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State/Territory Name: Rhode Island

State Plan Amendment (SPA) #:16-001

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
JFK Federal Building, Government Center
Room 2275
Boston, Massachusetts 02203

Division of Medicaid and Children's Health Operations / Boston Regional Office

January 18, 2017

Elizabeth Roberts, Secretary
Executive Office of Health and Human Services
State of Rhode Island and Providence Plantations
57 Howard Avenue, LP Building
Cranston, RI 02920

Dear Secretary Roberts:

We are pleased to inform you of the approval of Rhode Island State Plan Amendment (SPA) No. 16-001, submitted March 15, 2016. This approval was granted on January 13, 2017 and is effective as of January 1, 2016. This SPA grants authority to implement a rate decrease and methodology change for CEDAR services. This SPA also implements revised quality metrics and oversight.

The final, approved, state plan pages can be viewed in the Medicaid Model Data Lab (MMDL). Please be aware that the SPAs remaining in the MMDL will be converted into the newer MacPro system in the coming months.

Please also note that it is the State's responsibility to undertake whatever reconciliation and settlement process is necessary to ensure that the payments made on or after 1/1/16 are consistent with the hereby approved methodology and adjust federal claiming accordingly. Likewise, any payments made prior to 1/1/16 must reflect the payment methodology approved during that time.

If you have any questions regarding this matter you may contact Lynn DelVecchio (617) 565-1201 or by e-mail at Lynn.DelVecchio@cms.hhs.gov

Sincerely,

/s/

Richard R. McGreal
Associate Regional Administrator

Cc: Darren J. McDonald, Ph.D., Interim Medicaid Director
Melody Lawrence, Interdepartmental Project Manager

Health Home State Plan Amendment

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

Transmittal Number: 16-0001 Supersedes Transmittal Number: 11-0006 Approved Effective Date: Jan 1, 2016 Approval Date: Jan 13, 2017
Attachment 3.1-H Page Number:

Submission Summary

Transmittal Number:
Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

16-0001

Supersedes Transmittal Number:
Please enter the Supersedes Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

11-0006

☑ **he Health Homes State Plan option under Section 1945 of the**

Name of Health Homes Program:

CONVERTED Rhode Island Health Home Services - Amendment

State Information

State/Territory name:	**Rhode Island**
Medicaid agency:	Rhode Island Executive Office of Health & Human Services

Authorized Submitter and Key Contacts

The authorized submitter contact for this submission package.

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Proposed Effective Date

01/01/2016 (mm/dd/yyyy)

Executive Summary

Summary description including goals and objectives:
Data conversion from previous Medicaid Model Data Lab.
Supersedes Transmittal Number:11-006
Transmittal Number:16-0001
This State Plan Amendment is in Attachment 3.1-H(14) of the State Plan, except for the Payment Methodologies section, which is in Attachment 4.19-B(TN 09-004) of the State Plan.
Medicaid recipients under the age of 21 who meet the following criteria are eligible for Cedar Services: 1) Suspected of having a severe mental illness, or severe emotional disturbance, 2) Suspected of having two or more of the following chronic conditions Mental Health Condition, Asthma, Diabetes, Developmental Disabilities, Down Syndrome, Mental Retardation, or Seizure Disorders; or 3) has one chronic condition listed previously and is at risk of developing a second.
Cedar Family Centers meeting the Health Homes criteria as established by the State in consultation with CMS will be certified by the State as Health Home providers. Eligible clients are free to choose from any Cedar Family Center to receive services. Cedar Family Centers are designed to provide a structured system for facilitating the assessment of need for, and the provision of high quality, evidence based medically necessary service that may be available for children pursuant to federal EPSDT requirements, and referrals to community based services and supports that benefit the child and family. Cedar Family Center Health Homes will operate as a "Designated Provider" of Health Home Services. The CHH Team minimally consists of a Licensed Clinician and a Family Service Coordinator. The CHH Team will consult, coordinate and collaborate on a regular basis with the child's Primary Care Physician/Medical Home and with other providers providing treatment services to that child. Medical Specialists and other Medical professionals will be included on the CHH Team based on the unique needs of each enrolled child. Cedar Family Centers, by Standard, provide all services in a patient and family centered manner.

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2016	$ 1900000.00
Second Year	2017	$ 2030000.00

Federal Statute/Regulation Citation

Section 2703 of the Patient Protection and Affordable Care of 2010

Governor's Office Review

- ○ **No comment.**
- ○ **Comments received.**
  Describe:
- ○ **No response within 45 days.**
- ◉ **Other.**
  Describe:
  This amendment has not been reviewed specifically with the Governor's Office. Under the Rhode Island Medicaid State Plan, the Governor has elected not to review the details of state plan materials. However, in accordance with Rhode Island law and practice, the Governor is kept apprised of major changes in the state plan.

  The federal fiscal impact values reported above reflect negative values due to an estimated reduction in expenditures.
  FFY 2016 Fiscal Impact = - $1,900,000.00
  FFY 2017 Fiscal Impact = - $2,030,000.00

Transmittal Number: 16-0001 Supersedes Transmittal Number: 11-0006 Approved Effective Date: Jan 1, 2016 Approval Date: Jan 13, 2017
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Submission - Public Notice

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

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

Indicate how public notice was solicited:

- ☐ **Newspaper Announcement**
- ☐ **Publication in State's administrative record, in accordance with the administrative procedures requirements.**
  Date of Publication:
  (mm/dd/yyyy)
- ☑ **Email to Electronic Mailing List or Similar Mechanism.**
  Date of Email or other electronic notification:
  11/30/2015 (mm/dd/yyyy)
  Description:

Notification of proposed SPA sent via email to list of interested parties including state agencies, providers, advocates, and others.

☑ **Website Notice**

Select the type of website:

☑ Website of the State Medicaid Agency or Responsible Agency

Date of Posting:

11/30/2015 (mm/dd/yyyy)

Website URL:

http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/SPA/15-017_Oral_Hearing_Announcement

☐ Website for State Regulations

Date of Posting:

(mm/dd/yyyy)

Website URL:

☐ Other

☑ **Public Hearing or Meeting**

Date	Time	Location
Feb 4, 2016	**10 AM**	**Arnold Conference Center, 111 Howard Avenue, Cranston, RI 02920**

☐ **Other method**

Indicate the key issues raised during the public notice period:(This information is optional)

☐ **Access**

Summarize Comments

Summarize Response

☐ **Quality**

Summarize Comments

Summarize Response

☐ **Cost**

Summarize Comments

Summarize Response

☐ **Payment methodology**

Summarize Comments

Summarize Response

☐ **Eligibility**

Summarize Comments

Summarize Response

☐ **Benefits**

Summarize Comments

Summarize Response

☐ **Service Delivery**

Summarize Comments

Summarize Response

☐ **Other Issue**

Transmittal Number: 16-0001 Supersedes Transmittal Number: 11-0006 Approved Effective Date: Jan 1, 2016 Approval Date: Jan 13, 2017
Attachment 3.1-H Page Number:

Submission - Tribal Input

☑ **One or more Indian health programs or Urban Indian Organizations furnish health care services in this State.**

☐ **This State Plan Amendment is likely to have a direct effect on Indians, Indian health programs or Urban Indian Organizations.**

☑ **The State has solicited advice from Tribal governments prior to submission of this State Plan Amendment.**

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

Tribal consultation was conducted in the following manner:

☑ **Indian Tribes**

Indian Tribes	
Name of Indian Tribe: Narragansett Date of consultation: 11/30/2015 (mm/dd/yyyy) Method/Location of consultation: Email and USPS certified letter regarding the changes.	

☐ **Indian Health Programs**

☐ **Urban Indian Organization**

Indicate the key issues raised in Indian consultative activities:

☐ **Access**

Summarize Comments

Summarize Response

☐ **Quality**

Summarize Comments

Summarize Response

☐ **Cost**

Summarize Comments

Summarize Response

☐ **Payment methodology**

Summarize Comments

Summarize Response

☐ **Eligibility**

Summarize Comments

Summarize Response

☐ **Benefits**

Summarize Comments

Summarize Response

☐ **Service delivery**

Summarize Comments

Summarize Response

☑ **Other Issue**

Issues	
Issue Name: No issues raised **Summarize Comments** No issues raised **Summarize Response** N/A	

Transmittal Number: 16-0001 Supersedes Transmittal Number: 11-0006 Approved Effective Date: Jan 1, 2016 Approval Date: Jan 13, 2017
Attachment 3.1-H Page Number:

Submission - SAMHSA Consultation

☑ **The State provides assurance that it has consulted and coordinated with the Substance Abuse and Mental Health Services Administration (SAMHSA) in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.**

Date of Consultation	
Date of consultation: 04/21/2011 (mm/dd/yyyy)	

Transmittal Number: 16-0001 Supersedes Transmittal Number: 11-0006 Approved Effective Date: Jan 1, 2016 Approval Date: Jan 13, 2017
Attachment 3.1-H Page Number:

Health Homes Population Criteria and Enrollment

Population Criteria

The State elects to offer Health Homes services to individuals with:

☑ **Two or more chronic conditions**

Specify the conditions included:

- ☑ **Mental Health Condition**
- ☐ **Substance Abuse Disorder**
- ☑ **Asthma**
- ☑ **Diabetes**
- ☐ **Heart Disease**
- ☐ **BMI over 25**

Other Chronic Conditions	
Developmental Disability	
Down Syndrome	
Mental Retardation	
Seizure Disorders	

Additional description of other chronic conditions:

☑ **One chronic condition and the risk of developing another**

Specify the conditions included:

- ☑ **Mental Health Condition**
- ☐ **Substance Abuse Disorder**
- ☑ **Asthma**
- ☑ **Diabetes**
- ☐ **Heart Disease**
- ☐ **BMI over 25**

Other Chronic Conditions	
Developmental Disability	
Down Syndrome	
Mental Retardation	
Seizure Disorders	

Specify the criteria for at risk of developing another chronic condition:
Cedars will review medical records and collaborate with other service providers to assess if there is any evidence of risk factors present (such as meeting developmental milestones, activity level, weight, family history etc.). Cedars look at the child's clinical and treatment history to get an idea of their overall progress and functioning as well as the child and family's ability to engage in treatment. Overall family functioning plays a major role in determining family and environmental risk factors that could play into future clinical needs. For instance, a family history of substance abuse or mental health needs may put the child at risk for other medical and behavioral health needs (i.e. a parent who struggles with their own mental health needs may have difficulty following through with OT recommendations which may lead to increased medical problems and the need for more involved therapy).
Medicaid recipients who meet the following criteria are eligible for Cedar Services:
o Suspected of having a severe mental illness, or severe emotional disturbance
o Suspected of having two or more chronic conditions as listed below:
o Mental Health Condition

o Asthma
o Diabetes
o Developmental Disabilities
o Down Syndrome
o Mental Retardation
o Seizure Disorders
o Has one chronic condition listed above and is at risk of developing a second

Additional description of other chronic conditions:

☑ **One or more serious and persistent mental health condition**

Specify the criteria for a serious and persistent mental health condition:
As defined by SAMHSA, "Serious Emotional Disturbance (SED) is used to refer to children and youth who have had a diagnosable mental, behavioral, or emotional disorder in the past year, which resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities."

Geographic Limitations

☑ **Health Homes services will be available statewide**

Describe statewide geographical phase in/expansion. This should include dates and corresponding geographical areas that bring the program statewide.

If no, specify the geographic limitations:

○ **By county**

Specify which counties:

○ **By region**

Specify which regions and the make-up of each region:

○ **By city/municipality**

Specify which cities/municipalities:

○ **Other geographic area**

Describe the area(s):

Enrollment of Participants

Participation in a Health Homes is voluntary. Indicate the method the State will use to enroll eligible Medicaid individuals into a Health Home:

◉ **Opt-In to Health Homes provider**

Describe the process used:
Families may access a Cedar Family Center through self-referral or by other referral sources, including a Primary Care Physician, a Health Plan or other providers. When these sources initiate the referral, the Cedar Family Center must contact the family within ten (10) calendar days of referral. Cedar shall document attempts made to reach the family and response to the referral source.

A family may choose to use a Cedar Family Center for assessment of needs, referral, and care coordination. The Cedar staff will assist the family in identifying and coordinating services and supports. The Cedar staff will work with the family to support efforts to gain access to needed services and to track receipt of services.

Cedar Services are voluntary and the family may opt out at any time. Families may choose any certified Cedar Family Center. Families consent to treatment, in writing, with the Cedar Family Center of their choosing.

○ **Automatic Assignment with Opt-Out of Health Homes provider**

Describe the process used:

☐ **The State provides assurance that it will clearly communicate the opt-out option to all individuals assigned to a Health Home under an opt-out process and submit to CMS a copy of any letter or other communication used to inform such individuals of their right to choose.**

○ **Other**

Describe:

☑ **The State provides assurance that eligible individuals will be given a free choice of Health Homes providers.**

- ☑ **The State provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services.**
- ☑ **The State provides assurance that hospitals participating under the State Plan or a waiver of such plan will be instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Homes providers.**
- ☑ **The State provides assurance that it will have the systems in place so that only one 8-quarter period of enhanced FMAP for each Health Homes enrollee will be claimed. Enhanced FMAP may only be claimed for the first eight quarters after the effective date of a Health Homes State Plan Amendment that makes Health Home Services available to a new population, such as people in a particular geographic area or people with a particular chronic condition.**
- ☑ **The State assures that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.**

Transmittal Number: 16-0001 Supersedes Transmittal Number: 11-0006 Approved Effective Date: Jan 1, 2016 Approval Date: Jan 13, 2017
Attachment 3.1-H Page Number:

Health Homes Providers

Types of Health Homes Providers

☑ **Designated Providers**

Indicate the Health Homes Designated Providers the State includes in its program and the provider qualifications and standards:

☐ **Physicians**

Describe the Provider Qualifications and Standards:

☐ **Clinical Practices or Clinical Group Practices**

Describe the Provider Qualifications and Standards:

☐ **Rural Health Clinics**

Describe the Provider Qualifications and Standards:

☐ **Community Health Centers**

Describe the Provider Qualifications and Standards:

☐ **Community Mental Health Centers**

Describe the Provider Qualifications and Standards:

☐ **Home Health Agencies**

Describe the Provider Qualifications and Standards:

☑ **Other providers that have been determined by the State and approved by the Secretary to be qualified as a health home provider:**

☑ **Case Management Agencies**

Describe the Provider Qualifications and Standards:

Cedar Family Centers require RI state certification by the Executive Office of Health and Human Services (EOHHS) and must follow the EOHHS Practice Standards established for Cedar Family Centers. Link to updated standards:
http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/Cedarr_Updated_Certification_Standards.pdf

☐ **Community/Behavioral Health Agencies**

Describe the Provider Qualifications and Standards:

☐ **Federally Qualified Health Centers (FQHC)**

Describe the Provider Qualifications and Standards:

☐ **Other (Specify)**

☐ **Teams of Health Care Professionals**

Indicate the composition of the Health Homes Teams of Health Care Professionals the State includes in its program. For each type of provider indicate the required qualifications and standards:

☐ **Physicians**

Describe the Provider Qualifications and Standards:

☐ **Nurse Care Coordinators**

Describe the Provider Qualifications and Standards:

☐ **Nutritionists**

Describe the Provider Qualifications and Standards:

☐ **Social Workers**

Describe the Provider Qualifications and Standards:

☐ **Behavioral Health Professionals**

Describe the Provider Qualifications and Standards:

☐ **Other (Specify)**

☐ **Health Teams**

Indicate the composition of the Health Homes Health Team providers the State includes in its program, pursuant to Section 3502 of the Affordable Care Act, and provider qualifications and standards:

☐ **Medical Specialists**

Describe the Provider Qualifications and Standards:

☐ **Nurses**

Describe the Provider Qualifications and Standards:

☐ **Pharmacists**

Describe the Provider Qualifications and Standards:

☐ **Nutritionists**

Describe the Provider Qualifications and Standards:

☐ **Dieticians**

Describe the Provider Qualifications and Standards:

☐ **Social Workers**

Describe the Provider Qualifications and Standards:

☐ **Behavioral Health Specialists**

Describe the Provider Qualifications and Standards:

☐ **Doctors of Chiropractic**

Describe the Provider Qualifications and Standards:

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Describe the Provider Qualifications and Standards:

☐ **Physicians' Assistants**

Describe the Provider Qualifications and Standards:

Supports for Health Homes Providers

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

1. **Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered Health Homes services,**
2. **Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines,**

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

Description:

Technical assistance is offered to providers through monthly site visit meetings. Topics of discussion include: development of new informational materials-outreach efforts, code and diagnosis for billing, Kidsnet, billing segments, crisis plan development, Professional Development system (care coordination planning committee), RI Community Health Team collaboration, PCP and Health Plan coordination, Kidsnet- user roles and data sharing, hearings and complaints, FCCP/DCYF involved families, collaboration with direct service providers, performance measures/outcomes measures, and the Common Referral Tool.

The frequency of learning collaboratives vary, but are typically held at least twice annually. The learning collaboratives provide Cedars with an opportunity to learn best practices in various areas such as care coordination, integration of HIT, population health management, behavioral health, patient engagement, etc. Learning collaboratives are not mandatory, but providers are strongly encouraged to attend.

Cedars are typically very proficient in utilizing HIT. Therefore, specific trainings on the adoption and use of HIT, such as integration with KIDSNET, will be provided on an ad hoc basis if there is a need. EOHHS assesses the Cedar Health Homes upon certification to determine readiness and identify any needs for additional training. The information that Cedar Health Homes are required to provide as part of their application for certification includes, but is not limited to; organization background information, organizational structure, description of program approach (including family centeredness, community focus, staff competency, organizational capacities, ability to demonstrate relationships with provider community, scope of practice), quality improvement plan, compliance processes and procedures, administrative and financial systems, independent audits, ownership and control interests, and mechanisms for data collection and reporting of outcome measures.

Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Homes Services.

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

Cedar Family Centers meeting the Health Homes criteria as established by the State in consultation with CMS will be certified by the State as Health Home providers. Cedar family centers currently operate under Certification Standards established by the State. Certification Standards have been amended as required to ensure they meet Health Home requirements. Eligible clients are free to choose from any Cedar Family Center to receive services. Cedar Family Centers are designed to provide a structured system for facilitating the assessment of need for, and the provision of high quality, evidence based medically necessary service that may be available for children pursuant to federal Early and Periodic Screening Diagnosis and Treatment (EPSDT) requirements, as well as referrals to community based services and supports that benefit the child and family. Cedar Family Center Health Homes will operate as a "Designated Provider" of Health Home Services. All Cedar Family Centers employ independently licensed health care professional such as; Psychologists licensed Independent Clinical Social Workers Masters Level Registered Nurses, or licensed Marriage and Family Therapists; Cedar Family centers also employ staff trained to provide care coordination, individual and family support and other functions expected from a health home. The CHH Team minimally consists of a Licensed Clinician and a Family Service Coordinator, The CHH Team will consult, coordinate and collaborate on a regular basis with the child's Primary Care Physician/Medical Home and with other providers providing treatment services to that child. Medical Specialists and other Medical professionals will be included on the CHH Team based on the unique needs of each enrolled child. Cedar Family Centers, by Standard, provide all services in a patient and family centered manner.

Provider Standards

The State's minimum requirements and expectations for Health Homes providers are as follows:

Rhode Island has established Certification Standards for Cedar Family Centers and will utilize those Standards as the basis to certify Health Home providers. The Standards can be found at:
http://www.eohhs.ri.gov/Consumer/ConsumerInformation/Healthcare/PeoplewithSpecialNeedsandDisabilities/Children.aspx

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

Introduction

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

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

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

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

Provider Standards

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

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

Cedar family Centers are strongly encouraged to attend learning collaboratives, as offered, to increase their collaboration and integration with the State of RI's patient centered medical home initiative for children. Families may access a Cedar Family Center through self-referral or by other referral sources, including a Primary Care Physician, a Health Plan or other providers. When these sources initiate the referral, the Cedar Family Center must contact the family within ten (10) calendar days of referral. Cedar shall document attempts made to reach the family and response to the referral source.

The Cedars currently receive some admission/discharge notifications via fax, call or email from the medical/psychiatric inpatient facilities. To improve upon this process, the Cedars do active outreach to the medical/psychiatric inpatient facilities to remind the facilities of their request to receive admission/discharge notifications in order to facilitate effective transitional care.

Health Homes Service Delivery Systems

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

☑ **Fee for Service**
☐ **PCCM**

○ **PCCMs will not be a designated provider or part of a team of health care professionals. The State provides assurance that it will not duplicate payment between its Health Homes payments and PCCM payments.**

○ **The PCCMs will be a designated provider or part of a team of health care professionals.**

The PCCM/Health Homes providers will be paid based on the following payment methodology outlined in the payment methods section:

☐ **Fee for Service**

☐ **Alternative Model of Payment (describe in Payment Methodology section)**

☐ **Other**
Description:

☐ **Requirements for the PCCM participating in a Health Homes as a designated provider or part of a team of health care professionals will be different from those of a regular PCCM.**

If yes, describe how requirements will be different:

☐ **Risk Based Managed Care**

○ **The Health Plans will not be a Designated Provider or part of a Team of Health Care Professionals. Indicate how duplication of payment for care coordination in the Health Plans' current capitation rate will be affected:**

☐ **The current capitation rate will be reduced.**

☐ **The State will impose additional contract requirements on the plans for Health Homes enrollees.**

Provide a summary of the contract language for the additional requirements:

☐ **Other**

Describe:

○ **The Health Plans will be a Designated Provider or part of a Team of Health Care Professionals.**

Provide a summary of the contract language that you intend to impose on the Health Plans in order to deliver the Health Homes services.

☐ **The State provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review.**

The State intends to include the Health Homes payments in the Health Plan capitation rate.

○ **Yes**

☐ **The State provides an assurance that at least annually, it will submit to the regional office as part of their capitated rate Actuarial certification a separate Health Homes section which outlines the following:**

- **Any program changes based on the inclusion of Health Homes services in the health plan benefits**
- **Estimates of, or actual (base) costs to provide Health Homes services (including detailed a description of the data used for the cost estimates)**
- **Assumptions on the expected utilization of Health Homes services and number of eligible beneficiaries (including detailed description of the data used for utilization estimates)**
- **Any risk adjustments made by plan that may be different than overall risk adjustments**
- **How the final capitation amount is determined in either a percent of the total capitation or an actual PMPM**

☐ **The State provides assurance that it will design a reporting system/mechanism to monitor the use of Health Homes services by the plan ensuring appropriate documentation of use of services.**

☐ **The State provides assurance that it will complete an annual assessment to determine if the payments delivered were sufficient to cover the costs to deliver the Health Homes services and provide for adjustments in the rates to compensate for any differences found.**

○ **No**

Indicate which payment methodology the State will use to pay its plans:

☐ **Fee for Service**

☐ **Alternative Model of Payment (describe in Payment Methodology section)**

☐ **Other**

Description:

☐ **Other Service Delivery System:**

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

☐ **The State provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review.**

Transmittal Number: 16-0001 Supersedes Transmittal Number: 11-0006 Approved Effective Date: Jan 1, 2016 Approval Date: Jan 13, 2017
Attachment 3.1-H Page Number:

Health Homes Payment Methodologies

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

☐ **Fee for Service**

☐ **Fee for Service Rates based on:**

☐ **Severity of each individual's chronic conditions**

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

☐ **Capabilities of the team of health care professionals, designated provider, or health team.**

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

☐ **Other: Describe below.**

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

☐ **Per Member, Per Month Rates**

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

☐ **Incentive payment reimbursement**

Provide a comprehensive description of incentive payment policies that the State will use to reimburse in addition to the unit base rates. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain: the incentives that will be reimbursed through the methodology, how the supplemental incentive payments are tied to the base rate activities, the criteria used to determine a provider's eligibility to receive the payment, the methodology used to determine the incentive payment amounts, and the frequency and timing through which the Medicaid agency will distribute the payments to providers.

☐ **PCCM Managed Care (description included in Service Delivery section)**

☐ **Risk Based Managed Care (description included in Service Delivery section)**

☑ **Alternative models of payment, other than Fee for Service or PM/PM payments (describe below)**

☐ **Tiered Rates based on:**

☐ **Severity of each individual's chronic conditions**

☐ **Capabilities of the team of health care professionals, designated provider, or health team.**

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

☑ **Rate only reimbursement**

Provide a comprehensive description of the policies the State will use to establish Health Homes alternative models of payment. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain the nature of the payment, the activities and associated costs or other relevant factors used to determine the payment amount, any limiting criteria used to determine if a provider is eligible to receive the payment, and the frequency and timing through which the Medicaid agency will distribute the payments to providers.

Cedar Family Centers will receive an initial payment of $900.00 upon completion and submitted claims for the following deliverables: (1) An assessment of the family; and (2) Family Care Plan. Cedar Family Centers will then receive a Per Member Per Month (PMPM) of $25.00 upon submission of at least one claim per month totaling a minimum of one hour of child and/or family contact directly related to the achievement of action plan goals.

Twice annually, the EOHHS will conduct claims data reviews as well as Cedar Record Reviews during on site record reviews to ensure that the billed services were delivered and that all deliverables are complete and of a high quality. EOHHS will review a random sample of 5% of the open cases and 5% of the closed cases (minimum of ten (10) or maximum of forty (40) records). During the record reviews, EOHHS will review the following: timeliness of assessment, diagnosis, clinical endorsement, client/parent/caregiver endorsement, complete components of an assessment, complete components of a family care plan, crisis planning, care coordination aligned with family care plan, health promotion aligned with family care plan, face to face interactions with client/family, formal and informal connections aligned with family care plan, health screening (BMI, Depression screen) and Family Satisfaction Surveys.

The EOHHS and Cedar Family Centers will establish a performance baseline for which each Cedar will be held accountable to achieve based on data collected from the above mentioned Cedar Record Reviews. On a yearly basis, if a Cedar does not reach the established baseline, they may be subject to a 10% recoupment of funds.

Explain how the State will ensure non-duplication of payment for similar services that are offered through another method, such as 1915(c) waivers or targeted case management.

EOHHS will ensure non-duplication of payment for similar services through regular monitoring of the State of RI MMIS system which employs system edits that ensure non-duplication.

☑ **The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule**

☑ **The State provides assurance that it shall reimburse Health Homes providers directly, except when there are employment or contractual arrangements.**

Submission - Categories of Individuals and Populations Provided Health Homes Services

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

☑ **Categorically Needy eligibility groups**

Health Homes Services (1 of 2)

Category of Individuals
CN individuals

Service Definitions

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

Comprehensive Care Management

Definition:
Comprehensive CM services are conducted with an individual and involves the identification, development, and implementation of a care plan that addresses the needs of the whole person. CM includes providing access to and the coordination of long term services and supports. Comprehensive CM is provided by Cedar Family Centers by working with the child/family to assess current issues, identify continuing needs, and identify resources/services to assist the child/family to address needs through an Assessment and development of a Family Care Plan (FCP).Interventions/objectives identified in the FCP should map back to child and family's designated outcomes and must include; action steps, timelines for completion, responsible parties, and date action step is achieved.FCP shall be developed with the family in coordination with existing community resources and is based on assessment information, strengths/needs of the child/family and on clinical protocols which indicate the types and intensity of care considered medically necessary. Support shall be targeted to occur in the most natural environment and in the least restrictive setting.FCP can include a referral to direct treatment or support services and Cedar direct supports/care coordination and should identify both natural/formal supports needed.Natural supports are individuals identified by the youth and family who know the youth and family well and who provide support without being paid.Where formal supports are involved, attention should be given toward building on the strengths of the child, family, extended family and community supports to support long-term empowerment.An Assessment must be completed within 45 calendar days of initial request and the FCP must be completed within 45 calendar days from referral. A Needs Assessment and Family Care Plan may be in place for up to twelve (12) months. Updates shall be added, if needed, to the assessment and plan throughout the course of the case opening. The FCP must be developed with and signed by the child's parents/guardians as an agreement to work towards the action plan.FCPs must be reviewed and signed by clinician on an annual basis.If the child or family's needs change additional information can be obtained as needed.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
Cedar Family Centers utilize a secure HIPAA compliant electronic case management system to support the activities required in order to provide Comprehensive Care Management. These activities include: Identifying client needs by gathering data from other resources including: medical and human service providers, school programs. Integrating the information into the treatment planning process. Developing the child specific Action Plan. Facilitate cross-system coordination, integration and supports access to service interventions to address the medical, social, behavioral and other needs of the child. Assure active participation of the eligible child and family in the provision of care, assessment of progress and collection and analysis of both utilization and outcome data. Submit quarterly submission of enrollment data, with family notice and opportunity to opt out, to the RI Department of Health for the KIDSNET system. CEDARAccess RI KIDSNET Child Health information System which provides access to information vital to the provision of Comprehensive Care Management. This information includes: Blood Lead levels, Immunizations, Newborn Developmental Assessment, Hearing Assessment. WIC and Early Intervention participation CEDAR

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☑ **Behavioral Health Professionals or Specialists**

Description

BH Professional or Specialist - Description: Master's degree in Social Work or Psychology preferred. Must have one of the following professional licensures - LCSW, LICSW, LMHC, LMFT, Master's degree Level RN, PhD. Must have experience working with Children with Special Health Care Needs. Information for the Assessment and Family Care Plan may be collected by a licensed clinician. Each Assessment and Family Care plan must be reviewed and signed by an independently licensed clinician and may be in place for up to twelve (12) months.

☐ **Nurse Care Coordinators**

Description

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name
Family Service Coordinator

Description
Information for the Assessment and Family Care Plan may be collected by a Family Service Coordinator. Family Service Coordinators must have direct experience in, knowledge of, or demonstrate capacity in strength-based family centered practice, needs assessment and care plan development, community resources available to children and families, medical complexities, Autism Spectrum Disorders, behavioral health, developmental disabilities, and legal issues experienced by families of children with special health care needs.

Care Coordination

Definition:
Care coordination is the implementation of the Action Plan developed to guide comprehensive care management in a manner that is flexible and meets the need of the individual receiving services. The goal is to ensure that all services are coordinated across provider settings, which may include medical, social and, when age appropriate,

vocational educational services, Services must be coordinated and information must be centralized and readily available to all team members. care coordination also includes providing access to and the coordination of long term services and supports.Changes in any aspect of an individual's health must be noted, shared with the team, and used to change the care plan as necessary. All relevant Information is to be obtained and reviewed by the team. Care Coordination is designed to be delivered in a flexible manner best suited to the family's preferences and to support goals that have been identified by developing linkages and skills. In order for families to reach their full potential and Increase their independence in obtaining and accessing services. This includes: • Follow up with families, Primary Care provider, service providers and others involved in the child's care to ensure the efficient provision of services. • Provide information to families about specific disorders, treatment and provider options, systems of support, services, assistance and legal rights available to Children with Special Health Care Needs and their families, resources beyond the scope of services covered by Medicaid, such as those which may be available from other parents, family members, community-based organizations, service providers, grants, social programs, funding options, school-based services, faith based organizations, etc. • Assistance in locating and arranging specialty evaluations as needed, in coordination with the child's Primary Care Provider. Care Coordination will be performed by the member of the Cedar Team (Licensed Clinician or Family Service Coordinator) that is most appropriate based upon the issue that is being addressed.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
The electronic case management system described above will also be utilized to support the delivery of Care Coordination by providing easy and immediate access to comprehensive information and tools (such as the Individual care plan, contact information, other involvements such as school, behavioral health and specialty care) that will assist the Cedar Team in meeting the needs of each child and family.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☑ **Behavioral Health Professionals or Specialists**

Description
Master's degree in Social Work or Psychology preferred. Must have one of the following professional licensures -LCSW, LICSW, LMHC, LMFT, Master's degree Level RN, PhD. Independently licensed clinician that is licensed by the State of RI Dept of Health, demonstrating competency in strength-based family centered practice, needs assessment and care plan development, medical complexities, Autism Spectrum Disorders, behavioral health, and/or Developmental disabilities.

Licensed clinicians are required to sign off on all Assessments and Family Care Plans/Action Plans. Depending on the clinical necessity, licensed clinicians may also:
• Provide and assist families in obtaining information about specific disorders, treatment and provider options, systems of support, services, assistance and legal rights available to Children with Special Health Care Needs and their families, resources beyond the scope of services covered by Medicaid, such as those which may be available from other parents, family members, community-based organizations, service providers, grants, social programs, insurance plans, school-based services, faith based organizations, etc.
• Assistance in locating and arranging specialty evaluations as needed, in coordination with the child's Primary Care Provider and payer. This also includes follow-up and consultation with the evaluator as needed.
• Follow up with families, Primary Care provider, service providers and others involved in the child's care to ensure engagement of services and supports.

☐ **Nurse Care Coordinators**

Description

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name

Family Service Coordinator

Description

Family Service Coordinator demonstrating competency in strength-based family centered practice, community resources available to children and families, medical complexities and or legal issues experienced by families of children with special health care needs.

• Provide and assist families in obtaining information about specific disorders, treatment and provider options, systems of support, services, assistance and legal rights available to Children with Special Health Care Needs and their families, resources beyond the scope of services covered by Medicaid, such as those which may be available from other parents, family members, community-based organizations, service providers, grants, social programs, insurance plans, school-based services, faith based organizations, etc.
• Assistance in locating and arranging specialty evaluations as needed, in coordination with the child's Primary Care Provider and payer. This also includes follow-up and consultation with the evaluator as needed.
• Follow up with families, Primary Care provider, service providers and others involved in the child's care to ensure engagement of services and supports.

Health Promotion

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

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:

The electronic case management system described above will also be utilized to support the delivery of Health Promotion by providing easy and immediate access to comprehensive information and tools (such as the Individual care plan, contact information, other involvements such as school, behavioral health and specialty care) that will assist the Cedar Team in meeting the needs of each child and family.See Care Coordination description above. In addition Cedar Family Centers provide their staff with access to a wide range of resource/educational material(s) in multiple formats for use in supplementing and facilitating Health Promotion activities. This information will be provided in a hard copy or electronic format that is most appropriate for the child and families use, including multiple languages.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☑ **Behavioral Health Professionals or Specialists**

Description
Master's degree in Social Work or Psychology preferred. Must have one of the following professional licensures -LCSW, LICSW, LMHC, LMFT, Master's degree Level RN, PhD. Independently licensed clinician that is licensed by the State of RI Dept of Health, demonstrating competency in strength-based family centered practice, needs assessment and care plan development, medical complexities, Autism Spectrum Disorders, behavioral health, and/or Developmental disabilities.
Behavioral Health Professionals or Specialists work with the family to:
o assess the most pressing needs of the child and family;
o identify triggers and patterns linked with problems;
o set individual goals for the child/family in the areas of self-management and skill acquisition
o help develop specific intervention strategies that they will be able to carry out in the home environment to work toward the established goals

☐ **Nurse Care Coordinators**

Description

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name
Family Service Coordinator

Description
Family Service Coordinator demonstrating competency in strength-based family centered practice, community resources available to children and families, medical complexities and or legal issues experienced by families of children with special health care needs.
Family Service Coordinators work with the family to:
o Assist in assessing the most pressing needs of the child and family;
o Assist in identifying triggers and patterns linked with problems;
o Assist in setting individual goals for the child/family in the areas of self-management and skill acquisition
o Assist in helping develop specific intervention strategies that they will be able to carry out in the home environment to work toward the established goals

Health Homes Services (2 of 2)

Category of Individuals
CN individuals

Service Definitions

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

Comprehensive transitional care from inpatient to other settings, including appropriate follow-up

Definition:
OVERARCHING STATEWIDE DEFINITION; Comprehensive transitional care services focus on the movement of individuals from any medical/psychiatric inpatient or other out·of-home setting into a community setting and between different service delivery models. Members of the health team work closely with the individual to transition the individual smoothly back in to the community and share information with the discharging organization in order to prevent any gaps in treatment that could result in a re-admission. Cedar HEALTH HOME SPECIFIC DEFINITION: Transitional Care will be provided by the Cedar Team to both existing clients who have been hospitalized or placed in other non-community settings as well as newly Identified clients who are entering the community. Cedar Family Centers are not required to establish written protocols on the care transition process with hospitals or other institutions. The Cedar Team will collaborate with all parties involved including the facility, primary care physician, Health Plan (if enrolled) and community providers to ensure a smooth discharge into the community and prevent subsequent re-admission(s). These service include providing access to and the coordination of long term services and supports.Transitional Care is not limited to Institutional Transitions but applies to all transitions that will occur throughout the development of the child and includes transition from Early Intervention into School based services and pediatric services to adult services. Cedar Family Centers have and continue to improve on their relationships with the health plan providers of their children and families in order to facilitate effective transitional care.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
The electronic case management system described above will also be utilized to support the delivery of comprehensive transitional care by providing easy and immediate access to comprehensive information and tools (such as the Individual care plan, contact information, other involvements such as school, behavioral health and specialty care) that will assist the Cedar Team in meeting the needs of each child and family. In addition Cedar

Family Centers provide their staff with access to a wide range of resource/educational material(s) in multiple formats for use in supplementing and facilitating comprehensive transitional care activities. This information will be provided in hard copy or electronic format that is most appropriate for the child and families use, including multiple languages.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☑ **Behavioral Health Professionals or Specialists**

Description
Master's degree in Social Work or Psychology preferred. Must have one of the following professional licensures -LCSW, LICSW, LMHC, LMFT, Master's degree Level RN, PhD. Independently licensed clinician that is licensed by the State of RI Dept of Health, demonstrating competency in strength-based family centered practice, needs assessment and care plan development, medical complexities, Autism Spectrum Disorders, behavioral health, and/or Developmental disabilities.
Depending on the clinical necessity, licensed clinicians will collaborate with all parties involved with a family including the inpatient facility, primary care physician, Health Plan (if enrolled) and community providers to ensure a smooth discharge into the community and prevent subsequent re-admission(s). Transitional Care is not limited to Institutional Transitions and includes transition from pediatric services to adult services.

☐ **Nurse Care Coordinators**

Description

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name

Family Service Coordinator

Description
Family Service Coordinator demonstrating competency in strength-based family centered practice, community resources available to children and families, medical complexities and or legal issues experienced by families of children with special health care needs.
Collaborate with all parties involved with a family including the inpatient facility, primary care physician, Health Plan (if enrolled) and community providers to ensure a smooth discharge into the community and prevent subsequent re-admission(s). Transitional Care is not limited to Institutional Transitions and includes transition from pediatric services to adult services.

Individual and family support, which includes authorized representatives

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

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
The electronic case management system described above will also be utilized to support the delivery of individual/family support by providing easy and immediate access to comprehensive information and tools (such as the Individual care plan, contact information, other involvements such as school, behavioral health and specialty care) that will assist the Cedar Team in meeting the needs of each child and family. In addition Cedar Family Centers provide their staff with access to a wide range of resource/educational material(s) in multiple formats for use in supplementing and facilitating individual/family support activities. This information will be provided in a hard copy or electronic format that is most appropriate for the child and families use, including multiple languages.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☑ **Behavioral Health Professionals or Specialists**

Description
Master's degree in Social Work or Psychology preferred. Must have one of the following professional licensures -LCSW, LICSW, LMHC, LMFT, Master's degree Level RN, PhD. Independently licensed clinician that is licensed by the State of RI Dept of Health, demonstrating competency in strength-based family centered practice, needs assessment and care plan development, medical complexities, Autism Spectrum Disorders, behavioral health, and/or Developmental disabilities.
Depending on the clinical necessity, licensed clinicians will 1) provide assistance to the family in accessing and coordinating services (these services include the full range of services that impact on Children with Special Health Care Needs and their families and may include, but are not limited to, health, behavioral health, education, substance abuse, juvenile justice and social and family support services), 2) actively integrate the full range of services into a comprehensive Family Care Plan, and 3) at the family's request, play the principal role as organizer, information source, guide, advocate, and facilitator for the family by helping the family to assess strengths and needs, identify treatment goals and services, and navigate agency and system boundaries.

☐ **Nurse Care Coordinators**

Description

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

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☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name

Family Service Coordinator

Description

Family Service Coordinator demonstrating competency in strength-based family centered practice, community resources available to children and families, medical complexities and or legal issues experienced by families of children with special health care needs.
Family Service Coordinators will 1) provide assistance to the family in accessing and coordinating services (these services include the full range of services that impact on Children with Special Health Care Needs and their families and may include, but are not limited to, health, behavioral health, education, substance abuse, juvenile justice and social and family support services), 2) actively integrate the full range of services into a comprehensive Family Care Plan, and 3) at the family's request, play the principal role as organizer, information source, guide, advocate, and facilitator for the family by helping the family to assess strengths and needs, identify treatment goals and services, and navigate agency and system boundaries.

Referral to community and social support services, if relevant

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 medical1 behavioral, educational, and social and community issues. Cedar HEALTH HOME SPECIFIC DEFINITION: Referral to Community and Social Support Services will be provided by members of the Cedar Team and will include information about formal and informal resources beyond the scope of services covered by Medicaid, such as those which may be available from other parents, family members, community-based organizations, service providers, grants, social

programs, funding options including the family's health coverage, school-based services, faith based organizations, etc. This includes providing access to and the coordination of long term services and supports. Whenever possible, families will be informed of opportunities and supports that are closest to home, that are the least restrictive and that promote integration in the home and community. Members of the Cedar Team will emphasize the use of informal, natural community supports as a primary strategy to assist children and families.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum.
The electronic case management system described above will also be utilized to support the delivery of referral services by providing easy and immediate access to comprehensive information and tools (such as the Individual care plan, contact information, other involvements such as school, behavioral health and specialty care) that will assist the Cedar Team in meeting the needs of each child and family. In addition Cedar Family Centers provide their staff with access to a wide range of resource/educational material(s) in multiple formats for use in supplementing and facilitating Referral to Community and Social Support activities. This information will be provided in a hard copy or electronic format that is most appropriate for the child and families use, including multiple languages.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☑ **Behavioral Health Professionals or Specialists**

Description
Master's degree in Social Work or Psychology preferred. Must have one of the following professional licensures -LCSW, LICSW, LMHC, LMFT, Master's degree Level RN, PhD. Independently licensed clinician that is licensed by the State of RI Dept of Health, demonstrating competency in strength-based family centered practice, needs assessment and care plan development, medical complexities, Autism Spectrum Disorders, behavioral health, and/or Developmental disabilities.
Depending on the clinical necessity, licensed clinicians will 1) refer to Community and Social Support Services which will include information about formal and informal resources beyond the scope of services covered by Medicaid, such as those which may be available from other parents, family members, community-based organizations, service providers, grants, social programs, insurance payers, school-based services, faith based organizations, etc., 2) whenever possible, families will be informed of opportunities and supports that are closest to home, that are the least restrictive and that promote integration in the home and community and 3) emphasize the use of informal, natural community supports as a primary strategy to assist children and families.

☐ **Nurse Care Coordinators**

Description

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name

Family Service Coordinator

Description

Family Service Coordinator demonstrating competency in strength-based family centered practice, community resources available to children and families, medical complexities and or legal issues experienced by families of children with special health care needs.
Family Service Coordinators will 1) refer to Community and Social Support Services which will include information about formal and informal resources beyond the scope of services covered by Medicaid, such as those which may be available from other parents, family members, community-based organizations, service providers, grants, social programs, insurance payers, school-based services, faith based organizations, etc., 2) whenever possible, families will be informed of opportunities and supports that are closest to home, that are the least restrictive and that promote integration in the home and community, and 3) emphasize the use of informal, natural community supports as a primary strategy to assist children and families.

Health Homes Patient Flow

Describe the patient flow through the State's Health Homes system. The State must submit to CMS flow-charts of the typical process a Health Homes individual would encounter:

Families access a Cedar through self-referral or other referral sources.When these sources initiate the referral, the Cedar must contact family within 10 calendar days.A family may choose to use a Cedar for assessment of needs, referral, and care coordination.The Cedar staff will assist the family in identifying and coordinating services and supports and to support efforts to gain access to needed services and to track receipt of services.A Needs Assessment must be completed within 45 calendar days of initial request, or sooner, based upon the urgency of the child and family's needs.The initial Family Care Plan (FCP) must be completed within 45 calendar days from referral.FCP must be reviewed and signed by an independently licensed clinician and may be in place for up to 12 months.If needed, the Cedar will work with family to develop individualized Crisis Support Plan which includes individuals or agencies for the family to contact in the event of a specific crisis (e.g., child's PCP, local mental health center) and actions to take to ensure safety of child and family.The plan should be reviewed and updated as needed.From first contact family members are expected to be fully informed about the role of the Cedar and knowledgeable about transition/discharge planning from the start of services.Discharge planning may include meetings with families and other involved parties in order to ensure achievement of Family Care Plan goals.Any one of the following criterion may be used to determine the child's readiness for discharge: 1) the goals and actions established in the Family Care Plan have been successfully met and the family is not in need of additional Cedar services, 2) the family has been linked to services and supports identified in the Family Care Plan, 3) the family, guardian, or child withdraws consent for Cedar services, 4) the child has lost Medicaid eligibility or 5) it has been determined that an administrative discharge is needed.

☑ **Medically Needy eligibility groups**

◉ **All Medically Needy eligibility groups receive the same benefits and services that are provided to Categorically Needy eligibility groups.**

○ **Different benefits and services than those provided to Categorically Needy eligibility groups are provided to some or all Medically Needy eligibility groups.**

○ **All Medically Needy receive the same services.**

○ **There is more than one benefit structure for Medically Needy eligibility groups.**

Transmittal Number: 16-0001 Supersedes Transmittal Number: 11-0006 Approved Effective Date: Jan 1, 2016 Approval Date: Jan 13, 2017
Attachment 3.1-H Page Number:

Health Homes Monitoring, Quality Measurement and Evaluation

Monitoring

Describe the State's methodology for tracking avoidable hospital readmissions, including data sources and measurement specifications:
The state will measure re-admissions per 1000 member months for any diagnosis using a pre/post-period comparison among eligible Cedar Health Home clients.The data source will be claims and encounter data available in the Medicaid data warehouse.

Describe the State's methodology for calculating cost savings that result from improved coordination of care and chronic disease management achieved through the Health Homes program, including data sources and measurement specifications.
The State will annually perform an assessment of cost savings using a pre/post-period comparison of Cedar health home clients. Savings calculations will be based on data garnered from the MMIS, encounter data from Health Plans, encounter data submitted the Health Home providers, and any other applicable data available from the RI Data Warehouse.

Describe how the State will use health information technology in providing Health Homes services and to improve service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).
The state will phase-in the use of HIT to support health home services. Initially, providers will be supported in their delivery of health home services through data profiles supplied by Medicaid managed care plans for the 60% of the health home-eligible Cedar population enrolled in MCOs. The state is currently working with the MCOs to develop health utilization profiles minimally
comprised of the components below.
1)Claims Data to identify member's pattern of utilization based on previous 12 months (#Emergency Room Visits, Last ER Visit Date,Last ER Visit Primary Diagnosis, #Urgent Care Visits).
2) Claims data to identify member's primary care home (#PCP Sites, #PCP visits to current PCP Site. 3) Prescription Drug information
4) Behavioral Health Utilization

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

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

Quality Measurement

☑ **The State provides assurance that it will require that all Health Homes providers report to the State on all applicable quality measures as a condition of receiving payment from the State.**

☑ **The State provides assurance that it will identify measureable goals for its Health Homes model and intervention and also identify quality measures related to each goal to measure its success in achieving the goals.**

States utilizing a health team provider arrangement must describe how they will align the quality measure reporting requirements within section 3502 of the Affordable Care Act and section 1945(g) of the Social Security Act. Describe how the State will do this:

Evaluations

☑ **The State provides assurance that it will report to CMS information submitted by Health Homes 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.**

Describe how the State will collect information from Health Homes providers for purposes of determining the effect of the program on reducing the following:

Hospital Admissions

Measure:
Hospital admissions per 1000 member months for any member in Cedar Centers
Measure Specification, including a description of the numerator and denominator.
Numerator: All Cedar center enrollees with a hospital stay during the measurement year
Denominator: All Cedar center enrollees during the measurement year
Data Sources:
MMIS
Frequency of Data Collection:

- ○ **Monthly**
- ◉ **Quarterly**
- ○ **Annually**
- ○ **Continuously**
- ○ **Other**

N/A

Emergency Room Visits

Measure:
Emergency room visits per 1000 member months for any diagnosis among Cedar Center enrollees
Measure Specification, including a description of the numerator and denominator.
Numerator: All Cedar Center enrollees with an ER visit during the measurement year
Denominator: All Cedar Center enrollees during the measurement year
Data Sources:
MMIS
Frequency of Data Collection:

- ○ **Monthly**
- ◉ **Quarterly**
- ○ **Annually**
- ○ **Continuously**
- ○ **Other**

N/A

Skilled Nursing Facility Admissions

Measure:
SNF admissions per 1000 member months for any diagnosis among Cedar Center enrollees
Measure Specification, including a description of the numerator and denominator.
Numerator: All Cedar Center enrollees with a skilled nursing facility admission during the measurement year
Denominator: All Cedar Center enrollees during the measurement year
Data Sources:
MMIS

Frequency of Data Collection:

- ○ **Monthly**
- ◉ **Quarterly**
- ○ **Annually**
- ○ **Continuously**
- ○ **Other**

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

Hospital Admission Rates
Claims data will be collected through MMIS. Claims and Encounter data will be compared pre and post implementation.

Chronic Disease Management
Twice annually, the EOHHS will conduct claims data reviews as well as Cedar Record Reviews during on site record reviews to ensure that the billed services were delivered and that all deliverables are complete and of a high quality. EOHHS will review a random sample of 5% of the open cases and 5% of the closed cases (minimum of ten (10) or maximum of forty (40) records). During the record reviews, multiple areas will be reviewed, including BMI and depression screening.

Coordination of Care for Individuals with Chronic Conditions
Twice annually, the EOHHS will conduct claims data reviews as well as Cedar Record Reviews during on site record reviews to ensure that the billed services were delivered and that all deliverables are complete and of a high quality. EOHHS will review a random sample of 5% of the open cases and 5% of the closed cases (minimum of ten (10) or maximum of forty (40) records). During the record reviews, multiple areas will be reviewed, including timeliness of assessment, diagnosis, complete components of an assessment, complete components of a family care plan, crisis planning, care coordination aligned with family care plan, health promotion aligned with family care plan, face to face interactions with client/family, and formal/informal connections aligned with family care plan.

Assessment of Program Implementation
Qualitative feedback regarding program implementation will be collected by EOHHS at monthly Cedar meetings.

Processes and Lessons Learned
EOHHS will collect information from various sources to evaluate the current processes and identify lessons learned. These include review of the Family Satisfaction Surveys, which will be collected at biannual, on-site record reviews, feedback from providers at Cedar monthly meetings, and pre and post evaluation of the Family Outcomes Surveys, which will be distributed to and collected from Cedar families by EOHHS.

Assessment of Quality Improvements and Clinical Outcomes
Quality improvements and clinical outcomes will be assessed on an aggregate basis using the information collected from the biannual record reviews (timeliness of assessment, diagnosis, clinical endorsement, client/parent/caregiver endorsement, complete components of an assessment, complete components of a family care plan, crisis planning, care coordination aligned with family care plan, health promotion aligned with family care plan, face to face interactions with client/family, formal and informal connections aligned with family care plan, health screening (BMI, Depression screen) and Family Satisfaction Surveys) as well as the Family Outcomes Survey results, which will be distributed to and collected from Cedar families by EOHHS.

Estimates of Cost Savings

☑ **The State will use the same method as that described in the Monitoring section.**

If no, describe how cost-savings will be estimated.

PRA Disclosure Statement

Health Homes Administrative Component

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

Health Homes Administrative Component

Name of Health Homes Program:
CONVERTED Rhode Island Health Home Services - Amendment

Monitoring

Provide an estimate of the number of individuals to be served by the Health Homes program during the first year of operation:
4000

Provide an estimate of the cost-savings that will be achieved from implementation of the Health Homes program during the first year of operation:
$ 750000.00

Describe how this cost-saving estimate was calculated, whether it accounted for savings associated with dual eligibles, and if Medicare data was available to the State to utilize in arriving at its cost-savings estimates:
Savings calculations are based on data garnered from the MMIS, encounter data from Health Plans, encounter data submitted the Health Home providers, and any other applicable data available from the RI Data Warehouse. Due to the affected population, this estimate did not account for savings associated with dual eligibles.

Quality Measurement

CMS Recommended Core Measures

For each Health Homes core measure, indicate the data source, the measure specification, and how HIT will be utilized in reporting on the measure.

Health Homes Core Measure		
Hospital Admissions		
Emergency Room Visits		
Skilled Nursing Facility (SNF) Admissions		

Health Homes Administrative Component: Core Measure Detail

Measure

Measure Specification, including a description of the numerator and denominator.

Data Sources:

Frequency of Data Collection:

- **Monthly**
- **Quarterly**
- **Annually**
- **Continuously**
- **Other**

How Health IT will be utilized

Health Homes Administrative Component: Core Measure Detail

Measure
Hospital Admissions

Measure Specification, including a description of the numerator and denominator.
Admission per 1000 member months for any member in Cedar Centers.

Numerator: All Cedar center enrollees with a hospital stay during the measurement year
Denominator: All Cedar center enrollees during the measurement year

Data Sources:
Claims encounter data from MMIS

Frequency of Data Collection:

- **Monthly**

- (●) **Quarterly**
- ( ) **Annually**
- ( ) **Continuously**
- ( ) **Other**

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 plans for the 60% of the health home-eligible CEDAR population enrolled in MCOs. The state is currently working with the MCOs to develop health utilization profiles minimally comprised of the components below.
1)Claims Data to identify member's pattern of utilization based on previous 12 months (#Emergency Room Visits, Last ER Visit Date,Last ER Visit Primary Diagnosis, #Urgent Care Visits).
2) Claims data to identify member's primary care home (#PCP Sites, #PCP visits to current PCP Site. 3) Prescription Drug information
4) Behavioral Health Utilization

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

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

Health Homes Administrative Component: Core Measure Detail

Measure
Emergency Room Visits

Measure Specification, including a description of the numerator and denominator.
ER visits per 1000 member months for any diagnosis among Cedar Center enrollees.
Numerator: All Cedar Center enrollees with an ER visit during the measurement year
Denominator: All Cedar Center enrollees during the measurement year

Data Sources:
Claims encounter data from MMIS

Frequency of Data Collection:

- ( ) **Monthly**
- (●) **Quarterly**
- ( ) **Annually**
- ( ) **Continuously**

○ **Other**

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 plans for the 60% of the health home-eligible CEDAR population enrolled in MCOs. The state is currently working with the MCOs to develop health utilization profiles minimally comprised of the components below.
1)Claims Data to identify member's pattern of utilization based on previous 12 months (#Emergency Room Visits, Last ER Visit Date,Last ER Visit Primary Diagnosis, #Urgent Care Visits).
2) Claims data to identify member's primary care home (#PCP Sites, #PCP visits to current PCP Site. 3) Prescription Drug information
4) Behavioral Health Utilization

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

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

Health Homes Administrative Component: Core Measure Detail

Measure
Skilled Nursing Facility (SNF) Admissions

Measure Specification, including a description of the numerator and denominator.
Admission to Skilled Nursing Facility per 1000 member months for any diagnosis among Cedar Center enrollees
Numerator: All Cedar Center enrollees with a skilled nursing facility admission during the measurement year
Denominator: All Cedar Center enrollees during the measurement year

Data Sources:
Claims encounter data from MMIS

Frequency of Data Collection:

○ **Monthly**

◉ **Quarterly**

○ **Annually**

○ **Continuously**

○ **Other**

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 plans for the 60% of the health home-eligible CEDAR population enrolled in MCOs. The state is currently working with the MCOs to develop health utilization profiles minimally comprised of the components below.
1)Claims Data to identify member's pattern of utilization based on previous 12 months (#Emergency Room Visits, Last ER Visit Date,Last ER Visit Primary Diagnosis, #Urgent Care Visits).
2) Claims data to identify member's primary care home (#PCP Sites, #PCP visits to current PCP Site. 3) Prescription Drug information
4) Behavioral Health Utilization

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

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

State Goals and Quality Measures

In addition to the CMS recommended core measures, identify the goals and define the measures the State will use to assess its Health Homes model of service delivery:

Health Home Goal		
Decrease the occurrence of secondary conditions		
Decrease the use of Emergency Department and Inpatient Treatment for Ambulatory Sensitive Conditions		
Improve care coordination		
Improve Health Outcomes of Children and Youth with Special Health Care Needs (CYSHCN)		
Improve the quality of Transitions from Inpatient/Residential Care to Community		

Health Homes Administrative Component: Goal Detail

Health Home Goal:
Decrease the occurrence of secondary conditions

Measure		
Concept: Regular screenings for Obesity will result in a decrease of related conditions Measure:...		
Concept: Participants will be screened regularly for depression Measure: Yearly Screening for De...		
Concept: Clients perceive that they are receiving appropriate and effective services Measure: Sa...		

Measure		
Concept: Treatment for Depression Measures: Clients who screened positive for depression who rec...		
Concept: Rates of Obesity as measured by BMI < 85th percentile will decrease over time Measure: ...		

Health Homes Administrative Component: Measure Detail

Measure
Concept: Regular screeni. gs for Obesity will result in a decrease of related conditions
Measure: Yearly BMI Index is calculated for all clients 6 years of age and older with documented intervention if <85th percentile

○ **The measure is an Evaluation Measure from the Health Homes State Plan for purposes of determining the effect of the program on reducing one of the following:**

- ○ **Hospital Admissions**
- ○ **Emergency Room Visits**
- ○ **Skilled Nursing Facility Admissions**

◉ **The measure is not included in the Health Homes State Plan**

Measure Specification, including a description of the numerator and denominator.
Numerator: Number of participants 6 years of age or older with BMI screen documented

Denominator: Number of participants 6 years of age or older participating in CEDARR annually

Data Sources:
CEDARR Health Home Client Record Review (5% Sample)

Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ○ **Annually**
- ○ **Continuously**
- ○ **Other**

How Health IT will be utilized
RI will use the Medicaid data Warehouse to collect and store historical Medicaid Claims and Encounter data. In addition, monitoring of progress towards identified Health Homes goals will

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

Measure is related to:

- (●) **Clinical Outcomes**
- ( ) **Experience of Care**
- ( ) **Quality of Care**
- ( ) **Other**

Describe:

Health Homes Administrative Component: Measure Detail

Measure
Concept: Participants will be screened regularly for depression
Measure: Yearly Screening for Depression for all clients 12 years of age or above

- ( ) **The measure is an Evaluation Measure from the Health Homes State Plan for purposes of determining the effect of the program on reducing one of the following:**
  - ( ) **Hospital Admissions**
  - ( ) **Emergency Room Visits**
  - ( ) **Skilled Nursing Facility Admissions**
- (●) **The measure is not included in the Health Homes State Plan**

Measure Specification, including a description of the numerator and denominator.
Numerator: Number of participants 12 years of age or older with Depression screen conducted

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

Data Sources:
CEDARR Health Home Client Record Review (5% Sample)

Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ○ **Annually**
- ○ **Continuously**
- ○ **Other**

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

Measure is related to:

- ◉ **Clinical Outcomes**
- ○ **Experience of Care**
- ○ **Quality of Care**
- ○ **Other**

Describe:

Health Homes Administrative Component: Measure Detail

Measure
Concept: Clients perceive that they are receiving appropriate and effective services

Measure: Satisfaction with services, accessibility of services, availability of services

- ○ **The measure is an Evaluation Measure from the Health Homes State Plan for purposes of determining the effect of the program on reducing one of the following:**
  - ○ **Hospital Admissions**
  - ○ **Emergency Room Visits**
  - ○ **Skilled Nursing Facility Admissions**
- ◉ **The measure is not included in the Health Homes State Plan**

Measure Specification, including a description of the numerator and denominator.
umerator: patients saying they agree or strongly agree with each the following statements:
- The care plan met my child's needs
- I know who to contact at CEDARR for assistance if needed
- Appointments are scheduled in a timely manner.

Data Sources:
Annual Satisfaction surveys

Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ○ **Annually**
- ○ **Continuously**
- ○ **Other**

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

Measure is related to:

- ○ **Clinical Outcomes**
- ◉ **Experience of Care**
- ○ **Quality of Care**
- ○ **Other**

Describe:

Health Homes Administrative Component: Measure Detail

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

- ○ **The measure is an Evaluation Measure from the Health Homes State Plan for purposes of determining the effect of the program on reducing one of the following:**
  - ○ **Hospital Admissions**
  - ○ **Emergency Room Visits**
  - ○ **Skilled Nursing Facility Admissions**
- ◉ **The measure is not included in the Health Homes State Plan**

Measure Specification, including a description of the numerator and denominator.
Numerator: Number of clients with a positive depression a with claim for evaluation or treatment in subsequent two months

Denominator: Number of Clients with a positive screening for depression

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

Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**

- ○ **Annually**
- ○ **Continuously**
- ○ **Other**

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

Measure is related to:

- ○ **Clinical Outcomes**
- ○ **Experience of Care**
- ◉ **Quality of Care**
- ○ **Other**

Describe:

Health Homes Administrative Component: Measure Detail

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

- ○ **The measure is an Evaluation Measure from the Health Homes State Plan for purposes of determining the effect of the program on reducing one of the following:**
  - ○ **Hospital Admissions**
  - ○ **Emergency Room Visits**

○ **Skilled Nursing Facility Admissions**

◉ **The measure is not included in the Health Homes State Plan**

Measure Specification, including a description of the numerator and denominator.
Numerator: Number of clients with BMI <85th percentile

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

Data Sources:
CEDARR Health Home Client Record Review (5% Sample)

Frequency of Data Collection:

○ **Monthly**

○ **Quarterly**

○ **Annually**

○ **Continuously**

○ **Other**

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

Measure is related to:

○ **Clinical Outcomes**

○ **Experience of Care**

◉ **Quality of Care**

○ **Other**
Describe:

Health Homes Administrative Component: Goal Detail

Health Home Goal:
Decrease the use of Emergency Department and Inpatient Treatment for Ambulatory Sensitive Conditions

Measure		
Concept: Prevention of additional ED utilization Measures: Medical Follow up within 7 days of A...		
Concept: Prevention of further Acute Care utilization Measures: Medical Follow up within 7 days...		
Concept: Clients perceive that they are receiving appropriate and effective services Measures: ...		
Concept: Acute admissions for Ambulatory Sensitive Conditions that could be avoided with proper prev...		
Concept: Clients do not use the emergency department for care or treatment of an illness that could ...		

Health Homes Administrative Component: Measure Detail

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

- (●) **The measure is an Evaluation Measure from the Health Homes State Plan for purposes of determining the effect of the program on reducing one of the following:**
  - ( ) **Hospital Admissions**
  - (●) **Emergency Room Visits**
  - ( ) **Skilled Nursing Facility Admissions**
- ( ) **The measure is not included in the Health Homes State Plan**

Measure Specification, including a description of the numerator and denominator.

Data Sources:

Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ○ **Annually**
- ○ **Continuously**
- ○ **Other**

How Health IT will be utilized

Measure is related to:

- ○ **Clinical Outcomes**
- ○ **Experience of Care**
- ○ **Quality of Care**
- ○ **Other**

Describe:

Health Homes Administrative Component: Measure Detail

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

- ◉ **The measure is an Evaluation Measure from the Health Homes State Plan for purposes of determining the effect of the program on reducing one of the following:**

- ○ **Hospital Admissions**
- ◉ **Emergency Room Visits**
- ○ **Skilled Nursing Facility Admissions**

○ **The measure is not included in the Health Homes State Plan**

Measure Specification, including a description of the numerator and denominator.

Data Sources:

Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ○ **Annually**
- ○ **Continuously**
- ○ **Other**

How Health IT will be utilized

Measure is related to:

- ○ **Clinical Outcomes**
- ○ **Experience of Care**
- ○ **Quality of Care**
- ○ **Other**

Describe:

Health Homes Administrative Component: Measure Detail

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

- ○ **The measure is an Evaluation Measure from the Health Homes State Plan for purposes of determining the effect of the program on reducing one of the following:**
  - ○ **Hospital Admissions**
  - ○ **Emergency Room Visits**
  - ○ **Skilled Nursing Facility Admissions**
- ◉ **The measure is not included in the Health Homes State Plan**

Measure Specification, including a description of the numerator and denominator.
Numerator: patients saying they agree or strongly agree with each the following statements:
- The care plan met my child's needs
- I was assisted in identifying my child's needs.

Denominator: all clients who completed the annual family satisfaction survey

Data Sources:
Annual Satisfaction surveys

Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ◉ **Annually**
- ○ **Continuously**
- ○ **Other**

How Health IT will be utilized

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

Measure is related to:

- ○ **Clinical Outcomes**
- ◉ **Experience of Care**
- ○ **Quality of Care**
- ○ **Other**

Describe:

Health Homes Administrative Component: Measure Detail

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

- ◉ **The measure is an Evaluation Measure from the Health Homes State Plan for purposes of determining the effect of the program on reducing one of the following:**
  - ◉ **Hospital Admissions**
  - ○ **Emergency Room Visits**
  - ○ **Skilled Nursing Facility Admissions**
- ○ **The measure is not included in the Health Homes State Plan**

Measure Specification, including a description of the numerator and denominator.

Data Sources:

Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ○ **Annually**
- ○ **Continuously**
- ○ **Other**

How Health IT will be utilized

Measure is related to:

- ○ **Clinical Outcomes**
- ○ **Experience of Care**
- ○ **Quality of Care**
- ○ **Other**

Describe:

Health Homes Administrative Component: Measure Detail

Measure

Concept: Clients do not use the emergency department for care or treatment of an illness that could have been treated in a different setting

Measure: Percentage of patients with one or more ED visits for any conditions appearing in a state defined list of diagnoses that can be appropriately treated in a non-ED setting

- (●) **The measure is an Evaluation Measure from the Health Homes State Plan for purposes of determining the effect of the program on reducing one of the following:**
  - ( ) **Hospital Admissions**
  - (●) **Emergency Room Visits**
  - ( ) **Skilled Nursing Facility Admissions**
- ( ) **The measure is not included in the Health Homes State Plan**

Measure Specification, including a description of the numerator and denominator.

Data Sources:

Frequency of Data Collection:

- ( ) **Monthly**
- ( ) **Quarterly**
- ( ) **Annually**
- ( ) **Continuously**
- ( ) **Other**

How Health IT will be utilized

Measure is related to:

- ○ **Clinical Outcomes**
- ○ **Experience of Care**
- ○ **Quality of Care**
- ○ **Other**

Describe:

Health Homes Administrative Component: Goal Detail

Health Home Goal:
Improve care coordination

Measure		
Concept: Use of an electronic medical record ensures that recommended screenings, immunizations and ...		
Concept: Communication and collaboration between the Health Home Team and the Primary Care Physician...		
Concept: Well coordinated care reduces caregiver stress. Measure: % of clients who indicate hav...		
Concept: Timely delivery of Health Home services Measure: Percentage of Care Plans reviews comple...		
Concept: Timely delivery of Health Home services Measure: Percentage of Care Plans completed with...		
Concept: Communication and collaboration between the Health Home Team and the Managed Care Plan ensu...		
Concept: Clients perceive that they are receiving appropriate and effective services Measure: Sa...		
Concept: Timely delivery of Health Home services Measure: Percentage of Initial Assessment (IFIN...		
Concept: Knowledge of condition by client and family leads to improved management of condition and a...		

Health Homes Administrative Component: Measure Detail

Measure
Concept: Use of an electronic medical record ensures that recommended screenings, immunizations and assessments are performed.
Measure: Number of hits on the RI KIDSNET Child Health Information system per 1,000 enrollees (KIDSNET stores child specific information on blood lead levels, immunization, newborn developmental assessment,

newborn blood spot screening, hearing assessment, home visiting, WIC and Early Intervention).

○ **The measure is an Evaluation Measure from the Health Homes State Plan for purposes of determining the effect of the program on reducing one of the following:**

- ○ **Hospital Admissions**
- ○ **Emergency Room Visits**
- ○ **Skilled Nursing Facility Admissions**

◉ **The measure is not included in the Health Homes State Plan**

Measure Specification, including a description of the numerator and denominator.
Numerator: Number of times KIDSNET is accessed by each CEDARR

Denominator: Number of enrollees per CEDARR

Data Sources:
Kidsnet database report to Medicaid

Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ○ **Annually**
- ○ **Continuously**
- ○ **Other**

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

Measure is related to:

- (●) **Clinical Outcomes**
- ( ) **Experience of Care**
- ( ) **Quality of Care**
- ( ) **Other**

Describe:

Health Homes Administrative Component: Measure Detail

Measure
Concept: Communication and collaboration between the Health Home Team and the Primary Care Physician during the development and review of the plan of care leads to a comprehensive plan of care
Measure: Percentage of Physician Consultation claims to the number of Care plans developed and renewed.

- ( ) **The measure is an Evaluation Measure from the Health Homes State Plan for purposes of determining the effect of the program on reducing one of the following:**
  - ( ) **Hospital Admissions**
  - ( ) **Emergency Room Visits**
  - ( ) **Skilled Nursing Facility Admissions**
- (●) **The measure is not included in the Health Homes State Plan**

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

Denominator: Number of claims for Family Care Plan development or Family Care Plan Review

Data Sources:
Medicaid Claims

Frequency of Data Collection:

- ( ) **Monthly**
- ( ) **Quarterly**

- ○ **Annually**
- ○ **Continuously**
- ○ **Other**

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

Measure is related to:

- ◉ **Clinical Outcomes**
- ○ **Experience of Care**
- ○ **Quality of Care**
- ○ **Other**

Describe:

Health Homes Administrative Component: Measure Detail

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

- ○ **The measure is an Evaluation Measure from the Health Homes State Plan for purposes of determining the effect of the program on reducing one of the following:**
  - ○ **Hospital Admissions**
  - ○ **Emergency Room Visits**

○ **Skilled Nursing Facility Admissions**

◉ **The measure is not included in the Health Homes State Plan**

Measure Specification, including a description of the numerator and denominator.
Numerator: Number of clients scoring 4 or better on 1 (worse) to 7 (best) scale for the following outcome question:
o How much stress does your child's condition cause?

Denominator: Number of clients responding to above question.

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

Frequency of Data Collection:

○ **Monthly**

○ **Quarterly**

○ **Annually**

○ **Continuously**

○ **Other**

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

Measure is related to:

○ **Clinical Outcomes**

○ **Experience of Care**

◉ **Quality of Care**

○ **Other**
Describe:

Health Homes Administrative Component: Measure Detail

Measure
Concept: Timely delivery of Health Home services
Measure: Percentage of Care Plans reviews completed prior to expiration of current care plan.

- ○ **The measure is an Evaluation Measure from the Health Homes State Plan for purposes of determining the effect of the program on reducing one of the following:**
  - ○ **Hospital Admissions**
  - ○ **Emergency Room Visits**
  - ○ **Skilled Nursing Facility Admissions**
- ◉ **The measure is not included in the Health Homes State Plan**

Measure Specification, including a description of the numerator and denominator.
Numerator: Number of Care Plans Reviews completed prior to the expiration date of the current Care Plan.

Denominator: Number of completed Care Plan Reviews completed

Data Sources:

Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ○ **Annually**
- ○ **Continuously**
- ○ **Other**

How Health IT will be utilized

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

Measure is related to:

- ○ **Clinical Outcomes**
- ◉ **Experience of Care**
- ○ **Quality of Care**
- ○ **Other**

Describe:

Health Homes Administrative Component: Measure Detail

Measure
Concept: Timely delivery of Health Home services
Measure: Percentage of Care Plans completed within 30 days of completion of the Initial Assessment (IFIND)

- ○ **The measure is an Evaluation Measure from the Health Homes State Plan for purposes of determining the effect of the program on reducing one of the following:**
  - ○ **Hospital Admissions**
  - ○ **Emergency Room Visits**
  - ○ **Skilled Nursing Facility Admissions**
- ◉ **The measure is not included in the Health Homes State Plan**

Measure Specification, including a description of the numerator and denominator.
Numerator: Number of Care Plans completed within 30 days of completion of IFIND

Denominator: Number of completed Initial Assessments (IFIND)

Data Sources:

Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ○ **Annually**
- ○ **Continuously**
- ○ **Other**

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

Measure is related to:

- ○ **Clinical Outcomes**
- ◉ **Experience of Care**
- ○ **Quality of Care**
- ○ **Other**

Describe:

Health Homes Administrative Component: Measure Detail

Measure
Concept: Communication and collaboration between the Health Home Team and the Managed Care Plan ensures that services are not being duplicated.
Measure: Percentage of CEDARR MCO enrollees with outreach to MCO documented in the CEDARR record.

- ○ **The measure is an Evaluation Measure from the Health Homes State Plan for purposes of determining the effect of the program on reducing one of the following:**
  - ○ **Hospital Admissions**
  - ○ **Emergency Room Visits**
  - ○ **Skilled Nursing Facility Admissions**
- ◉ **The measure is not included in the Health Homes State Plan**

Measure Specification, including a description of the numerator and denominator.
Numerator: Number of MCO enrollees with outreach documented in the CEDARR chart.

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

Data Sources:
CEDARR Health Home Client Record Review (5% Sample)

Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ○ **Annually**
- ○ **Continuously**
- ○ **Other**

How Health IT will be utilized
RI will use the Medicaid data Warehouse to collect and store historical Medicaid Claims and Encounter data. In addition, monitoring of progress towards identified Health Homes goals will be accomplished through the analysis of reports submitted on a regular basis by the CEDARR Health Homes. Rhode Island will also use additional data sources to monitor the impact of its health home (HH) program on quality: an outcomes survey administered to all CEDARR families on intake and yearly thereafter; charts (either electronic or paper), and a client satisfaction survey. Rhode

Island exercised prudence in selecting measures to not overburden CEDARR or IT staff with new data collection and analysis. We will use standard, validated measure specifications where they exist to increase our ability and CMS's to make comparisons across populations, programs, and states.

Measure is related to:

- (●) **Clinical Outcomes**
- ( ) **Experience of Care**
- ( ) **Quality of Care**
- ( ) **Other**

Describe:

Health Homes Administrative Component: Measure Detail

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

- ( ) **The measure is an Evaluation Measure from the Health Homes State Plan for purposes of determining the effect of the program on reducing one of the following:**
  - ( ) **Hospital Admissions**
  - ( ) **Emergency Room Visits**
  - ( ) **Skilled Nursing Facility Admissions**
- (●) **The measure is not included in the Health Homes State Plan**

Measure Specification, including a description of the numerator and denominator.
Numerator: Clients saying they agree or strongly agree with each the following statements:
- The care plan met my child's needs
- I know who to contact at CEDARR for assistance if needed
- Appointments are scheduled in a timely manner.

Denominator: all clients who completed the annual family satisfaction survey

Data Sources:

Annual Satisfaction Surveys

Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ○ **Annually**
- ○ **Continuously**
- ○ **Other**

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

Measure is related to:

- ○ **Clinical Outcomes**
- ◉ **Experience of Care**
- ○ **Quality of Care**
- ○ **Other**
  Describe:

Health Homes Administrative Component: Measure Detail

Measure
Concept: Timely delivery of Health Home services
Measure: Percentage of Initial Assessment (IFIND) appointment dates offered within 30 days of request.

○ **The measure is an Evaluation Measure from the Health Homes State Plan for purposes of determining the effect of the program on reducing one of the following:**

- ○ **Hospital Admissions**
- ○ **Emergency Room Visits**
- ○ **Skilled Nursing Facility Admissions**

◉ **The measure is not included in the Health Homes State Plan**

Measure Specification, including a description of the numerator and denominator.
Numerator: Number of clients offered an initial appointment date within 30 days of request.

Denominator: Number of client requests for Initial Assessment (IFIND)

Data Sources:
CEDARR Health Home Quarterly Reporting to MEDICAID. Data obtained from CEDARR Automated Care Coordination System

Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ○ **Annually**
- ○ **Continuously**
- ○ **Other**

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

Measure is related to:

- ○ **Clinical Outcomes**
- ◉ **Experience of Care**
- ○ **Quality of Care**
- ○ **Other**

Describe:

Health Homes Administrative Component: Measure Detail

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

- ○ **The measure is an Evaluation Measure from the Health Homes State Plan for purposes of determining the effect of the program on reducing one of the following:**
  - ○ **Hospital Admissions**
  - ○ **Emergency Room Visits**
  - ○ **Skilled Nursing Facility Admissions**
- ◉ **The measure is not included in the Health Homes State Plan**

Measure Specification, including a description of the numerator and denominator.
Numerator: Number of clients scoring 4 or better on 1 (worse) to 7 (best) scale for the following outcome question:
o Has your knowledge of your child's condition improved?

Denominator: Number of clients responding to above question

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

Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ○ **Annually**

○ **Continuously**

○ **Other**

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

Measure is related to:

○ **Clinical Outcomes**

○ **Experience of Care**

◉ **Quality of Care**

○ **Other**
Describe:

Health Homes Administrative Component: Goal Detail

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

Measure		
Concept: Clients perceive that they are receiving appropriate and effective services Measure: Sa...		
Concept: Improved Medical Outcomes will result in lower stress levels related to the diagnosed condi...		
Concept: Increased participation in age appropriate activities Measure: Parent /Guardian self ...		

Measure		
Concept: Timely delivery of Health Home Care Coordination services Measure: Percentage of Commu...		
Concept: Increased knowledge of conditions and skills and strategies acquired to address consequence...		
Concept: Provision of clinical information and community based treatment options Measure: Number...		

Health Homes Administrative Component: Measure Detail

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

- ○ **The measure is an Evaluation Measure from the Health Homes State Plan for purposes of determining the effect of the program on reducing one of the following:**
  - ○ **Hospital Admissions**
  - ○ **Emergency Room Visits**
  - ○ **Skilled Nursing Facility Admissions**
- ◉ **The measure is not included in the Health Homes State Plan**

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

Denominator: all clients who completed the annual family satisfaction survey

Data Sources:
Annual Satisfaction surveys

Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ○ **Annually**
- ○ **Continuously**
- ○ **Other**

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

Measure is related to:

- ○ **Clinical Outcomes**
- ◉ **Experience of Care**
- ○ **Quality of Care**
- ○ **Other**
  Describe:

Health Homes Administrative Component: Measure Detail

Measure
Concept: Improved Medical Outcomes will result in lower stress levels related to the diagnosed condition
Measure: % of clients who indicate having a high level of stress caused by condition(s)

- ○ **The measure is an Evaluation Measure from the Health Homes State Plan for purposes of determining the effect of the program on reducing one of the following:**
  - ○ **Hospital Admissions**
  - ○ **Emergency Room Visits**
  - ○ **Skilled Nursing Facility Admissions**
- ◉ **The measure is not included in the Health Homes State Plan**

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

Denominator: Number of clients responding to above question.

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

Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ○ **Annually**
- ○ **Continuously**
- ○ **Other**

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

Measure is related to:

- ○ **Clinical Outcomes**
- ○ **Experience of Care**
- ◉ **Quality of Care**
- ○ **Other**
  Describe:

Health Homes Administrative Component: Measure Detail

Measure
Concept: Increased participation in age appropriate activities
Measure: Parent /Guardian self rating of child's ability to take part in age appropriate community and social activities

- ○ **The measure is an Evaluation Measure from the Health Homes State Plan for purposes of determining the effect of the program on reducing one of the following:**
  - ○ **Hospital Admissions**
  - ○ **Emergency Room Visits**
  - ○ **Skilled Nursing Facility Admissions**
- ◉ **The measure is not included in the Health Homes State Plan**

Measure Specification, including a description of the numerator and denominator.
Numerator: Number of clients scoring 4 or better on 1 (worse) to 7 (best) scale for the following outcome question:
o How much can your child take part in age appropriate community and social activities?

Denominator: Number of clients responding to above question.

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

Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ○ **Annually**
- ○ **Continuously**
- ○ **Other**

How Health IT will be utilized

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

Measure is related to:

- ○ **Clinical Outcomes**
- ○ **Experience of Care**
- ◉ **Quality of Care**
- ○ **Other**

Describe:

Health Homes Administrative Component: Measure Detail

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

- ○ **The measure is an Evaluation Measure from the Health Homes State Plan for purposes of determining the effect of the program on reducing one of the following:**
  - ○ **Hospital Admissions**
  - ○ **Emergency Room Visits**
  - ○ **Skilled Nursing Facility Admissions**
- ◉ **The measure is not included in the Health Homes State Plan**

Measure Specification, including a description of the numerator and denominator.
Numerator: Number of Treatment Plans Reviewed within 30 days of receipt.

Denominator: Number of Treatment Plans submitted

Data Sources:
CEDARR Health Home Quarterly Reporting to MEDICAID. Data obtained from CEDARR Automated Care Coordination System

Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ○ **Annually**
- ○ **Continuously**
- ○ **Other**

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

Measure is related to:

- ○ **Clinical Outcomes**
- ◉ **Experience of Care**
- ○ **Quality of Care**
- ○ **Other**

Describe:

Health Homes Administrative Component: Measure Detail

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

- ○ **The measure is an Evaluation Measure from the Health Homes State Plan for purposes of determining the effect of the program on reducing one of the following:**
  - ○ **Hospital Admissions**
  - ○ **Emergency Room Visits**
  - ○ **Skilled Nursing Facility Admissions**
- ◉ **The measure is not included in the Health Homes State Plan**

Measure Specification, including a description of the numerator and denominator.
Numerator: Number of clients scoring 4 or better on 1 (worse) to 7 (best) scale for the following outcome question:
o Has your knowledge of your child's condition improved?

Denominator: Number of clients responding to above question.

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

Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ○ **Annually**
- ○ **Continuously**
- ○ **Other**

How Health IT will be utilized
RI will use the Medicaid data Warehouse to collect and store historical Medicaid Claims and Encounter data. In addition, monitoring of progress towards identified Health Homes goals will be accomplished through the analysis of reports submitted on a regular basis by the CEDARR Health Homes. Rhode Island will also use additional data sources to monitor the impact of its health home (HH) program on quality: an outcomes survey administered to all CEDARR families on intake and yearly thereafter; charts (either electronic or paper), and a client satisfaction survey. Rhode

Island exercised prudence in selecting measures to not overburden CEDARR or IT staff with new data collection and analysis. We will use standard, validated measure specifications where they exist to increase our ability and CMS's to make comparisons across populations, programs, and states.

Measure is related to:

- (●) **Clinical Outcomes**
- ( ) **Experience of Care**
- ( ) **Quality of Care**
- ( ) **Other**

Describe:

Health Homes Administrative Component: Measure Detail

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

- ( ) **The measure is an Evaluation Measure from the Health Homes State Plan for purposes of determining the effect of the program on reducing one of the following:**
  - ( ) **Hospital Admissions**
  - ( ) **Emergency Room Visits**
  - ( ) **Skilled Nursing Facility Admissions**
- (●) **The measure is not included in the Health Homes State Plan**

Measure Specification, including a description of the numerator and denominator.
Numerator: Number of referrals made by CEDARR Health homes in one year

Denominator: Number of clients served during one year.

Data Sources:
CEDARR Quarterly Reporting to Medicaid. Data obtained from CEDARR Automated Care Coordination System

Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ○ **Annually**
- ○ **Continuously**
- ○ **Other**

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

Measure is related to:

- ◉ **Clinical Outcomes**
- ○ **Experience of Care**
- ○ **Quality of Care**
- ○ **Other**

Describe:

Health Homes Administrative Component: Goal Detail

Health Home Goal:
Improve the quality of Transitions from Inpatient/Residential Care to Community

Measure		

Measure		
Concept: Clients are able to avoid re-admissions for physical health conditions Measure: Percent...		
Concept: Clients perceive that they are receiving appropriate and effective services Measures: ...		
Concept: Re-Admissions for same diagnosis reduced Measure: Percentage of clients re-admitted or ...		
Concept: Health Home staff contacts client after discharge Measure: Percentage of discharges for...		
Concept: Health Home staff is actively involved in discharge planning Measure: Percentage of dis...		
Concept: : Clients are able to avoid re-admissions for psychiatric conditions Measure: Percentag...		

Health Homes Administrative Component: Measure Detail

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

○ **The measure is an Evaluation Measure from the Health Homes State Plan for purposes of determining the effect of the program on reducing one of the following:**

- ○ **Hospital Admissions**
- ○ **Emergency Room Visits**
- ○ **Skilled Nursing Facility Admissions**

◉ **The measure is not included in the Health Homes State Plan**

Measure Specification, including a description of the numerator and denominator.
Numerator: : Number of patients with an inpatient re-admission within 30 days of discharge

Denominator: Number of clients with an in-patient non-psychiatric admission

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

Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**

- ○ **Annually**
- ○ **Continuously**
- ○ **Other**

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

Measure is related to:

- ○ **Clinical Outcomes**
- ○ **Experience of Care**
- ◉ **Quality of Care**
- ○ **Other**

Describe:

Health Homes Administrative Component: Measure Detail

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

- ○ **The measure is an Evaluation Measure from the Health Homes State Plan for purposes of determining the effect of the program on reducing one of the following:**
  - ○ **Hospital Admissions**
  - ○ **Emergency Room Visits**

○ **Skilled Nursing Facility Admissions**

◉ **The measure is not included in the Health Homes State Plan**

Measure Specification, including a description of the numerator and denominator.
Numerator: patients saying they agree or strongly agree with each the following statements:
- The care plan met my child's needs
- I was assisted in identifying my child's needs.

Denominator: all clients who completed the annual family satisfaction survey

Data Sources:
Annual Satisfaction surveys

Frequency of Data Collection:

○ **Monthly**

○ **Quarterly**

○ **Annually**

○ **Continuously**

○ **Other**

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

Measure is related to:

○ **Clinical Outcomes**

◉ **Experience of Care**

○ **Quality of Care**

○ **Other**

Describe:

Health Homes Administrative Component: Measure Detail

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

- ○ **The measure is an Evaluation Measure from the Health Homes State Plan for purposes of determining the effect of the program on reducing one of the following:**
  - ○ **Hospital Admissions**
  - ○ **Emergency Room Visits**
  - ○ **Skilled Nursing Facility Admissions**
- ◉ **The measure is not included in the Health Homes State Plan**

Measure Specification, including a description of the numerator and denominator.
Numerator: Number of patients with a re-admission or ED visit within 30 days of discharge with same diagnosis

Denominator: Number of clients with an in-patient admission

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

Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ○ **Annually**
- ○ **Continuously**
- ○ **Other**

How Health IT will be utilized

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

Measure is related to:

- (●) **Clinical Outcomes**
- ( ) **Experience of Care**
- ( ) **Quality of Care**
- ( ) **Other**

Describe:

Health Homes Administrative Component: Measure Detail

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

- ( ) **The measure is an Evaluation Measure from the Health Homes State Plan for purposes of determining the effect of the program on reducing one of the following:**
  - ( ) **Hospital Admissions**
  - ( ) **Emergency Room Visits**
  - ( ) **Skilled Nursing Facility Admissions**
- (●) **The measure is not included in the Health Homes State Plan**

Measure Specification, including a description of the numerator and denominator.
Numerator: Number of patients with Health Home staff service claim date of service is within 7 days of discharge date

Denominator: Number of clients with an in-patient admission >7 days

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

Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ○ **Annually**
- ○ **Continuously**
- ○ **Other**

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

Measure is related to:

- ○ **Clinical Outcomes**
- ○ **Experience of Care**
- ○ **Quality of Care**
- ○ **Other**

Describe:

Health Homes Administrative Component: Measure Detail

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

- ○ **The measure is an Evaluation Measure from the Health Homes State Plan for purposes of determining the effect of the program on reducing one of the following:**
  - ○ **Hospital Admissions**
  - ○ **Emergency Room Visits**
  - ○ **Skilled Nursing Facility Admissions**
- ◉ **The measure is not included in the Health Homes State Plan**

Measure Specification, including a description of the numerator and denominator.
Numerator: Number of patients with Health Home staff service claim during dates of in-patient stay

Denominator: Number of clients with an in-patient admission >7 days

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

Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ○ **Annually**
- ○ **Continuously**
- ○ **Other**

How Health IT will be utilized
RI will use the Medicaid data Warehouse to collect and store historical Medicaid Claims and Encounter data. In addition, monitoring of progress towards identified Health Homes goals will be accomplished through the analysis of reports submitted on a regular basis by the CEDARR Health Homes. Rhode Island will also use additional data sources to monitor the impact of its health home (HH) program on quality: an outcomes survey administered to all CEDARR families on intake and yearly thereafter; charts (either electronic or paper), and a client satisfaction survey. Rhode

Island exercised prudence in selecting measures to not overburden CEDARR or IT staff with new data collection and analysis. We will use standard, validated measure specifications where they exist to increase our ability and CMS's to make comparisons across populations, programs, and states.

Measure is related to:

- (●) **Clinical Outcomes**
- ( ) **Experience of Care**
- ( ) **Quality of Care**
- ( ) **Other**

Describe:

Health Homes Administrative Component: Measure Detail

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

- ( ) **The measure is an Evaluation Measure from the Health Homes State Plan for purposes of determining the effect of the program on reducing one of the following:**
  - ( ) **Hospital Admissions**
  - ( ) **Emergency Room Visits**
  - ( ) **Skilled Nursing Facility Admissions**
- (●) **The measure is not included in the Health Homes State Plan**

Measure Specification, including a description of the numerator and denominator.
Numerator: : Number of patients with an inpatient psychiatric re-admission within 30 days of discharge

Denominator: : Number of clients with an in-patient psychiatric admission

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

Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ○ **Annually**
- ○ **Continuously**
- ○ **Other**

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

Measure is related to:

- ○ **Clinical Outcomes**
- ○ **Experience of Care**
- ◉ **Quality of Care**
- ○ **Other**
  Describe:

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 80 per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.