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.

Supersedes Transmital Number (TN)

11-0000

Transmital Number (TN)

11-0007

Please enter the Effective Date with the format MM/dd/yyyy where MM = two digit month number, dd = the two digit day of the month, and yyyy = the four digit year. Please also include the slashes (/).

Effective Date

10/01/2011

3.1 - A: Categorically Needy View

Attachment 3.1-H

Page 14

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

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

Health Home Services

How are Health Home Services Provided to the Medically Needy?

Same way as Categorically Needy

i. Geographic Limitations

Statewide Basis

If Targeted Geographic Basis,

ii. Population Criteria

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

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

from the list of conditions below:

- Mental Health Condition
- Substance Use Disorder
- Asthma
- Diabetes
- Heart Disease
- BMI Over 25
- Other Chronic Conditions Covered?
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 primary care services and implementation of CMH0 health home services will facilitate increased access to primary care. Individuals designated eligible for Rhode Island's Medicaid substance use disorder program and a severe or persistent mental or emotional disorder that seriously impairs the individual's functioning relative to such primary care needs. Eligible individuals must have either undergone psychiatric treatment more than the CMH0 health home and all will be notified 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, will be notified about eligible health homes and referred to a health home programTypedOut by other health home 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 coordinating or acting on findings associated with comprehensive care management, care coordination, and supports. 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 biopsychosocial 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 CMH0 health home providers specify that each health home coordinate, for example, how each provider will: structure team composition and member roles in CMH0s to achieve health home objectives; coordinate with primary care providers include co-locationalization of referral and follow-up services; and facilitate transfer from a pediatric to an adult system of care; - 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 support to individuals and families requiring management of their health conditions, including referral to community, social support, and recovery services; - Coordinate and provide access to long-term care supports and services. The seven CMH0s, Fellowship Health Resources, Inc and Riverwood Mental Health Services, represent the only entities that would be identified through data provided by Medicaid managed care organizations (MCOs) and other Information from the state's Medicaid data warehouse. CMH0 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 provider's role in providing care management services as well as encourage participation in care coordination efforts.

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

Rhode Island has seven CMH0s, 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 CMH0s and two specialty providers (Fellowship Health Resources, Inc. and Riverwood Mental Health Services) are licensed by the state under the authority of Rhode Island General Laws and operate in accordance with Rules and Regulations for the Licensing of Behavioral Healthcare Organizations. The seven CMH0s, Fellowship Health Resources, Inc. and Riverwood Mental Health Services, will serve as designated providers of CMH0 health home services. The seven CMH0s, Fellowship Health Resources, Inc and Riverwood Mental Health Services, represent the only entities that would be identified through data provided by Medicaid managed care organizations (MCOs) and other Information from the state's Medicaid data warehouse. CMH0 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 provider's role in providing care management services as well as encourage participation in care coordination efforts.

CMH0-SPECIFIC DEFINITION: Comprehensive care management services are conducted with high need individuals, their families and other relevant individuals or systems. Comprehensive care management services are provided to individuals that coordinate 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 transfer from a pediatric to an adult system of health care); - Coordinate and provide access to long-term care supports and 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 support to individuals and families requiring management of their health conditions, including referral to community, social support, and recovery services; - Coordinate and provide access to long-term care supports and services. The seven CMH0s, Fellowship Health Resources, Inc and Riverwood Mental Health Services, represent the only entities that would be identified through data provided by Medicaid managed care organizations (MCOs) and other Information from the state's Medicaid data warehouse. CMH0 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 provider's role in providing care management services as well as encourage participation in care coordination efforts.

OVERARCHING STATEWIDE DEFINITION: Comprehensive care management services are conducted with an individual and involve the interdisciplinary team in the assessment of care plan needs of the whole person. The first step is the development of a care plan for each individual that coordinates 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 transfer from a pediatric to an adult system of health care); - Coordinate and provide access to chronic disease management, including support to individuals and families requiring management of their health conditions, including referral to community, social support, and recovery services; - Coordinate and provide access to long-term care supports and services. The seven CMH0s, Fellowship Health Resources, Inc and Riverwood Mental Health Services, represent the only entities that would be identified through data provided by Medicaid managed care organizations (MCOs) and other Information from the state's Medicaid data warehouse. CMH0 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 provider's role in providing care management services as well as encourage participation in care coordination efforts.

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Ways Health IT Will Link

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
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 to develop health utilization profiles 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 to other PCP Site Provider NP; 3) Health utilization profile developed by MCOs as part of the CMHO certification process. The state will also provide 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.

CMHO-SPECIFIC DEFINITION: Health promotion services encourage and support healthy ideas and concepts to motivate individuals to adopt healthy behaviors. The services also enable individuals to self-manage their health.

CMHO-SPECIFIC 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.
coordinated care may also occur when transitioning an individual from a jail/prison setting into the community. Hospital liaisons, community liaisons, and other designated members of the team work closely 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 necessary. Referral to community and social support services can be provided to clients in need of additional 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: - 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 services; - Housing; - Social integration (NAMI support groups, MHCA OASIS, Alive Program (this program and MHCA are Advocacy and Social Centers) and/or Recovery Connection with the Office of Rehabilitation Service). 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 NPI; 3) Health utilization profile developed by MCOs as part of the CHMO certification process. The state will work closely with the MCOs and 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 DEFINITION: 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 DEFINITION: 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 direct self-help and assistance in accessing needed 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 health and access to care; 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 NPI; 3) Health utilization profile developed by MCOs as part of the CMHO certification process. The state will work closely with the MCOs and 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 DEFINITION: Referrals to community and social support services ensure that individuals have access to a myriad of formal and informal resources. Ideally, these resources are easily accessed by the individual in the service system and assists individuals in addressing medical, behavioral, educational, social and community issues.

CMHO-SPECIFIC DEFINITION: Referral to community and social support services provide individuals with referrals to a wide array of support services to help individuals overcome access or service barriers and improve overall health. Referrals 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 for 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 services; - Housing; - Social integration (NAMI support groups, MHCA OASIS, Alive Program (this program and MHCA are Advocacy and Social Centers) and/or Recovery Connection with the Office of Rehabilitation Service). 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 NPI; 3) Health utilization profile developed by MCOs as part of the CMHO certification process. The state will work closely with the MCOs and 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.

Ways Health IT Will Link

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v. Provider Standards

In addition to meeting state licensure requirements, BHHDD 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 BHHDD’s expectations and CMHO’s roles and responsibilities for conducting home health 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; Have available 24/7 for individuals in need of medical 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: - 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 services; - Housing; - Social integration (NAMI support groups, MHCA OASIS, Alive Program (this program and MHCA are Advocacy and Social Centers) and/or Recovery Connection with the Office of Rehabilitation Service). 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 NPI; 3) Health utilization profile developed by MCOs as part of the CMHO certification process. The state will work closely with the MCOs and 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.
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 patient 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 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 BDHH for approval the CMS-denominated performance measures for conducting health home services. -Blood Alcohol Levels (BAL) for conducting health home services. -The provider 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 provider's 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 provider or the CMHO, and, if applicable: An overview of how to develop and collect primary care services delivered at the CMHO health home provider. -Community support professionals will undergo a seventeen week Community Support Programming Training Program funded through a contract with the Department of Behavioral, Developmental Disabilities and Hospitals (BDHH) 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 care 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 major focus on the principles of the evidence practice Individual Placement and Support (IPS) model. 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 reevaluated 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 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.

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 on these services, the state will conduct a year end 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, BDHH 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).

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3.1. A: Categorically Needy View

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

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

viii. Quality Measures: Goal Based Quality Measures

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

Goal 1:
### 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 Medicare claims [visit to PCP]

**Measure Specification**

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

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

### 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
2. Denominator: All patients who complete Q1 on the RI OEI

1. 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
### 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

<table>
<thead>
<tr>
<th>Measure</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Percent of patients with one or more ED visits for any conditions named in NYU ED methodology, available at: <a href="http://wagner.nyu.edu/fi/lsr/index.html?g1">http://wagner.nyu.edu/fi/lsr/index.html?g1</a></td>
<td>Medicaid and Medicare claims</td>
</tr>
<tr>
<td>2. Percent of patients with one or more ED visits for a mental health condition</td>
<td>Medicaid and Medicare claims</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Measure Specification</th>
<th>How Health IT will be Utilized</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Numerator: Patients under age 75 who had an ED visit for non-emergency care or primary care preventable reasons</td>
<td>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.</td>
</tr>
<tr>
<td>2. Denominator: All patients under age 75 with an ED visit</td>
<td>1. Denominator: All patients under age 75 with an ED visit</td>
</tr>
<tr>
<td>2. Numerator: Patients who had one or more visits for a mental health condition (ICD-9 code and DSM codes to be specified)</td>
<td>2. Denominator: All patients with an ED visit</td>
</tr>
</tbody>
</table>

#### Experience of Care

<table>
<thead>
<tr>
<th>Measure</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Satisfaction with care, accessibility of care</td>
<td>RI OEI Survey</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Measure Specification</th>
<th>How Health IT will be Utilized</th>
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</thead>
<tbody>
<tr>
<td>Numerator: patients saying they agree or strongly agree with each the following statements:</td>
<td>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.</td>
</tr>
<tr>
<td>- The location of services was convenient.</td>
<td>1. Denominator: all patients completing each item on the RI OEI survey</td>
</tr>
<tr>
<td>- Staff were willing to see me as often as I felt it was necessary.</td>
<td>1. Denominator: all patients completing each item on the RI OEI survey</td>
</tr>
<tr>
<td>- Staff returned my call within 24 hours.</td>
<td>1. Denominator: all patients completing each item on the RI OEI survey</td>
</tr>
<tr>
<td>- Services were available at times that were good for me.</td>
<td>1. Denominator: all patients completing each item on the RI OEI survey</td>
</tr>
<tr>
<td>- I was able to get all the services I thought I needed.</td>
<td>1. Denominator: all patients completing each item on the RI OEI survey</td>
</tr>
<tr>
<td>- I was able to see a psychiatrist when I wanted to.</td>
<td>1. Denominator: all patients completing each item on the RI OEI survey</td>
</tr>
<tr>
<td>- I like the services I received here.</td>
<td>1. Denominator: all patients completing each item on the RI OEI survey</td>
</tr>
<tr>
<td>- I had other choices, I would still get services from this agency.</td>
<td>1. Denominator: all patients completing each item on the RI OEI survey</td>
</tr>
<tr>
<td>- I would recommend this agency to a friend or family member.</td>
<td>1. Denominator: all patients completing each item on the RI OEI survey</td>
</tr>
</tbody>
</table>

#### Quality of Care

<table>
<thead>
<tr>
<th>Measure</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>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</td>
<td>Chart review</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Measure Specification</th>
<th>How Health IT will be Utilized</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator: patients with a phone or in-person contact within 2 days of discharge</td>
<td>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.</td>
</tr>
<tr>
<td>Denominator: all patients with a hospital visit</td>
<td>1. Denominator: all patients completing each item on the RI OEI survey</td>
</tr>
</tbody>
</table>
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 measures 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

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Denominator</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Percentage of patients who report that they smoke</td>
<td>all patients</td>
</tr>
<tr>
<td>2. Percentage of patients who report using illicit substances or abusing alcohol</td>
<td>all patients completing the behavioral health assessment</td>
</tr>
<tr>
<td>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</td>
<td>Members 18-74 of age who had an outpatient visit</td>
</tr>
<tr>
<td>4. Age and gender appropriate use of pap test, mammogram, and colonoscopy, using HEDIS specifications</td>
<td>patients with timely receipt of mammogram, pap test, and colonoscopy</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Denominator</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. RI B-HOLD/DH (Behavioral Health Online Dataset)</td>
<td>patients who smoke</td>
</tr>
<tr>
<td>2. RI B-HOLD/DH (Behavioral Health Online Dataset)</td>
<td>reporting they use illicit drugs or abusing alcohol</td>
</tr>
<tr>
<td>3. RI B-HOLD/DH (Behavioral Health Online Dataset)</td>
<td>Body mass index documented during the measurement year or the year prior to the measurement year</td>
</tr>
<tr>
<td>4. RI B-HOLD/DH (Behavioral Health Online Dataset)</td>
<td>Members 18-74 of age who had an outpatient visit</td>
</tr>
</tbody>
</table>

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 of the following statements:
- The location of services was convenient.
- Staff were willing to see me as often as I felt it was necessary.
- Staff 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 measures 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.
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**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 diagnosis 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).
3. **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
4. **Numerator:** Patient counseled and referred to care for smoking cessation
   1. **Denominator:** Smokers
5. **Numerator:** Patients counseled and referred to care for alcohol abuse and illicit drug use
   1. **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
2. **Numerator:** For a given 90-day period, number of patients identified as having diabetes and having a documented HbA1c level is < 8%
3. **Numerator:** For a given 90 day period number of patients identified as having asthma and a prescription for a controller medication
4. **Numerator:** For a given 90 day period number of patients identified as having asthma
5. **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
6. **Numerator:** 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

How Health IT will be Utilized

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**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 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 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 measures 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 MMSIS vendor to calculate and report measures associated with improving the management of chronic conditions.

Experience of Care

Measure

Data Source

RI OEI Survey

Measure Specification

Numerator: patients saying they agree or strongly agree with each of the following statements:
- The location of services was convenient.
- Staff were willing to see me as often as I felt it was necessary.
- Staff answered 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 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 measures 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 MMSIS 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
2. Denominator: all patients with a hospital visit
3. 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 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 MMSIS 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 CMHC HEALTH HOME SERVICES.]
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.
   - If Medicare and Medicaid Claims are not available, use claims data obtained from dual-eligible populations.

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.
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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

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Measure Specification

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### Goal 9:

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### Clinical Outcomes

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### Clinical Outcomes

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### Experience of Care

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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

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<td>□ Comprehensive Transitional Care (including appropriate follow-up, from inpatient to other settings)</td>
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**Clinical Outcomes**

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<td>□ Individual and Family Support Services (including authorized representatives)</td>
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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

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

   ii. Emergency room visits

       Description
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.

Processes and lessons learned

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.

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

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

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.

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

### iv. Service Definitions

#### Comprehensive Care Management

- Service Definition
- Ways Health IT Will Link

#### Care Coordination

- Service Definition
- Ways Health IT Will Link

#### Health Promotion

- Service Definition
- Ways Health IT Will Link

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

- Service Definition
- Ways Health IT Will Link

#### Individual and Family Support Services (including authorized representatives)

- Service Definition
- Ways Health IT Will Link

#### Referral to Community and Social Support Services

- Service Definition
- Ways Health IT Will Link

### v. Provider Standards

### vi. Assurances

- A. The State assures that hospitals participating under the State plan or a waiver of such plan will establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated providers.
- B. The State has consulted and coordinated with the Substance Abuse and Mental Health Services Administration (SAMHSA) in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.
- C. The State will report to CMS information submitted by health home providers to inform the evaluation and Reports to Congress as described in section 2703(b) of the Affordable Care Act, and as described by CMS.

### vii. Monitoring

- A. Describe the State's methodology for tracking avoidable hospital readmissions, to include data sources and measure specifications.
- B. Describe the State's methodology for calculating cost savings that result from improved chronic care coordination and management achieved through this program, to include data sources and measure specifications.
C. Describe the State's proposal for using health information technology in providing health home services under this program and improving service
delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and
patient adherence to recommendations made by their provider).

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

Goal 1:

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
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Data Source
Measure Specification
How Health IT will be Utilized

Experience of Care
Measure
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Measure Specification
How Health IT will be Utilized

Quality of Care
### Goal 3: Clinical Outcomes

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### Experience of Care

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### Goal 4: Clinical Outcomes

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Goal 6:

Clinical Outcomes
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Experience of Care
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Quality of Care
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Goal 7:

Clinical Outcomes
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Experience of Care
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Quality of Care
Goal 8:
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Goal 9:
Clinical Outcomes
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Measure Specification
How Health IT will be Utilized
Quality of Care
Measure
Data Source
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
Service

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

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

Clinical Outcomes

Measure

Data Source
### Service

- Individual and Family Support Services (including authorized representatives)

### Clinical Outcomes

- Referral to Community and Social Support Services

### Experience of Care

#### Measure

- Data Source

### Quality of Care

#### Measure

- Data Source

### Measure Specification

- How Health IT will be Utilized
Quality of Care

<table>
<thead>
<tr>
<th>Measure</th>
<th>Data Source</th>
<th>Measure Specification</th>
<th>How Health IT will be Utilized</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>Description</th>
<th>Data Source</th>
<th>Frequency of Data Collection</th>
</tr>
</thead>
</table>

ii. Emergency room visits

<table>
<thead>
<tr>
<th>Description</th>
<th>Data Source</th>
<th>Frequency of Data Collection</th>
</tr>
</thead>
</table>

iii. Skilled Nursing Facility admissions

<table>
<thead>
<tr>
<th>Description</th>
<th>Data Source</th>
<th>Frequency of Data Collection</th>
</tr>
</thead>
</table>

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

Chronic disease management

ii. ii. Coordination of care for individuals with chronic conditions

iv. Assessment of program implementation

Processes and lessons learned

v. 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**

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>NA</td>
<td></td>
</tr>
</tbody>
</table>

**Payment Type: Alternate Payment Methodology**

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly Case Rate to CMHO Health Homes</td>
<td></td>
</tr>
</tbody>
</table>

**Systematic Literature Review**

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. 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.

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 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.

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 rates 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 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 data 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)**

<table>
<thead>
<tr>
<th>Position</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatrist</td>
<td>5</td>
</tr>
<tr>
<td>Registered Nurse</td>
<td>2.5</td>
</tr>
<tr>
<td>MA Level Clinician</td>
<td>5</td>
</tr>
<tr>
<td>CPST Specialist – Hospital Liaison</td>
<td>1.0</td>
</tr>
<tr>
<td>CPST Specialist</td>
<td>5.5</td>
</tr>
<tr>
<td>Peer Specialist</td>
<td>.25</td>
</tr>
<tr>
<td>Total FTE Personnel</td>
<td>11.25</td>
</tr>
</tbody>
</table>

Tiered?