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Submission - Summary

MEDICAID - Health Homes - NYS Health Home Program - NY - 2016

CMS-10434 OMB 0938-1188

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Package ID	NY2016MH0002O	SPA ID	NY-16-0034
Submission Type	Official - Review 1	Initial Submission Date	9/29/2016
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State Information

+/-

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

Submission Component

+/-

- State Plan Amendment

- Medicaid
- CHIP

Submission Type

+/-

- Official Submission Package
- Draft Submission Package

Allow this official package to be viewable by other states?

- Yes
- No

Key Contacts

+/-

Name	Title	Phone Number	Email Address
Gallagher, Regina	NYS Medicaid State Plan Coordinatro	(518)473-3658	regina.gallagher@health.ny.gov

SPA ID and Effective Date

+/-

SPA ID NY-16-0034

Reviewable Unit	Proposed Effective Date
Health Homes Intro	10/1/2016
Health Homes Population and Enrollment Criteria	10/1/2016
Health Homes Geographic Limitations	10/1/2016
Health Homes Services	10/1/2016
Health Homes Providers	10/1/2016
Health Homes Service Delivery Systems	10/1/2016
Health Homes Payment Methodologies	9/1/2016
Health Homes Monitoring, Quality Measurement and Evaluation	10/1/2016

Executive Summary

+/-

Summary Description Including Goals and Objectives: See executive summary within the intro

Dependency Description

+/-

Description of any dependencies between this submission package and any other submission package undergoing review: none

Disaster-Related Submission

+/-

This submission is related to a disaster

- Yes
- No

Federal Budget Impact and Statute/Regulation Citation

+/-

Federal Budget Impact

	Federal Fiscal Year	Amount
First	2016	$2,908,900.00
Second	2017	$5,905,500.00

Federal Statute / Regulation Citation
§1902(a) of the Social Security Act and 42 CFR 447

Governor's Office Review

+/-

- No comment
- Comments received

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Submission - Medicaid State Plan

MEDICAID - Health Homes - NYS Health Home Program - NY - 2016

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Submission - Medicaid State Plan

The submission includes the following

- [x] Benefits
  - [x] Health Homes Program
    - (•) Create new Health Homes program
    - ( ) Amend existing Health Homes program
    - ( ) Terminate existing Health Homes program
      - (•) Copy from existing Health Homes program
      - ( ) Create new program from blank form

Name of Health Homes Program: NYS Health Home Program

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Submission - Public Comment

MEDICAID - Health Homes - NYS Health Home Program - NY - 2016

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Name of Health Homes Program: NYS Health Home Program

Indicate whether public comment was solicited with respect to this submission.

- ○ Public notice was not required and comment was not solicited
- ○ Public notice was not required, but comment was solicited
- ◉ Public notice was required and comment was solicited

Indicate how the public notice was issued and public comment was solicited

- ☐ Newspaper Announcement
- ☑ Publication in state s administrative record, in accordance with the administrative procedures requirements — Date of Publication: Aug 17, 2016
- ☐ Email to Electronic Mailing ist or Similar Mechanism
- ☐ ebsite Notice
- ☐ Public Hearing or Meeting
- ☐ Other method

Upload copies of public notices and other documents used

Name	Date Created	Type
NYS Register (8-17-16)	9/13/2016 8:22 AM EDT	PDF
NYS Register (8-31-16)	9/13/2016 8:22 AM EDT	PDF

Upload with this application a written summary of public comments received (optional)

Name	Date Created	Type
No items available		

Name	Date Created	Type

Indicate the key issues raised during the public comment period (optional)

- [ ] Access
- [ ] Quality
- [ ] Cost
- [ ] Payment methodology
- [ ] Eligibility
- [ ] Benefits
- [ ] Service delivery
- [ ] Other issue

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Submission - Tribal Input

MEDICAID - Health Homes - NYS Health Home Program - NY - 2016

CMS-10434 OMB 0938-1188

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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 is likely to have a direct effect on Indians, Indian health programs or Urban Indian Organizations

- ( ) Yes
- (●) No

Explain why this SPA is not likely to have a direct effect on Indians, Indian Health Programs or Urban Indian Organizations: it extends health home legacy rates

- (●) Even though not required, the state has solicited advice from Indian Health Programs and/or Urban Indian Organizations prior to submission of this SPA
- ( ) The state has not solicited advice from Indian Health Programs and/or Urban Indian Organizations prior to submission of this SPA

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

Tribal consultation was conducted in the following manner

[x] Indian Health Programs

Name of Program	Date of consultation	Method/Location of consultation
Health Clinic	9/2/2016	tribal consultation sent, no comment recvd

[ ] 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

[x] Indian Tribes

Name of Tribe	Date of consultation	Method/Location of consultation
Cayuga Nation	9/2/2016	tribal consultation sent, no comment recvd
Oneida Indian Nation	9/2/2016	tribal consultation sent, no comment recvd
Onondaga Nation	9/2/2016	tribal consultation sent, no comment recvd
Seneca Nation of Indians	9/2/2016	tribal consultation sent, no comment recvd
Shinnecock Indian Nation Tribal Office	9/2/2016	tribal consultation sent, no comment recvd
St Regis Mohawk Tribe	9/2/2016	tribal consultation sent, no comment recvd
Tonowanda Seneca Nation Tribe	9/2/2016	tribal consultation sent, no comment recvd
Tuscarora Indian Nation	9/2/2016	tribal consultation sent, no comment recvd
Ukechang Indian Territory	9/2/2016	tribal consultation sent, no comment recvd

1-9 of 9

The state must upload copies of documents that support the solicitaion of advice in accordance with statutory requirements, including any notices sent to Indian Health Programs and/or Urban Indian Organizaions, 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	Type
Tribal 1	9/13/2016 8:51 AM EDT	
Tribal 2	9/13/2016 8:51 AM EDT	
Tribal 3	9/13/2016 8:51 AM EDT	
Tribal 4	9/13/2016 8:54 AM EDT	
Tribal 5	9/13/2016 8:54 AM EDT	

Indicate the key issues raised (optional)

- [ ] Access
- [ ] Quality
- [ ] Cost
- [ ] Payment methodology
- [ ] Eligibility
- [ ] Benefits
- [ ] Service delivery
- [ ] Other issue

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Submission - SAMHSA Consultation

MEDICAID - Health Homes - NYS Health Home Program - NY - 2016

CMS-10434 OMB 0938-1188

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Name of Health Homes Program	NYS 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

11/20/2014

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Health Homes Intro

MEDICAID - Health Homes - NYS Health Home Program - NY - 2016

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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 # 15-0020
Transmittal # 16-0034
This State Plan Amendment is in Attachment 3.1-H of the State Plan, except for the Payment Methodologies section, which is in Attachment 4.19-B of the State Plan.

Part I: Summary of new State Plan Amendment (SPA) #16-0034
The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for non-institutional services. The following changes are proposed:

Effective September 1, 2016 through November 30, 2016 the State will continue to reimburse converted Targeted Case Management (TCM) providers at their existing Health Home Legacy rates. Health Home per member rates, for Health Home providers including TCM providers, that are based on three tiers "High, Medium, Low", acuity, functional status, and region and a uniform case finding fee, which were currently scheduled to take effect on September 1, 2016, will now become effective on December 1, 2016. Health Home per member rates to implement court orders for Assisted Outpatient population (Health Home Plus) and the Adult Home population will remain in effect and unchanged.

Amendment change located in MACPRO Unit 7 p. 2 of 3
Key: [ ] represents deleted text and underlined represents new text.

On [September 1, 2016] December 1, 2016, the case finding fee will be set at $135.
Effective January 1, 2015 TCM programs for adults will be paid their existing TCM rates until [August 31, 2016] November 30, 2016.

Part II: Summary of Changes Concerning MMDL to MACPro Conversion:

In migrating information from New York State Health Home approved SPA #15-0020 housed in CMS' MMDL application to the newly released MACPro application, the following transactions/edits were executed with the assistance and agreement of CMS. Highlights of this conversion and subsequent decisions have been summarized in the following categories:

- Omitted language from previously approved SPA #15-0020;
- Suggested changes by CMS and NYS response;
- Acceptance of all assurances - new CMS requirement in MACPro that all assurances must be accepted in order to validate and complete submission;
- Completion of Monitoring, Quality Measurement and Evaluation; and
- Other: Required documentation, flowcharts, etc.

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.

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Health Homes Population and Enrollment Criteria

MEDICAID - Health Homes - NYS Health Home Program - NY - 2016

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Categories of Individuals and Populations Provided Health Homes Services

+/-

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

- ✓ Categorically Needy (Mandatory and Options for Coverage) Eligibility Groups
- ✓ Medically Needy Eligibility Groups

Mandatory Medically Needy

- ✓ Medically Needy Pregnant Women
- ✓ Medically Needy Children under Age 18

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

Families and Adults

- ✓ Medically Needy Children Age 18 through 20
- ✓ Medically Needy Parents and Other Caretaker Relatives

Aged, Blind and Disabled

- ✓ Medically Needy Aged, Blind or Disabled
- ✓ Medically Needy Blind or Disabled Individuals Eligible in 1973

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

- [x] Heart Disease
- [x] BMI over 25
- [x] 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.

- [x] 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
- [x] Other (specify)

Name	Description
HIV/AIDS	see description below
One Serious Mental illness	see description below
SED/Complex Trauma	see description below

Specify the criteria for at risk of developing another chronic condition

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

Of the 5.4M Medicaid enrollees who access services on a fee for service or managed care basis, 975,000 (including dual eligibles) have been identified as high cost/high need enrollees with two or more chronic conditions and/or a Serious Persistent Mental Illness. These high cost/high need enrollees are categorized into
four groups representing enrollees with intellectual disabilities, enrollees in need of long term care services,
enrollees with behavioral health issues, and enrollees with two or more chronic medical conditions. One of NY's first health home initiatives will focus on enrollees with behavioral health and/or chronic medical conditions.

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

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

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

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

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

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

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

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

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

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

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

Description of population selection criteria

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

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. Effective October 1, 2016 complex trauma and SED will each be a single qualifying condition.

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

Individuals eligible for health home services will be identified by the State. Individuals will be assigned to a
health home provider based on existing relationships with health care providers or health care delivery system relationships, geography, and/or qualifying condition. Individuals will be enrolled into an appropriate health home and be given the option to choose another health home when available, or opt out of enrollment in a health home. Individuals will be notified by U.S. mail of their health home enrollment. The notification letter will identify the assigned health home, describe the individual's option to select another health home or opt-out from receiving health home services with in a designated time period, and briefly describe health home services. The State will provide health home providers a roster of assigned enrollees and current demographic information to facilitate outreach and engagement.

Individuals that are under 21 years of age, 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.

✓ 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	Type
NY Health Home Brochure	9/14/2016 10:08 AM EDT	PDF

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Health Homes Geographic Limitations

MEDICAID - Health Homes - NYS Health Home Program - NY - 2016

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- (●) Health Homes services will be available statewide
- ( ) Health Homes services will be limited to the following geographic areas
- ( ) Health Homes services will be provided in a geographic phased-in approach

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Health Homes Services

MEDICAID - Health Homes - NYS Health Home Program - NY - 2016

CMS-10434 OMB 0938-1188

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Package Header

Package ID	NY2016MH0002O	SPA ID	NY-16-0034
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Service Definitions

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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.

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
- [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.

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.

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
- [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.

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
- [ ] Social Workers
- [ ] 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
- [ ] Physician's Assistants
- [ ] Pharmacists
- [ ] Social Workers
- [ ] 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.

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
- [ ] Physician's Assistants
- [ ] Pharmacists
- [ ] Social Workers
- [ ] 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.

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
- [ ] Physicians
- [ ] Physician's Assistants
- [ ] Pharmacists
- [ ] Social Workers
- [ ] 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.

Health Homes Patient Flow

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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	Type
NY Health Home Patient Flow Charts	9/19/2016 3:56 PM EDT	DOC

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Records / Submission Packages

NY - Submission Package - NY2016MH0002O - (NY-16-0034)

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Health Homes Providers

MEDICAID - Health Homes - NYS Health Home Program - NY - 2016

CMS-10434 OMB 0938-1188

Not Started | In Progress | Complete

Package Header

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Types of Health Homes Providers

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✓ 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

☐ Teams of Health Care Professionals

☐ Health Teams

Provider Infrastructure

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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 Alcoholism and Substance Abuse Services also participated in the development of these standards. The standards set the ground work for assuring that health home enrollees will receive appropriate, and timely access to medical, behavioral, and social services in a coordinated and integrated manner.

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

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

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

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

The Department of Health in partnership with the Office of Mental Health and the Office of Alcoholism and Substance Abuse Services 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.

Supports for Health Homes Providers

+/-

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

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

Description

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Other Health Homes Provider Standards

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The state's requirements and expectations for Health Homes providers are as follows

The state's minimum requirements and expectations for Health Home providers are as follows: Under New York State's approach to health home implementation, a health home provider is the central point for directing patient-centered care and is accountable for reducing avoidable health care costs, specifically preventable hospital admissions/readmissions and avoidable emergency room visits; providing timely post discharge follow-up, and improving patient outcomes by addressing primary medical, specialist and behavioral health care through direct provision, or through contractual arrangements with appropriate service providers, of comprehensive, integrated services.

General Qualifications

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

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

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

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

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

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

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

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

I. Comprehensive Care Management

Policies and procedures are in place to create, document, execute and update an individualized, patient centered plan of care for each individual.
1a. A comprehensive health assessment that identifies medical, mental health, chemical dependency and social service needs is developed.
1b. The individual's plan of care integrates the continuum of medical, behavioral health services, rehabilitative, long term care and social service needs and clearly identifies the primary care physician/nurse practitioner, specialist(s), behavioral health care provider(s), care manager and other providers directly involved in the individual's care.
1c.The individual (or their guardian) play a central and active role in the development and execution of their plan of care and should agree with the goals, interventions and time frames contained in the plan.
1d. The individual's plan of care clearly identifies primary, specialty, behavioral health and community networks and supports that address their needs.
1e. The individual's plan of care clearly identifies family members and other supports involved in the patient's care. Family and other supports are included in the plan and execution of care as requested by the individual.
1f. The individual's plan of care clearly identifies goals and timeframes for improving the patient's health and health care status and the interventions that will produce this effect.
1g. The individual's plan of care must included outreach and engagement activities that will support engaging patients in care and promoting continuity of care.
1h. The individual's plan of care includes periodic reassessment of the individual needs and clearly identifies the patient's progress in meeting goals and changes in the plan of care based on changes in patient's need.

II. Care Coordination and Health Promotion

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

2i. The health home provider will ensure the availability of priority appointments for health home enrollees to medical and behavioral health care services within their health home provider network to avoid unnecessary, inappropriate utilization of emergency room and inpatient hospital services.
2j. The health home provider promotes evidence based wellness and prevention by linking health home enrollees with resources for smoking cessation, diabetes, asthma, hypertension, self help recovery resources, and other services based on individual needs and preferences.
2k. The health home provider has a system to track and share patient information and care needs across providers and to monitor patient outcomes and initiate changes in care, as necessary, to address patient need.

III. Comprehensive Transitional Care

3a. The health home provider has a system in place with hospitals and residential/rehabilitation facilities in their network to provide the health home prompt notification of an individual's admission and/or discharge to/from an emergency room, inpatient, or residential/rehabilitation setting.
3b. The health home provider has policies and procedures in place with local practitioners, health facilities including emergency rooms, hospitals, and residential/rehabilitation settings, providers and community-based services to help ensure coordinated, safe transitions in care for its patients who require transfers in the site of care.
3c. The health home provider utilizes HIT as feasible to facilitate interdisciplinary collaboration among all providers, the patient, family, care givers, and local supports.
3d. The health home provider has a systematic follow-up protocol in place to assure timely access to follow-up care post discharge that includes at a minimum receipt of a summary care record from the discharging entity, medication reconciliation, timely scheduled appointments at recommended outpatient providers, care manager verification with outpatient provider that the patient attended the appointment, and a plan to outreach and reengage the patient in care if the appointment was missed.

IV. Patient and Family Support

4a. Patient's individualized plan of care reflects patient and family or caregiver preferences, education and support for self-management; self help recovery, and other resources as appropriate.
4b. Patient's individualized plan of care is accessible to the individual and their families or other caregivers based on the individual's preference.
4c. The health home provider utilizes peer supports, support groups and self-care programs to increase patients' knowledge about their disease, engagement and self management capabilities, and to improve adherence to prescribed treatment.
4d. The health home provider discusses advance directives with enrollees and their families or caregivers.
4e. The health home provider communicates and shares information with individuals and their families and other caregivers with appropriate consideration for language, literacy and cultural preferences.
4f. The health home provider gives the patient access to care plans and options for accessing clinical information.

V. Referral to Community and Social Support Services

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

VI. Use of Health Information Technology to Link Services

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

VII. Quality Measures Reporting to State

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

Name	Date Created	Type
No items available		

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Health Homes Service Delivery Systems

MEDICAID - Health Homes - NYS Health Home Program - NY - 2016

CMS-10434 OMB 0938-1188

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Package Header

Package ID	NY2016MH0002O	SPA ID	NY-16-0034
Submission Type	Official - Review 1	Initial Submission Date	9/29/2016
Approval Date	12/22/2016	Effective Date	10/1/2016
Superseded SPA ID	N/A		

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

- ☑ Fee for Service
- ☐ PCCM
- ☐ Risk Based Managed Care
- ☑ Other Service Delivery System

Describe if the providers in this other delivery system will be a designated provider or part of the Team of health care professionals and how payment will be delivered to these providers

Describe if the providers in this other delivery system will be a designated provider or part of the team of health care professionals and how payment will be delivered to these providers:
Managed Care Considerations
Similar to the NY patient centered Medical Home program, it is the intention of the State to coordinate and 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 State provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review.

Name	Date Created	Type
Unit 8 - Material on Quality Measures from previously approved 15-20 SPA	9/9/2016 3:43 PM EDT	DOC
Unit 8 Material on Monitoring omitted from MMDL p 54	9/14/2016 9:40 AM EDT	DOC

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Health Homes Payment Methodologies

MEDICAID - Health Homes - NYS Health Home Program - NY - 2016

CMS-10434 OMB 0938-1188

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Package Header

Package ID	NY2016MH0002O	SPA ID	NY-16-0034
Submission Type	Official - Review 1	Initial Submission Date	9/29/2016
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Superseded SPA ID	N/A		

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Payment Methodology

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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)

Agency Rates

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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

Rate Development

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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 provider 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 (from 3M Clinical Risk Groups (CRG) method for adults, or the Child and Adolescent Needs and Strength Assessment of New York (CANS-NY) for children age 0 through 20). This fee will eventually be adjusted by (after the data is available) patient functional status. Until such time as the behavioral health benefit is moved to managed care the fee will include a fee for conducting 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 through September 30, 2018. Rates for Health Home services furnished to other populations are set October 1, 2016 and apply to services furnished on and after that date.

State Health Home rates may be found at:
http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/rate_information.htm

This care management fee will be paid in two increments based on whether a patient is in 1) the case finding group or 2) the active care management group. The case finding group will receive a PMPM that is a reduced percentage (80%) of the active care management PMPM through [August 31, 2016] November 30, 2016. On [September 1, 2016] December 1, 2016, the case finding fee will be set at $135. The case finding PMPM will be available for the three months after a patient has been assigned to a health home. Then, nothing can be billed for that patient for the next three months. Following this interval, case finding can be billed for another three months while outreach and engagement is attempted once again. This PMPM is intended to cover the cost of outreach and engagement.

Effective August 1, 2014, the per member per month care management fee will be adjusted by a temporary rate add-on to distribute the annual amounts authorized under the State's Medicaid Redesign Team (MRT) Waiver and as shown below.

August 1, 2014 to March 31, 2015: $80 million
April 1, 2015 to December 31, 2015: $66.7 million
January 1, 2016 to December 31, 2016: $43.9 million

(SEE TABLE LOCATED UNDER SECTION ON NON-DUPLICATION OF PAYMENT. MOVED DUE TO SPACE CONSTRAINTS)

The temporary rate add on will be paid to State designated Health Homes. Funds received through this rate add-on must be used to support costs related to one or more of the following authorized purposes: 1) Member engagement and promotion of Health Homes, 2) Workforce training and retraining, 3) Health information technology (HIT) and clinical connectivity, and 4) Joint governance technical assistance.

Each Health Home will be required to submit semi-annual reports documenting how the funds were used in accordance with the four authorized purposes. Semi-annual reports shall be submitted until such time as it is verified that all funds have been used in accordance with authorized purposes. Funds that are not disbursed in accordance with authorized purposes will be recouped by the Department within 90 days of such finding.

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

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 will be modified at the next scheduled amendment to include language similar to that outlined below which will address 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) and Chronic Illness Demonstration Projects (CIDPs) 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 [August 31, 2016] 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. This existing TCM rate will be paid for both case finding and active care management. The case finding PMPM will be available for the three months after a patient has been assigned to a health home. Then, nothing can be billed for that patient for the next three months. Following this interval, case finding can be billed for another three months while outreach and engagement is attempted once again. This rate would be paid for both case finding and active care management.

New York State's health home services are set as of January 1, 2012 and are effective for services on or after that date. 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. All of the above payment policies have been developed to assure that there is no duplication of payment for health homes services.

CIDP information has been moved to non-duplication of payment for similar services section.

Assurances

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✓ 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 anticipates that most of the six CIDPs will convert to health homes. The CIDP providers are well positioned to become health homes and meet State and Federal health home standards. The CIDPs that convert to health homes will be paid at their existing CIDP rate for a period of one (1) year from the effective date of the SPA if they convert to health home for their existing patients. For new patients that may be assigned to a CIDP program that has converted to health home the State will pay the State set health home PMPM. At the beginning of the second year after the effective date of the SPA these converted programs will be paid for all patients under the State set health home PMPM. CIDPs that do not convert to health homes, if any, will end operations as CIDPs on March 29, 2012 when the contract with the State terminates.

HEALTH HOME DEVELOPMENT RATE ADD ON SCHEDULE FROM PREVIOUS SECTION PLACED HERE DUE TO SPACE CONSTRAINTS:

Payments will be applicable to claims with dates of service on and after August 1, 2014 and will be paid beginning March 2015, and quarterly thereafter as shown below. The rate add-on for each period will be calculated by dividing the authorized payment amount by total number of claims for such period.

Rate add on applied to claims with the following dates of payment	Rate Add-on Payment Date	Amount of Payment Authorized Under the Waiver
8/1/14 to 2/28/15	March 2015	$80 million
3/1/15 to 5/31/15	June 2015	$22.2 million
6/1/15 to 8/31/15	September 2015	$22.2 million
9/1/15 to 11/30/15	December 2015	$22.3 million
12/1/15 to 2/29/16	March 2016	$10.9 million
3/1/16 to 5/31/16	June 2016	$10.9 million
6/1/16 to 8/31/16	September 2016	$10.9 million
9/1/16 to 11/30/16	December 2016	$11.2 million

☑ The State meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), 1902(a)(30)(A), and 1903 with respect to non-payment for provider-preventable conditions.

☑ 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).

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Health Homes Monitoring, Quality Measurement and Evaluation

MEDICAID - Health Homes - NYS Health Home Program - NY - 2016

CMS-10434 OMB 0938-1188

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Package ID	NY2016MH0002O	SPA ID	NY-16-0034
Submission Type	Official - Review 1	Initial Submission Date	9/29/2016
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Monitoring

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Describe the state's methodology for calculating cost saving (and report cost savings annually in Quality Measure Report). Include savings that result from improved coordination of care and chronic disease management achieved through the Health Homes Program, including data sources and measurement specifications, as well as any savings associated with dual eligibles, and if Medicare data was available to the state to utilize in arriving at its cost-savings estimates

NYS will monitor cost savings from health homes through measures of preventable events, including PPRs, potentially preventable hospital admissions and potentially avoidable ER visits. These metrics are the same metrics for evaluation in section IX. Measures of preventable hospitalizations and avoidable ER will be calculated for the entire Medicaid program. Similar to Section VII, A, NYS will use health home rosters to calculate potential cost savings for enrollees in health homes.

NYS will also compare total costs of care for enrollees in health homes, including all services costs, health home costs and managed care capitation to similar cohorts that are not receiving health home services.

Describe how the state will use health information technology in providing Health Homes services and to improve service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider)

To facilitate the use of health information technology by health homes to improve service delivery and coordination across the care continuum, NY has developed initial and final HIT standards. Providers must meet the initial HIT standard to implement a health home. In addition, provider applicant must provide a plan in to achieve the final standards within eighteen months of program initiation in order to be approved as a health home provider.

The initial standards require health home providers to make use of available HIT for the following processes, as feasible:

1. Have a structured information systems, policies, procedures and practices to create, document, execute, and update a plan of care for every patient;
2. Have a systematic process to follow-up on tests, treatments, services and, and referrals which is incorporated into the patient's plan of care;
3. Have a health record system which allows the patient health information and plan of care to be accessible to the interdisciplinary team of providers and allow for population management and identification of gaps in care including preventive services; and
4.Is required to make use of available HIT and access members' data through the RHIO or QE to conduct all processes, as feasible.

The final standards require health home provider to use HIT for the following:

1. Have 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;
2.Utilize an electronic health record system that qualifies under the Meaningful Use provisions of the HITECH Act that 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 have to provide a plan for when and how they will implement it. Health home providers will comply with all current and future versions 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;
3.Join regional health information networks or qualified health IT entities for data exchange and make a commitment to share information with all providers

participating in a care plan. Regional Health Information Organization /Qualified Entities will be provided policy and technical services required for health information exchange through the Statewide Health Information Network of New York (SHIN-NY); and
4. Support the use of evidence based clinical decision making tools, consensus guidelines, and best practices to achieve optimal outcomes and cost avoidance. For example, in New York the Office of Mental Health has a web and evidence based practices system, known as Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES), which utilizes informatics to improve the quality of care, accountability, and cost-effectiveness of mental health prescribing practices in psychiatric centers.

NY health home providers will be encouraged to use wireless technology as available to improve coordination and management of care and patient adherence to recommendations made by their provider. This may include the use of cell phones, peripheral monitoring devices, and access patient care management records, as feasible.

To facilitate state reporting requirements to CMS, NY is working toward the development of a single portal to be used by health homes for submission of functional assessment and quality measure reporting to the State. Consideration is being given to also include a care management record, also accessed via the portal as an option for health home providers who currently do not have an electronic care management record system.

Significant investment has been made in New York's Health Information Infrastructure to ensure that medical information is in the hands of clinicians and New Yorkers to guide medical decisions and supports the delivery of coordinated, preventive, patient-centered and high quality care. Ongoing statewide evaluation designed to evaluate the impact of HIT on quality and outcomes of care is underway by the Office of Health Information Technology and Transformation.

Quality Measurement and Evaluation

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- [x] The state provides assurance that all Health Homes providers report to the state on all applicable quality measures as a condition of receiving payment from the state
- [x] The state provides assurance that it will identify measureable goals for its Health Homes model and intervention and also identify quality measures related to each goal to measure its success in achieving the goals
- [x] The state provides assurance that it will report to CMS information submitted by Health Homes providers to inform evaluations, as well as Reports to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS
- [x] The state provides assurance that it will track avoidable hospital readmissions and report annually in the Quality Measures report

Go to HHQM Reports

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