MEDICAID MODEL DATA LAB

Id: RHODE ISLAND-2
State: Rhode Island
Health Home Services Forms (ACA 2703)
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Transmital Numbers (TN) and Effective Date

Please enter the numerical part of the Transmital 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

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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

☑ 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.

CMHOs will be Rhode Island's designated provider for individuals with a serious and persistent mental health condition. Currently, many individuals with SPMI do not routinely access pr1mary care services and implementation of CMHO health home services will facilitate increased access to primary care. Individuals eligible for CMHO health home services must be eligible for Rhode Island's medical assistance program and have a severe or persistent mental or emotional disorder that seriously impairs the individual's functioning relative to such primary aspects of daily living as personal relations, living arrangements, or employment but for whom long term 24-hour care in a hospital, nursing home or protective facility can be averted. In addition, eligible individuals must have either undergone psychiatric treatment more intensive than outpatient care more than once in a lifetime, (e.g., emergency services, alternative home care, partial hospitalization or inpatient hospitalization); experienced a single episode of continuous, structured supportive residential care other than hospitalization for a duration of at least two months, or have impaired role functioning. In addition, eligible individuals must meet at least two of the following criteria, on a continuing or intermittent basis for at least two years: If employed, is employed in a sheltered setting, or has markedly limited skills or a poor work history; Requires public financial assistance for out-of-hospital maintenance and may be unable to procure such assistance without help; Shows inability to establish or maintain a personal social support system; Requires help in basic living skills, and; Exhibits inappropriate social behavior which results in demand for intervention by the mental health and/or judicial system. Rhode Island will auto-assign individuals to a health home with the option of opting out to choose another eligible health home provider. Individuals assigned to a health home will be notified by the state via U.S. mail and other methods as necessary about their assignment. Should individuals desire to receive health home services from another health home provider they will be able to change their health home assignment. Potentially eligible individuals receiving services in the hospital ED, or as an inpatient, will be notified about eligible health homes and referred to a health home provider in their geographic area. Eligibility for health home services will be identifiable through data provided by Medicaid managed care organizations (MCOs) and other Information from the state's Medicaid data warehouse. CMHO health home providers to which individuals have been auto-assigned will receive communication from the state regarding a patient's enrollment in health home services. The health home will in turn notify other treatment providers (e.g., primary care and specialists such as OB/GYN) about the goals and types of health home services as well as encourage participation in care coordination efforts.

iii. Provider Infrastructure

☑ Designated Providers as described in §ection 1945(h)(5)

Rhode Island has seven CMHOs, which along with two other providers of specialty mental health services form a statewide, fully integrated, mental health delivery system, providing a comprehensive range of services to clients. All seven CMHOs and two specialty providers (Fellowship Health Resources, Inc. and Riverwood Mental Health Services) are licensed by the state under the author1ty of Rhode Island General Laws and operate in accordance with Rules and Regulations for the Licensing of Behavioral Healthcare Organizations. The seven CMHOs, Fellowship Health Resources, Inc. and Riverwood Mental Health Services, will serve as designated providers of CMHO health home services. The seven CMHOS, Fellowship Health Resources, Inc and Riverwood Mental Health Services, represent the only entities that would meet eligibility requirements as a CMHO health home and all will be required to meet identical CMHO health home certification requirements, described under the Provider Standards section of this State plan amendment. Each CMHO health home is responsible for establishing an integrated service network within its own geographic area and for coordinating service provision with other geographic areas. Certification specifications for CMHO health homes will stipulate requirements for linkages with other health care providers and community supports as well as specify requirements for the establishment of transitional care agreements with inpatient and long-term care settings. The team of health professionals responsible for conducting or acting on findings associated with comprehensive care management, care coordination, comprehensive transitional, etc., will vary according to the unique needs of individuals served. However, the team will minimally consist of a Master's Team Coordinator who will serve as the central coordinator for health home services, Psychiatrist, Registered Nurse MA Level Clinician, CPST Specialist/Hospital Liaison and CPST Specialist and Peer Specialist. Other health team members may include, but are not limited to: primary care physicians, pharmacists, substance abuse specialists, vocational specialists and community integration specialists. Since the health home teams consist of individuals with expertise in several areas, any team member operating within his or her scope of practice, area of expertise and role or function on a health home team, may be called upon to coordinate care as necessary for an individual, (i.e., the bio-psychosocial assessment can only be conducted as described under Care Management; however, a community support professional operating in the role of a hospital liaison may provide transitional care, health promotion and individual and family support services, as an example). Certification requirements for CMHO health home providers specify that each health home indicate, for example, how each provider will: structure team composition and member roles in CMHOs to achieve health home objectives; coordinate with primary care (which could include co-location, embedded services, or the implementation of referral and follow-up procedures outlined in memoranda of understanding); formalize referral agreements with hospitals for comprehensive transitional care, and carry out health promotion activities. CMHOs will be supported in transferring service delivery by participating in statewide learning activities. Given CMHOs' varying levels of experience with practice transformation approaches, the State will assess providers to determine learning needs. CMHOs will therefore participate In a variety of learning supports, up to and including learning collaboratives, specifically designed to instruct CMHOs to operate as health homes and provide care using a whole-person approach that integrates behavioral health, primary care and other needed services and supports. Learning activities will support providers of health home services in addressing the following components: - Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered health home services; - Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines; - Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders; - Coordinate and provide access to mental health and substance abuse services; - 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); - Coordinate and provide access to chronic disease management, including self-management support to individuals and their families; - Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services; - Coordinate and provide access to long-term care supports and services; - 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; - Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health home team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate, and; - 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.

☐ Team of Health Care Professionals as described in §ection 1945(h)(6)

☐ Health Team as described in §ection 1945(h)(7), via reference to §ection 3502

iv. Service Definitions

Comprehensive Care Management

Service Definition

OVERARCHING STATEWIDE DEFINITION: Comprehensive care management services are conducted with an individual and involve the identification, development and implementation of care plans that address 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 teams 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.

CMHO-SPECIFIC DEFINITION: Comprehensive care management services are conducted with high need individuals, their families and supporters to develop and implement a whole-person oriented treatment plan and monitor the individual's success in engaging in treatment and supports. Comprehensive care management services are carried out through use of a bio-psychosocial assessment. A bio-psychosocial assessment of each individual's physical and psychological status and social functioning is conducted for each person evaluated for admission to the CMHO. Assessments may be conducted by a psychiatrist, registered nurse or a licensed and/or master's prepared mental health professional (consistent with the Rhode Island Rules and Regulations for the Licensing of Behavioral Healthcare Organizations). The assessment determines an individual's treatment needs and expectations of the individual served; the type and level of treatment to be provided, the need for specialized medical or psychological evaluations; the need for the participation of the family or other support persons; and identification of the staff person(s) and/or program to provide the treatment. Based on the bio-psychological assessment, a goal-oriented, person centered care plan is developed, implemented and monitored by a multi disciplinary team in conjunction with the individual served. Comprehensive care management services may be provided by any member of the CMHO health home team; however, Master's Level Health Home Team Coordinators will be the primary practitioners providing comprehensive care management services.

Ways Health IT Will Link

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 Organizations (MCOs) for the 35% of the health home-eligible SPMI population enrolled in MCOs. The state is currently working with the MCOs to develop health utilization profiles minimally comprised of the components below. To the extent possible, similar profiles will be derived from the Medicaid data warehouse and other applicable sources for the remaining fee-for-service individuals who are dually eligible for Medicare and Medicaid. The state will work closely with the Centers for Medicare and Medicaid Innovation to obtain Medicare utilization and cost data, including: 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 • Last PCP visit date to current PCP Site • Current PCP Provider NPI • Last PCP visit to current PCP Site Provider NPI •#PCP visits to other Providers • Last PCP visit date to other Providers • Last PCP visit to other PCP Site Provider NP; 3) Health utilization profile developed by MCOs as part of the CMHO certification process. The state will query providers about the use of HIT in the delivery of care coordination services. The state may establish pilot tests of a subset of providers (e.g., those with EHRs and patient registries) to measure changes in health outcomes, experience of care and quality of care among clients.

Care Coordination

Service Definition

OVERARCHING STATEWIDE DEFINITON: 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 health home 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.

CMHO-SPECIFIC DEFINITION: Care coordination is the implementation of the individualized treatment plan (with active involvement of the individual served) for attainment of the individuals' goals and improvement of chronic conditions. Care managers are responsible for conducting care coordination activities across providers and settings. Care coordination involves case management necessary for individuals to access medical, social, vocational, educational, as well as other individualized supportive services, including, but not limited to: - Assessing support and service needed to ensure the continuing availability of required services; - Assistance in accessing necessary health care; and follow up care and planning for any recommendations; -Assessment of housing status and providing assistance in accessing and maintaining safe and affordable housing; - Conducting outreach to family members and significant others in order to maintain individuals connection to services, and expand social network; - Assisting in locating and effectively utilizing all necessary community services in the medical, social, legal and behavioral health care areas and ensuring that all services are coordinated, and; - Coordinating with other providers to monitor individuals' health status, medical conditions, medications and side effects. Care coordination services may be provided by any member of the CMHO health home team; however, CPST Specialists will be the primary practitioners providing care coordination services.

Ways Health IT Will Link

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 Organizations (MCOs) for the 35% of the health home-eligible SPMI population enrolled in MCOs. The state is currently working with the MCOs to develop health utilization profiles minimally comprised of the components below. To the extent possible, similar profiles will be derived from the Medicaid data warehouse and other applicable sources for the remaining fee-for-service individuals who are dually eligible for Medicare and Medicaid. The state will work closely with the Centers for Medicare and Medicaid Innovation to obtain Medicare utilization and cost data, including: 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 • Last PCP visit date to current PCP Site • Current PCP Provider NPI • Last PCP visit to current PCP Site Provider NPI •#PCP visits to other Providers • Last PCP visit date to other Providers • Last PCP visit to other PCP Site Provider NP; 3) Health utilization profile developed by MCOs as part of the CMHO certification process. The state will query providers about the use of HIT in the delivery of care coordination services. The state may establish pilot tests of a subset of providers (e.g., those with EHRs and patient registries) to measure changes in health outcomes, experience of care and quality of care among clients.

Health Promotion

Service Definition

OVERARCHING STATEWIDE DEFINITON: 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.

CMHO-SPECIFIC DEFINITON: 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. Health promotion services may be provided by any member of the CMHO health home team. Health promotion activities place a strong emphasis on self-direction and skills development for monitoring and management of chronic health conditions. Health promotion assists individuals to take a self directed approach to health through the provision of health education. Specific health promotion services may include, but are not limited to, providing or coordinating assistance with: - Promoting individuals' health and ensuring that all personal health goals are included in person centered care plans; - Promotion of substance abuse prevention, smoking prevention and cessation, nutritional counseling, obesity reduction, and increased physical activity; - Providing health education to individuals and family members about chronic conditions; - Providing prevention education to individuals and family members about health screening and immunizations; - Providing self-management support and development of self-management plans and/or relapse prevention plans so that individuals can attain personal health goals; and - Promoting self direction and skill development in the area of independent administering of medication. Health promotion services may be provided by any member of the CMHO health home team; however, Psychiatrists and Nurses will be the primary practitioners providing health promotion services.

Ways Health IT Will Link

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 Organizations (MCOs) for the 35% of the health home-eligible SPMI population enrolled in MCOs. The state is currently working with the MCOs to develop health utilization profiles minimally comprised of the components below. To the extent possible, similar profiles will be derived from the Medicaid data warehouse and other applicable sources for the remaining fee-for-service individuals who are dually eligible for Medicare and Medicaid. The state will work closely with the Centers for Medicare and Medicaid Innovation to obtain Medicare utilization and cost data, including: 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 • Last PCP visit date to current PCP Site • Current PCP Provider NPI • Last PCP visit to current PCP Site Provider NPI •#PCP visits to other Providers • Last PCP visit date to other Providers • Last PCP visit to other PCP Site Provider NP; 3) Health utilization profile developed by MCOs as part of the CMHO certification process. The state will query providers about the use of HIT in the delivery of care coordination services. The state may establish pilot tests of a subset of providers (e.g., those with EHRs and patient registries) to measure changes in health outcomes, experience of care and quality of care among clients.

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 home 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 readmission.

CMHO-SPECIFIC DEFINITION: Comprehensive transitional care services focus on the transition of individuals from any medical, psychiatric, long-term care or other out-of-home setting into a community setting. Designated members of the health home 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. To facilitate timely and effective transitions from inpatient and long-term settings to the community, all health home providers will maintain collaborative relationships with hospital emergency departments, psychiatric units of local hospitals, long-term care and other applicable settings. In addition, all health home providers will utilize hospital liaisons to assist in the discharge planning of individuals, existing CMHO clients and new referrals, from inpatient settings to CMHOs. Care

coordination may also occur when transitioning an individual from a jail/prison setting into the community. Hospital liaisons, community support professionals and other designated members of the team may provide transitional care services. The team member collaborates with physicians, nurses, social workers, discharge planners and pharmacists within the hospital setting to ensure that a treatment plan has been developed and works with family members and community providers to ensure that the treatment plan is communicated, adhered to and modified as appropriate. Comprehensive transitional care services may be provided by any member of the CMHO health home team; however, Hospital Liaisons will be the primary practitioners providing comprehensive transitional care services.

Ways Health IT Will Link

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 Organizations (MCOs) for the 35% of the health home-eligible SPMI population enrolled in MCOs. The state is currently working with the MCOs to develop health utilization profiles minimally comprised of the components below. To the extent possible, similar profiles will be derived from the Medicaid data warehouse and other applicable sources for the remaining fee-for-service individuals who are dually eligible for Medicare and Medicaid. The state will work closely with the Centers for Medicare and Medicaid Innovation to obtain Medicare utilization and cost data, including: 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 • Last PCP visit date to current PCP Site • Current PCP Provider NPI • Last PCP visit to current PCP Site Provider NPI •#PCP visits to other Providers • Last PCP visit date to other Providers • Last PCP visit to other PCP Site Provider NP; 3) Health utilization profile developed by MCOs as part of the CMHO certification process. The state will query providers about the use of HIT in the delivery of care coordination services. The state may establish pilot tests of a subset of providers (e.g., those with EHRs and patient registries) to measure changes in health outcomes, experience of care and quality of care among clients.

Individual and Family Support Services (including authorized representatives)

Service Definition

OVERARCHING STATEWIDE DEFINITON: Individual and family support services assist individuals access 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.

CMHO-SPECIFIC DEFINITON: Individual and family support services are provided by community support professionals and other members of the health team to reduce barriers to individuals' care coordination, increase skills and engagement and improve health outcomes. Individual and family support services may include, but are not limited to: - Providing assistance in accessing needed self-help and peer support services; - Advocacy for individuals and families; - Assisting individuals to identify and develop social support networks; - Assistance with medication and treatment management and adherence; - Identifying resources that will help individuals and their families reduce barriers to their highest level of health and success; and - Connection to peer advocacy groups, wellness centers, NAMI and family psycho-educational programs. Individual and family support services may be provided by any member of the CMHO health home team; however, CPST Specialists will be the primary practitioners providing individual and family support services.

Ways Health IT Will Link

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 Organizations (MCOs) for the 35% of the health home-eligible SPMI population enrolled in MCOs. The state is currently working with the MCOs to develop health utilization profiles minimally comprised of the components below. To the extent possible, similar profiles will be derived from the Medicaid data warehouse and other applicable sources for the remaining fee-for-service individuals who are dually eligible for Medicare and Medicaid. The state will work closely with the Centers for Medicare and Medicaid Innovation to obtain Medicare utilization and cost data, including: 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 • Last PCP visit date to current PCP Site • Current PCP Provider NPI • Last PCP visit to current PCP Site Provider NPI •#PCP visits to other Providers • Last PCP visit date to other Providers • Last PCP visit to other PCP Site Provider NP; 3) Health utilization profile developed by MCOs as part of the CMHO certification process. The state will query providers about the use of HIT in the delivery of care coordination services. The state may establish pilot tests of a subset of providers (e.g., those with EHRs and patient registries) to measure changes in health outcomes, experience of care and quality of care among clients.

Referral to Community and Social Support Services

Service Definition

OVERARCHING STATEWIDE DEFINITON: Referrals to community and socials 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.

CMHO-SPECIFIC DEFINITON: Referral to community and social support services provide individuals with referrals to a wide array of support services that will help individuals overcome access or service barriers, increase self-management skills and improve overall health. Referral to community and social support involves facilitating access to support and assistance for individuals to address medical, behavioral, educational, and social and community issues that may impact overall health. The types of community and social support services to which individuals will be referred may include, but are not limited to: - Primary care providers and specialists; - Wellness programs, including smoking cessation, fitness, weight loss programs, yoga; - Specialized support groups (i.e. cancer, diabetes support groups); - Substance treatment links in addition to treatment - supporting recovery with links to support groups, recovery coaches, 12-step; - Housing; - Social integration (NAMI support groups, MHCA OASIS, Alive Program (this program and MHCA are Advocacy and Social Centers) and/or Recovery Center; - Assistance with the identification and attainment of other benefits; - Supplemental Nutrition Assistance Program (SNAP); - Connection with the Office of Rehabilitation Service as well as internal CMHO team to assist person in developing work/education goals and then identifying programs/jobs; - Assisting person in their social integration and social skill building; - Faith based organizations; - Access to employment and educational program or training; - Referral to community and social support services may be provided by any member of the CMHO health home team; however, CPST Specialists will be the primary practitioners providing referrals to community and social support services.

Ways Health IT Will Link

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 Organizations (MCOs) for the 35% of the health home-eligible SPMI population enrolled in MCOs. The state is currently working with the MCOs to develop health utilization profiles minimally comprised of the components below. To the extent possible, similar profiles will be derived from the Medicaid data warehouse and other applicable sources for the remaining fee-for-service individuals who are dually eligible for Medicare and Medicaid. The state will work closely with the Centers for Medicare and Medicaid Innovation to obtain Medicare utilization and cost data, including: 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 • Last PCP visit date to current PCP Site • Current PCP Provider NPI • Last PCP visit to current PCP Site Provider NPI •#PCP visits to other Providers • Last PCP visit date to other Providers • Last PCP visit to other PCP Site Provider NP; 3) Health utilization profile developed by MCOs as part of the CMHO certification process. The state will query providers about the use of HIT in the delivery of care coordination services. The state may establish pilot tests of a subset of providers (e.g., those with EHRs and patient registries) to measure changes in health outcomes, experience of care and quality of care among clients.

v.Provider Standards

In addition to meeting state licensure requirements, BHDDH will also require each CMHO health home to meet the following conditions, which may be amended from time-to-time as necessary and appropriate: Each CMHO will report on designated Core Quality Measures.- Each CMHO health home provider must sign a certification agreement that outlines BHDDH's expectations and CMHO's roles and responsibilities for conducting CMHO health home services, which will minimally require that each CMHO: Have psychiatrists/advanced practice psychiatric registered nurse specialists assigned for the purpose of health home team participation to each individual receiving CMHO health home services, and is available 24/7 for individuals in need of referral, mental health crisis intervention or stabilization and other services that address whole-person needs. Conduct wellness interventions as indicated based on individuals' level of risk. Agree to participate in any statewide learning sessions that may be implemented for health home providers (topics covered during learning sessions may include, but are

not limited to: Wagner's Care Model, Stanford Self-Management, transitional care management, primary care coordination, quality measures and reporting and other topics to be identified by the State); Within three months of health home service implementation, have developed a contract or MOU with regional hospitals or system(s) to ensure a formalized structure for transitional care planning, to include communication of inpatient admissions of health home participants, as well as maintain a mutual awareness and collaboration to identify individuals seeking ED services that might benefit from connection with a CMHO health home provider; Agree to convene regular, ongoing and documented internal health home team meetings with all relevant providers to plan and implement goals and objectives of practice transformation; Agree to participate in EMS and state-required evaluation activities; Agree to develop required reports describing CMHO health home activities, efforts and progress in implementing health home services (e.g., monthly clinical quality indicator reports); and Maintain compliance with all of the terms and conditions as a CMHO health home provider or face termination as a provider of CMHO health home services. -Each CMHO health home must develop and submit to BHDDH for approval its approach for conducting health home services. Proposals must include: An overview of the provider's health home approach (e.g., discussion of a care management model, techniques to be employed to prevent avoidable hospital ED visits); A description of the health team, including team member roles and functions; Local hospitals with which the CMHO health home will establish transitional care agreements; A description of the health home's processes for integrating physical and behavioral health care, including coordinating care with primary care providers; A list of primary care practices with which the CMHO will develop referral agreements; An overview of how each of the six health home service components will be carried out by the CMHO health home, and, if applicable: A description of the provider's use of electronic health records or patient registries; A description of the providers use of health Information technology to support care management (e.g., care management software); A list and description of quality measures currently collected and tracked by the CMHO, and, if applicable; An overview of embedded or collected primary care services delivered at the CMHO health home provider. -Community support professionals will undergo a seventeen week Community Support Professional Certification Training Program funded through a contract with the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) and administered by the Rhode Island Council of Community Mental Health Organizations (RICCMHO). Since 1987, community support professionals have participated in the training, which is for direct service mental health case managers and other direct service staff working in the state licensed community mental health organizations. The program provides education in the knowledge, values and skills that enable staff refine their casework and clinical skills, and to more effectively fulfill the vital responsibilities they have to those they serve. Courses included in this curriculum are Cultural Awareness, Co-occurring Disorders, Methods for Effecting Change, Medication, Healthcare Issues, Crisis Intervention, Focus on Families and Recovery and the Effects of Trauma, as well as other relevant topics. The Department also funds training and certification for community support professionals in the area of supported employment with a major focus on the principles of the evidence based practice Individual Placement and Support (IPS). The current course curriculum addresses: Whole-Person Care, Prevention and Health Promotion, Self-Management Education and Individual Family Support, Chronic Illness Care (e.g., diabetes and asthma education), Primary Care Referrals and Coordination, and Linkage to Community Services. The curriculum is being revaluated to determine where revisions may be necessary consistent with the objectives of CMHO health home services.

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 among eligible CMHO clients using the Medicaid health home.

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 determine baseline costs of Medicaid and Medicare beneficiaries who would have been eligible for CMHO health home services at any time during the 4th quarter of state fiscal year 2011 (April 2011 through June 30, 2011). In order to calculate costs savings and the impact of health home services, the State will perform an annual assessment of baseline costs compared with total Medicaid and Medicare costs of those same CMHO health users one year and two years following the SPA effective date. The assessment will also include the performance measures enumerated in the Quality Measures section. In addition to looking at overall cost, BHDDH will work with EOHHS to determine specific targeted areas of cost most likely to be impacted by health home implementation for a more detailed analysis. In order to perform both of these operations, the State will require timely and affordable access to Medicare data.

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 Organizations (MCOs) for the 35% of the health home-eligible SPMI population enrolled in MCOs. The state is currently working with the MCOs to develop health utilization profiles minimally comprised of the components below. To the extent possible, similar profiles will be derived from the Medicaid data warehouse and other applicable sources for the remaining fee-for-service individuals who are dually eligible for Medicare and Medicaid. The state will work closely with the Centers for Medicare and Medicaid Innovation to obtain Medicare utilization and cost data, including: 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 • Last PCP visit date to current PCP Site • Current PCP Provider NPI • Last PCP visit to current PCP Site Provider NPI •#PCP visits to other Providers • Last PCP visit date to other Providers • Last PCP visit to other PCP Site Provider NP; 3) Health utilization profile developed by MCOs as part of the CMHO certification process. The state will query providers about the use of HIT in the delivery of care coordination services. The state may establish pilot tests of a subset of providers (e.g., those with EHRs and patient registries) to measure changes in health outcomes, experience of care and quality of care among clients.

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 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:

Improve Care Coordination [FOR PURPOSES OF CMHC HEALTH HOME QUALITY MEASURES, “PATIENT” REFERS TO MEDICAID BENEFICIARIES RECEIVING CMHO HEALTH HOME SERVICES.]

Clinical Outcomes

Measure

1. Percentage of patients whose chart includes documentation of physical and behavioral health needs
2. Percentage of hospital-discharged patients with a follow-up visit within 14 days of hospital discharge

Data Source

1. Chart/EHR
2. Medicare claims [hospitalization] and encounter data [visit to CMHO provider] or Medicaid claims [visit to PCP]

Measure Specification

1. Numerator: patients whose chart includes documentation of physical and behavioral health needs
1. Denominator: all patients

2. Numerator: Patients with a clinician visit within 14 days of hospital discharge
2. Denominator: All patients with a hospital stay

How Health IT will be Utilized

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 Organizations (MCOs) for the 35% of the health home-eligible SPMI population enrolled in MCOs. The state is currently working with the MCOs to develop health utilization profiles. To the extent possible, similar profiles will be derived from the Medicaid data warehouse and other applicable sources for the remaining fee-for-service individuals who are dually eligible for Medicare and Medicaid. The state will work closely with the Centers for Medicare and Medicaid Innovation to obtain Medicare utilization and cost data. Rhode Island will use 4 data sources to monitor the impact of its health home (HH) program on quality: claims; an intake survey of CMHO clients; charts (either electronic or paper), and; a client satisfaction survey. Rhode Island exercised prudence in selecting measures to not overburden CMHOs 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. We expect that Medicare claims for dual eligibles will be available promptly as many measures examine the coordination between inpatient and outpatient care. We have not recommended meaningful use measures because they are unlikely to be available in the 8 quarter timeframe. In the first year, providers will be self-attesting to the presence of measures. If they become available quickly, they will be added. Chart sampling methodology to be developed collaboratively with CMHOs to achieve statistical validity. The state will also develop a plan in collaboration with the MMIS vendor to calculate and report measures associated with improving the management of chronic conditions.

Experience of Care

Measure

1. Percentage of patients with a regular source of health care
2. Percentage of patients who had a physical exam in the past 12 months

Data Source

1.Rhode Island Outcomes Evaluation Instrument (RI OEI)
2.RI OEI

Measure Specification

1. Numerator: Patients identifying a person or place they regularly get physical health care, other than a hospital emergency department
1. Denominator: All patients who complete Q1 on the RI OEI

2. Numerator: Patients reporting they had a physical exam in the past 12 months
2. Denominator: All patients who complete Q3 on the RI OEI

How Health IT will be Utilized

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 Organizations (MCOs) for the 35% of the health home-eligible SPMI population enrolled in MCOs. The state is currently working with the MCOs to develop health utilization profiles. To the extent possible, similar profiles will be derived from the Medicaid data warehouse and other applicable sources for the remaining fee-for-service individuals who are dually eligible for Medicare and Medicaid. The state will work closely with the Centers for Medicare and Medicaid Innovation to obtain Medicare utilization and cost data. Rhode Island will use 4 data sources to monitor the impact of its health home (HH) program on quality: claims; an intake survey of CMHO clients; charts (either electronic or paper), and; a client satisfaction survey. Rhode Island exercised prudence in selecting measures to not overburden CMHOs 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. We expect that Medicare claims for dual eligibles will be available promptly as many measures examine the coordination between inpatient and outpatient care. We have not recommended meaningful use measures because they are unlikely to be available in the 8 quarter timeframe. In the first year, providers will be self-attesting to the presence of measures. If they become available quickly, they will be added. Chart sampling methodology to be developed collaboratively with CMHOs to achieve statistical validity. The state will also develop a plan in collaboration with the MMIS vendor to calculate and report measures associated with improving the management of chronic conditions.

Quality of Care

Measure

Percentage of hospital-discharged patients contacted by the CMHO hospital liaison or a member of the health home team by phone or in person within 2 days of discharge

Data Source

Medicare claims [hospitalizations] and encounter data [visit to CMHO provider] or EHR

Measure Specification

Numerator: Patients with a phone or in-person contact within 2 days of discharge
Denominator: All patients with a hospital stay

How Health IT will be Utilized

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 Organizations (MCOs) for the 35% of the health home-eligible SPMI population enrolled in MCOs. The state is currently working with the MCOs to develop health utilization profiles. To the extent possible, similar profiles will be derived from the Medicaid data warehouse and other applicable sources for the remaining fee-for-service individuals who are dually eligible for Medicare and Medicaid. The state will work closely with the Centers for Medicare and Medicaid Innovation to obtain Medicare utilization and cost data. Rhode Island will use 4 data sources to monitor the impact of its health home (HH) program on quality: claims; an intake survey of CMHO clients; charts (either electronic or paper), and; a client satisfaction survey. Rhode Island exercised prudence in selecting measures to not overburden CMHOs 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. We expect that Medicare claims for dual eligibles will be available promptly as many measures examine the coordination between inpatient and outpatient care. We have not recommended meaningful use measures because they are unlikely to be available in the 8 quarter timeframe. In

the first year, providers will be self-attesting to the presence of measures. If they become available quickly, they will be added. Chart sampling methodology to be developed collaboratively with CMHOs to achieve statistical validity. The state will also develop a plan in collaboration with the MMIS vendor to calculate and report measures associated with improving the management of chronic conditions.

Goal 2:

Reduce preventable hospital emergency department (ED) visits [FOR PURPOSES OF CMHC HEALTH HOME QUALITY MEASURES, “PATIENT” REFERS TO MEDICAID BENEFICIARIES RECEIVING CMHO HEALTH HOME SERVICES.]

Clinical Outcomes

Measure

1. Percent of patients with one or more ED visits for any conditions named in NYU ED methodology, available at: http://wagner.nyu.edu/ld.lpsr/Index.html?p=61
2. Percent of patients with one or more ED visits for a mental health condition

Data Source

1. Medicaid and Medicare claims
2. Medicaid and Medicare claims

Measure Specification

1. Numerator: Patients under age 75 who had an ED visit for non-emergency care or primary care preventable reasons
1. Denominator: All patients under age 75 with an ED visit

2. Numerator: Patients who had one or more visits for a mental health condition (ICD-9 code and DSM codes to be specified)
2. Denominator: All patients with an ED visit

How Health IT will be Utilized

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 Organizations (MCOs) for the 35% of the health home-eligible SPMI population enrolled in MCOs. The state is currently working with the MCOs to develop health utilization profiles. To the extent possible, similar profiles will be derived from the Medicaid data warehouse and other applicable sources for the remaining fee-for-service individuals who are dually eligible for Medicare and Medicaid. The state will work closely with the Centers for Medicare and Medicaid Innovation to obtain Medicare utilization and cost data. Rhode Island will use 4 data sources to monitor the impact of its health home (HH) program on quality: claims; an intake survey of CMHO clients; charts (either electronic or paper), and; a client satisfaction survey. Rhode Island exercised prudence in selecting measures to not overburden CMHOs 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. We expect that Medicare claims for dual eligibles will be available promptly as many measures examine the coordination between inpatient and outpatient care. We have not recommended meaningful use measures because they are unlikely to be available in the 8 quarter timeframe. In the first year, providers will be self-attesting to the presence of measures. If they become available quickly, they will be added. Chart sampling methodology to be developed collaboratively with CMHOs to achieve statistical validity. The state will also develop a plan in collaboration with the MMIS vendor to calculate and report measures associated with improving the management of chronic conditions.

Experience of Care

Measure

Satisfaction with care, accessibility of care

Data Source

RI OEI Survey

Measure Specification

Numerator: patients saying they agree or strongly agree with each the following statements:
- The location of services was convenient.
- Staff were willing to see me as often as I felt it was necessary.
- Staff returned my call within 24 hours.
- Services were available at times that were good for me.
- I was able to get all the services I thought I needed.
- I was able to see a psychiatrist when I wanted to.
- I like the services I received here.
- If I had other choices, I would still get services from this agency.
- I would recommend this agency to a friend or family member.

Denominator: all patients completing each item on the RI OEI survey

How Health IT will be Utilized

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 Organizations (MCOs) for the 35% of the health home-eligible SPMI population enrolled in MCOs. The state is currently working with the MCOs to develop health utilization profiles. To the extent possible, similar profiles will be derived from the Medicaid data warehouse and other applicable sources for the remaining fee-for-service individuals who are dually eligible for Medicare and Medicaid. The state will work closely with the Centers for Medicare and Medicaid Innovation to obtain Medicare utilization and cost data. Rhode Island will use 4 data sources to monitor the impact of its health home (HH) program on quality: claims; an intake survey of CMHO clients; charts (either electronic or paper), and; a client satisfaction survey. Rhode Island exercised prudence in selecting measures to not overburden CMHOs 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. We expect that Medicare claims for dual eligibles will be available promptly as many measures examine the coordination between inpatient and outpatient care. We have not recommended meaningful use measures because they are unlikely to be available in the 8 quarter timeframe. In the first year, providers will be self-attesting to the presence of measures. If they become available quickly, they will be added. Chart sampling methodology to be developed collaboratively with CMHOs to achieve statistical validity. The state will also develop a plan in collaboration with the MMIS vendor to calculate and report measures associated with improving the management of chronic conditions.

Quality of Care

Measure

Percentage of hospital-discharged patients contacted by the CMHO hospital liaison or a member of the Health Home team by phone or in person within 2 days of discharge

Data Source

Chart review

Measure Specification

Numerator: patients with a phone or in-person contact within 2 days of discharge
Denominator: all patients with a hospital visit

How Health IT will be Utilized

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 Organizations (MCOs) for the 35% of the health home-eligible SPMI population enrolled in MCOs. The state is currently working with the MCOs to develop health utilization profiles. To the extent possible, similar profiles will be derived from the Medicaid data warehouse and other applicable sources for the remaining fee-for-service individuals who are dually eligible for Medicare and Medicaid. The state will work closely with the Centers for Medicare and Medicaid Innovation to obtain Medicare utilization and cost data. Rhode Island will use 4 data sources to monitor the impact of its health home (HH) program on quality: claims; an intake survey of CMHO clients; charts (either electronic or paper), and; a client satisfaction survey. Rhode Island exercised prudence in selecting measures to not overburden CMHOs 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. We expect that Medicare claims for dual eligibles will be available promptly as many measures examine the coordination between inpatient and outpatient care. We have not recommended meaningful use measures because they are unlikely to be available in the 8 quarter timeframe. In the first year, providers will be self-attesting to the presence of measures. If they become available quickly, they will be added. Chart sampling methodology to be developed collaboratively with CMHOs to achieve statistical validity. The state will also develop a plan in collaboration with the MMIS vendor to calculate and report measures associated with improving the management of chronic conditions.

Goal 3:

Increase use of preventive services [FOR PURPOSES OF CMHC HEALTH HOME QUALITY MEASURES, “PATIENT” REFERS TO MEDICAID BENEFICIARIES RECEIVING CMHO HEALTH HOME SERVICES.]

Clinical Outcomes

Measure

1. Percentage of patients who report that they smoke
2. Percentage of patients who report using illicit substances or abusing alcohol
3. Percentage of members 18-74 years of age who had an outpatient visit and who had their body mass index (BMI) documented during the measurement year or the year prior to the measurement year
4. Age and gender appropriate use of pap test, mammogram, and colonoscopy, using HEDIS specifications.

Data Source

1. RI B-HOLD (Behavioral Health Online Dataset)
2. RI B-HOLD (Behavioral Health Online Dataset)
3. RI B-HOLD
4. Medicaid and Medicare claims

Measure Specification

1. Numerator: patients who smoke
1. Denominator: all patients

2. Numerator: patients reporting they use illicit drugs or abusing alcohol
2. Denominator: all patients completing the behavioral health assessment

3. Numerator:Body mass index documented during the measurement year or the year prior to the measurement year
3. Denominator:Members 18-74 of age who had an outpatient visit

4. Numerator: patients with timely receipt of mammogram, pap test, and colonoscopy
4. Denominator: patients eligible for screening, per HEDIS specifications

How Health IT will be Utilized

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 Organizations (MCOs) for the 35% of the health home-eligible SPMI population enrolled in MCOs. The state is currently working with the MCOs to develop health utilization profiles. To the extent possible, similar profiles will be derived from the Medicaid data warehouse and other applicable sources for the remaining fee-for-service individuals who are dually eligible for Medicare and Medicaid. The state will work closely with the Centers for Medicare and Medicaid Innovation to obtain Medicare utilization and cost data. Rhode Island will use 4 data sources to monitor the impact of its health home (HH) program on quality: claims; an intake survey of CMHO clients; charts (either electronic or paper), and; a client satisfaction survey. Rhode Island exercised prudence in selecting measures to not overburden CMHOs 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. We expect that Medicare claims for dual eligibles will be available promptly as many measures examine the coordination between inpatient and outpatient care. We have not recommended meaningful use measures because they are unlikely to be available in the 8 quarter timeframe. In the first year, providers will be self-attesting to the presence of measures. If they become available quickly, they will be added. Chart sampling methodology to be developed collaboratively with CMHOs to achieve statistical validity. The state will also develop a plan in collaboration with the MMIS vendor to calculate and report measures associated with improving the management of chronic conditions.

Experience of Care

Measure

Percentage of patients who are satisfied with their access to outpatient services and with the quality of those services

Data Source

RI OEI Survey

Measure Specification

Numerator: patients saying they agree or strongly agree with each the following statements:
- The location of services was convenient.
- Staff
- were willing to see me as often as I felt it was necessary.
- Staff returned my call within 24 hours.
- Services were available at times that were good for me.
- I was able to get all the services I thought I needed.
- I was able to see a psychiatrist when I wanted to.
- I like the services I received here.
- If I had other choices, I would still get services from this agency.
- I would recommend this agency to a friend or family member.

Denominator: all patients completing the relevant item on the RI OEI survey

How Health IT will be Utilized

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 Organizations (MCOs) for the 35% of the health home-eligible SPMI population enrolled in MCOs. The state is currently working with the MCOs to develop health utilization profiles. To the extent possible, similar profiles will be derived from the Medicaid data warehouse and other applicable sources for the remaining fee-for-service individuals who are dually eligible for Medicare and Medicaid. The state will work closely with the Centers for Medicare and Medicaid Innovation to obtain Medicare utilization and cost data. Rhode Island will use 4 data sources to monitor the impact of its health home (HH) program on quality: claims; an intake survey of CMHO clients; charts (either electronic or paper), and; a client satisfaction survey. Rhode Island exercised prudence in selecting measures to not overburden CMHOs 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. We expect that Medicare claims for dual eligibles will be available promptly as many measures examine the coordination between inpatient and outpatient care. We have not recommended meaningful use measures because they are unlikely to be available in the 8 quarter timeframe. In the first year, providers will be self-attesting to the presence of measures. If they become available quickly, they will be added. Chart sampling methodology to be developed collaboratively with CMHOs to achieve statistical validity. The state will also develop a plan in collaboration with the MMIS vendor to calculate and report measures associated with improving the management of chronic conditions.

Quality of Care

Measure

1. Percentage of patients aged 18 years and older screened for clinical depression using a standardized tool AND follow-up documented
2. Percentage of adolescents and adults members with a new episode of alcohol or other drug (AOD) dependence who received the following: (a) Initiation of AOD treatment (b) Engagement of AOD treatment
3. Percentage of patients having one or more well-visits/physical examination visits in 12 month period
4. Percentage of smokers counseled and referred for smoking cessation
5. Percentage of drug/alcohol abusers counseled and referred to drug/alcohol treatment

Data Source

1. Medicare and Medicaid Claims
2. Medicare and Medicaid Claims
3. Medicare and Medicaid Claims
4. Chart review and screening assessment
5. Chart review and screening assessment

Measure Specification

1. Numerator:Total number of patients from the denominator who have follow-up documentation
1. Denominator: All patients 18 years and older screened for clinical depression using a standardized tool

2. Numerator:Initiation of Alcohol and other Drug (AOD) Dependence Treatment: Members with initiation of AOD treatment through an inpatient admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of diagnosis. Engagement of Alcohol and other Drug (AOD) Treatment: Initiation of AOD treatment and two or more inpatient admissions, outpatient visits, intensive outpatient encounters or partial hospitalizations with any AOD diagnosis within 30 days after the date of the Initiation encounter (inclusive). Multiple engagement visits may occur on the same day, but they must be with different providers in order to be counted.
2. Denominator: Members 13 years of age and older as of December 31 of the measurement year with a new episode of alcohol or other drug (AOD) during the intake period, reported in two age stratifications (13-17 years, 18+ years) and a total rate. The total rate is the sum of the two numerators divided by the sum of the two denominators.

3. Numerator: patients with a preventive or primary care visit
3. Denominator: all patients

4. Numerator: patient counseled and referred to care for smoking cessation
4. Denominator: smokers

5. Numerator: patients counseled and referred to care for alcohol abuse and illicit drug use
5. Denominator: illicit drug/alcohol abusers

How Health IT will be Utilized

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 Organizations (MCOs) for the 35% of the health home-eligible SPMI population enrolled in MCOs. The state is currently working with the MCOs to develop health utilization profiles. To the extent possible, similar profiles will be derived from the Medicaid data warehouse and other applicable sources for the remaining fee-for-service individuals who are dually eligible for Medicare and Medicaid. The state will work closely with the Centers for Medicare and Medicaid Innovation to obtain Medicare utilization and cost data. Rhode Island will use 4 data sources to monitor the impact of its health home (HH) program on quality: claims; an intake survey of CMHO clients; charts (either electronic or paper), and; a client satisfaction survey. Rhode Island exercised prudence in selecting measures to not overburden CMHOs 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. We expect that Medicare claims for dual eligibles will be available promptly as many measures examine the coordination between inpatient and outpatient care. We have not recommended meaningful use measures because they are unlikely to be available in the 8 quarter timeframe. In the first year, providers will be self-attesting to the presence of measures. If they become available quickly, they will be added. Chart sampling methodology to be developed collaboratively with CMHOs to achieve statistical validity. The state will also develop a plan in collaboration with the MMIS vendor to calculate and report measures associated with improving the management of chronic conditions.

Goal 4:

Improve management of chronic conditions [FOR PURPOSES OF CMHC HEALTH HOME QUALITY MEASURES, “PATIENT” REFERS TO MEDICAID BENEFICIARIES RECEIVING CMHO HEALTH HOME SERVICES.]

Clinical Outcomes

Measure

1. % of patients with diabetes (type 1 or type 2) who had HbA1c < 8.0%
2. % of patients identified as having persistent asthma & were appropriately prescribed medication (controller medication) during the measurement period.
3. % of patients with a diagnosis of hypertension who have been seen for at least 2 office visits, w/ blood pressure adequately controlled (BP < 140/90) during the measurement period
4. % of patients diagnosed with CAD with lipid level adequately controlled (LDL<100).

Data Source

1. Medicare and Medicaid Claims
2. Medicare and Medicaid Claims
3. Medicare and Medicaid Claims
4. Medicare and Medicaid Claims

Measure Specification

1. Numerator : For a given 90-day period, number of patients identified as having diabetes and a documented Hba1c in the previous 12 months for whom the most recent documented Hba1c level is .8%
1. Denominator : For a given 90-day period, number of patients identified as having diabetes and having a documented Hba1c in the previous 12 months

2. Numerator : for a given 90 day period number of patients identified as having asthma and a prescription for a controller medication
2. Denominator : for a given 90 day period number of patients identified as having asthma

3. Numerator : for a given 90 day period number of patients identified as having hypertension and who had two documented episodes of care in the previous 12 months where the most recent documented blood pressure in the previous 12 months is < 140/90
3. Denominator : for a given 90 day period number of patients identified as having hypertension who had two documented episodes of care in the previous 12 months

4. Numerator : for a given 90 day period number of patients identified as having cardiovascular disease where the most recent documented LDL level in the previous 12 months is < 100
4. Denominator : for a given 90 day period number of patients identified as having cardiovascular disease

How Health IT will be Utilized

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 Organizations (MCOs) for the 35% of the health home-eligible SPMI population enrolled in MCOs. The state is currently working with the MCOs to develop health utilization profiles. To the extent possible, similar profiles will be derived from the Medicaid data warehouse and other applicable sources for the remaining fee-for-service individuals who are dually eligible for Medicare and Medicaid. The state will work closely with the Centers for Medicare and Medicaid Innovation to obtain Medicare utilization and cost data. Rhode Island will use 4 data sources to monitor the impact of its health home (HH) program on quality: claims; an intake survey of CMHO clients; charts (either electronic or paper), and; a client satisfaction survey. Rhode Island exercised prudence in selecting measures to not overburden CMHOs 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. We expect that Medicare claims for dual eligibles will be available promptly as many measures examine the coordination between inpatient and outpatient care. We have not recommended meaningful use measures because they are unlikely to be available in the 8 quarter timeframe. In the first year, providers will be self-attesting to the presence of measures. If they become available quickly, they will be added. Chart sampling methodology to be developed collaboratively with CMHOs to achieve statistical validity. The state will also develop a plan in collaboration with the MMIS vendor to calculate and report measures associated with improving the management of chronic conditions.

Experience of Care

Measure

NA

Data Source

NA

Measure Specification

NA

How Health IT will be Utilized

NA

Quality of Care

Measure

1. % of patients who are adherent to prescription medications for asthma and/or COPD.
2. % of patients who are adherent to Meds – CVD and Anti-Hypertensive Meds
3. % of patients using a statin medications who have a history of CAD (coronary artery disease).

Data Source

1. Medicare and Medicaid Claims
2. Medicare and Medicaid Claims
3. Medicare and Medicaid Claims

Measure Specification

1. Numerator: number of members on medication for asthma/COPD in the past 90 days with medication possession ratio (MPR) > 80%
1. Denominator: number of all patients on medication for asthma/COPD in the past 90 days

2. Numerator: number of patients on that class of medication in the past 90 days with medication possession ratio (MPR) > 80%
2. Denominator: number of all patients on that class of medication in the past 90 days

3. Numerator: for a given 90 day period number of patients identified as having coronary artery disease and a prescription for a statin
3. Denominator: for a given 90 day period number of patients coronary artery disease

How Health IT will be Utilized

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 Organizations (MCOs) for the 35% of the health home-eligible SPMI population enrolled in MCOs. The state is currently working with the MCOs to develop health utilization profiles. To the extent possible, similar profiles will be derived from the Medicaid data warehouse and other applicable sources for the remaining fee-for-service individuals who are dually eligible for Medicare and Medicaid. The state will work closely with the Centers for Medicare and Medicaid Innovation to obtain Medicare utilization and cost data. Rhode Island will use 4 data sources to monitor the impact of its health home (HH) program on quality: claims; an intake survey of CMHO clients; charts (either electronic or paper), and; a client satisfaction survey. Rhode Island exercised prudence in selecting measures to not overburden CMHOs 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. We expect that Medicare claims for dual eligibles will be available promptly as many measures examine the coordination between inpatient and outpatient care. We have not recommended meaningful use measures because they are unlikely to be available in the 8 quarter timeframe. In the first year, providers will be self-attesting to the presence of measures. If they become available quickly, they will be added. Chart sampling methodology to be developed collaboratively with CMHOs to achieve statistical validity. The state will also develop a plan in collaboration with the MMIS vendor to calculate and report measures associated with improving the management of chronic conditions.

Goal 5:

Improve Transitions to CMHO Services [FOR PURPOSES OF CMHC HEALTH HOME QUALITY MEASURES, “PATIENT” REFERS TO MEDICAID BENEFICIARIES RECEIVING CMHO HEALTH HOME SERVICES.]

Clinical Outcomes

Measure

Mental health: percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge. http://qualitymeasures.ahrq.gov/content.aspx?id=14965

Data Source

Medicare and Medicaid claims

Measure Specification

Numerator: An outpatient visit, intensive outpatient encounter, or partial hospitalization (refer to Table FUH-C in the original measure documentation for codes to identify visits) with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge.

Denominator: Members 6 years of age and older discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis on or between January 1 and December of the measurement year

How Health IT will be Utilized

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 Organizations (MCOs) for the 35% of the health home-eligible SPMI population enrolled in MCOs. The state is currently working with the MCOs to develop health utilization profiles. To the extent possible, similar profiles will be derived from the Medicaid data warehouse and other applicable sources for the remaining fee-for-service individuals who are dually eligible for Medicare and Medicaid. The state will work closely with the Centers for Medicare and Medicaid Innovation to obtain Medicare utilization and cost data. Rhode Island will use 4 data sources to monitor the impact of its health home (HH) program on quality: claims; an intake survey of CMHO clients; charts (either electronic or paper), and; a client satisfaction survey. Rhode Island exercised prudence in selecting measures to not overburden CMHOs 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. We expect that Medicare claims for dual eligibles will be available promptly as many measures examine the coordination between inpatient and outpatient care. We have not recommended meaningful use measures because they are unlikely to be available in the 8 quarter timeframe. In the first year, providers will be self-attesting to the presence of measures. If they become available quickly, they will be added. Chart sampling methodology to be developed collaboratively with CMHOs to achieve statistical validity. The state will also develop a plan in collaboration with the MMIS vendor to calculate and report measures associated with improving the management of chronic conditions.

Experience of Care

Measure

Percentage of patients satisfied with their access to outpatient services and with the quality of those services

Data Source

RI OEI Survey

Measure Specification

Numerator: patients saying they agree or strongly agree with each the following statements:
- The location of services was convenient.
- Staff were willing to see me as often as I felt it was necessary.
- Staff returned my call within 24 hours.
- Services were available at times that were good for me.
- I was able to get all the services I thought I needed.
- I was able to see a psychiatrist when I wanted to.
- I like the services I received here.
- If I had other choices, I would still get services from this agency.
- I would recommend this agency to a friend or family member.

Denominator: all patients completing the relevant item in the RI OEI survey

How Health IT will be Utilized

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 Organizations (MCOs) for the 35% of the health home-eligible SPMI population enrolled in MCOs. The state is currently working with the MCOs to develop health utilization profiles. To the extent possible, similar profiles will be derived from the Medicaid data warehouse and other applicable sources for the remaining fee-for-service individuals who are dually eligible for Medicare and Medicaid. The state will work closely with the Centers for Medicare and Medicaid Innovation to obtain Medicare utilization and cost data. Rhode Island will use 4 data sources to monitor the impact of its health home (HH) program on quality: claims; an intake survey of CMHO clients; charts (either electronic or paper), and; a client satisfaction survey. Rhode Island exercised prudence in selecting measures to not overburden CMHOs 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. We expect that Medicare claims for dual eligibles will be available promptly as many measures examine the coordination between inpatient and outpatient care. We have not recommended meaningful use measures because they are unlikely to be available in the 8 quarter timeframe. In the first year, providers will be self-attesting to the presence of measures. If they become available quickly, they will be added. Chart sampling methodology to be developed collaboratively with CMHOs to achieve statistical validity. The state will also develop a plan in collaboration with the MMIS vendor to calculate and report measures associated with improving the management of chronic conditions.

Quality of Care

Measure

1. Percentage of hospital-discharged patients contacted by the CMHO hospital liaison/or a member of the Health Home team) by phone or in person within 2 days of discharge
2. Care transitions: percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge. http://qualitymeasures.ahrq.gov/content.aspx?id=15178

Data Source

1. CHMO chart review
2. Medicare and Medicaid claims

Measure Specification

1. Numerator: patients with a phone or in-person contact within 2 days of discharge
1. Denominator: all patients with a hospital visit

2. Numerator:Patients for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge
2. Denominator:All patients, regardless of age, discharged from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self-care or any other site of care

How Health IT will be Utilized

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 Organizations (MCOs) for the 35% of the health home-eligible SPMI population enrolled in MCOs. The state is currently working with the MCOs to develop health utilization profiles. To the extent possible, similar profiles will be derived from the Medicaid data warehouse and other applicable sources for the remaining fee-for-service individuals who are dually eligible for Medicare and Medicaid. The state will work closely with the Centers for Medicare and Medicaid Innovation to obtain Medicare utilization and cost data. Rhode Island will use 4 data sources to monitor the impact of its health home (HH) program on quality: claims; an intake survey of CMHO clients; charts (either electronic or paper), and; a client satisfaction survey. Rhode Island exercised prudence in selecting measures to not overburden CMHOs 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. We expect that Medicare claims for dual eligibles will be available promptly as many measures examine the coordination between inpatient and outpatient care. We have not recommended meaningful use measures because they are unlikely to be available in the 8 quarter timeframe. In the first year, providers will be self-attesting to the presence of measures. If they become available quickly, they will be added. Chart sampling methodology to be developed collaboratively with CMHOs to achieve statistical validity. The state will also develop a plan in collaboration with the MMIS vendor to calculate and report measures associated with improving the management of chronic conditions.

Goal 6:

Reduce Hospital Readmissions [FOR PURPOSES OF CMHC HEALTH HOME QUALITY MEASURES, “PATIENT” REFERS TO MEDICAID BENEFICIARIES RECEIVING CMHO HEALTH HOME SERVICES.]

Measure

Clinical Outcomes

1. Ambulatory care sensitive conditions: age-standardized acute care hospitalization rate for conditions where appropriate ambulatory care prevents or reduces the need for admission to the hospital, per 100,000 population under age 75 years. http://www.guideline.gov/content.aspx?id=15067
2. For members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.

Data Source

1. Medicare and Medicaid Claims
2. Medicare and Medicaid Claims

Measure Specification

1. Numerator: Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years
1. Denominator: Total mid-year population under age 75

2. Numerator: Count the number of Index Hospital Stays with a readmission within 30 days for each age, gender, and total combination
2. Denominator: Count the number of Index Hospital Stays for each age, gender, and total combination

How Health IT will be Utilized

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 Organizations (MCOs) for the 35% of the health home-eligible SPMI population enrolled in MCOs. The state is currently working with the MCOs to develop health utilization profiles. To the extent possible, similar profiles will be derived from the Medicaid data warehouse and other applicable sources for the remaining fee-for-service individuals who are dually eligible for Medicare and Medicaid. The state will work closely with the Centers for Medicare and Medicaid Innovation to obtain Medicare utilization and cost data. Rhode Island will use 4 data sources to monitor the impact of its health home (HH) program on quality: claims; an intake survey of CMHO clients; charts (either electronic or paper), and; a client satisfaction survey. Rhode Island exercised prudence in selecting measures to not overburden CMHOs 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. We expect that Medicare claims for dual eligibles will be available promptly as many measures examine the coordination between inpatient and outpatient care. We have not recommended meaningful use measures because they are unlikely to be available in the 8 quarter timeframe. In the first year, providers will be self-attesting to the presence of measures. If they become available quickly, they will be added. Chart sampling methodology to be developed collaboratively with CMHOs to achieve statistical validity. The state will also develop a plan in collaboration with the MMIS vendor to calculate and report measures associated with improving the management of chronic conditions.

Experience of Care

Measure

Satisfaction with care, accessibility of care

Data Source

RI OEI Survey

Measure Specification

Numerator: patients saying they agree or strongly agree with each the following statements:
- The location of services was convenient.
- Staff were willing to see me as often as I felt it was necessary.
- Staff returned my call within 24 hours.
- Services were available at times that were good for me.
- I was able to get all the services I thought I needed.
- I was able to see a psychiatrist when I wanted to.
- I like the services I received here.
- If I had other choices, I would still get services from this agency.
- I would recommend this agency to a friend or family member.

Denominator: all patients completing the relevant items of the RI OEI survey

How Health IT will be Utilized

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 Organizations (MCOs) for the 35% of the health home-eligible SPMI population enrolled in MCOs. The state is currently working with the MCOs to develop health utilization profiles. To the extent possible, similar profiles will be derived from the Medicaid data warehouse and other applicable sources for the remaining fee-for-service individuals who are dually eligible for Medicare and Medicaid. The state will work closely with the Centers for Medicare and Medicaid Innovation to obtain Medicare utilization and cost data. Rhode Island will use 4 data sources to monitor the impact of its health home (HH) program on quality: claims; an intake survey of CMHO clients; charts (either electronic or paper), and; a client satisfaction survey. Rhode Island exercised prudence in selecting measures to not overburden CMHOs 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. We expect that Medicare claims for dual eligibles will be available promptly as many measures examine the coordination between inpatient and outpatient care. We have not recommended meaningful use measures because they are unlikely to be available in the 8 quarter timeframe. In the first year, providers will be self-attesting to the presence of measures. If they become available quickly, they will be added. Chart sampling methodology to be developed collaboratively with CMHOs to achieve statistical validity. The state will also develop a plan in collaboration with the MMIS vendor to calculate and report measures associated with improving the management of chronic conditions.

Quality of Care

Measure

1. Percentage of hospital-discharged patients with a follow-up visit to a CMHO or medical provider within 14 days of hospital discharge.
2. Percentage of hospital-discharged patients contacted by the CMHO hospital liaison or a member of the Health Home team by phone or in person within 2 days of discharge

Data Source

1. Medicare and Medicaid Claims
2. Chart Review

Measure Specification

1. Numerator: patients with a CMHO or medical provider visit within 14 days of discharge
1. Denominator: all patients with a hospital visit

2. Numerator: patients contacted by the CMHO liaison by phone or in person within 2 days of discharge
2. Denominator: all patients with a hospital visit

How Health IT will be Utilized

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 Organizations (MCOs) for the 35% of the health home-eligible SPMI

population enrolled in MCOs. The state is currently working with the MCOs to develop health utilization profiles. To the extent possible, similar profiles will be derived from the Medicaid data warehouse and other applicable sources for the remaining fee-for-service individuals who are dually eligible for Medicare and Medicaid. The state will work closely with the Centers for Medicare and Medicaid Innovation to obtain Medicare utilization and cost data. Rhode Island will use 4 data sources to monitor the impact of its health home (HH) program on quality: claims; an intake survey of CMHO clients; charts (either electronic or paper), and; a client satisfaction survey. Rhode Island exercised prudence in selecting measures to not overburden CMHOs 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. We expect that Medicare claims for dual eligibles will be available promptly as many measures examine the coordination between inpatient and outpatient care. We have not recommended meaningful use measures because they are unlikely to be available in the 8 quarter timeframe. In the first year, providers will be self-attesting to the presence of measures. If they become available quickly, they will be added. Chart sampling methodology to be developed collaboratively with CMHOs to achieve statistical validity. The state will also develop a plan in collaboration with the MMIS vendor to calculate and report measures associated with improving the management of chronic conditions.

Goal 7:

NA

Clinical Outcomes

Measure

NA

Data Source

NA

Measure Specification

NA

How Health IT will be Utilized

NA

Experience of Care

Measure

NA

Data Source

NA

Measure Specification

NA

How Health IT will be Utilized

NA

Quality of Care

Measure

NA

Data Source

NA

Measure Specification

NA

How Health IT will be Utilized

NA

Goal 8:

NA

Clinical Outcomes

Measure

NA

Data Source

NA

Measure Specification

NA

How Health IT will be Utilized

NA

Experience of Care

Measure

NA

Data Source

NA

Measure Specification

NA

How Health IT will be Utilized

NA

Quality of Care

Measure

NA

Data Source

NA

Measure Specification

NA

How Health IT will be Utilized

NA

Goal 9:

NA

Clinical Outcomes

Measure

NA

Data Source

NA

Measure Specification

NA

How Health IT will be Utilized

NA

Experience of Care

Measure

NA

Data Source

NA

Measure Specification

NA

How Health IT will be Utilized

NA

Quality of Care

Measure

NA

Data Source

NA

Measure Specification

NA

How Health IT will be Utilized

NA

Goal 10:

NA

Clinical Outcomes

Measure

NA

Data Source

NA

Measure Specification

NA

How Health IT will be Utilized

NA

Experience of Care

Measure

NA

Data Source

NA

Measure Specification

NA

How Health IT will be Utilized

NA

Quality of Care

Measure

NA

Data Source

NA

Measure Specification

NA

How Health IT will be Utilized

NA

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

NA

Data Source

NA

Measure Specification

NA

How Health IT will be Utilized

NA

Experience of Care

Measure

NA

Data Source

NA

Measure Specification

NA

How Health IT will be Utilized

NA

Quality of Care

Measure

NA

Data Source

NA

Measure Specification

NA

How Health IT will be Utilized

NA

Service

☐ Care Coordination

Clinical Outcomes

Measure

NA

Data Source

NA

Measure Specification

NA

How Health IT will be Utilized

NA

Experience of Care

Measure

NA

Data Source

NA

Measure Specification

NA

How Health IT will be Utilized

NA

Quality of Care

Measure

NA

Data Source

NA

Measure Specification

NA

How Health IT will be Utilized

NA

Service

☐ Health Promotion

Clinical Outcomes

Measure

NA

Data Source

NA

Measure Specification

NA

How Health IT will be Utilized

NA

Experience of Care

Measure

NA

Data Source

NA

Measure Specification

NA

How Health IT will be Utilized

NA

Quality of Care

Measure

NA

Data Source

NA

Measure Specification

NA

How Health IT will be Utilized

NA

Service

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

Clinical Outcomes

Measure

NA

Data Source

NA

Measure Specification

NA

How Health IT will be Utilized

NA

Experience of Care

Measure

NA

Data Source

NA

Measure Specification

NA

How Health IT will be Utilized

NA

Quality of Care

Measure

NA

Data Source

NA

Measure Specification

NA

How Health IT will be Utilized

NA

Service

☐ Individual and Family Support Services (including authorized representatives)

Clinical Outcomes

Measure

NA

Data Source

NA

Measure Specification

NA

How Health IT will be Utilized

NA

Experience of Care

Measure

NA

Data Source

NA

Measure Specification

NA

How Health IT will be Utilized

NA

Quality of Care

Measure

NA

Data Source

NA

Measure Specification

NA

How Health IT will be Utilized

NA

Service

☐ Referral to Community and Social Support Services

Clinical Outcomes

Measure

NA

Data Source

NA

Measure Specification

NA

How Health IT will be Utilized

NA

Experience of Care

Measure

NA

Data Source

NA

Measure Specification

NA

How Health IT will be Utilized

NA

Quality of Care

Measure

NA

Data Source

NA

Measure Specification

NA

How Health IT will be Utilized

NA

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

Admission per 1000 member months for any diagnosis among CMHO users with SPMI.

Data Source

Claims

Frequency of Data Collection

Annual

ii. Emergency room visits

Description

ED visits per 1000 member months for any diagnosis among CMHO users with SPMI.

Data Source

Claims

Frequency of Data Collection

Annual

iii. Skilled Nursing Facility admissions

Description

Admission per 1000 member months for any diagnosis among CMHO users with SPMI.

Data Source

Claims

Frequency of Data Collection

Annual

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

The State will consolidate data from its Medicaid data warehouse which contains both FSS claims and managed care encounter data, to assess general and psychiatric hospital readmission rates of CMHO health home service users. The state will calculate readmissions per 1000 member months among CMHO users. The state will track pre/post hospital readmission rates among health home participants. Rates will also be compared with clinically similar individuals not receiving CMHO health home services.

ii. Chronic disease management

For new individuals of CMHO health home services, the State will track hospital referrals and/or hospital liaison encounters as well as track face-to-face follow-up by a health team member within 2 days after hospitalization discharge. The state will also monitor the number of referrals/post discharge follow-up contacts that resulted in the development of a care plan.

iii. Coordination of care for individuals with chronic conditions

The State will monitor updates to RI-BHOLD to track changes in psychiatric diagnoses, determine individuals' difficulty with Axis N diagnoses (e.g., housing problems, problems with access to health care services) and track individuals' self-reported co-occurring physical health conditions.

iv. Assessment of program implementation

The State will monitor implementation through processes developed for regularly occurring meetings of DHS, BHDDH, RICCMHO, MCOs and PCCMs.

v. Processes and lessons learned

The State and RICCMHO will develop tools to elicit feedback from CMHOs to understand any operational barriers of implementing CMHO health home services.

vi. Assessment of quality improvements and clinical outcomes

The State will utilize quality process and outcome measures described in the prior section to assess quality improvements and clinical outcomes.

vii. Estimates of cost savings

The state will analyze Medicaid and Medicare claims cost and utilization data in order to conduct the cost savings methodology. The state will determine baseline costs of Medicaid and Medicare beneficiaries who would have been eligible for CMHO health home services at any time during the 4th quarter of state fiscal year 2011 (April 2011 through June 30, 2011). In order to calculate costs savings and the impact of health home services, the State will perform an annual assessment of baseline costs compared with total Medicaid and Medicare costs of those same CMHO health users one year and two years following the SPA effective date. The assessment will also include the performance measures enumerated in the Quality Measures section. In addition to looking at overall cost, BHDDH will work with EOHHS to determine specific targeted areas of cost most likely to be impacted by health home implementation for a more detailed analysis. In order to perform both of these operations, the State will require timely and affordable access to Medicare data.

Page

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
☐ Mental Health Condition

from the list of conditions below:

- 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 §ection 1945(h)(5)
- Team of Health Care Professionals as described in §ection 1945(h)(6)
- Health Team as described in §ection 1945(h)(7), via reference to §ection 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).

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

Quality of Care

Measure

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:

Measure

Clinical Outcomes

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

Page Principles of Reimbursement TN 09-004

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

NA

Description

NA

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Payment Type: Alternate Payment Methodology

Provider Type

Monthly Case Rate to CMHO Health Homes

Description

1. The State will establish a fee structure designed to enlist participation of a sufficient number of providers in the Health Homes program so that eligible persons can receive the services included in the plan, at least to the extent that these are available to the general population.
2. Providers must be Community Mental Health Centers or other private, not-for-profit providers of mental health services who are licensed by the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) and who also meet the Department's certification requirements for Health Home providers.
3. All providers must conform to the requirements of the current Rules and Regulations for the Licensing of Behavioral Healthcare Organizations, any applicable requirements contained in the RI Community Mental Health Medicaid Procedure Manual, and all other applicable state and local fire and safety codes and ordinances.
4. Providers must agree to accept the rates paid by the Medicaid program as the sole and complete payment in full for services delivered to beneficiaries, except for any potential payments made from the beneficiary's applied income, authorized co-payments, or cost sharing spend down liability.
5. Providers must be enrolled in the RI Medicaid Program and agree to meet all requirements of same.
6. The State will not claim FFP for any non-institutional service provided to individuals who are residents of facilities that meet the Federal definition of an institution for mental diseases or a psychiatric residential treatment facility as described in Federal regulations at 42 CFR 440.140 and 440.160 and 42 CFR441 Subparts C and D.
7. The State will not include the cost of room and board or for non-Medicaid services as a component of the rate for services authorized by this section of the state plan.
8. The State will pay for services under this section on the basis of a cost-related case rate encompassing all Health Home services. See attached basic case rate methodology.
9. The amount of time allocated to Health Homes for any individual staff member is reflective of the actual time that that staff member is expected to spend providing reimbursable Health Home services to Medicaid recipients.
10. Providers will be required to collect and submit complete encounter data on a monthly basis utilizing standard Medicaid coding and units in an electronic format to be determined by BHDDH. Six months after the effective date of this SPA and following the receipt of encounter data, the state will conduct an analysis of the data to develop recipient profiles, study service patterns, and analyze program costs vs. services received by recipients, for potential adjustments to the case rate as well as for consideration of alternative payment methodologies. Analysis will be conducted annually after the first six month review.
11. The State assures that Health Home services under this submission will be separate and distinct and that duplicate payment will not be made for similar services available under other program authorities.
12. The agency's rates were set as of October 1, 2011 and are effective for services on or after that date. All rates are published on the RI DHS website at http://www.dhs.ri.gov/ForProvidersVendors/MedicalAssistanceProviders/FeeSchedules/tabid/170/Default.aspx. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.
13. Attachment 1: Basic Case Rate Methodology. The overall Community Mental Health Medicaid program utilizes a set of cost-related fees. In general, the process is based on a CMS approved methodology that utilizes reliable estimates of the actual costs to the provider agencies for staff and operating/support and then feeding those costs into a fee model. For Health Homes, the process also included the development of a standard core Health Home team composition and suggested caseload based on estimates of available staff hours and client need (see Table 1 below). The costs for human resources are based on the RI Community Mental Health Staff Database, which follows the minimum data recommendations of the CMHS Mental Health Statistics Improvement Program. This annual data collection effort includes every employee of the community MH system from psychiatrists to cleaners and provides current electronic data on salary, fringe, hours worked and a wide range of other personnel data such as degree, licenses, languages spoken, job function, etc. The licensing and job function fields of the database were used to aggregate similar disciplines (e.g. physicians, nurses, etc.). The salary, fringe, work week and scheduled hours fields were then used to determine the average statewide cost for a full time equivalent Health Home staff member taking into consideration the cost of payroll only. The costs of operating and support take into account everything required to enable the provision of a Health Home service over and above the payroll cost for the actual team staff. Operating costs include, but are not limited to, the cost of travel, staff training and conferences, insurance, general supplies and expenses, telephone and communications, etc. The costs of room and board are not included. Support costs include, but are not limited to, salary and fringe benefits for all individuals who provide the necessary staff supports for the core team members including reception, secretarial, medical records, billing, MIS, and CMHO administrative staff. The overall cost of putting a staff member on the team is arrived at by applying the operating/support percentage to the basic payroll cost of a FTE staff member. The case rate was determined by utilizing the costs of an individual team member, the team composition, and the overall estimated case load to yield a single statewide average case rate. All costs are considered to be direct in that they are incurred by the private, non-profit provider agencies for the direct operation of the Health Home Team. In the proposed fee calculation, operating and support costs are approximately 38% of the overall amount required to field a Health Home team.

Table 1: Health Home Team Staff Composition Qualifications (Team Serving 200 Clients)
Health Home FTE Master's Team Coordinator 1.0
Psychiatrist .5
Registered Nurse 2.5
MA Level Clinician .5
CPST Specialist – Hospital Liaison 1.0
CPST Specialist 5.5
Peer Specialist .25
Total FTE Personnel 11.25

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