraph:

- (i) SUD-ELIGIBLE INDIVIDUALS.—The term “SUD-eligible individual” means, with respect to a State, an individual who satisfies all of the following:
 - (I) The individual is an eligible individual with chronic conditions.
 - (II) The individual is an individual with a substance use disorder.

(III) The individual has not previously received health home services under any other State plan amendment approved for the State under this section by the Secretary.

(ii) SUD-FOCUSED STATE PLAN AMENDMENT.—The term “SUD-focused State plan amendment” means a State plan amendment under this section that is designed to provide health home services primarily to SUD-eligible individuals.

(d) HOSPITAL REFERRALS.—A State shall include in the State plan amendment a requirement for hospitals that are participating providers under the State plan or a waiver of such plan to establish procedures for referring any eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated providers.

(e) COORDINATION.—A State shall consult and coordinate, as appropriate, with the Substance Abuse and Mental Health Services Administration in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.

(f) MONITORING.—A State shall include in the State plan amendment—

(1) a methodology for tracking avoidable hospital readmissions and calculating savings that result from improved chronic care coordination and management under this section; and

(2) a proposal for use of health information technology in providing health home services under this section and improving service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).

(g) REPORT ON QUALITY MEASURES.—As a condition for receiving payment for health home services provided to an eligible individual with chronic conditions, a designated provider shall report to the State, in accordance with such requirements as the Secretary shall specify, on all applicable measures for determining the quality of such services. When appropriate and feasible, a designated provider shall use health information technology in providing the State with such information.

(h) DEFINITIONS.—In this section:

(1) ELIGIBLE INDIVIDUAL WITH CHRONIC CONDITIONS.—

(A) IN GENERAL.—Subject to subparagraph (B), the term “eligible individual with chronic conditions” means an individual who—

(i) is eligible for medical assistance under the State plan or under a waiver of such plan; and

(ii) has at least—

(I) 2 chronic conditions;

(II) 1 chronic condition and is at risk of having a second chronic condition; or

(III) 1 serious and persistent mental health condition.

(B) RULE OF CONSTRUCTION.—Nothing in this paragraph shall prevent the Secretary from establishing higher levels as to the number or severity of chronic or mental health conditions for purposes of determining eligibility for receipt of health home services under this section.

(2) CHRONIC CONDITION.—The term “chronic condition” has the meaning given that term by the Secretary and shall include, but is not limited to, the following:

(A) A mental health condition.

- (B) Substance use disorder.
- (C) Asthma.
- (D) Diabetes.
- (E) Heart disease.
- (F) Being overweight, as evidenced by having a Body Mass Index (BMI) over 25.

(3) HEALTH HOME.—The term “health home” means a designated provider (including a provider that operates in coordination with a team of health care professionals) or a health team selected by an eligible individual with chronic conditions to provide health home services.

(4) HEALTH HOME SERVICES.—

(A) IN GENERAL.—The term “health home services” means comprehensive and timely high-quality services described in subparagraph (B) that are provided by a designated provider, a team of health care professionals operating with such a provider, or a health team.

(B) SERVICES DESCRIBED.—The services described in this subparagraph are—

- (i) comprehensive care management;
- (ii) care coordination and health promotion;
- (iii) comprehensive transitional care, including appropriate follow-up, from inpatient to other settings;
- (iv) patient and family support (including authorized representatives);
- (v) referral to community and social support services, if relevant; and
- (vi) use of health information technology to link services, as feasible and appropriate.

(5) DESIGNATED PROVIDER.—The term “designated provider” means a physician, clinical practice or clinical group practice, rural clinic, community health center, community mental health center, home health agency, or any other entity or provider (including pediatricians, gynecologists, and obstetricians) that is determined by the State and approved by the Secretary to be qualified to be a health home for eligible individuals with chronic conditions on the basis of documentation evidencing that the physician, practice, or clinic—

- (A) has the systems and infrastructure in place to provide health home services; and
- (B) satisfies the qualification standards established by the Secretary under subsection (b).

(6) TEAM OF HEALTH CARE PROFESSIONALS.—The term “team of health care professionals” means a team of health professionals (as described in the State plan amendment) that may—

- (A) include physicians and other professionals, such as a nurse care coordinator, nutritionist, social worker, behavioral health professional, or any professionals deemed appropriate by the State; and
- (B) be free standing, virtual, or based at a hospital, community health center, community mental health center, rural clinic, clinical practice or clinical group practice, academic health center, or any entity deemed appropriate by the State and approved by the Secretary.

(7) HEALTH TEAM.—The term “health team” has the meaning given such term for purposes of section 3502 of the Patient Protection and Affordable Care Act.

[412] See Vol. II, P.L. 111-148, §2703(b), with respect to the evaluation and assessment of States that have elected the option to provide coordinated care through a health home for individuals with chronic conditions.

[413] P.L. 115-271, §1006(a)(1), inserted “subject to paragraph (4),” after “except that,”. See Vol. II, P.L. 115-271, §1006, for effective

date.

[414] P.L. 115–271, §1006(a)(2) added paragraph (4). See Vol. II, P.L. 115–271, §1006 for effective date.



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PREVIOUS	UP	NEXT
SECTION 365-K	TITLE 11	SECTION 365-M
Provision of prenatal care services	Medical Assistance For Needy Persons	Administration and management of behavioral health services

THIS ENTRY WAS PUBLISHED ON 2018-04-20 3
 SEE MOST RECENT VERSION
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SECTION 365-L

Health homes

Social Services (SOS) CHAPTER 55, ARTICLE 5, TITLE 11

§ 365-1. Health homes. 1. Notwithstanding any law, rule or regulation to the contrary, the commissioner of health is authorized, in consultation with the commissioners of the office of mental health, office of alcoholism and substance abuse services, and office for people with developmental disabilities, to (a) establish, in accordance with applicable federal law and regulations, standards for the provision of health home services to Medicaid enrollees with chronic conditions, (b) establish payment methodologies for health home services based on factors including but not limited to the complexity of the conditions providers will be managing, the anticipated amount of patient contact needed to manage such conditions, and the health care cost savings realized by provision of health home services, (c) establish the criteria under which a Medicaid enrollee will be designated as being an eligible individual with chronic conditions for purposes of this program, (d) assign any Medicaid enrollee designated as an eligible individual with chronic conditions to a provider of health home services.

2. In addition to payments made for health home services pursuant to subdivision one of this section, the commissioner is authorized to pay additional amounts to providers of health home services that meet process or outcome standards specified by the commissioner. Such additional amounts may be paid with state funds only if federal financial participation for such payments is unavailable.

2-a. Up to fifteen million dollars in state funding may be used to fund health home infrastructure development. Such funds shall be used to develop enhanced systems to support Health Home operations including

assignments, workflow, and transmission of data. Funding will also be disbursed pursuant to a formula established by the commissioner to be designated health homes. Such formula may consider prior access to similar funding opportunities, geographic and demographic factors, including the population served, and prevalence of qualifying conditions, connectivity to providers, and other criteria as established by the commissioner.

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

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

2-d. The commissioner shall establish reasonable targets for health home participation by enrollees of special needs managed care plans designated pursuant to subdivision four of section three hundred sixty-five-m of this title and by high-risk enrollees of other Medicaid managed care plans operating pursuant to section three hundred sixty-four-j of this title, and shall encourage both the managed care providers and the health homes to work collaboratively with each other to achieve such targets. The commissioner may assess penalties under this subdivision in instances of failure to meet the participation targets established pursuant to this subdivision, where the department has determined that such failure reflected the absence of a good faith and reasonable effort to achieve the participation targets, except that managed care providers shall not be penalized for the failure of a health home to work collaboratively toward meeting the participation targets and a health home shall not be penalized for the failure of a managed care provider to work collaboratively toward meeting the participation targets.

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

4. Payments authorized pursuant to this section will be made with state funds only, to the extent that such funds are appropriated therefore, until such time as federal financial participation in the costs of such services is available.

5. The commissioner is authorized to submit amendments to the state plan for medical assistance and/or submit one or more applications for waivers of the federal social security act, to obtain federal financial participation in the costs of health home services provided pursuant to this section, and as provided in subdivision three of this section.

6. Notwithstanding any limitations imposed by section three hundred sixty-four-1 of this title on entities participating in demonstration projects established pursuant to such section, the commissioner is authorized to allow such entities which meet the requirements of this section to provide health home services.

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

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

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

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

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

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

(i) The department of health shall post on its website, for a period

of no less than thirty days:

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

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

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

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

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

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

9. The contract entered into by the commissioner of health prior to January first, two thousand thirteen pursuant to subdivision eight of this section may be amended or modified without the need for a competitive bid or request for proposal process, and without regard to the provisions of sections one hundred twelve and one hundred sixty-three of the state finance law, section one hundred forty-two of the economic development law, or any other provision of law, excepting the responsible vendor requirements of the state finance law, including,

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

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NEWS & ISSUES

SENATORS & COMMITTEES

**Appendix IV
2024 Title XIX State Plan
First Quarter Amendment
Public Notice**

MISCELLANEOUS NOTICES/HEARINGS

Notice of Abandoned Property Received by the State Comptroller

Pursuant to provisions of the Abandoned Property Law and related laws, the Office of the State Comptroller receives unclaimed monies and other property deemed abandoned. A list of the names and last known addresses of the entitled owners of this abandoned property is maintained by the office in accordance with Section 1401 of the Abandoned Property Law. Interested parties may inquire if they appear on the Abandoned Property Listing by contacting the Office of Unclaimed Funds, Monday through Friday from 8:00 a.m. to 4:30 p.m., at:

1-800-221-9311
or visit our web site at:
www.osc.state.ny.us

Claims for abandoned property must be filed with the New York State Comptroller's Office of Unclaimed Funds as provided in Section 1406 of the Abandoned Property Law. For further information contact: Office of the State Comptroller, Office of Unclaimed Funds, 110 State St., Albany, NY 12236.

PUBLIC NOTICE Department of Health

Pursuant to 42 CFR Section 447.205, the Department of Health hereby gives public notice of the following:

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for non-institutional services to revise provisions of the Ambulatory Patient Group (APG) reimbursement methodology in accordance with the Public Health Law § 2807(2-a)(e) and remove restrictions for licensed social workers in accordance with Public Health Law § 2807(2-a)(f)(ii)(C). The following changes are proposed:

Non-Institutional Services

Effective on or after January 1, 2024, the Ambulatory Patient Group (APG) reimbursement methodology is revised to include recalculated weight and component updates in order to update reimbursement for APG payments. Also, the restriction limiting services rendered by licensed social workers only to individual psychotherapy and only for persons under the age of 21 and individuals requiring services as a result of pregnancy or giving birth, is removed as of the same effective date.

The estimated annual aggregate increase in gross Medicaid expenditures as a result of this proposed amendment is \$8.3 Million.

The public is invited to review and comment on this proposed State Plan Amendment, a copy of which will be available for public review on the Department's website at http://www.health.ny.gov/regulations/state_plans/status. Individuals without Internet access may view the State Plan Amendments at any local (county) social services district.

For the New York City district, copies will be available at the following places:

New York County
250 Church Street
New York, New York 10018
Queens County, Queens Center

3220 Northern Boulevard
Long Island City, New York 11101

Kings County, Fulton Center
114 Willoughby Street
Brooklyn, New York 11201

Bronx County, Tremont Center
1916 Monterey Avenue
Bronx, New York 10457

Richmond County, Richmond Center
95 Central Avenue, St. George
Staten Island, New York 10301

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

PUBLIC NOTICE Department of Health

Pursuant to 42 CFR Section 447.205, the Department of Health hereby gives public notice of the following:

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for non-institutional services to comply with Section 1945 of the Social Security Act and other enacted statutory provisions. The following changes are proposed:

Non-Institutional Services

Effective on or after January 1, 2024, the proposed amendment establishes revised rates for Health Home Serving Children care management and authorizes payment for High Fidelity Wraparound 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.

The estimated annual net aggregate increase in annual gross Medicaid expenditures attributable to these initiatives is \$2.8 million.

The public is invited to review and comment on this proposed State Plan Amendment, a copy of which will be available for public review on the Department's website at http://www.health.ny.gov/regulations/state_plans/status. Individuals without Internet access may view the State Plan Amendments at any local (county) social services district.

For the New York City district, copies will be available at the following places:

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New York, New York 10018

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3220 Northern Boulevard
Long Island City, New York 11101
Kings County, Fulton Center

114 Willoughby Street
Brooklyn, New York 11201

Bronx County, Tremont Center
1916 Monterey Avenue
Bronx, New York 10457

Richmond County, Richmond Center
95 Central Avenue, St. George
Staten Island, New York 10301

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

PUBLIC NOTICE

Department of Health

Pursuant to 42 CFR Section 447.205, the Department of Health hereby gives public notice of the following:

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for institutional and non-institutional services to comply with subparagraph (iv-a) of paragraph (b) of subdivision 35 of section 2807-c of the Public Health Law. The following changes are proposed:

Institutional Services

Effective on or after January 1, 2024, the Department of Health will invest in Medicaid inpatient reimbursement rates, through the development of acute and specialty hospital rate add-ons based on Medicaid patient days and discharges, for public hospitals in a city with a population of one million or more.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative is \$325 million.

Non-Institutional Services

Effective on or after January 1, 2024, the Department of Health will invest in Medicaid outpatient reimbursement rates, through the development of general clinic, emergency department and ambulatory surgery rate add-ons based on Medicaid patient visits, for public hospitals in a city with a population of one million or more.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget is \$80 million.

The public is invited to review and comment on this proposed State Plan Amendment, a copy of which will be available for public review on the Department's website at http://www.health.ny.gov/regulations/state_plans/status. Individuals without Internet access may view the State Plan Amendments at any local (county) social services district.

For the New York City district, copies will be available at the following places:

New York County
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1916 Monterey Avenue
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Richmond County, Richmond Center

95 Central Avenue, St. George
Staten Island, New York 10301

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

PUBLIC NOTICE

Department of Health

Pursuant to 42 CFR Section 447.205, the Department of Health hereby gives public notice of the following:

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for institutional, non-institutional and long-term care services to comply with Section 652 of Article 19 of the New York State Labor Law. The following changes are proposed:

All Services

Effective on or after January 1, 2024, the Department of Health will adjust Medicaid rates for all regions of the State to account for increased labor costs resulting from statutorily required increases in the New York State minimum wage as well as the statutorily required decreases in wage parity.

The estimated net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2024 is \$6 million.

The public is invited to review and comment on this proposed State Plan Amendment, a copy of which will be available for public review on the Department's website at http://www.health.ny.gov/regulations/state_plans/status. Individuals without Internet access may view the State Plan Amendments at any local (county) social services district.

For the New York City district, copies will be available at the following places:

New York County
250 Church Street
New York, New York 10018

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

PUBLIC NOTICE

Department of Health

Pursuant to 42 CFR Section 447.205, the Department of Health hereby gives public notice of the following:

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for Institutional Services in accordance with Chapter 53 of the Laws of 2023 and Subdivision 5 of section 365-m of the Social Services Law. The following changes are proposed:

Appendix V
2024 Title XIX State Plan
First Quarter Amendment
Responses to Standard Funding Questions

**NON-INSTITUTIONAL SERVICES
State Plan Amendment #24-0023**

CMS Standard Funding Questions

The following questions are being asked and should be answered in relation to all payments made to all providers reimbursed pursuant to a methodology described in Attachment 4.19-B of the state plan.

- 1. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State plan. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)**

Response: Providers receive and retain 100 percent of total Medicaid expenditures claimed by the State and the State does not require any provider to return any portion of such payments to the State, local government entities, or any other intermediary organization.

- 2. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local government entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:**
 - (i) a complete list of the names of entities transferring or certifying funds;**
 - (ii) the operational nature of the entity (state, county, city, other);**

- (iii) the total amounts transferred or certified by each entity;
- (iv) clarify whether the certifying or transferring entity has general taxing authority; and,
- (v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

Response: The Non-Federal share Medicaid provider payment is funded by a combination of the following funds/funding sources through enacted appropriations authority to the Department of Health (DOH) for the New York State Medicaid program.

Payment Type	Non-Federal Share Funding	1/1/24 – 1/31/25	
		Non-Federal	Gross
Normal Per Diem	General Fund; County Contribution	\$1,483,775.00	\$2,967,549.00

A. **General Fund:** Revenue resources for the State’s General Fund includes taxes (e.g., income, sales, etc.), and miscellaneous fees (including audit recoveries). Medicaid expenditures from the State’s General Fund are authorized from Department of Health Medicaid.

- 1) New York State Audit Recoveries: The Department of Health collaborates with the Office of the Medical Inspector General (OMIG) and the Office of the Attorney General (AG) in recovering improperly expended Medicaid funds. OMIG conducts and coordinates the investigation, detection, audit, and review of Medicaid providers and recipients to ensure they are complying with all applicable laws and regulation. OMIG recovers any improper payments through cash collections and voided claim recoveries. Cash collections are deposited into the State’s General Fund to offset Medicaid costs.

In addition to cash collections, OMIG finds inappropriately billed claims within provider claims. To correct an error, OMIG and DOH process the current accurate claim, and reduce this claim by the inappropriate claim value to recoup the previous overclaim and decrease state spending.

B. Additional Resources for Non-Federal Share Funding:

County Contribution: In State Fiscal Year 2006, through enacted State legislation (Part C of Chapter 58 of the laws of 2005), New York State “capped” the amount localities contributed to the non-Federal share of providers claims. This was designed to relieve pressure on county property taxes and the NYC budget by limiting local contributions having New York State absorb all local program costs above this fixed statutory inflation rate (3% at the time).

However, in State Fiscal Year 2013 New York State provided additional relief to Localities by reducing local contributions annual growth from three percent to zero over a three-year period. Beginning in State Fiscal Year 2016, counties began paying a fixed cost in perpetuity as follows:

Entity	Annual Amount
New York City	\$5.200B
Suffolk County	\$226M
Nassau County	\$217M
Westchester County	\$204M
Erie County	\$194M
Rest of State (53 Counties)	\$1.187B
Total	\$7.228B

By eliminating the growth in localities Medicaid costs, the State has statutorily capped total Statewide County Medicaid expenditures at 2015 levels. All additional county Medicaid costs are funded by the State through State funding as described above. DOH provides annual letters to counties providing weekly contributions. Contributions are deposited directly into State escrow account and used to offset 'total' State share Medicaid funding.

NOTE: The Local Contribution is not tied to a specific claim or service category and instead is a capped amount based on 2015 county spending levels as stated above.

- 3. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.**

Response: The Medicaid payments under this State Plan Amendment are not supplemental payments.

- 4. For clinic or outpatient hospital services please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (state owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e., applicable to the current rate year) UPL demonstration. Under regulations at 42 CFR 447.272, States are prohibited from setting payment rates for Medicaid inpatient services that exceed a reasonable estimate of the amount that would be paid under Medicare payment principals.**

Response: The Medicaid payments authorized under this State Plan Amendment do not impact the UPL demonstrations.

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

Response: Providers do not receive payments that in the aggregate exceed their reasonable costs of providing services. If any providers received payments that in the aggregate exceeded their reasonable costs of providing services, the State would recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report.

ACA Assurances:

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

MOE Period.

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

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

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

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

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

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

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

Tribal Assurance:

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

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

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

Response: Tribal consultation was performed in accordance with the State's tribal consultation policy as approved in SPA 17-0065, and documentation of such is included with this submission. To date, no feedback has been received from any tribal representative in response to the proposed change in this SPA.