

MEDICAID MODEL DATA LAB

Id: RHODE ISLAND
 State: Rhode Island
 Health Home Services Forms (ACA 2703)
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Transmittal Numbers (TN) and Effective Date

Please enter the numerical part of the Transmittal Numbers (TN) in the format YY-0000 where YY = the last two digits of the year for which the document relates to, and 0000 = a four digit number with leading zeros. The dashes must also be entered. State abbreviation will be added automatically.

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Effective Date

10/01/2011

3.1 - A: Categorically Needy View

Attachment 3.1-H

Page 14

**Health Homes for Individuals with Chronic Conditions
 Amount, Duration, and Scope of Medical and Remedial Care Services: Categorically Needy**

Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation

Health Home Services

How are Health Home Services Provided to the Medically Needy?

Same way as Categorically Needy

i. Geographic Limitations

Statewide Basis

If Targeted Geographic Basis,

ii. Population Criteria

The State elects to offer Health Home Services to individuals with:

- Two chronic conditions
- One chronic condition and the risk of developing another
- One serious mental illness

from the list of conditions below:

- Mental Health Condition
- Substance Use Disorder
- Asthma
- Diabetes
- Heart Disease
- BMI Over 25
- Other Chronic Conditions Covered?

Description of Other Chronic Conditions Covered.

Developmental Disability, Down Syndrome, Mental Retardation, Seizure Disorders

iii. Provider Infrastructure

Designated Providers as described in Section 1945(h)(5)

CEDARR Family Centers meeting the Health Homes criteria as established by the State in consultation with CMS will be certified by the State as Health Home providers. CEDARR family centers (Health Homes) currently operate under Certification Standards established by the State. Certification Standards will be amended as required to ensure they meet Health Home requirements. Eligible clients are free to choose from any CEDARR Family Center (Health Home) to receive services.

CEDARR Family Centers are designed to provide a structured system for facilitating the assessment of need for, and the provision of high quality, evidenced based Medically Necessary services that may be available for children pursuant to federal Early and Periodic Screening, Diagnosis and Treatment (EPSDT) requirements, as well as referrals to community based services and supports that benefit the child and family.

CEDARR Family Center Health Homes will operate as a "Designated Provider" of Health Home Services. All CEDARR Family Centers employ independently licensed health care professional such as; Psychologists, Licensed Independent Clinical Social Workers, Masters Level Registered Nurses, or Licensed Marriage and Family Therapists; CEDARR Family centers also employ staff trained to provide care coordination, individual and family support and other functions expected from a health home. The CHH Team minimally consists of a Licensed Clinician and a Family Service Coordinator. The CHH Team will consult, coordinate and collaborate on a regular basis with the child's Primary Care Physician/Medical Home and with other providers providing treatment services to that child. Medical Specialists and other Medical professionals will be included on the CHH Team based on the unique needs of each enrolled child. CEDARR Family Centers, by Standard, provide all services in a patient and family centered manner.

The State assures that health homes services will be separate and distinct and duplicate payment will not be made for similar services available under other program authorities.

Team of Health Care Professionals as described in Section 1945(h)(6)

Health Team as described in Section 1945(h)(7), via reference to Section 3502

iv. Service Definitions

Comprehensive Care Management

Service Definition

OVERARCHING STATEWIDE DEFINITION: Comprehensive care management services are conducted with an individual and involves the identification, development, and implementation care plan that addresses the needs of the whole person. Family/Peer Supports can also be included in the process. The service involves the development of a care plan based on the completion of an assessment. A particular emphasis is the use of the multi-disciplinary team including medical personnel who may or may not be directly employed by the provider of the health home. The recipient of comprehensive care management is an individual with complex physical and behavioral health needs. CEDARR HEALTH HOME SPECIFIC DEFINITION: Comprehensive Care Management is provided by CEDARR Health Homes by working with the child and family to: assess current circumstances and presenting issues, identify continuing needs, and identify resources and/or services to assist the child and family to address their needs through the provision of an Initial Family Intake and Needs Determination; develop a Family Care (or Treatment) Plan which will include child specific goals, treatment interventions and meaningful functional outcomes; and regular review and revision of the Family Care Plan to determine efficacy of interventions and emerging needs. Integral to this service is ongoing communication and collaboration between the CEDARR Health Homes Team and the clients Primary Care Physician/Medical Home Managed Care Organization, Behavioral Health and Institutional/Long Term Care providers. This service will be performed by the Licensed Clinician with the support of the Family Service Coordinator.

Ways Health IT Will Link

CEDARR Health Homes utilize a secure HIPPA compliant electronic case management system to support the activities required in order to provide Comprehensive Care Management. These activities include:

- o Identifying client needs by gathering data from other resources including medical and human service providers, school programs
- o Integrating the information into the treatment planning process.
- o Developing the child specific treatment plan
- o Facilitate cross-system coordination, integration and supports access to specific service interventions to address the medical, social, behavioral and other needs of the child
- o Assure active participation of the eligible child and family in the provision of care, assessment of progress, and collection and analysis of both utilization and outcome data

CEDARR Family Centers also access RI KIDSNET Child Health Information System which provides access to information vital to the provision of Comprehensive Care Management. This information includes:

- o Blood Lead levels
- o Immunizations
- o Newborn Developmental Assessment
- o Hearing Assessment
- o WIC and Early Intervention participation

CEDARR Health Homes will also offer to enroll all clients into "CurrentCare" RI's electronic health information exchange.

Care Coordination

Service Definition

OVERARCHING STATEWIDE DEFINITION: Care coordination is the implementation of the treatment plan developed to guide comprehensive care management in a manner that is flexible and meets the need of the individual receiving services. The goal is to ensure that all services are coordinated across provider settings, which may include medical, social and, when age appropriate, vocational educational services. Services must be coordinated and information must be centralized and readily available to all team members. Changes in any aspect of an individual's health must be noted, shared with the team, and used to change the care plan as necessary. All relevant information is to be obtained and reviewed by the team. CEDARR HEALTH HOME SPECIFIC DEFINITION: Care Coordination is designed to be delivered in a flexible manner best suited to the family's preferences and to support goals that have been identified by developing linkages and skills in order for families to reach their full potential and increase their independence in obtaining and accessing services. This includes:

- Follow up with families, Primary Care provider, service providers and others involved in the child's care to ensure the efficient provision of services.
- Provide information to families about specific disorders, treatment and provider options, systems of support, services, assistance and legal rights available to Children with Special Health Care Needs and their families, resources beyond the scope of services covered by Medicaid, such as those which may be available from other parents, family members, community-based organizations, service providers, grants, social programs, funding options, school-based services, faith based organizations, etc.
- Service delivery oversight and coordination to ensure that services are being delivered in the manner that satisfies the requirements of the individual program(s) and meet the needs of the child and family.
- Assistance in locating and arranging specialty evaluations as needed, in coordination with the child's Primary Care Provider. This also includes follow-up and ongoing consultation with the evaluator as needed. This service will be performed by the Licensed Clinician or the Family Service Coordinator depending on the exact nature of the activity.

Ways Health IT Will Link

The electronic case management system described above will also be utilized to support the delivery of Care Coordination by providing easy and immediate access to comprehensive information and tools (such as the individual care plan, contact information, other involvements such as school, behavioral health and specialty care) that will assist the CEDARR Health Homes Team in meeting the needs of each child and family.

Health Promotion

Service Definition

OVERARCHING STATEWIDE DEFINITION: Health promotion services encourage and support healthy ideas and concepts to motivate individuals to adopt healthy behaviors. The services also enable individuals to self-manage their health. **CEDARR HEALTH HOME SPECIFIC DEFINITION:** Health Promotion assists children and families in implementing the Family Care Plan and in developing the skills and confidence to independently identify, seek out and access resources that will assist in managing and mitigating the child's condition(s), preventing the development of secondary or other chronic conditions, addressing family and child engagement, promoting optimal physical and behavioral health, and addressing and encouraging activities related to health and wellness. This service will include the provision of health education, information, and resources with an emphasis on resources easily available in the families' community and peer group(s). This service will be performed by the Licensed Clinician.

Ways Health IT Will Link

See Care Coordination description above. In addition CEDARR Health Homes provide their staff with access to a wide range of resource/educational material(s) in multiple formats for use in supplementing and facilitating Health Promotion activities. This information will be provided in a format that is most appropriate for the child and families use, including multiple languages.

Comprehensive Transitional Care (including appropriate follow-up, from inpatient to other settings)

Service Definition

OVERARCHING STATEWIDE DEFINITION: Comprehensive transitional care services focus on the movement of individuals from any medical/psychiatric inpatient or other out-of-home setting into a community setting, and between different service delivery models. Members of the health team work closely with the individual to transition the individual smoothly back into the community and share information with the discharging organization in order to prevent any gaps in treatment that could result in a re-admission. **CEDARR HEALTH HOME SPECIFIC DEFINITION:** Transitional Care will be provided by the CEDARR Health Homes Team to both existing clients who have been hospitalized or placed in other non-community settings as well as newly identified clients who are entering the community. The CEDARR Health Homes Team will collaborate with all parties involved including the facility, primary care physician, Health Plan (if enrolled) and community providers to ensure a smooth discharge into the community and prevent subsequent re-admission(s). Transitional Care is not limited to Institutional Transitions but applies to all transitions that will occur throughout the development of the child and includes transition from Early Intervention into School based services and pediatric services to adult services. This service will be performed by the Licensed Clinician with the support of the Family Service Coordinator.

Ways Health IT Will Link

See Care Coordination description above. In addition CEDARR Health Homes provide their staff with access to a wide range of resource/educational material(s) in multiple formats for use in supplementing and facilitating Health Promotion activities. This information will be provided in a format that is most appropriate for the child and families use, including multiple languages.

Individual and Family Support Services (including authorized representatives)

Service Definition

OVERARCHING STATEWIDE DEFINITION: Individual and family support services assist individuals to accessing services that will reduce barriers to treatment and improve health outcomes. Family involvement may vary based on the age, ability, and needs of each individual. Support services may include advocacy, information, navigation of the treatment system, and the development of self-management skills. **CEDARR HEALTH HOME SPECIFIC DEFINITION:** The CEDARR Health Homes Team is responsible for providing assistance to the family in accessing and coordinating services. These services include the full range of services that impact on Children with Special Health Care Needs and include, but are not limited to, health, behavioral health, education, substance abuse, juvenile justice and social and family support services. The CEDARR Health Home Team will actively integrate the full range of services into a comprehensive program of care. At the family's request, the CEDARR Team can play the principal role as organizer, information source, guide, advocate, and facilitator for the family by helping the family to assess strengths and needs, identify treatment goals and services, and navigate agency and system boundaries. This service will be performed by the Licensed Clinician or the Family Service Coordinator depending on the exact nature of the activity.

Ways Health IT Will Link

See Care Coordination description above. In addition CEDARR Health Homes provide their staff with access to a wide range of resource/educational material(s) in multiple formats for use in supplementing and facilitating Individual and Family Support activities. This information will be provided in a format that is most appropriate for the child and families use, including multiple languages.

Referral to Community and Social Support Services

Service Definition

OVERARCHING STATEWIDE DEFINITION: Referrals to community and social support services ensure that individuals have access to a myriad of formal and informal resources. Ideally, these resources are easily accessed by the individual in the service system and assists individuals in addressing medical, behavioral, educational, social and community issues. **CEDARR HEALTH HOME SPECIFIC DEFINITION:** Referral to Community and Social Support Services will be provided by members of the CEDARR Health Homes Team and will include information about formal and informal resources beyond the scope of services covered by Medicaid, such as those which may be available from other parents, family members, community-based organizations, service providers, grants, social programs, funding options, school-based services, faith based organizations, etc. Whenever possible, families will be informed of opportunities and supports that are closest to home, that are the least restrictive and that promote integration in the home and community. Members of the CEDARR Health Homes Team will emphasize the use of informal, natural community supports as a primary strategy to assist children and families. This service will be performed by the Licensed Clinician or the Family Service Coordinator depending on the exact nature of the activity.

Ways Health IT Will Link

See Care Coordination description above. In addition CEDARR Family Centers provide their staff with access to a wide range of resource/educational material(s) in multiple formats for use in supplementing and facilitating Referral to Community and Social Support activities. This information will be provided in a format that is most appropriate for the child and families use, including multiple languages.

v.Provider Standards

Rhode Island has established Certification Standards for CEDARR Family Centers and will utilize those Standards as the basis to certify Health Home providers. The Standards can be found at: http://www.dhs.ri.gov/Portals/0/Uploads/Documents/Public/Children%20w%20Spec%20Needs/CEDARR_cert_stdts.pdf

In addition an appendix to the existing Certification Standards (Appendix VI) has been developed which relates to the Health Homes initiative the text of the Appendix follows:

Introduction

Section 2703 of the Patient Protection and Affordable Care of 2010 afforded States the option of adding "Health Homes for Enrollees with Chronic Conditions" to the scope of services offered to individuals receiving Medicaid by applying for an Amendment to the RI Medicaid State Plan. This provision is an important opportunity for Rhode to address and receive additional Federal support for the enhanced integration and coordination of primary, acute, behavioral health (mental health and substance use), and long-term services and supports for persons across

the lifespan with chronic illness.

The Rhode Island Executive Office of Health and Human Services (EOHHS), as the designated Medicaid entity, submitted a request to the Centers for Medicare and Medicaid Services (CMS) on August 26, 2011, to designate CEDARR Family Centers as Health Homes for Children and Youth with Disabilities and Chronic conditions.

The design of the CEDARR System of Care and the CEDARR Family Centers makes this a unique opportunity to implement the principles of Section 2703 Health Homes within an existing infrastructure of providers, trained professionals and engaged stakeholders. Utilizing CEDARR Family Centers as Health Home providers allows RI to begin implementing this program with a minimum of delay and expenditure of valuable resources.

CMS has issued guidelines (summarized below) to the State on required services, eligibility criteria, quality management and program evaluation. For purposes of the Health Homes initiative all current and future Certified CEDARR Family Centers will be required to abide by these requirements, in addition to the existing CEDARR Certification Standards as revised in 2009.

Health Homes Requirements

Population Criteria

Medicaid recipients who meet the following criteria are eligible for CEDARR Health Home services:

- o Has a severe mental illness, or severe emotional disturbance
- o Has two or more chronic conditions as listed below:
 - o Mental Health Condition
 - o Asthma
 - o Diabetes
 - o Developmental Disabilities
 - o Down Syndrome
 - o Mental Retardation
 - o Seizure Disorders
- o Has one chronic condition listed above and is at risk of developing a second

Provider Standards

As previously mentioned, the current CEDARR certification standards, under which all CEDARR Family Centers operate will be utilized as the Provider Standards for CEDARR Health Homes. In addition all providers of Health Home Services agree to:

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

Health Home Services

Health Homes are required to provide the following services to all eligible individuals.

o Comprehensive Care Management- Comprehensive Care Management is provided by CEDARR Family Centers by working with the child and family to: assess current circumstances and presenting issues, identify continuing needs, and identify resources and/or services to assist the child and family to address their needs through the provision of an Initial Family Intake and Needs Determination; develop a Family Care (or Treatment) Plan which will include child specific goals, treatment interventions and meaningful functional outcomes; and regular review and revision of the Family Care Plan to determine efficacy of interventions and emerging needs. Integral to this service is ongoing communication and collaboration between the CEDARR Team and the clients Primary Care Physician/Medical Home. CEDARR staff (Licensed Clinician and Family Service Coordinator) shall utilize the Initial Family Intake and Needs Determination (IFIND), Family Care Plan (FCP) and Family Care Plan Review (FCPR) to provide Comprehensive Care Management.

o Care Coordination- Care Coordination is designed to be delivered in a flexible manner best suited to the family's preferences and to support goals that have been identified by developing linkages and skills in order for families to reach their full potential and increase their independence in obtaining and accessing services. This includes:

- o Follow up with families, Primary Care provider, service providers and others involved in the child's care to ensure the efficient provision of services.
- o Provide information to families about specific disorders, treatment and provider options, systems of support, services, assistance and legal rights available to Children with Special Health Care Needs and their families, resources beyond the scope of services covered by Medicaid, such as those which may be available from other parents, family members, community-based organizations, service providers, grants, social programs, funding options, school-based services, faith based organizations, etc.
- o Service delivery oversight and coordination to ensure that services are being delivered in the manner that satisfies the requirements of the individual program(s) and meet the needs of the child and family.
- o Assistance in locating and arranging specialty evaluations as needed, in coordination with the child's Primary Care Provider. This also includes follow-up and ongoing consultation with the evaluator as needed.

Care Coordination will be performed by the member of the CEDARR Team (Licensed Clinician or Family Service Coordinator) that is most appropriate based upon the issue that is being addressed. CEDARR staff (Licensed Clinician and Family Service Coordinator) shall utilize Health Needs Coordination (HNC) to provide Care Coordination.

Health Promotion- Health Promotion assists children and families in implementing the Family Care Plan and in developing the skills and confidence to independently identify, seek out and access resources that will assist in managing and mitigating the child's condition(s), preventing the development of secondary or other chronic conditions, addressing family and child engagement, promoting optimal physical and behavioral health, and addressing and encouraging activities related to health and wellness. This service will include the provision of health education, information, and resources with an emphasis on resources easily available in the families' community and peer group(s). CEDARR staff (Licensed Clinician) shall utilize Therapeutic Counseling and Group Intervention to provide Health Promotion.

Comprehensive Transitional Care- Transitional Care will be provided by the CEDARR Team to both existing clients who have been hospitalized or placed in other non-community settings as well as newly identified clients who are entering the community. The CEDARR Team will collaborate with all parties involved including the facility, primary care physician, Health Plan (if enrolled) and community providers to ensure a smooth discharge into the community and prevent subsequent re-admission(s). Transitional Care is not limited to Institutional Transitions but applies to all transitions that will occur throughout the development of the child and includes transition from Early Intervention into School

based services and pediatric services to adult services. CEDARR staff (Licensed Clinician and Family Service Coordinator) shall utilize Health Needs Coordination (HNC) to provide Comprehensive Transitional Care.

Individual and Family Support Services- The CEDARR Team is responsible for providing assistance to the family in accessing and coordinating services. These services include the full range of services that impact on Children with Special Health Care Needs and include, but are not limited to, health, behavioral health, education, substance abuse, juvenile justice and social and family support services. The CEDARR Team will actively integrate the full range of services into a comprehensive program of care. At the family's request, the CEDARR Team can play the principal role as organizer, information source, guide, advocate, and facilitator for the family by helping the family to assess strengths and needs, identify treatment goals and services, and navigate agency and system boundaries. CEDARR staff (Licensed Clinician and Family Service Coordinator) shall utilize Health Needs Coordination (HNC) to provide Individual and Family Support Services.

Referral to Community and Social Support Services- Referral to Community and Social Support Services will be provided by members of the CEDARR Team and will include information about formal and informal resources beyond the scope of services covered by Medicaid, such as those which may be available from other parents, family members, community-based organizations, service providers, grants, social programs, funding options, school-based services, faith based organizations, etc. Whenever possible, families will be informed of opportunities and supports that are closest to home, that are the least restrictive and that promote integration in the home and community. Members of the CEDARR Team will emphasize the use of informal, natural community supports as a primary strategy to assist children and families. CEDARR staff (Licensed Clinician and Family Service Coordinator) shall utilize Health Needs Coordination (HNC) to provide Referral to Community and Social Supports.

Additional Requirements

To fully achieve the goals of the Health Homes initiative, certain actions which were previously viewed as suggested are now required and subject to EOHHS performance review requirements. Those include:

- o Documented yearly outreach to the child's Primary Care Physician and Medicaid Managed Care Plan (if applicable)
- o Documented yearly Body Mass Index (BMI) Screening for all children 6 years of age or older. If BMI screen is not clinically indicated, reason must be documented
- o Documented yearly Depression Screening utilizing the Center for Epidemiological Studies Depression Scale for Children (CES-DC) (or equivalent) for all children 12 years of age or older. If depression screening is not clinically indicated, reason must be documented
- o Yearly review of immunizations, screenings and other clinical information contained in the KIDSNET Health Information System

In order for an entity to be certified as a CEDARR Health Home they must agree, in writing, to abide by both the existing CEDARR Certification Standards as well as the Health Home addendum and Appendix.

vi. Assurances

- A. The State assures that hospitals participating under the State plan or a waiver of such plan will establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated providers.
- B. The State 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.
- C. The State will report to CMS information submitted by health home providers to inform the evaluation and Reports to Congress as described in section 2703(b) of the Affordable Care Act, and as described by CMS.

vii. Monitoring

A. Describe the State's methodology for tracking avoidable hospital readmissions, to include data sources and measure specifications.

The state will measure re-admissions per 1000 member months for any diagnosis using a pre/post-period comparison among eligible CEDARR Health Home clients. The data source will be claims and encounter data available in the Medicaid data warehouse.

B. Describe the State's methodology for calculating cost savings that result from improved chronic care coordination and management achieved through this program, to include data sources and measure specifications.

The State will annually perform an assessment of cost savings using a pre/post-period comparison of CEDARR health home clients. Savings calculations will be based on data garnered from the MMIS, encounter data from Health Plans, encounter data submitted the Health Home providers, and any other applicable data available from the RI Data Warehouse.

C. Describe the State's proposal for using health information technology in providing health home services under this program 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).

The state will phase-in the use of HIT to support health home services. Initially, providers will be supported in their delivery of health home services through data profiles supplied by Medicaid managed care plans for the 60% of the health home-eligible CEDARR population enrolled in MCOs. The state is currently working with the MCOs to develop health utilization profiles minimally comprised of the components below.

- 1) Claims Data to identify member's pattern of utilization based on previous 12 months (#Emergency Room Visits, Last ER Visit Date, Last ER Visit Primary Diagnosis, #Urgent Care Visits).
- 2) Claims data to identify member's primary care home (#PCP Sites, #PCP visits to current PCP Site.
- 3) Prescription Drug information
- 4) Behavioral Health Utilization

In addition CEDARR Health Homes also accesses the RI KIDSNET Child Health Information System which provides access to information vital to the provision of Comprehensive Care Management. This information includes: Blood Lead levels, Immunizations, Newborn Developmental Assessment, Hearing Assessment, WIC and Early Intervention participation.

CEDARR Health Homes will also offer to enroll all clients into "CurrentCare" RI's electronic health information exchange.

3.1 - A: Categorically Needy View

**Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Care Services: Categorically Needy**

Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation

viii. Quality Measures: Goal Based Quality Measures

Please describe a measurable goal of the health home model that will be operationalized utilizing measures within the domains listed below. The measures may or may not be tied to the services depending on the goal. If the measure is tied to a service, please complete the service-based quality measure section. If the measure is tied to a goal, please complete the goal-based measure section.

Goal 1:

Improve care coordination

Clinical Outcomes

Measure

1. Concept: Communication and collaboration between the Health Home Team and the Primary Care Physician during the development and review of the plan of care leads to a comprehensive plan of care
Measure: Percentage of Physician Consultation claims to the number of Care plans developed and renewed.
2. Concept: Use of an electronic medical record ensures that recommended screenings, immunizations and assessments are performed.
Measure: Number of hits on the RI KIDSNET Child Health Information system per 1,000 enrollees (KIDSNET stores child specific information on blood lead levels, immunization, newborn developmental assessment, newborn blood spot screening, hearing assessment, home visiting, WIC and Early Intervention).
3. Concept: Communication and collaboration between the Health Home Team and the Managed Care Plan ensures that services are not being duplicated.
Measure: Percentage of CEDARR MCO enrollees with outreach to MCO documented in the CEDARR record.

Data Source

1. Medicaid Claims
2. Kidsnet database report to Medicaid
3. CEDARR Health Home Client Record Review (5% Sample)

Measure Specification

1. Numerator: number of Physician claims for CPT code 99637 (Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by physician)

Denominator: Number of claims for Family Care Plan development or Family Care Plan Review
2. Numerator: Number of times KIDSNET is accessed by each CEDARR

Denominator: Number of enrollees per CEDARR
3. Numerator: Number of MCO enrollees with outreach documented in the CEDARR chart.

Denominator: Number of CEDARR enrollees who are enrolled in a Medicaid MCO.

How Health IT will be Utilized

RI will use the Medicaid data Warehouse to collect and store historical Medicaid Claims and Encounter data. In addition, monitoring of progress towards identified Health Homes goals will be accomplished through the analysis of reports submitted on a regular basis by the CEDARR Health Homes. Rhode Island will also use additional data sources to monitor the impact of its health home (HH) program on quality: an outcomes survey administered to all CEDARR families on intake and yearly thereafter; charts (either electronic or paper), and a client satisfaction survey. Rhode Island exercised prudence in selecting measures to not overburden CEDARR or IT staff with new data collection and analysis. We will use standard, validated measure specifications where they exist to increase our ability and CMS's to make comparisons across populations, programs, and states.

Experience of Care

Measure

1. Concept: Clients perceive that they are receiving appropriate and effective services
Measure: Satisfaction with services, accessibility of services, availability of services
2. Concept: Timely delivery of Health Home services
Measure: Percentage of Initial Assessment (IFIND) appointment dates offered within 30 days of request.
3. Concept: Timely delivery of Health Home services
Measure: Percentage of Care Plans completed within 30 days of completion of the Initial Assessment (IFIND)
4. Concept: Timely delivery of Health Home services
Measure: Percentage of Care Plans reviews completed prior to expiration of current care plan.

Data Source

1. Annual Satisfaction Surveys
2. CEDARR Health Home Quarterly Reporting to MEDICAID. Data obtained from CEDARR Automated Care Coordination System

Measure Specification

1. Numerator: Clients saying they agree or strongly agree with each the following statements:
 - The care plan met my child's needs
 - I know who to contact at CEDARR for assistance if needed
 - Appointments are scheduled in a timely manner.
 Denominator: all clients who completed the annual family satisfaction survey
2. Numerator: Number of clients offered an initial appointment date within 30 days of request.

Denominator: Number of client requests for Initial Assessment (IFIND)
3. Numerator: Number of Care Plans completed within 30 days of completion of IFIND

Denominator: Number of completed Initial Assessments (IFIND)
4. Numerator: Number of Care Plans Reviews completed prior to the expiration date of the current Care Plan.

Denominator: Number of completed Care Plan Reviews completed

How Health IT will be Utilized

RI will use the Medicaid data Warehouse to collect and store historical Medicaid Claims and Encounter data. In addition, monitoring of progress towards identified Health Homes goals will be accomplished through the analysis of reports submitted on a regular basis by the CEDARR Health Homes. Rhode Island will also use additional data sources to monitor the impact of its health home (HH) program on quality: an outcomes survey administered to all CEDARR families on intake and yearly thereafter; charts (either electronic or paper), and a client satisfaction survey. Rhode Island exercised prudence in selecting measures to not overburden CEDARR or IT staff with new data collection and analysis. We will use standard, validated measure specifications where they exist to increase our ability and CMS's to make comparisons across populations, programs, and states.

Quality of Care

Measure

1. Concept: Knowledge of condition by client and family leads to improved management of condition and access to care.
Measure: % of clients who indicate having adequate or higher level of knowledge of condition

2. Concept: Well coordinated care reduces caregiver stress.
Measure: % of clients who indicate having a high level of stress caused by condition(s)

Data Source

Reports on responses to baseline and annual review of outcome questions submitted by CEDARR Health Homes to Medicaid

Measure Specification

1. Numerator: Number of clients scoring 4 or better on 1 (worse) to 7 (best) scale for the following outcome question:
o Has your knowledge of your child's condition improved?

Denominator: Number of clients responding to above question

2. Numerator: Number of clients scoring 4 or better on 1 (worse) to 7 (best) scale for the following outcome question:
o How much stress does your child's condition cause?

Denominator: Number of clients responding to above question.

How Health IT will be Utilized

RI will use the Medicaid data Warehouse to collect and store historical Medicaid Claims and Encounter data. In addition, monitoring of progress towards identified Health Homes goals will be accomplished through the analysis of reports submitted on a regular basis by the CEDARR Health Homes. Rhode Island will also use additional data sources to monitor the impact of its health home (HH) program on quality: an outcomes survey administered to all CEDARR families on intake and yearly thereafter; charts (either electronic or paper), and a client satisfaction survey. Rhode Island exercised prudence in selecting measures to not overburden CEDARR or IT staff with new data collection and analysis. We will use standard, validated measure specifications where they exist to increase our ability and CMS's to make comparisons across populations, programs, and states.

Goal 2:

Improve Health Outcomes of Children and Youth with Special Health Care Needs (CYSHCN)

Clinical Outcomes

Measure

1. Concept: Increased knowledge of conditions and skills and strategies acquired to address consequences of condition will result in better health outcomes.
Measure: % of clients who indicate having adequate or higher level of knowledge of condition.

2. Concept: Provision of clinical information and community based treatment options
Measure: Number of referrals to Community Based Resources per member per year

Data Source

1. Reports on responses to baseline and annual review of outcome questions submitted by CEDARR Health Homes to Medicaid.
2. CEDARR Quarterly Reporting to Medicaid. Data obtained from CEDARR Automated Care Coordination System

Measure Specification

1. Numerator: Number of clients scoring 4 or better on 1 (worse) to 7 (best) scale for the following outcome question:
o Has your knowledge of your child's condition improved?

Denominator: Number of clients responding to above question.

2. Numerator: Number of referrals made by CEDARR Health homes in one year

Denominator: Number of clients served during one year.

How Health IT will be Utilized

RI will use the Medicaid data Warehouse to collect and store historical Medicaid Claims and Encounter data. In addition, monitoring of progress towards identified Health Homes goals will be accomplished through the analysis of reports submitted on a regular basis by the CEDARR Health Homes. Rhode Island will also use additional data sources to monitor the impact of its health home (HH) program on quality: an outcomes survey administered to all CEDARR families on intake and yearly thereafter; charts (either electronic or paper), and a client satisfaction survey. Rhode Island exercised prudence in selecting measures to not overburden CEDARR or IT staff with new data collection and analysis. We will use standard, validated measure specifications where they exist to increase our ability and CMS's to make comparisons across populations, programs, and states.

Experience of Care

Measure

1. Concept: Clients perceive that they are receiving appropriate and effective services
Measure: Satisfaction with services, accessibility of services, availability of services

2. Concept: Timely delivery of Health Home Care Coordination services
Measure: Percentage of Community Based service treatment plans reviewed within 30 days of submission to the Health Home.

Data Source

1. Annual Satisfaction surveys
2. CEDARR Health Home Quarterly Reporting to MEDICAID. Data obtained from CEDARR Automated Care Coordination System

Measure Specification

1. Numerator: patients saying they agree or strongly agree with each the following statements:
 - The care plan met my child's needs
 - I know who to contact at CEDARR for assistance if needed
 - Appointments are scheduled in a timely manner.
- Denominator: all clients who completed the annual family satisfaction survey
2. Numerator: Number of Treatment Plans Reviewed within 30 days of receipt.
- Denominator: Number of Treatment Plans submitted

How Health IT will be Utilized

RI will use the Medicaid data Warehouse to collect and store historical Medicaid Claims and Encounter data. In addition, monitoring of progress towards identified Health Homes goals will be accomplished through the analysis of reports submitted on a regular basis by the CEDARR Health Homes. Rhode Island will also use additional data sources to monitor the impact of its health home (HH) program on quality: an outcomes survey administered to all CEDARR families on intake and yearly thereafter; charts (either electronic or paper), and a client satisfaction survey. Rhode Island exercised prudence in selecting measures to not overburden CEDARR or IT staff with new data collection and analysis. We will use standard, validated measure specifications where they exist to increase our ability and CMS's to make comparisons across populations, programs, and states.

Quality of Care

Measure

1. Concept: Improved Medical Outcomes will result in lower stress levels related to the diagnosed condition
Measure: % of clients who indicate having a high level of stress caused by condition(s)
2. Concept: Increased participation in age appropriate activities
Measure: Parent /Guardian self rating of child's ability to take part in age appropriate community and social activities

Data Source

1. Reports on responses to baseline and annual review of outcome questions submitted by CEDARR Health Homes to Medicaid
2. Reports on responses to baseline and annual review of outcome questions submitted by CEDARR Health Homes to Medicaid

Measure Specification

1. Numerator: Number of clients scoring 4 or better on 1 (worse) to 7 (best) scale for the following outcome question:
o How much stress does your child's condition cause you?

Denominator: Number of clients responding to above question.
2. Numerator: Number of clients scoring 4 or better on 1 (worse) to 7 (best) scale for the following outcome question:
o How much can your child take part in age appropriate community and social activities?

Denominator: Number of clients responding to above question.

How Health IT will be Utilized

RI will use the Medicaid data Warehouse to collect and store historical Medicaid Claims and Encounter data. In addition, monitoring of progress towards identified Health Homes goals will be accomplished through the analysis of reports submitted on a regular basis by the CEDARR Health Homes. Rhode Island will also use additional data sources to monitor the impact of its health home (HH) program on quality: an outcomes survey administered to all CEDARR families on intake and yearly thereafter; charts (either electronic or paper), and a client satisfaction survey. Rhode Island exercised prudence in selecting measures to not overburden CEDARR or IT staff with new data collection and analysis. We will use standard, validated measure specifications where they exist to increase our ability and CMS's to make comparisons across populations, programs, and states.

Goal 3:

Decrease the occurrence of secondary conditions

Clinical Outcomes

Measure

1. Concept: Regular screenings for Obesity will result in a decrease of related conditions
Measure: Yearly BMI Index is calculated for all clients 6 years of age and older with documented intervention if <85th percentile
2. Concept: Participants will be screened regularly for depression
Measure: Yearly Screening for Depression for all clients 12 years of age or above

Data Source

1. CEDARR Health Home Client Record Review (5% Sample)
2. CEDARR Health Home Client Record Review (5% Sample)

Measure Specification

1. Numerator: Number of participants 6 years of age or older with BMI screen documented

Denominator: Number of participants 6 years of age or older participating in CEDARR annually
2. Numerator: Number of participants 12 years of age or older with Depression screen conducted

Denominator: Number of participants 12 years of age or older participating in CEDARR annually

How Health IT will be Utilized

RI will use the Medicaid data Warehouse to collect and store historical Medicaid Claims and Encounter data. In addition, monitoring of progress towards identified Health Homes goals will be accomplished through the analysis of reports submitted on a regular basis by the CEDARR Health Homes. Rhode Island will also use additional data sources to monitor the impact of its health home (HH) program on quality: an outcomes survey administered to all CEDARR families on intake and yearly thereafter; charts (either electronic or paper), and a client satisfaction survey. Rhode Island exercised prudence in selecting measures to not overburden CEDARR or IT staff with new data collection and analysis. We will use standard, validated measure specifications where they exist to increase our ability and CMS's to make comparisons across populations, programs, and states.

Experience of Care

Measure

1. Concept: Clients perceive that they are receiving appropriate and effective services
 Measure: Satisfaction with services, accessibility of services, availability of services

Data Source

1. Annual Satisfaction surveys

Measure Specification

1. Numerator: patients saying they agree or strongly agree with each the following statements:
 - The care plan met my child's needs
 - I know who to contact at CEDARR for assistance if needed
 - Appointments are scheduled in a timely manner.

 Denominator: all clients who completed the annual family satisfaction survey

How Health IT will be Utilized

RI will use the Medicaid data Warehouse to collect and store historical Medicaid Claims and Encounter data. In addition, monitoring of progress towards identified Health Homes goals will be accomplished through the analysis of reports submitted on a regular basis by the CEDARR Health Homes. Rhode Island will also use additional data sources to monitor the impact of its health home (HH) program on quality: an outcomes survey administered to all CEDARR families on intake and yearly thereafter; charts (either electronic or paper), and a client satisfaction survey. Rhode Island exercised prudence in selecting measures to not overburden CEDARR or IT staff with new data collection and analysis. We will use standard, validated measure specifications where they exist to increase our ability and CMS's to make comparisons across populations, programs, and states.

Quality of Care

Measure

1. Concept: Rates of Obesity as measured by BMI < 85th percentile will decrease over time
 Measure: Reduction of Clients with a BMI >85th percentile.

 2. Concept: Treatment for Depression
 Measures: Clients who screened positive for depression who received further treatment or evaluation.

Data Source

1. CEDARR Health Home Client Record Review (5% Sample)
 2. CEDARR Health Home Client Record Review (5% Sample) and claims and encounter data (State will not have access to medical claims for those clients who have some form of Third Party Coverage, currently 38% of the CEDARR population)

Measure Specification

1. Numerator: Number of clients with BMI <85th percentile

 Denominator: Number of participants 6 years of age or older with BMI screen documented

 2. Numerator: Number of clients with a positive depression a with claim for evaluation or treatment in subsequent two months

 Denominator: Number of Clients with a positive screening for depression

How Health IT will be Utilized

RI will use the Medicaid data Warehouse to collect and store historical Medicaid Claims and Encounter data. In addition, monitoring of progress towards identified Health Homes goals will be accomplished through the analysis of reports submitted on a regular basis by the CEDARR Health Homes. Rhode Island will also use additional data sources to monitor the impact of its health home (HH) program on quality: an outcomes survey administered to all CEDARR families on intake and yearly thereafter; charts (either electronic or paper), and a client satisfaction survey. Rhode Island exercised prudence in selecting measures to not overburden CEDARR or IT staff with new data collection and analysis. We will use standard, validated measure specifications where they exist to increase our ability and CMS's to make comparisons across populations, programs, and states.

Goal 4:

Decrease the use of Emergency Department and Inpatient Treatment for Ambulatory Sensitive Conditions

Clinical Outcomes

Measure

1. Concept: Clients do not use the emergency department for care or treatment of an illness that could have been treated in a different setting
 Measure: Percentage of patients with one or more ED visits for any conditions appearing in a state defined list of diagnoses that can be appropriately treated in a non-ED setting

 2. Concept: Acute admissions for Ambulatory Sensitive Conditions that could be avoided with proper preventive care.
 Measures: Percentage of patients with one or more acute care admissions for any conditions appearing in a state defined list of diagnoses that can be avoided through proper preventive care

Data Source

1. Encounter Data (State will not have access to medical claims for those clients who have some form of Third Party Coverage, currently 38% of the CEDARR population)
 2. Encounter Data (State will not have access to medical claims for those clients who have some form of Third Party Coverage, currently 38% of the CEDARR population)

Measure Specification

1. Numerator: Number of ED visits for conditions appearing in a state defined list of diagnoses that can be appropriately treated in a non-ED setting. These diagnoses include, but are not limited to; Asthma, Otitis Media and Upper Respiratory Infections. A complete list of Diagnoses Codes are available upon request.

 Denominator: Number of Clients with ED visits

 2. Numerator: Number of admissions for conditions appearing in a state defined list of diagnoses that can be avoided with proper preventive care. These diagnoses include, but are not limited to; Asthma, Otitis Media and Upper Respiratory Infections. A complete list of Diagnoses Codes are available upon request.

Denominator: Number of Clients with Acute admissions

How Health IT will be Utilized

RI will use the Medicaid data Warehouse to collect and store historical Medicaid Claims and Encounter data. In addition, monitoring of progress towards identified Health Homes goals will be accomplished through the analysis of reports submitted on a regular basis by the CEDARR Health Homes. Rhode Island will also use additional data sources to monitor the impact of its health home (HH) program on quality: an outcomes survey administered to all CEDARR families on intake and yearly thereafter; charts (either electronic or paper), and a client satisfaction survey. Rhode Island exercised prudence in selecting measures to not overburden CEDARR or IT staff with new data collection and analysis. We will use standard, validated measure specifications where they exist to increase our ability and CMS's to make comparisons across populations, programs, and states.

Experience of Care

Measure

1. Concept: Clients perceive that they are receiving appropriate and effective services
Measures: Satisfaction with Care, accessibility of care

Data Source

1. Annual Satisfaction surveys

Measure Specification

1. Numerator: patients saying they agree or strongly agree with each the following statements:
- The care plan met my child's needs
- I was assisted in identifying my child's needs.

Denominator: all clients who completed the annual family satisfaction survey

How Health IT will be Utilized

RI will use the Medicaid data Warehouse to collect and store historical Medicaid Claims and Encounter data. In addition, monitoring of progress towards identified Health Homes goals will be accomplished through the analysis of reports submitted on a regular basis by the CEDARR Health Homes. Rhode Island will also use additional data sources to monitor the impact of its health home (HH) program on quality: an outcomes survey administered to all CEDARR families on intake and yearly thereafter; charts (either electronic or paper), and a client satisfaction survey. Rhode Island exercised prudence in selecting measures to not overburden CEDARR or IT staff with new data collection and analysis. We will use standard, validated measure specifications where they exist to increase our ability and CMS's to make comparisons across populations, programs, and states.

Quality of Care

Measure

1. Concept: Prevention of further Acute Care utilization
Measures: Medical Follow up within 7 days of ACS admission

2. Concept: Prevention of additional ED utilization
Measures: Medical Follow up within 7 days of ACS ED visit

Data Source

1. Claims and encounter data housed in Data Warehouse (State will not have access to medical claims for those clients who have some form of Third Party Coverage, currently 38% of the CEDARR population)

Measure Specification

1. Numerator: Number of clients admitted who had medical follow-up within 7 days of discharge

Denominator: Number of admissions for conditions appearing in a state defined list of diagnoses that can be avoided with proper preventive care.

2. Numerator: Number of clients with ACS ED visits who had medical follow-up within 7 days of visit

Denominator: Number of ED visits for conditions appearing in a state defined list of diagnoses that can be appropriately be treated in a non-ED setting.

How Health IT will be Utilized

RI will use the Medicaid data Warehouse to collect and store historical Medicaid Claims and Encounter data. In addition, monitoring of progress towards identified Health Homes goals will be accomplished through the analysis of reports submitted on a regular basis by the CEDARR Health Homes. Rhode Island will also use additional data sources to monitor the impact of its health home (HH) program on quality: an outcomes survey administered to all CEDARR families on intake and yearly thereafter; charts (either electronic or paper), and a client satisfaction survey. Rhode Island exercised prudence in selecting measures to not overburden CEDARR or IT staff with new data collection and analysis. We will use standard, validated measure specifications where they exist to increase our ability and CMS's to make comparisons across populations, programs, and states.

Goal 5:

Improve the quality of Transitions from Inpatient/Residential Care to Community

Clinical Outcomes

Measure

1. Concept: Health Home staff is actively involved in discharge planning
Measure: Percentage of discharges for admissions >7 days in length with active participation of Health Home staff.

2. Concept: Health Home staff contacts client after discharge
Measure: Percentage of discharges for admissions >7 days in length who are contacted by Health Home staff within 7 days of discharge.

3. Concept: Re-Admissions for same diagnosis reduced
Measure: Percentage of clients re-admitted or utilizing ED within 30 days of discharge with same diagnosis as admission

Data Source

1. Claims and encounter data housed in Data Warehouse (State will not have access to medical claims for those clients who have some form of Third Party Coverage, currently 38% of the CEDARR population)
2. Claims and encounter data housed in Data Warehouse (State will not have access to medical claims for those clients who have some form of Third Party Coverage, currently 38% of the CEDARR population)

3. Claims and encounter data housed in Data Warehouse (State will not have access to medical claims for those clients who have some form of Third Party Coverage, currently 38% of the CEDARR population)

Measure Specification

1. Numerator: Number of patients with Health Home staff service claim during dates of in-patient stay
 Denominator: Number of clients with an in-patient admission >7 days

2. Numerator: Number of patients with Health Home staff service claim date of service is within 7 days of discharge date
 Denominator: Number of clients with an in-patient admission >7 days

3. Numerator: Number of patients with a re-admission or ED visit within 30 days of discharge with same diagnosis
 Denominator: Number of clients with an in-patient admission

How Health IT will be Utilized

RI will use the Medicaid data Warehouse to collect and store historical Medicaid Claims and Encounter data. In addition, monitoring of progress towards identified Health Homes goals will be accomplished through the analysis of reports submitted on a regular basis by the CEDARR Health Homes. Rhode Island will also use additional data sources to monitor the impact of its health home (HH) program on quality: an outcomes survey administered to all CEDARR families on intake and yearly thereafter; charts (either electronic or paper), and a client satisfaction survey. Rhode Island exercised prudence in selecting measures to not overburden CEDARR or IT staff with new data collection and analysis. We will use standard, validated measure specifications where they exist to increase our ability and CMS's to make comparisons across populations, programs, and states.

Experience of Care

Measure

1. Concept: Clients perceive that they are receiving appropriate and effective services
 Measures: Satisfaction with Care, accessibility of care

Data Source

1. Annual Satisfaction surveys

Measure Specification

1. Numerator: patients saying they agree or strongly agree with each the following statements:
 - The care plan met my child's needs
 - I was assisted in identifying my child's needs.

Denominator: all clients who completed the annual family satisfaction survey

How Health IT will be Utilized

RI will use the Medicaid data Warehouse to collect and store historical Medicaid Claims and Encounter data. In addition, monitoring of progress towards identified Health Homes goals will be accomplished through the analysis of reports submitted on a regular basis by the CEDARR Health Homes. Rhode Island will also use additional data sources to monitor the impact of its health home (HH) program on quality: an outcomes survey administered to all CEDARR families on intake and yearly thereafter; charts (either electronic or paper), and a client satisfaction survey. Rhode Island exercised prudence in selecting measures to not overburden CEDARR or IT staff with new data collection and analysis. We will use standard, validated measure specifications where they exist to increase our ability and CMS's to make comparisons across populations, programs, and states.

Quality of Care

Measure

1. Concept: Clients are able to avoid re-admissions for physical health conditions
 Measure: Percentage of clients with non-psychiatric admissions within 30 days of hospital discharge

2. Concept: : Clients are able to avoid re-admissions for psychiatric conditions
 Measure: Percentage of clients with a psychiatric admission within 30 days of psychiatric hospital discharge

Data Source

1. Claims and encounter data housed in Data Warehouse (State will not have access to medical claims for those clients who have some form of Third Party Coverage, currently 38% of the CEDARR population)
 2. Claims and encounter data housed in Data Warehouse (State will not have access to medical claims for those clients who have some form of Third Party Coverage, currently 38% of the CEDARR population)

Measure Specification

1. Numerator: : Number of patients with an inpatient re-admission within 30 days of discharge
 Denominator: Number of clients with an in-patient non-psychiatric admission

2. Numerator: : Number of patients with an inpatient psychiatric re-admission within 30 days of discharge
 Denominator: : Number of clients with an in-patient psychiatric admission

How Health IT will be Utilized

RI will use the Medicaid data Warehouse to collect and store historical Medicaid Claims and Encounter data. In addition, monitoring of progress towards identified Health Homes goals will be accomplished through the analysis of reports submitted on a regular basis by the CEDARR Health Homes. Rhode Island will also use additional data sources to monitor the impact of its health home (HH) program on quality: an outcomes survey administered to all CEDARR families on intake and yearly thereafter; charts (either electronic or paper), and a client satisfaction survey. Rhode Island exercised prudence in selecting measures to not overburden CEDARR or IT staff with new data collection and analysis. We will use standard, validated measure specifications where they exist to increase our ability and CMS's to make comparisons across populations, programs, and states.

Goal 6:

N/A

Clinical Outcomes

Measure

N/A

Data Source

N/A

Measure Specification

N/A

How Health IT will be Utilized

N/A

Experience of Care

Measure

N/A

Data Source

N/A

Measure Specification

N/A

How Health IT will be Utilized

N/A

Quality of Care

Measure

N/A

Data Source

N/A

Measure Specification

N/A

How Health IT will be Utilized

N/A

Goal 7:

N/A

Clinical Outcomes

Measure

N/A

Data Source

N/A

Measure Specification

N/A

How Health IT will be Utilized

N/A

Experience of Care

Measure

N/A

Data Source

N/A

Measure Specification

N/A

How Health IT will be Utilized

N/A

Quality of Care

Measure

N/A

Data Source

N/A

Measure Specification

N/A

How Health IT will be Utilized

N/A

Goal 8:

N/A

Clinical Outcomes

Measure

N/A

Data Source

N/A

Measure Specification

N/A

How Health IT will be Utilized

N/A

Experience of Care

Measure

N/A

Data Source

N/A

Measure Specification

N/A

How Health IT will be Utilized

N/A

Quality of Care

Measure

N/A

Data Source

N/A

Measure Specification

N/A

How Health IT will be Utilized

N/A

Goal 9:

N/A

Clinical Outcomes

Measure

N/A

Data Source

N/A

Measure Specification

N/A

How Health IT will be Utilized

N/A

Experience of Care

Measure

N/A

Data Source

N/A

Measure Specification

N/A

How Health IT will be Utilized

N/A

Quality of Care

Measure

N/A

Data Source

N/A

Measure Specification

N/A
How Health IT will be Utilized
N/A

Goal 10:

N/A

Clinical Outcomes

Measure
N/A
Data Source
N/A
Measure Specification
N/A
How Health IT will be Utilized
N/A

Experience of Care

Measure
N/A
Data Source
N/A
Measure Specification
N/A
How Health IT will be Utilized
N/A

Quality of Care

Measure
N/A
Data Source
N/A
Measure Specification
N/A
How Health IT will be Utilized
N/A

3.1 - A: Categorically Needy View

Health Homes for Individuals with Chronic Conditions

Amount, Duration, and Scope of Medical and Remedial Care Services: Categorically Needy

Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation

viii. Quality Measures: Service Based Measures

Service

- Comprehensive Care Management

Clinical Outcomes

Measure
N/A
Data Source
N/A
Measure Specification
N/A
How Health IT will be Utilized
N/A

Experience of Care

Measure

N/A
Data Source
N/A
Measure Specification
N/A
How Health IT will be Utilized
N/A

Quality of Care

Measure
N/A
Data Source
N/A
Measure Specification
N/A
How Health IT will be Utilized
N/A

Service

- Care Coordination

Clinical Outcomes

Measure
N/A
Data Source
N/A
Measure Specification
N/A
How Health IT will be Utilized
N/A

Experience of Care

Measure
N/A
Data Source
N/A
Measure Specification
N/A
How Health IT will be Utilized
N/A

Quality of Care

Measure
N/A
Data Source
N/A
Measure Specification
N/A
How Health IT will be Utilized
N/A

Service

- Health Promotion

Clinical Outcomes

Measure
N/A
Data Source
N/A
Measure Specification
N/A
How Health IT will be Utilized

N/A

Experience of Care

Measure

N/A

Data Source

N/A

Measure Specification

N/A

How Health IT will be Utilized

N/A

Quality of Care

Measure

N/A

Data Source

N/A

Measure Specification

N/A

How Health IT will be Utilized

N/A

Service

- Comprehensive Transitional Care (including appropriate follow-up, from inpatient to other settings)

Clinical Outcomes

Measure

N/A

Data Source

N/A

Measure Specification

N/A

How Health IT will be Utilized

N/A

Experience of Care

Measure

N/A

Data Source

N/A

Measure Specification

N/A

How Health IT will be Utilized

N/A

Quality of Care

Measure

N/A

Data Source

N/A

Measure Specification

N/A

How Health IT will be Utilized

N/A

Service

- Individual and Family Support Services (including authorized representatives)

Clinical Outcomes

Measure

N/A

Data Source

N/A
Measure Specification
N/A
How Health IT will be Utilized
N/A

Experience of Care

Measure
N/A
Data Source
N/A
Measure Specification
N/A
How Health IT will be Utilized
N/A

Quality of Care

Measure
N/A
Data Source
N/A
Measure Specification
N/A
How Health IT will be Utilized
N/A

Service

- Referral to Community and Social Support Services

Clinical Outcomes

Measure
N/A
Data Source
N/A
Measure Specification
N/A
How Health IT will be Utilized
N/A

Experience of Care

Measure
N/A
Data Source
N/A
Measure Specification
N/A
How Health IT will be Utilized
N/A

Quality of Care

Measure
N/A
Data Source
N/A
Measure Specification
N/A
How Health IT will be Utilized
N/A

3.1 - A: Categorically Needy View

**Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Care Services: Categorically Needy**

Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation

ix. Evaluations

A. Describe how the State will collect information from health home providers for purposes of determining the effect of this program on reducing the following (include the data source and frequency of data collection):

i. Hospital admissions

Description

MEDICAID will compare rate of admissions and length of stays pre and post Health Homes implementation

Data Source

Claims and Encounter data stored in the data warehouse

Frequency of Data Collection

Bi-annually

ii. Emergency room visits

Description

MEDICAID will compare number of ED visits pre and post Health Home implementation

Data Source

Claims and Encounter data stored in the data warehouse

Frequency of Data Collection

Bi-annually

iii. Skilled Nursing Facility admissions

Description

MEDICAID will compare number of skilled nursing facility admissions pre and post Health Home implementation

Data Source

Claims and Encounter data stored in the data warehouse

Frequency of Data Collection

Bi-annually

i.

B. Describe how the State will collect information for purposes of informing the evaluations, which will ultimately determine the nature, extent and use of this program, as it pertains to the following:

Hospital admission rates

Comparison of Claims and Encounter data pre and post implementation of health homes

ii.

Chronic

disease management

Comparison of Claims and Encounter data pre and post implementation of health homes

iii. Coordination of care for individuals with chronic conditions

Comparison of quarterly and annual data pre and post implementation of health homes

iv. Assessment of program implementation

Comparison of quarterly and annual data pre and post implementation of health homes

v.

Processes and lessons learned

CEDARR Health Homes survey to be developed

vi. Assessment of quality improvements and clinical outcomes

Comparison of quarterly and annual data pre and post implementation of health homes

vii. Estimates of cost savings

Rhode Island Medicaid total spend (all services) on CEDARR enrolled children for SFY 2010 was \$2,553 per member per month (PMPM). The predicted PMPM trend increase used in the actuarially certified rates is 7.2%. Using this trend increase, projected total spend (all services) on CEDARR enrolled children for SFY 2011 is \$2,736 PMPM. RI Medicaid estimates that the Health Home intervention will reduce this trend by 5% - to a trend of 6.84%.

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Assuming that the Health Home intervention begins on October 1, 2011, one quarter of SFY 2012 will not have the "Health Home effect". Three quarters of SFY 2012 will. All four quarters of SFY 2013 will see the "Health Home effect". Assuming enrollment of 2440 children, using this methodology, savings for SFY 2012 is \$79.44 PMPM (\$2,325,908.10 total). Using this methodology, savings for SFY 2013 is \$95.43 PMPM or \$2,794,253.24. Total aggregate savings over this period is \$5,120,161.34.

SFY 2010 = \$2553 PMPM
SFY 2011 = \$2736.82 PMPM(7.2% increase over SFY 2010)

SFY 2012 do nothing scenario = \$2,933.87 PMPM (7.2% increase over SFY 2011)
SFY 2012 Health Home scenario = \$2854.43 PMPM (one quarter of 1.8% increase, and 3 quarters of 5.13% increase)

Savings in SFY 2012 = \$2933- \$2854.43 = \$79.44 PMPM

\$79.44 PMPM x 2440 children x 12 months = \$2,325,908.10

SFY 2013 do nothing scenario = \$3145.11 PMPM
 SFY 2013 Health Home scenario = \$3049.67 PMPM
 Savings in SFY 2013 = \$3145.11 - \$3049.67 = \$95.43 PMPM
 95.43 PMPM x 2440 children x 12 months = \$2,794,253.24

Total two-year savings = \$2,325,908.10 + \$2,794,253.24 = \$5,120,161.34

3.1 - B: Medically Needy View

Attachment 3.1-H

**Health Homes for Individuals with Chronic Conditions
 Amount, Duration, and Scope of Medical and Remedial Services: Medically Needy**

Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation

Health Home Services

i. Geographic Limitations

If Targeted Geographic Basis,

ii. Population Criteria

The State elects to offer Health Home Services to individuals with:

- Two chronic conditions
- One chronic condition and the risk of developing another
- One serious mental illness

from the list of conditions below:

- Mental Health Condition
- Substance Use Disorder
- Asthma
- Diabetes
- Heart Disease
- BMI Over 25
- Other Chronic Conditions Covered?

Description of Other Chronic Conditions Covered.

iii. Provider Infrastructure

- Designated Providers as described in Section 1945(h)(5)
- Team of Health Care Professionals as described in Section 1945(h)(6)
- Health Team as described in Section 1945(h)(7), via reference to Section 3502

iv. Service Definitions

Comprehensive Care Management

Service Definition

Ways Health IT Will Link

Care Coordination

Service Definition

Ways Health IT Will Link

Health Promotion

Service Definition

Ways Health IT Will Link

Comprehensive Transitional Care (including appropriate follow-up, from inpatient to other settings)

Service Definition

Ways Health IT Will Link

Individual and Family Support Services (including authorized representatives)

Service Definition
Ways Health IT Will Link

Referral to Community and Social Support Services

Service Definition
Ways Health IT Will Link

v.Provider Standards

--

vi. Assurances

- A. The State assures that hospitals participating under the State plan or a waiver of such plan will establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated providers.
- B. The State 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.
- C. The State will report to CMS information submitted by health home providers to inform the evaluation and Reports to Congress as described in section 2703(b) of the Affordable Care Act, and as described by CMS.

vii. Monitoring

- A. Describe the State's methodology for tracking avoidable hospital readmissions, to include data sources and measure specifications.

--
- B. Describe the State's methodology for calculating cost savings that result from improved chronic care coordination and management achieved through this program, to include data sources and measure specifications.

--
- C. Describe the State's proposal for using health information technology in providing health home services under this program 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).

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3.1 - B: Medically Needy View

**Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Services: Medically Needy**

Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation

viii. Quality Measures: Goal Based Quality Measures

Please describe a measureable goal of the health home model that will be operationalized utilizing measures within the domains listed below. The measures may or may not be tied to the services depending on the goal. If the measure is tied to a service, please complete the service-based quality measure section. If the measure is tied to a goal, please complete the goal-based measure section.

Goal 1:

--

Clinical Outcomes

Measure
Data Source
Measure Specification
How Health IT will be Utilized

Experience of Care

Measure
Data Source
Measure Specification
How Health IT will be Utilized
Measure

Quality of Care

Data Source
Measure Specification
How Health IT will be Utilized

Goal 2:

--

Clinical Outcomes

Measure
Data Source
Measure Specification
How Health IT will be Utilized

Experience of Care

Measure
Data Source
Measure Specification
How Health IT will be Utilized

Quality of Care

Measure
Data Source
Measure Specification
How Health IT will be Utilized

Goal 3:

--

Clinical Outcomes

Measure
Data Source
Measure Specification
How Health IT will be Utilized

Experience of Care

Measure
Data Source
Measure Specification
How Health IT will be Utilized

Quality of Care

Measure
Data Source
Measure Specification
How Health IT will be Utilized

Goal 4:

--

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Goal 5:

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Goal 6:

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Goal 7:

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Goal 8:

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Goal 9:

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Goal 10:

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

3.1 - B: Medically Needy View

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Services: Medically Needy

Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation

viii. Quality Measures: Service Based Measures

Service

Comprehensive Care Management

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Service

Care Coordination

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Service

Health Promotion

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Service

- Comprehensive Transitional Care (including appropriate follow-up, from inpatient to other settings)

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Service

- Individual and Family Support Services (including authorized representatives)

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Service

- Referral to Community and Social Support Services

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

3.1 - B: Medically Needy View

Health Homes for Individuals with Chronic Conditions

Amount, Duration, and Scope of Medical and Remedial Services: Medically Needy

Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation

ix. Evaluations

A. Describe how the State will collect information from health home providers for purposes of determining the effect of this program on reducing the following (include the data source and frequency of data collection):

i. Hospital admissions

Description

Data Source

Frequency of Data Collection

ii. Emergency room visits

Description

Data Source

Frequency of Data Collection

iii. Skilled Nursing Facility admissions

Description

 Data Source

 Frequency of Data Collection

B. Describe how the State will collect information for purposes of informing the evaluations, which will ultimately determine the nature, extent and use of this program, as it pertains to the following:

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

vi. Assessment of quality improvements and clinical outcomes

vii. Estimates of cost savings

4.19 – B: Payment Methodology View

Attachment 4.19-B

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**Health Homes for Individuals with Chronic Conditions
 Amount, Duration, and Scope of Medical and Remedial Care Services: Categorically Needy**

Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation

Payment Methodology

Payment Type: Per Member Per Month

Provider Type
 CEDARR Health Home
 Description
 N/A
 Tiered?

Payment Type: Alternate Payment Methodology

Provider Type
 CEDARR Health Homes
 Description
 The Health Home Service Comprehensive Care Management translates to three CEDARR services - initial family intake and needs assessment (IFIND), Family Care Plan Development (FCP) and Family Care Plan Review (FCPR). This service is performed by a family counselor, who is a licensed clinician, and a family service coordinator, in consultation with the child's primary cre provider, specialty provider, HCBS service provider and MCO.
 Care Coordination is defined in the CEDARR as Health Needs Coordination. This function is performed by a Family Service Coordination (60%) and a Family Counselor (40%).
 Health Promotion is defined in CEDARR as Therapeutic Consultation. This service is performed by a Family Counselor.
 Comprehensive Transitional Care is defined in CEDARR as Health Needs Coordination. This service is performed by a Family Counselor (50%) and a Family Service Coordinator (50%).
 Individual and Family Support services are defined in CEDARR also as Health Needs Coordination. This service is performed by a Family Service Coordinator (70%) and a Family Counselor (30%).
 Referral to Community and Social Support Services is defined in CEDARR as Health Needs Coordination. This service is performed by a Family Service Coordinator (80%) and a Family Counselor (20%).
 Note #1: The Family Counselor must be a Clinician licensed by the Rhode Island Department of Health (DOH) in one of the following disciplines: LICSW or LCSW (Licensed (Independent) Social Worker, Psychologist, LMFT (Licensed Marriage and Family Therapist), LMHC (Licensed Mental Health Counselor), MD (Medical Doctor), RN (Registered Nurse), OT (Occupational Therapist), PT (Physician Therapist), and SLP (Speech and Language Therapist).
 Note #2: The Family Service Coordinator has a knowledge base of, and/or direct experience with children having special health care needs as the result of being the parent of, or close relative of a Child with Special Health Care Needs, or possess a Bachelors Degree from an accredited College or University in a Health or Human Services Field and prior experience working with individuals with disabilities. The Family Service Coordinator works under the direct clinical supervision of the Family Counselor.

Rate Setting Factors

- o The average level of effort required of the CEDARR Family Center service team in order to perform the specific service (see Figure 2)
- o The relative level of effort by the Family Counselor and the Family Service Coordinator (see figure 2)
- o Development of a market based, hourly rate based, considering labor costs for staff with comparable qualifications and associated employment costs, including:
 - o Prevailing wages for comparable personnel
 - § Family Counselor (Licensed Clinician) - Masters Degree or above, prevailing wage
 - § Family Service Coordinator- Less than Masters Degree, prevailing wage
- o Adjustments to direct wages to recognize payroll taxes, fringe benefits, productivity standards (direct client service hours as a percentage of total work hours), administrative overhead.

In 2009 Fixed Rates were developed for three CEDARR Services; Initial Family Intake and Needs Assessment (IFIND), Family Care Plan development (FCP), and Family Care Plan Review (FCPR).

The Figures below represent the assumptions of time, level of effort and staff involvement in order to successfully complete each service per DHS service definition based upon an analysis of service delivery practices of CEDARR staff from 2001-2009.

Figure 2

IFIND = \$366.00

Cost Structure

Clinician = \$66.50 per hour: .75 hours for travel, 1.5 hours for meeting time with family including work plan and crisis plan development, 1.25 hours for prep and follow-up activities. 3.5 hours total.
 Family Service Counselor = \$38 per hour: .75 hours for travel, 1.5 hours for meeting time with family including work plan and crisis plan development, 1.25 hours for prep and follow-up activities. 3.5 hours total.

Family Care Plan (FCP) = \$347

Cost Structure

Clinician = \$66.50 per hour: .75 hours for travel, 1 hour for meeting time with family, 0 hours for prep and follow-up activities, and 1.75 hours for plan development, including collaboration with PCP and MCO. 3.5 hours total.
 Family Service Counselor = \$38 per hour: .75 hours for travel, 1 hour for meeting time with family, 1.25 hours for prep and follow-up activities, and 0 hours for Plan development, in collaboration with PCP and MCO. 3 hours total.

Family Care Plan Review (FCPR) = \$397

Cost Structure

Clinician = \$66.50 per hour: .75 hours for travel, 1 hour for meeting time with family, 0 hours for follow-up activities, and 2.5 hours for plan review and revision, including collaboration with PCP and MCO. 4.25 hours total.
 Family Service Counselor = \$38 per hour: .75 hours for travel, 1 hour for meeting time with family, 1.25 hours for follow-up activities, and 0 hours for Plan development, in collaboration with PCP and MCO. 3 hours total.

Other CEDARR Health Home Billable Services

Health Needs Coordination: Per 15 minutes of effort, two rates based upon qualifications

- o Masters Degree and above- \$16.63 per unit (\$66.52 per hour)
- o Less than Masters Degree- \$9.50 per unit (\$38.00 per hour)

Therapeutic Consultation: Per 15 minutes of effort, performed by Clinician \$16.63 per unit (\$66.52 per hour)

Tiered?