NY - Submission Package - NY2022MS0020O - (NY-22-0088) - Health Homes

CMS-10434 OMB 0938-1188

Package Information

Package ID	NY2022MS0020O	**Submission Type**	Official
Program Name	NYS Health Home Program	**State**	NY
SPA ID	NY-22-0088	**Region**	New York, NY
Version Number	2	**Package Status**	Approved
Submitted By	Michelle Levesque	**Submission Date**	12/30/2022
Package Disposition		**Approval Date**	3/27/2023 4:24 PM EDT
Priority Code	P2		

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Medicaid and CHIP Operations Group
601 E. 12th Street, Room 355
Kansas City, MO 64106

Center for Medicaid & CHIP Services

March 27, 2023

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

Re: Approval of State Plan Amendment NY-22-0088 NYS Health Home Program

Dear Amir Bassiri,

On December 30, 2022, the Centers for Medicare and Medicaid Services (CMS) received New York State Plan Amendment (SPA) NY-22-0088 for NYS Health Home Program 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 add an assessment fee to the Health Home program 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 an HCBS assessment under the Health Home program.

We approve New York State Plan Amendment (SPA) NY-22-0088 with an effective date(s) of October 01, 2022.

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

Sincerely,

James G. Scott

Director, Division of Program Operations

Center for Medicaid & CHIP Services

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | NY2022MS0020O | NY-22-0088 | NYS Health Home Program

Package Header

Package ID NY2022MS0020O
SPA ID NY-22-0088
Submission Type Official
Initial Submission Date 12/30/2022
Approval Date 3/27/2023
Effective Date N/A
Superseded SPA ID N/A

State Information

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

Submission Component

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

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | NY2022MS0020O | NY-22-0088 | NYS Health Home Program

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Superseded SPA ID N/A

SPA ID and Effective Date

SPA ID NY-22-0088

Reviewable Unit	Proposed Effective Date	Superseded SPA ID
Health Homes Intro	10/1/2022	22-0072
Health Homes Payment Methodologies	10/1/2022	22-0072
Health Homes Services	10/1/2022	22-0072

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | NY2022MS0020O | NY-22-0088 | NYS Health Home Program

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Effective Date N/A
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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 add an assessment fee to the Health Home program 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 an HCBS assessment under the Health Home program

Federal Budget Impact and Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First	2023	$1000000
Second	2024	$1000000

Federal Statute / Regulation Citation

§ 1945 of the Social Security Act

Supporting documentation of budget impact is uploaded (optional).

Name	Date Created	
Fiscal Calculations (22-0088)	11/14/2022 4:28 PM EST	XLS
HCFA 179 for 22-0088-12-30-22	12/21/2022 12:41 PM EST	PDF

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | NY2022MS0020O | NY-22-0088 | NYS Health Home Program

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Superseded SPA ID	N/A		

Governor's Office Review

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

Health Homes Intro

MEDICAID | Medicaid State Plan | Health Homes | NY2022MS0020O | NY-22-0088 | NYS Health Home Program

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Superseded SPA ID	22-0072		
	User-Entered		

Program Authority

1945 of the Social Security Act

The state elects to implement the Health Homes state plan option under Section 1945 of the Social Security Act.

Name of Health Homes Program

NYS Health Home Program

Executive Summary

Provide an executive summary of this Health Homes program including the goals and objectives of the program, the population, providers, services and service delivery model used

Summary description including goals and objectives
New state plan amendment supersedes transmittal# 21-0072
Transmittal# 22-0088

Part I: Summary of new State Plan Amendment (SPA) #22-0088

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 add an assessment fee to the Health Home program 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 an HCBS assessment under the Health Home program.

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 SPA. 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 Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | NY2022MS0020O | NY-22-0088 | NYS Health Home Program

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Payment Methodology

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

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

        Describe below

        see text box below regarding rates
  - [ ] Comprehensive Methodology Included in the Plan
  - [ ] Incentive Payment Reimbursement

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

see text below

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

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | NY2022MS0020O | NY-22-0088 | NYS Health Home Program

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Effective Date 10/1/2022

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

4/1/2022

Website where rates are displayed

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

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | NY2022MS0020O | NY-22-0088 | NYS Health Home Program

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Rate Development

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

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

Comprehensive Description

Provide a comprehensive description of the rate-setting policies the State will use to establish Health Homes provider reimbursement fee for service or PMPM rates. Explain how the methodology is consistent with the goals of efficiency, economy, and quality of care. Within your description, please explain: the reimbursable unit(s) of service, the cost assumptions and other relevant factors used to determine the payment amounts, the minimum level of activities that the State agency requires for providers to receive payment per the defined unit, and the State's standards and process required for service documentation.

Provider Type

NYS Medicaid providers eligible to become health homes include managed care plans; hospitals; medical, mental and chemical dependency treatment clinics; primary care practitioner practices; PCMHs; FQHCs; Targeted Case Management (TCM) providers; certified home health care agencies and any other Medicaid enrolled providers that meet health home provider standards.

Care Management Fee:

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

Effective May 1, 2018, the per member per month care management fee for adults will be based on region and case mix defined by populations as indicated below. Health Home rates for children will continue to be determined by an algorithm applied to the CANS-NY assessment. The risk adjusted payments will allow providers to receive a diverse population of patients and assign patients to various levels of care management intensity without having to meet preset standards for contact counts. Providers will be able to respond to and adjust the intensity and frequency of intervention based on patient's current condition and needs (from tracking to high touch). All rates will be published on the DOH website. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers. Rates for Health Home services to children are effective October 1, 2016 and apply to services furnished on and after October 1, 2016.

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

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

State Health Home Rates and Rate Codes Effective October 1, 2017 can be found at:
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_rates_eective_october_2017.xlsx

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

State Health Home Rates and Rate Codes Effective October 1, 2018 can be found at:
https://health.ny.gov/health_care/medicaid/program/medicaid_health_homes/billing/docs/hh_rates_effective_october_201

8.xlsx

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

Population Case Mix Definitions for Health Home Adult Rates

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

Health Home High Risk/Need Care Management Rates, include adults that are HARP enrolled members not included in the Health Home Plus/Care Management; any adult member meeting high risk criteria based on the high, medium and low, Clinical and Functional Assessment; and members identified at the discretion of the Medicaid Managed Care Plan or state designated entity for adults not currently enrolled in a Medicaid Managed Care Plan.

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

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

Effective July 1, 2020, the PMPM for case finding will be reduced to $0 as indicated in the State Health Home Rates and Rate Codes posted to the State's website as indicated above.

A unit of service will be defined as a billable unit per service month. In order to be reimbursed for a billable unit of service per month health home providers must, at a minimum, provide one of the core health home services per month. The monthly payment will be paid via the active care management PMPM. Once a patient has consented to received services and been assigned a care manager and is enrolled in the health home program the active care management PMPM may be billed. Care managers must document all services provided to the member in the member's care plan.

Managed Care Considerations:

Similar to the NY patient centered Medical Home program, it is the intention of the State to coordinate and pay for health home services through health plans but at State set rates for the service. The State will address any existing care management resources in the current plan premium for health home enrollees under CMS guidelines (bring this resource out of the capitation and create federal matching for those resources under the health home payment). Plans will pay health home providers State set rates when providers are contracted to provide all health home services. In the case where the plan does a portion of the health home service (e.g. telephonic post discharge tracking) and downstream providers do a separate portion (e.g. face to face care management) the plan will then split the State generated PMPM proportional to the contracted effort.

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

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

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

Targeted Case Management (TCM) Conversion Considerations:

The State envisions that eventually all targeted case management programs operating in New York will convert to or become part of health homes, and these providers will require time to meet State and Federal health home standards. The State will allow TCM providers that can meet health home standards to convert to health homes or join with larger health homes. TCM providers that convert to health homes will be governed under NYS Health Home Provider Qualification Standards, not TCM standards. The payment method will be designed to transition all existing TCM capacity from the current rates to the new Health Home payment structure. Effective January 1, 2015 TCM programs for adults will be paid

their existing TCM rates until November 30, 2016. Effective October 1, 2016 through September 30, 2018 TCM programs for children will be paid a transitional rate that is as financially equivalent as practicable to their current rate.

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

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

Children's Transitional Rates

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

Children's Health Home Transition Rates

January 1, 2019 through June 30, 2019

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

July 1, 2019 through December 31, 2019

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

January 1, 2020 through June 30, 2020

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

July1, 2020 through December 31, 2020

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

January 1, 2019 through June 30, 2019

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

July 1, 2019 through December 31, 2019

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

January 1, 2020 through June 30, 2020

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

July 1, 2020 through December 31, 2020

Health Home	Add-On			Transitional Rate				
	Upstate	Downstate		Upstate	Downstate		Upstate	Downstate
1869: Low	$225.00	$240.00	8002: B2H (L)	$231.00	$240.00	B2H (L)	$456.00	$480.00
1870: Medium	$450.00	$479.00	8001: B2H (M)	$175.00	$180.00	B2H (M)	$625.00	$659.00

1871: High	$750.00	$799.00	8000: B2H (H)	$100.00	$100.00	B2H (H)	$850.00	$899.00

Effective October,1, 2022, Children's Health Homes may receive an assessment fee to ensure that any child who may be eligible for Home and Community-Based Services (HCBS) under the Children's Waiver, demonstration or State Plan authority will be eligible
to receive a timely HCBS assessment under the Health Home program. The HH HCBS assessment fee will compensate the HH for the costs associated with conduct of:

- Evaluation and/or re-evaluation of HCBS level of care;
- Assessment and/or reassessment of the need for HCBS;
- Inclusion of all aspects of an HCBS Plan of Care in the HH's Comprehensive Care Plan.

This fee will be paid in addition to the PMPM calculated above and is contingent upon the Health Home completing a timely and
complete assessment.

Health Homes Payment Methodologies

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Assurances

☑ The State provides assurance that it will ensure non-duplication of payment for services similar to Health Homes services that are offered/covered under a different statutory authority, such as 1915(c) waivers or targeted case management.

Describe below how non-duplication of payment will be achieved

All rates are published on the DOH website. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers. All of the above payment policies have been developed to assure that there is no duplication of payment for health home services.

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/rate_information.htm.

☑ The state has developed payment methodologies and rates that are consistent with section 1902(a)(30)(A).

☑ The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule, unless otherwise described above.

☑ The State provides assurance that it shall reimburse providers directly, except when there are employment or contractual arrangements consistent with section 1902(a)(32).

Optional Supporting Material Upload

Name	Date Created	
Auth Provisions-1915c Children_s Waiver-22-0088	11/18/2022 2:55 PM EST	PDF
Auth Provisions-other -Combined 22-0088	11/18/2022 2:56 PM EST	PDF
SFQs-MACPro (22-0088) 11.14.22	12/6/2022 12:48 PM EST	PDF
Original Submission Letter for 22-0088-12-30-22)	12/21/2022 12:39 PM EST	PDF

Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | NY2022MS0020O | NY-22-0088 | NYS Health Home Program

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Service Definitions

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

Comprehensive Care Management

Definition

A comprehensive individualized patient centered care plan will be required for all health home enrollees. The care plan will be developed based on the information obtained from a comprehensive health risk assessment used to identify the enrollee's physical, mental health, chemical dependency and social service needs. The individualized care plan will be required to include and integrate the individual's medical and behavioral health services, rehabilitative, long term care, social service needs, as applicable. The care plan will be required to clearly identify the primary care physician/nurse practitioner, specialist(s), behavioral health care provider(s), care manager and other providers directly involved in the individual's care. The individual's plan of care must also identify community networks and supports that will be utilized to address their needs. Goals and timeframes for improving the patient's health, their overall health care status and the interventions that will produce this effect must also be included in the plan of care.

The care manager will be required to make sure that the individual (or their guardian) plays a central and active part in the development and execution of their plan of care, and that they are in agreement with the goals, interventions and time frames contained in the plan. Family members and other supports involved in the patient's care should be identified and included in the plan and execution of care as requested by the individual.

The care plan must also include outreach and engagement activities which will support engaging the patient in their own care and promote continuity of care. In addition, the plan of care will include periodic reassessment of the individual's needs and goals and clearly identify the patient's progress in meeting goals. Changes in the plan of care will be made based on changes in patient need.

Care managers are responsible for the development and maintenance of a comprehensive care plan including all aspects of an HCBS Plan of Care for children enrolled under the Children's Waiver.

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

To facilitate the use of health information technology by health homes to improve service delivery and coordination across the care continuum, NY has developed initial and final HIT standards. Providers must meet the initial HIT standard to implement a health home, as feasible. NY anticipates that a portion of health home providers may not utilize HIT in their current programs. These providers will be encouraged to utilize regional health information organizations (RHIOs) or a qualified entity to access patient data and to develop partnerships that maximize the use of HIT across providers (i.e. hospitals, TCMs). Applicants must provide a plan in order to achieve the final HIT standards within eighteen months of program initiation in order to be approved as a health home provider. Health home providers will be encouraged to utilize HIT as feasible to create, document and execute and update a plan of care for every patient that is accessible to the interdisciplinary team of providers. Health home providers will also be encouraged to utilize HIT as feasible to process and follow up on patient testing, treatments, services and referrals.

Scope of service

The service can be provided by the following provider types

- [ ] Behavioral Health Professionals or Specialists
- [ ] Nurse Practitioner
- [ ] Nurse Care Coordinators
- [ ] Nurses
- [ ] Medical Specialists
- [ ] Physicians
- [ ] Physician's Assistants
- [ ] Pharmacists
- [ ] Social Workers
- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [ ] Nutritionists

☑ Other (specify)

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

Care Coordination

Definition

The health home provider will be accountable for engaging and retaining health home enrollees in care, as well as coordinating and arranging for the provision of services, supporting adherence to treatment recommendations, and monitoring and evaluating the enrollee's needs. The individualized plan of care will identify all the services necessary to meet goals needed for care management of the enrollee such as prevention, wellness, medical treatment by specialists and behavioral health providers, transition of care from provider to provider, and social and community services where appropriate.

In order to fulfill the care coordination requirements, the health home provider will assign each individual enrollee one dedicated care manager who is responsible for overall management of the enrollee's plan of care. The enrollee's health home care manager will be clearly identified in the patient record and will have overall responsibility and accountability for coordinating all aspects of the individual's care. The health home provider will be responsible to assure that communication will be fostered between the dedicated care manager and treating clinicians to discuss as needed enrollee's care needs, conflicting treatments, change in condition, etc. which may necessitate treatment change (i.e., written orders and/or prescriptions).

The health home provider will be required to develop and have policies, procedures and accountabilities (contractual agreements) in place, to support and define the roles and responsibilities for effective collaboration between primary care, specialist, behavioral health providers and community-based organizations. The health home providers policies and procedures will direct and incorporate successful collaboration through use of evidence-based referrals, follow-up consultations, and regular, scheduled case review meetings with all members of the interdisciplinary team. The health home provider will have the option of utilizing technology conferencing tools including audio, video and /or web deployed solutions when security protocols and precautions are in place to protect PHI to support care management/coordination activities.

The health home provider will be required to develop and utilize a system to track and share patient information and care needs across providers, monitor patient outcomes, and initiate changes in care as necessary to address patient need.

Care managers are responsible for initiating the process to evaluate and/or re-evaluate the individual's HCBS level of care and to assess and/or reassess of the need for HCBS at least annually for children enrolled under the Children's Waiver.

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

Health home providers will be encouraged to utilize RHIOs or a qualified entity to access patient data and to develop partnerships that maximize the use of HIT across providers (i.e. hospitals, TCMs). Health home providers will utilize HIT as feasible to create, document and execute and update a plan of care for every patient that is accessible to the interdisciplinary team of providers. Health home providers will also be encouraged to utilize HIT as feasible to monitor patient outcomes, initiate changes in care and follow up on patient testing, treatments, services and referrals.

Scope of service

The service can be provided by the following provider types

☐ Behavioral Health Professionals or Specialists

☐ Nurse Practitioner

☐ Nurse Care Coordinators

☐ Nurses

☐ Medical Specialists

☐ Physicians

☐ Physician's Assistants

☐ Pharmacists

☐ Social Workers

☐ Doctors of Chiropractic

☐ Licensed Complementary and alternative Medicine Practitioners

☐ Dieticians

☐ Nutritionists

☑ Other (specify)

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

Health Promotion

Definition

Health promotion begins for eligible health home enrollees with the commencement of outreach and engagement activities. NYS' health home plan for outreach and engagement will require a health home provider to actively seek to engage patients in care by phone, letter, HIT and community "in reach" and outreach. Each of these outreach and engagement functions will all include aspects of comprehensive care management, care coordination, and referral to community and social support services. All of the activities are built around the notion of linkages to care that address all of the clinical and non-clinical care needs of an individual and health promotion. The health home provider will support continuity of care and health promotion through the development of a treatment relationship with the individual and the interdisciplinary team of providers. The health home provider will promote evidence 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. Health promotion activities will be utilized to promote patient education and self management of their chronic condition.

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

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

Scope of service

The service can be provided by the following provider types

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

Provider Type	Description
multidisciplinary teams	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.

Comprehensive Transitional Care from Inpatient to Other Settings (including appropriate follow-up)

Definition

Comprehensive transitional care will be provided to prevent enrollee avoidable readmission after discharge from an inpatient facility (hospital, rehabilitative, psychiatric, skilled nursing or treatment facility) and to ensure proper and timely follow up care. To accomplish this, the health home provider will be required to develop and have a system in place with hospitals and residential/rehabilitation facilities in their network to provide the health home care manager prompt notification of an enrollee's admission and/or discharge to/from an emergency room, inpatient, or residential/rehabilitation setting.

The health home provider will also have policies and procedures in place with local practitioners, health facilities including emergency rooms, hospitals, and residential/rehabilitation settings, providers and community-based services to ensure coordinated, and safe transition in care for its patients who require transfer to/from sites of care.

The health home provider will be required to develop and have a systematic follow-up protocol in place to assure timely access to follow-up care post discharge

that includes at a minimum receipt of a summary care record from the discharging entity, medication reconciliation, and a plan for timely scheduled appointments at recommended outpatient providers.

The health home care manager will be an active participant in all phases of care transition: including: discharge planning and follow-up to assure that enrollees received follow up care and services and re-engagement of patients who have become lost to care.

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

Health home providers will be encouraged to utilize RHIOs or a qualified entity to access patient data and to develop partnerships that maximize the use of HIT across providers (i.e. hospitals, TCMs). The health home provider will utilize HIT as feasible to communicate with health facilities and to facilitate interdisciplinary collaboration among all providers, the patient, family, care givers and local supports.

Scope of service

The service can be provided by the following provider types

- [ ] Behavioral Health Professionals or Specialists
- [ ] Nurse Practitioner
- [ ] Nurse Care Coordinators
- [ ] Nurses
- [ ] Medical Specialists
- [ ] Physicians
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- [ ] Dieticians
- [ ] Nutritionists
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Provider Type	Description
multidisciplinary teams	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.

Individual and Family Support (which includes authorized representatives)

Definition

The patient's individualized plan of care will reflect and incorporate the patient and family or caregiver preferences, education and support for self-management; self help recovery, and other resources as appropriate. The provider will share and make assessable to the enrollee, their families or other caregivers (based on the individual's preferences), the individualized plan of care by presenting options for accessing the enrollee's clinical information.

Peer supports, support groups, and self-care programs will be utilized by the health home provider to increase patients' and caregivers knowledge about the individual's disease(s), promote the enrollee's engagement and self management capabilities, and help the enrollee improve adherence to their prescribed treatment. The provider will discuss and provide the enrollee, the enrollee's family and care givers, information on advance directives in order to allow them to make informed end-of-life decisions ahead of time.

The health home provider will ensure that all communication and information shared with the enrollee, the enrollee's family and caregivers is language, literacy and culturally appropriate so it can be understood.

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

Health home providers will be encouraged to utilize RHIOs or a qualified entity to access patient data and to develop partnerships that maximize the use of HIT across providers (i.e. hospitals, TCMs). The health home provider will utilize HIT as feasible to provide the patient access to care plans and options for accessing clinical information.

Scope of service

The service can be provided by the following provider types

- [ ] Behavioral Health Professionals or Specialists
- [ ] Nurse Practitioner

- [ ] Nurse Care Coordinators
- [ ] Nurses
- [ ] Medical Specialists
- [ ] Physicians
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Provider Type	Description
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Referral to Community and Social Support Services

Definition

The health home provider will identify available community-based resources and actively manage appropriate referrals, access to care, engagement with other community and social supports, coordinate services and follow-up post engagement with services. To accomplish this, the health home provider will develop policies, procedures and accountabilities (through contractual agreements) to support effective collaboration with community-based resources, that clearly define the roles and responsibilities of the participants.

The plan of care will include community-based and other social support services, appropriate and ancillary healthcare services that address and respond to the patient's needs and preferences, and contribute to achieving the patient's goals.

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

Health home providers will be encouraged to utilize RHIOs or a qualified entity to access patient data and to develop partnerships that maximize the use of HIT across providers (i.e. hospitals, TCMs). The health home providers will utilize HIT as feasible to initiate, manage and follow up on community-based and other social service referrals.

Scope of service

The service can be provided by the following provider types

- [ ] Behavioral Health Professionals or Specialists
- [ ] Nurse Practitioner
- [ ] Nurse Care Coordinators
- [ ] Nurses
- [ ] Medical Specialists
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Provider Type	Description
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Health Homes Services

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Package Header

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Health Homes Patient Flow

Describe the patient flow through the state's Health Homes system. Submit with the state plan amendment flow-charts of the typical process a Health Homes individual would encounter

See NY Health Home Patient flow chart below

Name	Date Created	
NY Health Home Patient Flow Charts	9/19/2016 3:56 PM EDT	

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