NEW YORK STATE OF OPPORTUNITY. Department of Health

KATHY HOCHUL
Governor

MARY T. BASSETT, M.D., M.P.H.
Commissioner

KRISTIN M. PROUD
Acting Executive Deputy Commissioner

December 30, 2022

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

RE: SPA #22-0088
Non-Institutional Services

Dear Scott:

The State requests approval of the enclosed amendment #22-0088 the Title XIX (Medicaid) State Plan for non-institutional services to be effective October 1, 2022 (Appendix I). This amendment is being submitted based on enacted legislation. A summary of the plan amendment is provided in Appendix II.

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

A copy of pertinent sections of enacted legislation is enclosed for your information (Appendix III). A copy of the public notice of this plan amendment, which was given in the New York State Register on September 28, 2022, is also enclosed for your information (Appendix IV). In addition, responses to the five standard funding questions are also enclosed (Appendix V).

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

Sincerely,

[redacted]

Amir Bassiri
Medicaid Director
Office of Health Insurance Programs

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 22-0088

2. STATE: NY

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 2022

5. FEDERAL STATUTE/REGULATION CITATION
§ 1945 of the Social Security Act

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 10/01/22-09/30/23 $ 1,000,000
b. FFY 10/01/23-09/30/24 $ 1,000,000

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
MACPro Portal SPA

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
MACPro Portal SPA

9. SUBJECT OF AMENDMENT
Health Home Assessment Fee

10. GOVERNOR'S REVIEW *(Check One)*
(●) GOVERNOR'S OFFICE REPORTED NO COMMENT
( ) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
( ) OTHER, AS SPECIFIED:

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Amir Bassiri

13. TITLE
Medicaid Director

14. DATE SUBMITTED
December 30, 2022

15. RETURN TO
New York State Department of Health
Division of Finance and Rate Setting
99 Washington Ave – One Commerce Plaza
Suite 1432
Albany, NY 12210

FOR CMS USE ONLY

16. DATE RECEIVED

17. DATE APPROVED

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL

19. SIGNATURE OF APPROVING OFFICIAL

20. TYPED NAME OF APPROVING OFFICIAL

21. TITLE OF APPROVING OFFICIAL

22. REMARKS

Instructions on Back

Appendix I
2022 Title XIX State Plan
Fourth Quarter Amendment
Amended SPA Pages

Records / Submission Packages - Your State

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

Summary Reviewable Units News Related Actions

CMS-10434 OMB 0938-1188

Package Information

Package ID	NY2022MS0020O	**Submission Type**	Official
Program Name	NYS Health Home Program	**State**	NY
SPA ID	NY-22-0088	**Region**	New York, NY
Version Number	1	**Package Status**	Submitted
Submitted By	Michelle Levesque	**Submission Date**	12/30/2022
		Regulatory Clock	90 days remain
		Review Status	Review 1

Submission - Summary

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

Package Header

Package ID NY2022MS0020O
SPA ID NY-22-0088
Submission Type Official
Initial Submission Date 12/30/2022
Approval Date N/A
Effective Date N/A
Superseded SPA ID N/A
Reviewable Unit Instructions

State Information

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

Submission Component

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

Submission - Summary

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

Package Header

Package ID NY2022MS0020O
Submission Type Official
Approval Date N/A
Superseded SPA ID N/A
Reviewable Unit Instructions
SPA ID NY-22-0088
Initial Submission Date 12/30/2022
Effective Date N/A

SPA ID and Effective Date

SPA ID NY-22-0088

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

Submission - Summary

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

Package Header

Package ID NY2022MS0020O
SPA ID NY-22-0088
Submission Type Official
Initial Submission Date 12/30/2022
Approval Date N/A
Effective Date N/A
Superseded SPA ID N/A
Reviewable Unit Instructions

Executive Summary

Summary Description Including Goals and Objectives The Department of Health proposes to amend the Title XIX (Medicaid) State Plan Amendment for non-institutional services to comply with enacted statutory provisions. The changes proposed in the State Plan Amendment seek to add an assessment fee to the Health Home program to ensure that any child who may be eligible for Home and Community-Based Services (HCBS) under the Children's Waiver, demonstration or State Plan authority will be eligible to receive an HCBS assessment under the Health Home program

Federal Budget Impact and Statute/Regulation Citation

Federal Budget Impact

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

Federal Statute / Regulation Citation

§ 1945 of the Social Security Act

Supporting documentation of budget impact is uploaded (optional).

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

Submission - Summary

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

Package Header

Package ID	NY2022MS0020O	**SPA ID**	NY-22-0088
Submission Type	Official	**Initial Submission Date**	12/30/2022
Approval Date	N/A	**Effective Date**	N/A
Superseded SPA ID	N/A		
Reviewable Unit Instructions			

Governor's Office Review

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

Submission - Medicaid State Plan

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

CMS-10434 OMB 0938-1188

The submission includes the following:

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

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

- ( ) Create new Health Homes program
- (•) Amend existing Health Homes program
- ( ) Terminate existing Health Homes program

NYS Health Home Program

Health Homes SPA - Reviewable Units

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

*

	Reviewable Unit Name	Included in Another Submission Package	Source Type
[ ]	Health Homes Intro	( )	APPROVED
[ ]	Health Homes Geographic Limitations	( )	APPROVED
[ ]	Health Homes Population and Enrollment Criteria	( )	APPROVED
[ ]	Health Homes Providers	( )	APPROVED
[ ]	Health Homes Service Delivery Systems	( )	APPROVED
[ ]	Health Homes Payment Methodologies	( )	APPROVED
[ ]	Health Homes Services	( )	APPROVED
[ ]	Health Homes Monitoring, Quality Measurement and Evaluation	( )	APPROVED

1 – 8 of 8

- [ ] 1945A Health Home Program

Submission - Public Notice/Process

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

Package Header

Package ID	NY2022MS0020O	**SPA ID**	NY-22-0088
Submission Type	Official	**Initial Submission Date**	12/30/2022
Approval Date	N/A	**Effective Date**	N/A
Superseded SPA ID	N/A		
Reviewable Unit Instructions			

Name of Health Homes Program

NYS Health Home Program

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

Upload copies of public notices and other documents used

Name	Date Created	
FPN-NYS Register (9-28-22)(22-0088)	11/9/2022 2:30 PM EST	

Submission - Tribal Input

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

Package Header

Package ID NY2022MS0020O
SPA ID NY-22-0088
Submission Type Official
Initial Submission Date 12/30/2022
Approval Date N/A
Effective Date N/A
Superseded SPA ID N/A
Reviewable Unit Instructions

Name of Health Homes Program:

NYS Health Home Program

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

- (●) Yes
- ( ) No

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

- (●) Yes
- ( ) No

☐ The state has solicited advice from Indian Health Programs and/or Urban Indian Organizations, as required by section 1902(a)(73) of the Social Security Act, and in accordance with the state consultation plan, prior to submission of this SPA.

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

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

☐ All Indian Health Programs

Date of solicitation/consultation:	Method of solicitation/consultation:
12/15/2022	Paper mailing/electronic mail

☐ All Urban Indian Organizations

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

☐ All Indian Tribes

Date of consultation:	Method of consultation:
12/15/2022	paper mailing/electronic mail

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

Name	Date Created	
Tribal Consultation 22-0088-Summary- 12-15-22 for upload	12/16/2022 9:03 AM EST	PDF

Indicate the key issues raised (optional)

☐ Access
☐ Quality
☐ Cost
☐ Payment methodology
☐ Eligibility

- [ ] Benefits
- [ ] Service delivery
- [ ] Other issue

Submission - Other Comment

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

Package Header

Package ID NY2022MS0020O
SPA ID NY-22-0088
Submission Type Official
Initial Submission Date 12/30/2022
Approval Date N/A
Effective Date N/A
Superseded SPA ID N/A
Reviewable Unit Instructions

SAMHSA Consultation

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

Health Homes Intro

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

Package Header

Package ID	NY2022MS0020O	**SPA ID**	NY-22-0088
Submission Type	Official	**Initial Submission Date**	12/30/2022
Approval Date	N/A	**Effective Date**	10/1/2022
Superseded SPA ID	22-0072		
	User-Entered		
Reviewable Unit Instructions			

Program Authority

1945 of the Social Security Act

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

Name of Health Homes Program

NYS Health Home Program

Executive Summary

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

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

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

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan Amendment for non-institutional services to comply with enacted statutory provisions. The changes proposed in the State Plan Amendment seek to add an assessment fee to the Health Home program to ensure that any child who may be eligible for Home and Community Based Services (HCBS) under the Children's Waiver, demonstration, or State Plan authority will be eligible to receive an HCBS assessment under the Health Home program.

General Assurances

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

Health Homes Payment Methodologies

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

Package Header

Package ID	NY2022MS0020O	**SPA ID**	NY-22-0088
Submission Type	Official	**Initial Submission Date**	12/30/2022
Approval Date	N/A	**Effective Date**	10/1/2022
Superseded SPA ID	22-0072		

User-Entered

Reviewable Unit Instructions

Payment Methodology

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

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

    Describe below

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

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

see text below

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

Health Homes Payment Methodologies

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

Package Header

Package ID NY2022MS0020O
SPA ID NY-22-0088
Submission Type Official
Initial Submission Date 12/30/2022
Approval Date N/A
Effective Date 10/1/2022
Superseded SPA ID 22-0072

User-Entered

Reviewable Unit Instructions

Agency Rates

Describe the rates used

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

Effective Date

4/1/2022

Website where rates are displayed

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

Health Homes Payment Methodologies

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

Package Header

Package ID	NY2022MS0020O	**SPA ID**	NY-22-0088
Submission Type	Official	**Initial Submission Date**	12/30/2022
Approval Date	N/A	**Effective Date**	10/1/2022
Superseded SPA ID	22-0072		
	User-Entered		
Reviewable Unit Instructions			

Rate Development

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

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

Comprehensive Description

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

Provider Type

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

Care Management Fee:

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

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

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

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

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

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

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

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

Population Case Mix Definitions for Health Home Adult Rates

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

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

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

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

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

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

Managed Care Considerations:

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

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

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

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

Targeted Case Management (TCM) Conversion Considerations:

The State envisions that eventually all targeted case management programs operating in New York will convert to or become part of health homes, and these providers will require time to meet State and Federal health home standards. The State will allow TCM providers that can meet health home standards to convert to health homes or join with larger health homes. TCM providers that convert to health homes will be governed under NYS Health Home Provider Qualification

Standards, not TCM standards. The payment method will be designed to transition all existing TCM capacity from the current rates to the new Health Home payment structure. Effective January 1, 2015 TCM programs for adults will be paid their existing TCM rates until November 30, 2016. Effective October 1, 2016 through September 30, 2018 TCM programs for children will be paid a transitional rate that is as financially equivalent as practicable to their current rate.

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

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

Children's Transitional Rates

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

Children's Health Home Transition Rates

January 1, 2019 through June 30, 2019

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

July 1, 2019 through December 31, 2019

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

January 1, 2020 through June 30, 2020

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

July1, 2020 through December 31, 2020

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

January 1, 2019 through June 30, 2019

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

July 1, 2019 through December 31, 2019

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

January 1, 2020 through June 30, 2020

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

July 1, 2020 through December 31, 2020

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

1869: Low	$225.00	$240.00	8002: B2H (L)	$231.00	$240.00	B2H (L)	$456.00	$480.00
1870: Medium	$450.00	$479.00	8001: B2H (M)	$175.00	$180.00	B2H (M)	$625.00	$659.00
1871: High	$750.00	$799.00	8000: B2H (H)	$100.00	$100.00	B2H (H)	$850.00	$899.00

Enhanced FMAP from Section 9817 of the American Rescue Plan Act of 2021 will be utilized to fund an assessment fee from April 1, 2021 until March 31, 2024, in accordance with the ARPA spending plan, at which time regular FMAP will be utilized for the continuation of the fee.

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

Health Homes Payment Methodologies

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

Package Header

Package ID	NY2022MS0020O	**SPA ID**	NY-22-0088
Submission Type	Official	**Initial Submission Date**	12/30/2022
Approval Date	N/A	**Effective Date**	10/1/2022
Superseded SPA ID	22-0072		
	User-Entered		
Reviewable Unit Instructions			

Assurances

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

Describe below how non-duplication of payment will be achieved

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

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

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

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

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

Optional Supporting Material Upload

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

Health Homes Services

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

Package Header

Package ID	NY2022MS0020O	**SPA ID**	NY-22-0088
Submission Type	Official	**Initial Submission Date**	12/30/2022
Approval Date	N/A	**Effective Date**	10/1/2022
Superseded SPA ID	22-0072		
	User-Entered		
Reviewable Unit Instructions			

Service Definitions

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

Comprehensive Care Management

Definition

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

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

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

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

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

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

Scope of service

The service can be provided by the following provider types

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

- [ ] Nutritionists
- [ ] Other (specify)

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

Care Coordination

Definition

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

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

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

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

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

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

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

Scope of service

The service can be provided by the following provider types

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

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

Health Promotion

Definition

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

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

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

Scope of service

The service can be provided by the following provider types

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

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

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
- [ ] 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
- [ ] 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
- [ ] 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 Services

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

Package Header

Package ID NY2022MS0020O
SPA ID NY-22-0088
Submission Type Official
Initial Submission Date 12/30/2022
Approval Date N/A
Effective Date 10/1/2022
Superseded SPA ID 22-0072

User-Entered

Reviewable Unit Instructions

Health Homes Patient Flow

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

See NY Health Home Patient flow chart below

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

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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Appendix II
2022 Title XIX State Plan
Fourth Quarter Amendment
Summary

SUMMARY
SPA #22-0088

This State Plan Amendment proposes to add an assessment fee to the Health Home program to ensure that any child who may be in need of Home and Community-Based Services (HCBS) under a waiver, demonstration or State Plan authority will be eligible to receive an HCBS assessment under the Health Home program.

Appendix III
2022 Title XIX State Plan
Fourth Quarter Amendment
Authorizing Provisions

The information collected for eligibility, at a minimum, includes: family background, diagnosis, a complete description of the child's medical and behavioral health condition, type and frequency of needed medical/clinical interventions, developmental level of the child, and any other medical or social information pertinent to the child in order to determine and document the level of care at which the child is assessed.

If the HHCM or IEIE needs additional information to complete the eligibility evaluation, he/she may directly request the information from the parent, child if appropriate, or the child's physician. The Children's waiver will utilize the CANSNY or ICF/IID to determine a potential waiver participant's initial level of care and his/her annual LOC re- evaluations. The assessment will be completed only by individuals who have successfully completed the training in the use of CANSNY (or DDRO trained individuals in the ICF-IID tool) and only those individuals will be able to access the web based technology of the UAS-NY, which houses the CANS-NY and ICF-IID eligibility information.

The eligibility evaluation presents care options for the individual and identifies persons who are nursing home, ICF/IID, or hospital level of care eligible. Assessors are required to use their professional judgment to determine the appropriate program options for the individual.

The web based eligibility evaluation will be made available to the HHCM, IEIE, and MCO (if applicable). If there appears to be any question regarding the applicant's nursing home or hospital level of care, the selected HHCM or IEIE will consult with the NYSDOH to resolve any identified issues. The DDRO will consult with OPWDD and NYSDOH regarding any ICF-IID questions.

As part of the POC review, the HHCM or IEIE reviews the Eligibility Evaluation to confirm that the applicant meets the LOC criteria for waiver participation; confirms Medicaid eligibility; reviews recent documentation to support a functional eligibility; and confirms the age of the applicant.

The HH or IE is responsible for assuring that the initial and annual LOC assessments are completed by qualified evaluators and in a manner timely to waiver participation. NYSDOH staff are able to access the UAS-NY through the Health Commerce System for review.

The Health Commerce System (HCS) is the NYS Department of Health's web portal. HCS is a secure, private network designed for sharing health-related information with health organizations throughout New York State. The HCS meets all of the requirements of HIPAA and HITECH, as well as other New York State laws. It contains the UAS-NY for LOC determinations as well as the MAPP-HHTS for Health Home outreach and enrollment.

Initial level of care evaluations must be completed prior to the approved enrollment date for community based individuals. Family of One eligibles must have an initial level of care evaluation, plan of care and financial eligibility completed prior to enrollment in the HCBS waiver and Medicaid. Enrolled waiver participants are reevaluated annually in conjunction with the POC review or at any time the participant experiences a significant change of condition.

The Complete NYS 1915c Waiver can be found here:
https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/2022-04-01_app_hcbs_waiver_renew.pdf

SPA 22-0088

Social Security Law

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

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

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

(c) PAYMENTS.—

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

(2) METHODOLOGY.—

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

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

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

(B) ALTERNATE MODELS OF PAYMENT.—The methodology for determining payment for provision of health home services under this section shall not be limited to a per-member per-month basis and may provide (as proposed by the State and subject to approval by the Secretary) for alternate models of payment.

(3) PLANNING GRANTS.—

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

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

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

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

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

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

(i) The quality of health care provided to such individuals, with a focus on outcomes relevant to the recovery of each such individual.

(ii) The access of such individuals to health care.

(iii) The total expenditures of such individuals for health care.

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

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

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

(i) SUD-ELIGIBLE INDIVIDUALS.—The term "SUD-eligible individual" means, with respect to a State, an individual who satisfies all of the following:

(I) The individual is an eligible individual with chronic conditions.

(II) The individual is an individual with a substance use disorder.

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

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

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

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

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

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

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

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

(h) DEFINITIONS.—In this section:

(1) ELIGIBLE INDIVIDUAL WITH CHRONIC CONDITIONS.—

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

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

(ii) has at least—

(I) 2 chronic conditions;

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

(III) 1 serious and persistent mental health condition.

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

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

(A) A mental health condition.

(B) Substance use disorder.

(C) Asthma.

(D) Diabetes.

(E) Heart disease.

(F) Being overweight, as evidenced by having a Body Mass Index (BMI) over 25.

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

(4) HEALTH HOME SERVICES.—

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

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

(i) comprehensive care management;

(ii) care coordination and health promotion;

(iii) comprehensive transitional care, including appropriate follow-up, from inpatient to other settings;

(iv) patient and family support (including authorized representatives);

(v) referral to community and social support services, if relevant; and

(vi) use of health information technology to link services, as feasible and appropriate.

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

(A) has the systems and infrastructure in place to provide health home services; and

(B) satisfies the qualification standards established by the Secretary under subsection (b).

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

(A) include physicians and other professionals, such as a nurse care coordinator, nutritionist, social worker, behavioral health professional, or any professionals deemed appropriate by the State; and

(B) be free standing, virtual, or based at a hospital, community health center, community mental health center, rural clinic, clinical practice or clinical group practice, academic health center, or any entity deemed appropriate by the State and approved by the Secretary.

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

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

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

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

SPA 22-0088

SECTION 365-L
Health homes
Social Services (SOS) CHAPTER 55, ARTICLE 5, TITLE 11
§ 365-l. Health homes. 1. Notwithstanding any law, rule or regulation to the contrary, the commissioner of health is authorized, in consultation with the commissioners of the office of mental health, office of alcoholism and substance abuse services, and office for people with developmental disabilities, to (a) establish, in accordance with applicable federal law and regulations, standards for the provision of health home services to Medicaid enrollees with chronic conditions, (b) establish payment methodologies for health home services based on factors including but not limited to the complexity of the conditions providers will be managing, the anticipated amount of patient contact needed to manage such conditions, and the health care cost savings realized by provision of health home services, (c) establish the criteria under which a Medicaid enrollee will be designated as being an eligible individual with chronic conditions for purposes of this program, (d) assign any Medicaid enrollee designated as an eligible individual with chronic conditions to a provider of health home services.

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

2-a. Up to fifteen million dollars in state funding may be used to fund health home infrastructure development. Such funds shall be used to develop enhanced systems to support Health Home operations including assignments, workflow, and transmission of data. Funding will also be disbursed pursuant to a formula established by the commissioner to be designated health homes. Such formula may consider prior access to similar funding opportunities, geographic and demographic factors, including the population served, and prevalence of qualifying conditions, connectivity to providers, and other criteria as established by the commissioner.

2-b. The commissioner is authorized to make lump sum payments or adjust rates of payment to providers up to a gross amount of five million dollars, to establish coordination between the health homes and the criminal justice system and for the integration of information of health homes with state and local correctional facilities, to the extent

permitted by law. Such rate adjustments may be made to health homes participating in a criminal justice pilot program with the purpose of enrolling incarcerated individuals with serious mental illness, two or more chronic conditions, including substance abuse disorders, or HIV/AIDS, into such health home. Health homes receiving funds under this subdivision shall be required to document and demonstrate the effective use of funds distributed herein.

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

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

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

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

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

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

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

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

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

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

8. (a) The commissioner of health is authorized to contract with one or more entities to assist the state in implementing the provisions of this section. Such entity or entities shall be the same entity or entities chosen to assist in the implementation of the multipayor patient centered medical home program pursuant to section twenty-nine

hundred fifty-nine-a of the public health law. Responsibilities of the contractor shall include but not be limited to: developing recommendations with respect to program policy, reimbursement, system requirements, reporting requirements, evaluation protocols, and provider and patient enrollment; providing technical assistance to potential medical home and health home providers; data collection; data sharing; program evaluation, and preparation of reports.

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

(i) The department of health shall post on its website, for a period of no less than thirty days:

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

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

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

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

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

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

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

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

receive information regarding reduced cost-sharing for eligible individuals under section 18071 of this title, and any other assistance or subsidies available for coverage obtained through the Exchange;

(D) ensuring that the State agency responsible for administering the State plan under this subchapter (in this section referred to as the ''State Medicaid agency''), the State agency responsible for administering the State child health plan under subchapter XXI (in this section referred to as the ''State CHIP agency'') and an Exchange established by the State under section 18031 of this title utilize a secure electronic interface sufficient to allow for a determination of an individual's eligibility for such medical assistance, child health assistance, or premium assistance, and enrollment in the State plan under this subchapter, subchapter XXI, or a qualified health plan, as appropriate;

(E) coordinating, for individuals who are enrolled in the State plan or under a waiver of the plan and who are also enrolled in a qualified health plan offered through such an Exchange, and for individuals who are enrolled in the State child health plan under subchapter XXI and who are also enrolled in a qualified health plan, the provision of medical assistance or child health assistance to such individuals with the coverage provided under the qualified health plan in which they are enrolled, including services described in section 1396d(a)(4)(B) of this title (relating to early and periodic screening, diagnostic, and treatment services defined in section 1396d(r) of this title) and provided in accordance with the requirements of section 1396a(a)(43) of this title; and

(F) conducting outreach to and enrolling vulnerable and underserved populations eligible for medical assistance under this subchapter or for child health assistance under subchapter XXI, including children, unaccompanied homeless youth, children and youth with special health care needs, pregnant women, racial and ethnic minorities, rural populations, victims of abuse or trauma, individuals with mental health or substance-related disorders, and individuals with HIV/AIDS.

(2) Agreements with State health insurance exchanges

The State Medicaid agency and the State CHIP agency may enter into an agreement with an Exchange established by the State under section 18031 of this title under which the State Medicaid agency or State CHIP agency may determine whether a State resident is eligible for premium assistance for the purchase of a qualified health plan under section 36B of the Internal Revenue Code of 1986 (and, if applicable, advance payment of such assistance under section 18082 of this title), so long as the agreement meets such conditions and requirements as the Secretary of the Treasury may prescribe to reduce administrative costs and the likelihood of eligibility errors and disruptions in coverage.

(3) Streamlined enrollment system

The State Medicaid agency and State CHIP agency shall participate in and comply with the requirements for the system established under section 18083 of this title (relating to streamlined procedures for enrollment through an Exchange, Medicaid, and CHIP).

(4) Enrollment website requirements

The procedures established by State under paragraph (1) shall include establishing and having in operation, not later than January 1, 2014, an Internet website that is linked to any website of an Exchange established by the State under section 18031 of this title and to the State CHIP agency (if different from the State Medicaid agency) and allows an individual who is eligible for medical assistance under the State plan or under a waiver of the plan and who is eligible to receive premium credit assistance for the purchase of a qualified health plan under section 36B of the Internal Revenue Code of 1986 to compare the benefits, premiums, and cost-sharing applicable to the individual under the State plan or waiver with the benefits, premiums, and cost-sharing available to the individual under a qualified health plan offered through such an Exchange, including, in the case of a child, the coverage that would be provided for the child through the State plan or waiver with the coverage that would be provided to the child through enrollment in family coverage under that plan and as supplemental coverage by the State under the State plan or waiver.

(5) Continued need for assessment for home and community-based services

Nothing in paragraph (1) shall limit or modify the requirement that the State assess an individual for purposes of providing home and community-based services under the State plan or under any waiver of such plan for individuals described in subsection (a)(10)(A)(ii)(VI).[2]

(Aug. 14, 1935, ch. 531, title XIX, § 1943, as added Pub. L. 111–148, title II, § 2201, Mar. 23, 2010, 124 Stat. 289.)

REFERENCES IN TEXT

The Internal Revenue Code of 1986, referred to in subsec. (b)(1)(C), (2), (4), is classified generally to Title 26, Internal Revenue Code.

§ 1396w–4. State option to provide coordinated care through a health home for individuals with chronic conditions

(a) In general

Notwithstanding section 1396a(a)(1) of this title (relating to statewideness), section 1396a(a)(10)(B) of this title (relating to comparability), and any other provision of this subchapter for which the Secretary determines it is necessary to waive in order to implement this section, beginning January 1, 2011, a State, at its option as a State plan amendment, may provide for medical assistance under this subchapter to eligible individuals with chronic con-

[2] Probably means subsection (a)(10)(A)(ii)(VI) of section 1396a of this title.

ditions who select a designated provider (as described under subsection (h)(5)), a team of health care professionals (as described under subsection (h)(6)) operating with such a provider, or a health team (as described under subsection (h)(7)) as the individual's health home for purposes of providing the individual with health home services.

(b) Health home qualification standards

The Secretary shall establish standards for qualification as a designated provider for the purpose of being eligible to be a health home for purposes of this section.

(c) Payments

(1) In general

A State shall provide a designated provider, a team of health care professionals operating with such a provider, or a health team with payments for the provision of health home services to each eligible individual with chronic conditions that selects such provider, team of health care professionals, or health team as the individual's health home. Payments made to a designated provider, a team of health care professionals operating with such a provider, or a health team for such services shall be treated as medical assistance for purposes of section 1396b(a) of this title, except that, during the first 8 fiscal year quarters that the State plan amendment is in effect, the Federal medical assistance percentage applicable to such payments shall be equal to 90 percent.

(2) Methodology

(A) In general

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

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

(ii) shall be established consistent with section 1396a(a)(30)(A) of this title.

(B) Alternate models of payment

The methodology for determining payment for provision of health home services under this section shall not be limited to a per-member per-month basis and may provide (as proposed by the State and subject to approval by the Secretary) for alternate models of payment.

(3) Planning grants

(A) In general

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

(B) State contribution

A State awarded a planning grant shall contribute an amount equal to the State percentage determined under section 1396d(b) of this title (without regard to section 5001 of Public Law 111–5) for each fiscal year for which the grant is awarded.

(C) Limitation

The total amount of payments made to States under this paragraph shall not exceed $25,000,000.

(d) Hospital referrals

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

(e) Coordination

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

(f) Monitoring

A State shall include in the State plan amendment—

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

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

(g) Report on quality measures

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

(h) Definitions

In this section:

(1) Eligible individual with chronic conditions

(A) In general

Subject to subparagraph (B), the term ''eligible individual with chronic conditions'' means an individual who—

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

(ii) has at least—

(I) 2 chronic conditions;

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

(III) 1 serious and persistent mental health condition.

(B) Rule of construction

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

(2) Chronic condition

The term ''chronic condition'' has the meaning given that term by the Secretary and shall include, but is not limited to, the following:

(A) A mental health condition.

(B) Substance use disorder.

(C) Asthma.

(D) Diabetes.

(E) Heart disease.

(F) Being overweight, as evidenced by having a Body Mass Index (BMI) over 25.

(3) Health home

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

(4) Health home services

(A) In general

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

(B) Services described

The services described in this subparagraph are—

(i) comprehensive care management;

(ii) care coordination and health promotion;

(iii) comprehensive transitional care, including appropriate follow-up, from inpatient to other settings;

(iv) patient and family support (including authorized representatives);

(v) referral to community and social support services, if relevant; and

(vi) use of health information technology to link services, as feasible and appropriate.

(5) Designated provider

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

(A) has the systems and infrastructure in place to provide health home services; and

(B) satisfies the qualification standards established by the Secretary under subsection (b).

(6) Team of health care professionals

The term ''team of health care professionals'' means a team of health professionals (as described in the State plan amendment) that may—

(A) include physicians and other professionals, such as a nurse care coordinator, nutritionist, social worker, behavioral health professional, or any professionals deemed appropriate by the State; and

(B) be free standing, virtual, or based at a hospital, community health center, community mental health center, rural clinic, clinical practice or clinical group practice, academic health center, or any entity deemed appropriate by the State and approved by the Secretary.

(7) Health team

The term ''health team'' has the meaning given such term for purposes of section 256a–1 of this title.

(Aug. 14, 1935, ch. 531, title XIX, § 1945, as added Pub. L. 111–148, title II, § 2703(a), Mar. 23, 2010, 124 Stat. 319.)

REFERENCES IN TEXT

Section 5001 of Public Law 111–5, referred to in subsec. (c)(3)(B), is set out as a note under section 1396d of this title.

SURVEY AND INTERIM REPORT

Pub. L. 111–148, title II, § 2703(b)(2), Mar. 23, 2010, 124 Stat. 322, provided that:

''(A) IN GENERAL.—Not later than January 1, 2014, the Secretary of Health and Human Services shall survey States that have elected the option under section 1945 of the Social Security Act [42 U.S.C. 1396w–4] (as added by subsection (a)) and report to Congress on the nature, extent, and use of such option, particularly as it pertains to—

''(i) hospital admission rates;

''(ii) chronic disease management;

''(iii) coordination of care for individuals with chronic conditions;

''(iv) assessment of program implementation;

''(v) processes and lessons learned (as described in subparagraph (B));

''(vi) assessment of quality improvements and clinical outcomes under such option; and

''(vii) estimates of cost savings.

''(B) IMPLEMENTATION REPORTING.—A State that has elected the option under section 1945 of the Social Security Act (as added by subsection (a)) shall report to the Secretary, as necessary, on processes that have been developed and lessons learned regarding provision of coordinated care through a health home for Medicaid beneficiaries with chronic conditions under such option.''

§ 1396w–5. Addressing health care disparities

(a) Evaluating data collection approaches

The Secretary shall evaluate approaches for the collection of data under this subchapter and subchapter XXI, to be performed in conjunction with existing quality reporting requirements and programs under this subchapter and subchapter XXI, that allow for the ongoing, accurate, and timely collection and evaluation of data on disparities in health care services and

Appendix IV
2022 Title XIX State Plan
Fourth Quarter Amendment
Public Notice

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

PUBLIC NOTICE

Department of Health

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

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for non-institutional services to comply with recently enacted statutory provisions in § 365-g of the Social Services Law with regards to certain prospective utilization thresholds.

The following changes are proposed:

Non-Institutional Services

Effective on or after October 1, 2022, this notice proposes to decrease an administrative burden on enrolled fee-for-service Medicaid members and providers by eliminating the requirement for provider submitted benefit increase requests for certain services. The current regulatory thresholds established pursuant to the statutory authority of § 365-g are physician and clinic services (excluding anesthesiology and psychiatric services, mental health clinic services; and article 28 ambulatory clinic services ordered to test, diagnose, or treat a member); laboratory services, and dental clinic services. This proposal does not affect drug utilization review. The Department will continue to meet the federal regulatory requirements at 42 CFR Part 456, Subparts A and B, through continued utilization monitoring, in a post-payment review process, with referral to the Department's prepayment Provider on Review Program, and to the Office of the Medicaid Inspector General (OMIG) where suspected fraud, waste or abuse are identified in the unnecessary or inappropriate use of care, services or supplies by members or providers.

The estimated net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2022/2023 is ($23,100).

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

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

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

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

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

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

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

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

PUBLIC NOTICE

Department of Health

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

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for non-institutional services.

Non-Institutional Services

State established rates for state-plan approved Children and Family Treatment and Support Services (CFTSS) will continue the additional 25 percent enhancement initially authorized as a temporary increase under provisions of Section 9817 of the American Rescue Plan Act of 2021 (ARPA). Effective on or after October 1, 2022, the following CFTSS rate enhancements will continue under the state-plan: Other Licensed Practitioners (OLP), Community Psychiatric Supports and Treatment (CPST), Psychosocial Rehabilitation (PSR), Youth Peer Support (YPS), Crisis Intervention (CI) and Family Peer Support Services (FPSS).

The estimated net aggregate increase in gross Medicaid expenditures as a result of the proposed amendments for CFTSS services is $1,167,032.

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

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

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

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

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

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

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

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

PUBLIC NOTICE

Department of Health

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

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

Non-Institutional Services

Effective on or after October 1, 2022, the proposed amendment adds an annual assessment fee to the Health Home program to ensure that any child eligible for Home and Community-Based Services (HCBS) under a waiver, demonstration, or State Plan authority will be

eligible to receive an annual HCBS Eligibility Determination assessment under the Health Home program.

The estimated net aggregate increase in gross Medicaid expenditures attributable to this initiative is approximately $2,000,000. All children receiving HCBS already receive care management under the existing authorities.

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

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

PUBLIC NOTICE

New York State Homes and Community Renewal
Plus One ADU Program
For the creation and improvement of Accessory Dwelling Units

Purpose

The Housing Trust Fund Corporation ("HTFC") as part of New York State Homes and Community Renewal ("HCR") invites eligible applicants to apply to administer the Plus One ADU Program, an initiative to create and improve Accessory Dwelling Units (ADUs). This RFP describes the purpose for which the available funds are to be used and the methodology for disbursing those funds.

Through this RFP, HTFC plans to make up to twenty million dollars ($20,000,000) available to ten (10) eligible applicants for the administration of the Plus One ADU Program. As such, ten million dollars ($10,000,000) shall be available to applicants within New York City and Long Island and ten million dollars ($10,000,000) for the rest of the state. Eligible applicants are invited to submit applications for funding to cover grants to eligible homeowners and for the anticipated costs associated with program delivery.

Applications must be submitted via email to NOFA_Applications@hcr.ny.gov no later than 3:00 PM (EST) on October 28, 2022. The initial contract shall be for two (2) years, with the potential for an extension depending on the need and at the discretion of HCR staff.

Program Overview

By working with units of local government and community development partners, Plus One ADU will provide a full-service program to support low- and middle-income single-family homeowner occupants who wish to build a new ADU on their property or improve an existing ADUs that needs to be brought into compliance with local and state code requirements. Depending on the property and what the locality permits, ADU's may be small, stand-alone (detached) units on single-family lots, basement apartments, garage conversions, or other permitted units.

Background

The 2022-2023 NYS Capital Budget made available $85,000,000 for the purposes of creating and upgrading accessory dwelling units across the state, as part of a five (5) year Housing Plan. Since each community's need for ADUs are different, HTFC is initially making funding available, to select awardees, with the aim of crafting community-specific programs for generating safe, quality ADUs. HCR anticipates subsequent opportunities for ADU funding.

Eligible Applicants

Competitive applications must include partnerships between a non-profit housing organization and a municipal or county government. Either the governmental or non-profit entity may serve in the role of the lead Applicant and the proposal should specify which entity is the lead.

Eligible Activities

Applicants selected by HTFC to administer the Plus One ADU Program (the "Awardees") will be expected to work with HCR staff to create a work plan, which shall include, pre-development activities, construction oversight and post construction monitoring.

1. Pre-development Activities:

Awardees will identify low- and moderate-income homeowner occupants who wish to add an ADU to their property or make capital repairs to an existing ADU. In all cases, awardees will be required to cap participation of homeowners with household income of no more than one hundred percent (100%) AMI for the County or MSA, adjusted for family size and all ADUs must be permitted by the locality.

Awardees will establish standards for eligibility and perform assessments of potential homeowner participants to include current mortgage debt and affordability, building violation searches, documentation of good standing for any existing mortgages, and other due diligence to determine the likelihood that the homeowner participant will maintain the property in good financial and physical health.

Awardees will oversee the pre-development process including design, budgeting, permitting, environmental assessment, appraisals, and other required due diligence to secure funding from HTFC or other needed sources.

Awardees will secure the services of appropriate design professional(s). Each property must have plans and an identified scope, which complies with design standards approved by HCR staff.

Prior to the formal commitment or expenditure funds, the environmental effects of each program activity must be assessed in accordance with the State Environmental Quality Review Act ("SEQRA") at 6 NYCRR Part 617.

2. Construction Oversight:

Awardees will oversee all aspects of the construction process from contractor bidding and selection, compliance with MWBE utilization standards, general construction oversight and coordination between property owners and contractors, preparation of payment requests and other essential activities to ensure efficient construction for each ADU.

3. Post-Construction Monitoring:

Awardees are required to enter a Regulatory Agreement, and associated declining balance enforcement documents, with the participating homeowners for the Regulatory Period which shall not be less ten (10) years.

Compliance monitoring will include the collection of annual compliance certifications including confirmation that the ADU is being used as permanent housing rather than as a short-term rental', and site visits every two years to ensure appropriate property maintenance and quality housing standards, among other standards. The Awardee is expected to assist with the completion of the compliance documentation from homeowners as needed.

Appendix V
2022 Title XIX State Plan
Fourth Quarter Amendment
Responses to Standard Funding Questions

NON-INSTITUTIONAL SERVICES
State Plan Amendment #22-0088

CMS Standard Funding Questions

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

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

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

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

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

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

		4/1/22 – 3/31/23	
Payment Type	**Non-Federal Share Funding**	**Non-Federal**	**Gross**
Normal Per Diem	General Fund; County Contribution	$500,000.00	$1,000,000.00

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

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

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

B. Additional Resources for Non-Federal Share Funding:

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

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

Entity	Annual Amount
New York City	$4.882B
Suffolk County	$216M
Nassau County	$213M
Westchester County	$199M
Erie County	$185M
Rest of State (53 Counties)	$979M
Total	**$6.835B**

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

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

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

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

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

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

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

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

ACA Assurances:

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

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

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

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

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

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

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

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

Tribal Assurance:

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

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

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

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