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State/Territory Name: Rhode Island

State Plan Amendment (SPA) #:16-002

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, 2016

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. 16-002, submitted March 23, 2016. This approval was granted on January 12, 2017 and is effective as of January 1, 2016. This SPA grants authority to add CMHO Health Home services as an in-plan benefit for the Medicaid Managed care Organizations. The SPA further revises outcome measures and imposes a payment withhold.

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: 16-002 Supersedes Transmittal Number: RI-11-0007 Approved Effective Date: Jan 1, 2016 Approval Date: Jan 12, 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.

16-002

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.

RI-11-0007

☑ **State elects to implement the Health Homes State Plan option under Section 1945 of the Soc**

Name of Health Homes Program:

CONVERTED Rhode Island-2 Health Home Services

State Information

State/Territory name:	**Rhode Island**
Medicaid agency:	RI 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: 11-0007 Transmittal Number:16-002
The full integration of clients' medical and behavioral benefits into managed care creates new opportunities for further clinical integration across the continuum of care. This integration will allow integrated health homes (IHH) greater capacity to work with clients across all levels of care in order to achieve substantial clinical improvement. Services provided through IHHs and Assertive Community Treatment (ACT) are the fixed points of responsibility to coordinate and ensure the delivery of person-centered care, provide timely post-discharge follow-up, and improve patient health outcomes by addressing primary medical, specialist, and behavioral health care. Emphasis is placed on the monitoring of chronic conditions, preventative and educational services focused on self-care, wellness, and recovery.
This program is accountable for reducing health care costs, specifically preventable hospital admissions/readmissions and avoidable emergency room visits. These outcomes are achieved by adopting a whole-person approach to the consumer's needs and addressing the consumer's primary medical, specialist, and behavioral health care needs; and by providing the following timely and comprehensive services:
Comprehensive Care Management;
Care Coordination/Health Promotion;
Comprehensive Transitional Care;
Individual/Family Support Services; and
Chronic Condition Management/Population Management.
Clients eligible for IHH services will meet diagnostic and functional criteria established by the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH). The required diagnoses are as follows:
Schizophrenia
Schizoaffective Disorder
Schizoid Personality Disorder
Bipolar Disorder
Major Depressive Disorder, recurrent
Obsessive-Compulsive Disorder

Borderline Personality Disorder
Delusional Disorder
Psychotic Disorder

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2016	$ 2550000.00
Second Year	2017	$ 3400000.00

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.**
- [x] **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 = - $2,550,000.00
  FFY 2017 Fiscal Impact = - $3,400,000.00

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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:

(mm/dd/yyyy)

Description:

☑ **Website Notice**

Select the type of website:

☑ Website of the State Medicaid Agency or Responsible Agency

Date of Posting:

12/18/2015 (mm/dd/yyyy)

Website URL:

http://www.eohhs.ri.gov/ReferenceCenter/StatePlanAmendmentsand1115WaiverChanges.asp

☐ Website for State Regulations

Date of Posting:

(mm/dd/yyyy)

Website URL:

☐ Other

☑ **Public Hearing or Meeting**

Date	Time	Location
Feb 16, 2016	10am	Arnold Conference Center, Eleanor Slater Hospital, 111 Howard Ave, 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

The state received feedback regarding the SPA and held a hearing to facilitate greater involvement from the public. Many of the complaints we received pertained to the provider's dissatisfaction with the proposed rates.

Summarize Response

As a result of the public comments, the IHH rate was re-examined by the state and was increased by $50 PMPM.

☐ **Eligibility**

Summarize Comments

Summarize Response

☐ **Benefits**

Summarize Comments

Summarize Response

☐ Service Delivery

Summarize Comments

Summarize Response

☐ Other Issue

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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: 12/18/2015 (mm/dd/yyyy) Method/Location of consultation: USPS Letter with return receipt. Email notification	

☐ **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 were raised. **Summarize Response** No issues were raised.	

Transmittal Number: 16-002 Supersedes Transmittal Number: RI-11-0007 Approved Effective Date: Jan 1, 2016 Approval Date: Jan 12, 2017

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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)	

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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	

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	

Specify the criteria for at risk of developing another chronic condition:

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:
Previously Health Home services were available to both individuals with SPMI and SMI as long as the center determined there was a need. BHDDH decided to be more prescriptive in eligibility for the bifurcated levels of service based on illness acuity. Therefore the following eligibility requirements were adopted:

Clients eligible for IHH services will meet diagnostic and functional criteria established by the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH). The required diagnoses are as follows:

• Schizophrenia
• Schizoaffective Disorder
• Schizoid Personality Disorder
• Bipolar Disorder
• Major Depressive Disorder, recurrent
• Obsessive-Compulsive Disorder
• Borderline Personality Disorder
• Delusional Disorder
• Psychotic Disorder

Members will qualify for IHH and ACT based, in part on their score on the Daily Living Assessment of Functioning (DLA). Based on material disseminated at the DLA training in November 2015, the average DLA scores are interpreted as follows:

5.1-6.0- Mild Impairments, minimal interruption in recovery
4.1-5.0-Moderate Impairments in functioning
3.1-4.0-Serious Impairment in functioning
2.1-3.0-Severe Impairment in functioning
2.0-Extremely severe impairments in functioning

Along with the established diagnostic categories, BHDDH has established the following guidelines for program assignment based on the client’s DLA score:
<3.0 - ACT
>3.0-5.0 - IHH
>5.0 - Outpatient

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:

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

Describe the process used:
Rhode Island will auto-assign individuals to a health home with the option of opting out to choose another eligible health home provider. Individuals assigned to a health home will be notified by the state via U.S. mail and other methods as necessary about their assignment. Should individuals desire to receive health home services from another health home provider they will be able to change their health home assignment. Potentially eligible individuals receiving services in the hospital ED, or as an inpatient, will be notified about eligible health homes and referred to a health home provider in their geographic area. Eligibility for health home services will be identifiable through data provided by Medicaid managed care organizations (MCOs) and other Information from the state's Medicaid data warehouse. CMHO health home providers to which individuals have been auto-assigned will receive communication from the state regarding a patient's enrollment in health home services. The health home will in turn notify other treatment providers (e.g., primary care and specialists such as OB/GYN) about the goals and types of health home services as well as encourage participation in care coordination efforts. Providers are required to have clients sign an enrollment form. The provider keeps the enrollment form in the client's medical record. Every 6 months, providers attest to the fact that an enrollment form was signed for all clients enrolled in the program.

- [x] **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:

- [x] **The State provides assurance that eligible individuals will be given a free choice of Health Homes providers.**
- [x] **The State provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services.**
- [x] **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.**
- [x] **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.**
- [x] **The State assures that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.**

Transmittal Number: 16-002 Supersedes Transmittal Number: RI-11-0007 Approved Effective Date: Jan 1, 2016 Approval Date: Jan 12, 2017

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:

CMHCs must be licensed as Community Mental Health Centers by BHDDH, certified as Health Home providers by BHDDH and currently providing Health Home services to the SMI population.

☐ **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:

☐ **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:
CMHOs will participate in a variety of learning supports, up to and including learning collaboratives (which are not mandatory), designed to instruct CMHOs to operate as health homes (HH) and provide care using a whole-person approach that integrates behavioral health, primary care and other needed services and supports. The following components will be addressed: Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered HH services; Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines, preventive and health promotion services, including prevention of mental illness and substance use disorders, mental health and substance abuse services, comprehensive care management, care coordination, and transitional care across settings (including appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care); Coordinate and provide access to chronic disease management, including self-management support to individuals and their families, individual and family supports, including referral to community, social support, and recovery services, long-term care supports and services; Develop a person-centered treatment plan for each individual that coordinates and integrates all of clients' clinical and non-clinical health-care related needs and services; Demonstrate capacity to use HIT to link services, facilitate communication among team members and between the HH team and individual and family caregivers, and provide feedback to practices, and; Establish a continuous quality improvement program to collect and report on data that facilitates 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.

Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Homes Services.
Rhode Island has six Community Mental Health Organizations (CMHOs), which along with two other providers of specialty mental health services form a statewide, fully integrated, mental health delivery system, providing a comprehensive range of services to clients. All CMHOs and two specialty providers
(Fellowship Health Resources, Inc. and Riverwood Mental Health Services) are licensed by the state under the author1ty of Rhode Island General Laws and operate in accordance with Rules and Regulations for the Licensing of Behavioral Healthcare Organizations. The six CMHOs, Fellowship Health Resources, Inc. and Riverwood Mental Health Services, will serve as designated providers of CMHO health home services. The six CMHOS, Fellowship Health Resources, Inc. and Riverwood Mental Health Services, represent the only entities that would
meet eligibility requirements as a CMHO health home. Each CMHO health home is responsible for establishing an integrated service network statewide for coordinating service provision. CMHO health homes will have agreements, memorandums of understanding, and linkages with other health care providers, in-patient settings and long-term care settings that specify requirements for the establishment of coordinating comprehensive care.

The health home teams consist of individuals with expertise in several areas, any team member operating within his or her scope of practice, area of expertise and role or function on a health home team, may be called upon to coordinate care as necessary for an individual,
(i.e., the bio-psychosocial assessment can only be conducted as described under Care Management; however, a community support professional operating in the role of a hospital liaison may provide transitional care, health promotion and individual and family support
services, as an example).

Standards for CMHO health home providers specify that each health home indicate
how each provider will: structure team composition and member roles in CMHOs to achieve health home objectives and outcomes; coordinate with primary care (which could include co-location, embedded services, or the implementation of referral and follow-up procedures outlined in memoranda of understanding); formalize referral agreements with hospitals for comprehensive transitional care, and carry out health promotion activities.

Provider Standards

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

The IHH and ACT shall provide evidence of compliance with the following:

1. Service capacity and team composition; roles and responsibilities meet staffing requirements.

2. A comprehensive and culturally appropriate health assessment is used that yields both subjective and objective findings regarding the consumer's health needs.

3. The consumer's treatment plan clearly identifies primary, specialty, community networks and supports to address identified needs; along with family members and other supports involved in the consumer's care.

4. A consumer's treatment plan reflects the consumer's engagement level in goal setting, issue identification, self-management action, and the interventions to support self-management efforts to maintain health and wellness.

5. Service coordination activities use treatment guidelines that establish integrated clinical care pathways for health teams to provide organized and efficient care coordination across risk levels or health conditions.

6. The Program functions as the fixed point of responsibility for engaging and retaining consumers in care and monitoring individual and population health status to determine adherence or variance from recommended treatment guidelines.

7. Routine/periodic reassessment, using the Daily Living Activities Scale (DLA), conducted every 6 months at a minimum, to include reassessment of the care management process and the consumer's progress towards meeting clinical and person-centered health action plan goals.

8. The Program assumes primary responsibility for psychotropic medications, including administration; documentation of non-psychotropic medications prescribed by physicians and any medication adherence, side effects, issues etc.

9. The Program uses peer supports (certified Peer Recovery Specialists) and self-care programs to increase the consumer's knowledge about their health care conditions and to improve adherence to prevention and treatment activities.

10. Evidence that the outcome and evaluation tools being used by the health care team uses quality metrics, including assessment and survey results and utilization of services to monitor and evaluate the impact of interventions.

Care Coordination and Health Promotion

The medical record shall provide evidence that:

1. Each consumer on the Program's team has a dedicated case manager who has overall responsibility and accountability for coordinating all aspects of the consumer's care.

2. A Program has a relationship with the community agencies in its local area. To that end it can provide evidence that the case managers can converse with these agencies on an as-needed basis when there are changes in a consumer's condition.

3. A Program facilitates collaboration through the establishment of relationships with all members of consumer's interdisciplinary health team.

4. Policies, procedures and accountabilities (contractual or memos of understanding agreements) have been developed to support and define the roles and responsibilities for effective collaboration between primary care, specialists, behavioral health, long-term services and supports and community-based organizations.

5. A psychiatrist or Advanced Practice Registered Nurse (APRN) /Nurse Practitioner provides medical leadership to the implementation and coordination of program's activities by developing and maintaining working relationships with primary and specialty care providers including various inpatient and long-term care facilities.

6. Protocol has been developed for priority appointments for Program's consumers to behavioral health providers and services, and within the Program's provider network to avoid unnecessary or inappropriate utilization of emergency room, inpatient hospital and institutional services.

7. The Program's provider has a system to track and share consumer's patient care information and care needs across providers and to monitor consumer's outcomes and initiate changes in care, as necessary, to address consumer needs.

8. 24 hours/seven days a week availability to provide information/emergency consultation services to the consumer.

Comprehensive Transitional Care

The consumer’s medical record shall provide evidence that:

1. A Program’s case manager is an active participant in all phases of care transition, including timely access to follow-up care and post-hospital discharge (see metrics).

2. The Program’s provider has policies and procedures in place with local practitioners, health facilities including emergency rooms, hospitals, residential/rehabilitation settings, and community-based services, to help ensure coordinated, safe transitions in care.

3. A notification system is in place with Managed Care Organizations to notify the Programs of a consumer’s admission and/or discharge from an emergency room, inpatient unit, nursing home or residential/rehabilitation facility.

4. The Program collaborates with physicians, nurses, social workers, discharge planners, pharmacists, and others to continue implementation of the treatment plan with a specific focus on increasing the consumer’s ability to self-mange care and live safely in the community.

5. Care coordination is used when transitioning an individual from jail/prison into the community.

Individual and Family Support Services

The consumer’s medical record shall:

1. Incorporate, through the consumer’s treatment plan, the consumer and family preferences, education, support for self-management, self-help, recovery, and other resources as needed to implement the consumer’s health action goals.

2. Identify and refer to resources that support the consumer in attaining the highest level of health and functioning in their families and in the community, including ensuring transportation to and from medically necessary services.

3. Demonstrate communication and information shared with consumers and their families and other caregivers with appropriate consideration of language, activation level, literacy and cultural preferences.

Chronic Condition Management and Population Management

The consumer’s medical record shall:

1. Identify available community-based resources discussed with consumers and evidence of actively managed appropriate referrals, demonstrate advocating for access to care and services, and include evidence of the provision of coaching for consumers to engage in self-care and follow-up with required services.

2. Reflect policies, procedures, and accountabilities (through contractual or memos of understanding, affiliation agreements or quality service agreements) to support effective collaboration with community-based resources, which clearly define roles and responsibilities.

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Attachment 3.1-H Page Number:

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 language included in the contract between EOHHS and the MCOs addresses the goals of the program, patient eligibility, provider eligibility, descriptions of core functions and responsibilities of IHH/ACT providers, assessment and reporting requirements, descriptions of services, and MCO responsibilities. Managed Care contracts will also include a description of the payment arrangement between the state and the MCO. MCO responsibilities include contracting with HHs to serve their members, coordinating care with the member's use of other MCO covered services, referring other MCO members who meet the enrollment criteria to Health Homes, providing HH with reporting to facilitate the coordination of medical and behavioral health care, use utilization data (inpatient admissions, readmissions, ER visits, and Pharmacy reports) along with predictive models to identify members with new health risks to share with Health Homes, oversight to ensure contract requirements are being met, assist the HHs with identifying necessary components of metric reporting, adhere to the reporting date requirements based on a reporting calendar, adhere to continuity of care requirements, including maintenance of relationships between members and treating providers (including beneficiaries transitioning into the managed care organization), holding the member harmless, and ensure that the HHs are submitting HIPAA compliant claims data for services delivered under the IHH and ACT bundles.

For MCO enrollees active with IHH/ACT, the MCO will leverage the care management provided at the Health Home and will not duplicate services. The MCO will work collaboratively with Health Homes to ensure all the member's needs are met.

☑ **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.**

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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:
Per Diem Rate to CMHO for Integrated Health Home (IHH) and Assertive Community Treatment (ACT)

1. The State will establish a fee structure designed to enlist participation of a sufficient number of providers in the IHH and ACT program so that eligible persons can receive the services included in the plan, at least to the extent that these are available to the general population.
2. Providers must be Community Mental Health Centers or other private, not-for-profit providers of mental health services who are licensed by the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH).
3. All providers must conform to the requirements of the current Rules and Regulations for the Licensing of Behavioral Healthcare Organizations, and all other applicable state and local fire and safety codes and ordinances.
4. Providers must agree to contract and accept the rates paid by the Managed Care Organization as established with the Executive Office of Health and Human Service (EOHHS) and BHDDH as the sole and complete payment in full for services delivered to beneficiaries, except for any potential payments made from the beneficiary's applied income, authorized co-payments, or cost sharing spend down liability.
5. Providers must be enrolled in the RI Medicaid Program, have a contract with the Managed Care Organizations and agree to meet all requirements, such as, timely access to care and matching beneficiaries service needs.
6. The State will not include the cost of room and board or for non-Medicaid services as a component of the rate for services authorized by this section of the state plan.
7. The State will pay for services under this section on the basis of the methodology described in the section titled "Basis for IHH Methodology" of this document.
8. The amount of time allocated to IHH and ACT for any individual staff member is reflective of the actual time that staff member is expected to spend providing reimbursable IHH and ACT services to Medicaid recipients.
9. Providers will be required to collect and submit complete encounter data for all IHH/ACT claims on a monthly basis utilizing standard Medicaid coding and units in an electronic format to be determined by EOHHS, BHDDH and Managed Care Organizations. Six months after the effective date of this SPA and following the receipt of encounter data, the state will conduct an analysis of the data to develop recipient profiles, study service patterns, and analyze program costs vs. services received by recipients, for potential adjustments to the case rate as well as for consideration of alternative payment methodologies.
Analysis will be conducted annually after the first six month review.
10. The State assures that IHH and ACT services under this submission will be separate and distinct and that duplicate payment will not be made for similar services available under other program authorities.
11. The rates were set as of January 1, 2016 and are effective through the state fiscal year, pending additional analysis for services. All rates are published on the RI EOHHS website at http://www.dhs.ri.gov/ForProvidersVendors/MedicalAssistanceProviders/FeeSchedules/tabid/170/Default.aspx.

Staffing Model and Rates for ACT

ACT/High Acuity Team:
12.75 FTE: 100 Team Census
FTE = 35 Hour Work Week
Program Staff FTE Cost/FTE Total Cost
Program Director (LICSW, LMHC, LMFT, LCDP, RN) 1 $68,000 $68,000
Registered Nurse 2 $66,000 $132,000
Master's Level Clinician 1 $60,000 $60,000
Vocational Specialist, Bachelor's level 1 $44,000 $44,000
Substance Abuse Specialist, Bachelor's level 2 $44,000 $88,000
CPST Specialist, Bachelor's level 4 $41,000 $164,000
Peer Specialist 1 $41,000 $41,000
Psychiatrist 0.75 $230,000 $172,500
Fringe at 30% $230,850
Total Salaries & Fringe $1,000,350

Indirect/Administrative Costs including: Rent, Utilities, Facility Maintenance, Program Supplies, Information Technology (EHR, Hardware, Phone), Data Collection (e.x. Use of RNL, Collection of Outcomes), Quality Improvement Staff, Health Information
Total Administrative and Operating Expense @52% $520,182
All Cost Total Annual $1,520,532
Base Rate (Monthly Unit) $1,267

Salaries are based on mean of RI Department of Labor Occupational Statistics

The following is a list of allowable services for ACT:
A. Service Coordination/Case Management
B. Crisis Assessment and Intervention
C. Symptom Assessment and Management
D. Medication Prescription, Administration, Monitoring and Documentation
E. Dual Diagnosis Substance Use Disorder Services
F. Work-Related Services
G. Services to support activities of daily living in community-based settings
H. Social/Interpersonal Relationship and Leisure-Time Skill Training
I. Peer Support Services
J. Other Support Services--Support services or direct assistance to ensure that clients obtain the basic necessities of daily life, including but not limited to:
1. Medical and dental services
2. Safe, clean, affordable housing
3. Financial support and/or benefits counseling (e.g., SSI, SSDI, Food Stamps, Section 8, Home Energy Assistance)
4. Social service
5. Transportation
6. Legal advocacy and representation
K. Education, Support, and Consultation to Clients' Families and Other Major Supports

12. Basis for IHH Methodology for IHH:
The process is based on a CMS approved methodology that utilizes reliable estimates of the actual costs to the provider agencies for staff and operating/support and then feeding those costs into a fee model. The process also included the development of a standard core IHH team composition and suggested caseload based on estimates of available staff hours and client need.
Flexibility is given to the providers for the costs of the entire team. Ten positions are noted as core expectations that consists of one (1) Master's level coordinator, two (2) registered nurses, one (1) hospital liaison, five (5) CPST specialists and one (1) peer specialist.
Agencies will also be able to flex staff by need to certain teams. Agencies are still accountable to the entire number of staff, cost and salaries for all positions for Health Homes of the agency.
Any deviation from the model must have clinical and financial justification that is approved by BHDDH, the state Mental Health Authority. The goal is to give providers flexibility so that providers are able to manage the team to obtain the outcomes.
Staffing Model (per 200 clients):

Title	FTE
Master's Level Program Director	1
Registered Nurse	2

Hospital Liaison	1
CPST Specialist	5- 6
Peer Specialist	1
Medical Assistant	1 (optional)

IHH
OCCUPANCY 100.0%
CLIENTS 200
Program Staff:
Qualifications: FTE Cost/FTE Total Cost

Master's Level Coordinator 1.0 $78,817 $78,817
Registered Nurse 2.0 $81,500 $163,000
Hospital Liaison 1.0 $44,200 $44.200
CPST Specialist BA 6.0 $44,200 $265,200
Peer Specialist 1.0 $43,711.00 $43,711.00
Medical Assistant 1.0 $39,360 $39,360
$634,288
12.0
Fringe (Included in base cost) 0

Total base staff cost $634,288

Total all staff cost $634,288

Total administration and operating at state average 59% $374,230

Total all costs $1,008,518

PMPM $420.22

Payment Methodology Withhold:

All CMHOs will be required to report to the MCOs and RI Medicaid on a quarterly basis on a set of Year 1 required metrics. EOHHS and BHDDH support the importance of standardized reporting on outcome measures to ensure providers are increasing quality so clients make gains in overall health.

CMHO's will receive 90% of IHH and 90% of the health home services imbedded in the ACT rate. If the CMHO is able to demonstrate meeting the minimum quarterly reporting requirements and identified quality thresholds, the CMHC will receive the additional 10% payment from the MCOs. The quality metrics are included in the IHH/ACt Provider Billing Manual. The 10% payment will be reconciled after all reports are received and approved by BHDDH and the Managed Care Organizations.

☐ **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.

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.
To avoid duplication of payment for similar services, the State has employed an on-line portal developed by Hewlett Packard Enterprises that validates the dates of enrollment in Health Home programs. Providers must enter client data into the on-line portal. If the client is already a client of another Health Home program, including Opiate Treatment Health Home

or an Assertive Community Treatment program, the portal will give them an error message. This provides the State with assurances that duplicate programming and billing does not occur.

☑ **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.**

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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 care management services are conducted with an individual and involve the identification, development and implementation of treatment plans that address the needs of the whole person. Family/Peer Supports can also be included in the process. The service involves the development of a treatment plan based on the completion of an assessment. Health Home staff will adjust treatment plans as changes in status and conditions dictate. A particular emphasis is the use of the multi-disciplinary teams including medical personnel who may or may not be directly employed by the provider of the health home. The recipient of comprehensive care management is an individual with complex physical and behavioral health needs.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
The State implemented Current Care via the State Health Information Exchange (RIQI). CurrentCare allows authorized providers to see their clients’ health information using secure technology. CurrentCare lets authorized providers view clients’ health information from different doctors, hospitals and laboratories, which results in far more certainty and safety, less paperwork and greater satisfaction all around. The State is also in the process of providing a care management dashboard that will send real time alerts of inpatient and ED visits to CMHCs. This dashboard was developed by RIQI and is being purchased through the SIM initiative to increase the capacity of CMHOs (the only providers of IHH and ACT services) to be responsive to inpatient utilization by their clients.

Scope of benefit/service

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

☑ **Behavioral Health Professionals or Specialists**

Description
Qualified Behavioral Health Specialists will conduct initial bio-psychosocial assessments and work with patients and other team members to develop care plans. Case managers will be responsible for ensuring adherence to the plan, engaging family members and other supports, and monitoring outcomes, and thus have primary responsibility for this activity. Case managers will assist patients in accessing other specialized care, encouraging patients to keep appointments and follow through with care recommendations.

Behavioral Health professional shall have the following qualifications: be a Licensed Independent Practitioner; Licensed Chemical Dependency Supervisor; Licensed Chemical Dependency Professional, or Certified Co-Occurring Disorder Professionals-Diplomate, or Certified Co-Occurring Disorder Professional who has completed a Clinical supervision course approved by the Department or be a Clinician with a relevant Master's degree and licensed, at least 2 full years or a Registered Nurse with ANCC certification as a Psychiatric and Mental Health Nurse with 2 years' experience. Each professionally licensed staff shall have a current license to practice.

Within the organization no less than 50% of the staff will hold a RI license in behavioral health clinical specialty with certification in chemical dependency from a nationally recognized entity or shall be licensed chemical dependency specialists, or certified co-occurring disorder professionals or Diplomate, the remaining 50% will be actively engaged in the process of meeting the requirements.

☐ **Nurse Care Coordinators**

Description

☑ **Nurses**

Description
As part of the multi-disciplinary team, nurses will assist in the development of the care plan. Nurses will regularly coordinate with other healthcare providers and establish routine communications. Nurses will continue to assess patients throughout treatment and monitor progress in achieving health care plan goals.

☐ **Medical Specialists**

Description

☑ **Physicians**

Description
Physicians review assessments and treatment plans and meet as necessary with Health Home participants. Physicians are central to the creation of the care plan and lead teams to identify need for specialized care. Physicians prescribe and monitor medication and are available to consult with all other providers.

☐ **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

Description

Care Coordination

Definition:
Chronic Condition Management and Population Management

Service Definition:
The IHH team supports its consumers as they participate in managing the care they receive.
Interventions provided under IHH may include, but are not limited to:

Assisting in the development of symptom self-management, communication skills, and appropriate social networks to assist clients in gaining effective control over their psychiatric symptoms;

Provide health education, counseling, and symptom management to enable client to be knowledgeable in the oversight of chronic medical illness as advised by the client's primary/specialty medical team;

Maintaining up-to-date assessments and evaluations necessary to ensure the continuing availability of required services;

Assisting the client in locating and effectively utilizing all necessary medical, social, and psychiatric community services;

Assisting in the development and implementation of a plan for assuring client income maintenance, including the provision of both supportive counseling and problem-focused interventions in whatever setting is required, to enable the client to manage their psychiatric and medical symptoms to live in the community. This includes:

• Provide a range of support services or direct assistance to ensure that clients obtain the basic necessities of daily life, including but not necessarily limited to: financial support and/or benefits counseling;
• Teach money-management skills (e.g. budgeting and bill paying) and assist client assessing financial services (e.g. payeeship etc.).
• Develop skills related to reliable transportation (help obtain driver's license, arrange for cabs, finds rides).
• Provide individual supportive therapy (e.g. problem solving, role playing, modeling and support), social skill development, and assertive training to increase client social and interpersonal activities in community settings) e.g. plan, structure, and prompt social and leisure activities on evenings, weekends, and holidays, including direct support and coaching.

Assistance with other activities necessary to maintain personal and medical stability in a community setting and to assist the client to gain mastery over their psychiatric symptoms or medical conditions and disabilities in the context of daily living. For example:
• Support the client to consistently adhere to their medication regimens, especially for clients who are unable to engage due to symptom impairment issues.
• Accompanying clients to and assisting them at pharmacies to obtain medications.

• Accompany consumers to medical appointments, facilitate medical follow up.
• Provide direct support and coaching to help clients socialize - structure clients' time, increase social experiences, and provide opportunities to practice social skills and receive feedback and support.

The IHH team will conduct the necessary analysis related to how well they are managing entire populations, based on measurable health outcomes and utilization. This information helps IHHs improve their care delivery system, to the benefit of each IHH clients receiving care.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
The State implemented Current Care via the State Health Information Exchange (RIQI). CurrentCare allows authorized providers to see their clients' health information using secure technology. CurrentCare lets authorized providers view clients' health information from different doctors, hospitals and laboratories, which results in far more certainty and safety, less paperwork and greater satisfaction all around. The State is also in the process of providing a care management dashboard that will send real time alerts of inpatient and ED visits to CMHCs. This dashboard was developed by RIQI and is being purchased through the SIM initiative to increase the capacity of CMHOs (the only providers of IHH and ACT services) to be responsive to inpatient utilization by their clients.

Scope of benefit/service

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

☑ **Behavioral Health Professionals or Specialists**

Description
The position with primary responsibility for this service will be case managers. Case managers are responsible for conducting care coordination activities across providers and settings. Care coordination involves case management necessary for individuals to access medical, social, vocational, educational, as well as other individualized supportive services, including, but not limited to: Assessing support and service needed to ensure the continuing availability of required services; Assistance in accessing necessary health care and follow up care and planning for any recommendations; Assessment of housing status and providing assistance in accessing and maintaining safe and affordable housing; Conducting outreach to family members and significant others in order to maintain individuals connection to services, and expand social network; Assisting in locating and effectively utilizing all necessary community services in the medical, social, legal and behavioral health care areas and ensuring that all services are coordinated, and; Coordinating with other providers to monitor individuals' health status, medical conditions, medications and side effects.

Behavioral Health professional shall have the following qualifications: be a Licensed Independent Practitioner; Licensed Chemical Dependency Supervisor; Licensed Chemical Dependency Professional, or Certified Co-Occurring Disorder Professionals-Diplomate, or Certified Co-Occurring Disorder Professional who has completed a Clinical supervision course approved by the Department or be a Clinician with a relevant Master's degree and licensed, at least 2 full years or a Registered Nurse with ANCC certification as a Psychiatric and Mental Health Nurse with 2 years' experience. Each professionally licensed staff shall have a current license to practice.

☐ **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

Description

Health Promotion

Definition:
Each client will be assigned a primary case manager who coordinates and monitors the activities of the individual treatment team and has primary responsibility to write the person-centered treatment/care coordination plan, ensure plans are revised as necessary, and advocate for client rights and preferences. The case manager will collaborate with primary and specialty care providers as required. Additionally, the case manager will provide medical education to the client (e.g. educating through written materials, etc.).

The IHH team is responsible for managing clients' access to other healthcare providers and to act as a partner in encouraging compliance with treatment plans established by these providers. Health promotion activities are delivered by the team to engage clients in addressing healthy lifestyles and include services such as smoking cessation, nutrition, and stress management. The Managed Care Organizations (MCOs) and CMHOs will meet regularly to review performance metrics and to collaborate on improvement plans. The IHH will coordinate with the client's Primary Care Physician (PCP). These additional plans will be incorporated into the patient's overall treatment plan.

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

The State implemented Current Care via the State Health Information Exchange (RIQI). CurrentCare allows authorized providers to see their clients' health information using secure technology. CurrentCare lets authorized providers view clients' health information from different doctors, hospitals and laboratories, which results in far more certainty and safety, less paperwork and greater satisfaction all around. The State is also in the process of providing a care management dashboard that will send real time alerts of inpatient and ED visits to CMHCs. This dashboard was developed by RIQI and is being purchased through the SIM initiative to increase the capacity of CMHOs (the only providers of IHH and ACT services) to be responsive to inpatient utilization by their clients.

Scope of benefit/service

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

☑ **Behavioral Health Professionals or Specialists**

Description
Master's level team leaders will be responsible for the oversight of this service. Case managers may assist in the provision of health promotion activities.

Behavioral Health professional shall have the following qualifications: be a Licensed Independent Practitioner; Licensed Chemical Dependency Supervisor; Licensed Chemical Dependency Professional, or Certified Co-Occurring Disorder Professionals-Diplomate, or Certified Co-Occurring Disorder Professional who has completed a Clinical supervision course approved by the Department or be a Clinician with a relevant Master's degree and licensed, at least 2 full years or a Registered Nurse with ANCC certification as a Psychiatric and Mental Health Nurse with 2 years' experience. Each professionally licensed staff shall have a current license to practice.

Within the organization no less than 50% of the staff will hold a RI license in behavioral health clinical specialty with certification in chemical dependency from a nationally recognized entity or shall be licensed chemical dependency specialists, or certified co-occurring disorder professionals or Diplomate, the remaining 50% will be actively engaged in the process of meeting the requirements.

☐ **Nurse Care Coordinators**

Description

☑ **Nurses**

Description
Health Home team RNs will have primary responsibility for the provision of health promotion activities. Nurses will create and facilitate groups targeting health promotion (i.e.nutrition, smoking cessation, exercise) as well as meet with participants individually to monitor and encourage health promotion activities. Nurses will provide educational materials to individuals and be available as primary consultants for any questions related to health promotion activities.

☐ **Medical Specialists**

Description

☑ **Physicians**

Description
Physicians will have routine contact with Health Home patients and will encourage participation in health promotion activities.

☐ **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

Description

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:
Service Definition:
The IHH team will ensure consumers are engaged by assuming an active role in discharge planning. IHH/ACT Provider manual defines the care transition protocols that OTP HHs must implement. Patient information and care transition records will be shared in real time to improve the quality of care delivered and to ensure a smooth transition for all patients. The IHH team will ensure collaboration between consumers and medical professionals to reduce missed appointments and dissatisfaction with care. Specific functions include:

Engage with the client upon admission to the hospital and ensure that the discharge plan addresses physical and behavioral health needs. For all medical and behavioral health inpatient stays, the IHH team conducts an on-site visit with client early in the hospital stay, participates in discharge planning, and leads the care transition until the client is stabilized.

Upon hospital discharge (phone calls or home visit):
• Ensure that reconciliation of pre- and post-hospitalization medication lists is completed.
• Assist consumer to identify and obtain answers to key questions or concerns.
• Ensure the consumer understands their medications, can identify if their condition is worsening and how to respond, knows how to prevent a health problem from becoming worse, and has scheduled all follow-up appointments.
• Prepare the consumer for what to expect if another care site is required (i.e. how to seek immediate care in the setting to which they have transitioned).

Identify linkages between long-term care and home and community-based services.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
The State implemented Current Care via the State Health Information Exchange (RIQI). CurrentCare allows authorized providers to see their clients' health information using secure technology. CurrentCare lets authorized providers view clients' health information from different doctors, hospitals and laboratories, which results in far more certainty and safety, less paperwork and greater satisfaction all around. The State is also in the process of providing a care management dashboard that will send real time alerts of inpatient and ED visits to CMHCs. This dashboard was developed by RIQI and is being purchased through the SIM initiative to increase the capacity of CMHOs (the only providers of IHH and ACT services) to be responsive to inpatient utilization by their clients.

The CMHO will be required to achieve the following preliminary standards:

1. Program has structured information systems, policies, procedures, and practices to create, document, implement, and update a treatment plan for every consumer.

2. Health Home provider has a systematic process/system to follow-up on tests, treatments, services/referrals which is integrated into the consumer's treatment plan.

Guidance: Programs have a system/process to identify, track, and proactively manage the consumers' care needs using up-to-date information. In order to coordinate and manage care, the program practice has a system in place to produce and track basic information about its consumer population, including a system to proactively coordinate/manage care of a consumer population with specific disease/health care needs.

3. The program has a developed process and/or system which allows the consumer's health information and treatment plan to be accessible to the interdisciplinary provider team of providers, and which allows for population management/identification of gaps in care including preventative services.

4. Programs are committed to work with Rhode Island's health information exchange system (CurrentCare) and be in compliance with any future version of the Statewide Policy Guidance regarding information, polices, standards, and technical approaches, governing health information exchange.

Guidance: Provider is committed to promote, populate, use, and access data through the statewide health information exchange system. Provider is to work with RI's Health Information Exchange to ensure they receive the technical assistance in regards to any of the above requirements.

5. Programs have the capability to share information with other providers and collect specific quality measures as required by EOHHS and CMS.

6. Program is able to use EOHHS and CMS quality measures as an accountability framework for assessing progress towards reducing avoidable health costs, specifically preventable hospital admissions/readmissions, avoidable emergency room visits, and providing timely post discharge follow-up care.

Guidance: Provider is committed to and is engaged in utilizing quality measures to improve services.

Scope of benefit/service

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

☑ **Behavioral Health Professionals or Specialists**

Description
The Master's Level team leader will need to assess the consistency of the care plan(s) established in relation to the clinical treatment plan. This person will interact with other providers in addressing the patient's treatment and health needs while in another setting and work with the team to establish a transitional plan. The case manager will be responsible for the application of services in a transitional care plan. The case manager will be responsible for assuring the patient is able to follow through with transition plans and is assisted in doing so.

The hospital liaison will work closely with the hospital staff, especially discharge planners, to assess the suitability of transition plans. Hospital liaisons will work with other long term facilities to plan for coordination of care during and after a residential stay.

Behavioral Health professional shall have the following qualifications: be a Licensed Independent Practitioner; Licensed Chemical Dependency Supervisor; Licensed Chemical Dependency Professional, or Certified Co-Occurring Disorder Professionals-Diplomate, or Certified Co-Occurring Disorder Professional who has completed a Clinical supervision course approved by the Department or be a Clinician with a relevant Master's degree and licensed, at least 2 full years or a Registered Nurse with ANCC certification as a Psychiatric and Mental Health Nurse with 2 years' experience. Each professionally licensed staff shall have a current license to practice.

Within the organization no less than 50% of the staff will hold a RI license in behavioral health clinical specialty with certification in chemical dependency from a nationally recognized entity or shall be licensed chemical dependency specialists, or certified co-occurring disorder professionals or Diplomate, the remaining 50% will be actively engaged in the process of meeting the requirements.

☐ **Nurse Care Coordinators**

Description

☑ **Nurses**

Description

The registered nurse will be the primary provider/monitor of transitional care activities. Nurses have the most day-to-day interaction with other physical health care providers. Nurses are responsible for the oversight of medication delivery and administration. The RN will be the party responsible to develop the transitional care plan and accommodate any of the needs of individuals, such as transportation, ambulation, and risk of infection, etc.

☐ **Medical Specialists**

Description

☑ **Physicians**

Description

The team physician will be responsible for the review of other treatment received and re-integration in the CMHO setting. Physicians will need to coordinate with other physicians to ensure continuity of care. Physicians will guide other team members in the establishment of a transitional care plan.

☐ **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

Description

Individual and family support, which includes authorized representatives

Definition:
Service Definition:
IHH team will provide practical help and support, advocacy, coordination, and direct assistance in helping clients to obtain medical and dental health care. Services include individualized education about the client's illness and service coordination for clients with children (e.g. services to help client fulfill parenting responsibilities, services to help client restore relationship with children, etc.).

IHH peer specialists will help consumers utilize support services in the community and encourage them in their recovery efforts by sharing their lived experience and perspective. Peer support validates clients' experiences, guides and encourages clients to take responsibility for their own recovery. In addition, peer supports will:

• Help clients establish a link to primary health care and health promotion activities,
• Assist clients in reducing high-risk behaviors and health-risk factors such as smoking, poor illness self-management, inadequate nutrition, and infrequent exercise,
• Assist clients in making behavioral changes leading to positive lifestyle improvement, and
• Help clients set and achieve a wellness or health goal using standardized programs such as Whole Health Action Maintenance (WHAM).

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
The State implemented Current Care via the State Health Information Exchange (RIQI). CurrentCare allows authorized providers to see their clients' health information using secure technology. CurrentCare lets authorized providers view clients' health information from different doctors, hospitals and laboratories, which results in far more certainty and safety, less paperwork and greater satisfaction all around. The State is also in the process of providing a care management dashboard that will send real time alerts of inpatient and ED visits to CMHCs. This dashboard was developed by RIQI and is being purchased through the SIM initiative to increase the capacity of CMHOs (the only providers of IHH and ACT services) to be responsive to inpatient utilization by their clients.

Scope of benefit/service

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

☑ **Behavioral Health Professionals or Specialists**

Description
All members of the Health Home teams may be involved in the provision of individual and family support services. While case managers may have primary responsibility, it is reasonable to assume that all of a Health Home client's supports may have access to all team members.

Behavioral Health professional shall have the following qualifications: be a Licensed Independent Practitioner; Licensed Chemical Dependency Supervisor; Licensed Chemical Dependency Professional, or Certified Co-Occurring Disorder Professionals-Diplomate, or Certified Co-Occurring Disorder Professional who has completed a Clinical supervision course approved by the Department or be a Clinician with a relevant Master's degree and licensed, at least 2 full years or a Registered Nurse with ANCC certification as a Psychiatric and Mental Health Nurse with 2 years' experience. Each professionally licensed staff shall have a current license to practice.

Within the organization no less than 50% of the staff will hold a RI license in behavioral health clinical specialty with certification in chemical dependency from a nationally recognized entity or shall be licensed chemical dependency specialists, or certified co-occurring disorder professionals or Diplomate, the remaining 50% will be actively engaged in the process of meeting the requirements.

☐ **Nurse Care Coordinators**

Description

☑ **Nurses**

Description
Nurses may involve family in instructions for following care plans and discussions around medication adherence.

☐ **Medical Specialists**

Description

☑ **Physicians**

Description
Doctors may include family members or patient advocates in their meetings with patients.

☐ **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

Description

Referral to community and social support services, if relevant

Definition:

OVERARCHING STATEWIDE DEFINITON: Referrals to community and socials support services ensure that individuals have access to a myriad of formal and informal resources. Ideally, these resources are easily accessed by the individual in the service system and assists individuals in addressing medical, behavioral, educational, social and community Issues.

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

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum.
The State implemented Current Care via the State Health Information Exchange (RIQI). CurrentCare allows authorized providers to see their clients' health information using secure technology. CurrentCare lets authorized providers view clients' health information from different doctors, hospitals and laboratories, which results in far more certainty and safety, less paperwork and greater satisfaction all around. The State is also in the process of providing a care management dashboard that will send real time alerts of inpatient and ED visits to CMHCs. This dashboard was developed by RIQI and is being purchased through the SIM initiative to increase the capacity of CMHOs (the only providers of IHH and ACT services) to be responsive to inpatient utilization by their clients.

Scope of benefit/service

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

☑ **Behavioral Health Professionals or Specialists**

Description
Case managers will make the bulk of referrals that are not specific to medical appointments, though would not be restricted from doing so when appropriate. Case managers are the primary link to resources of recovery support in the community. Working with the Master's Level Team Leader, case managers will be responsible for maintaining updated lists of resources with contact information. Case managers will ensure follow through on referrals and assist patients, when needed, in getting to appointments or ensuring connection.

Behavioral Health professional shall have the following qualifications: be a Licensed Independent Practitioner; Licensed Chemical Dependency Supervisor; Licensed Chemical Dependency Professional, or Certified Co-Occurring Disorder Professionals-Diplomate, or Certified Co-Occurring Disorder Professional who has completed a Clinical supervision course approved by the Department or be a Clinician with a relevant Master's degree and licensed, at least 2 full years or a Registered Nurse with ANCC certification as a Psychiatric and Mental Health Nurse with 2 years' experience. Each professionally licensed staff shall have a current license to practice.

Within the organization no less than 50% of the staff will hold a RI license in behavioral health clinical specialty with certification in chemical dependency from a nationally recognized entity or shall be licensed chemical dependency specialists, or certified co-occurring disorder professionals or Diplomate, the remaining 50% will be actively engaged in the process of meeting the requirements.

☐ **Nurse Care Coordinators**

Description

☑ **Nurses**

Description
Nurses will be the primary source of referral for medical appointments, ensuring that patients are properly referred and that essential information is provided and received.

☐ **Medical Specialists**

Description

☑ **Physicians**

Description
Physicians may make referrals for HH patients on a regular basis. It would be expected that in referrals to specialty care for individuals with specific complications, a physician referral would be most appropriate.

☐ **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

Description

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:
Clients eligible for IHH services will meet diagnostic and functional criteria established by BHDDH.Individuals will also be assessed for eligibility using the Daily Living Activities (DLA) Functional Assessment. The DLA must be completed at admission and every 6 months after admission as well as after an IP admission or significant change in clinical presentation. The assessment tool identifies where interventions are needed for rehabilitation and recovery so clinicians can address those functional deficits on individualized treatment plans.Individuals who do not meet diagnostic criteria, but require IHH services due to significant functional impairment as measured by the DLA, may be admitted to the program through an

exception process established by BHDDH in collaboration with MCOs.For all HH admissions, a BHDDH enrollment form must be completed and kept in the client's medical record.The Provider must submit a HH admission request via the HP web portal. The client's primary eligible diagnosis, the DLA score and the program (OTP, IHH or ACT) must be entered in the portal. In addition, CMHO will verify that client has signed an agreement to receive ACT/IHH services or needs this level of service and was unable/unwilling to sign.Staff at BHDDH will review and either approve or deny requests within 2 business days.A comprehensive and culturally appropriate health assessment is used. Each client will be assigned a service coordinator (case manager) who coordinates and monitors the activities of the client's individual treatment team and the greater IHH/ACT team. The primary responsibility of the service coordinator is to work with the client to develop the treatment plan, provide individual supportive counseling, offer options and choices in the treatment plan, ensure that immediate changes are made as the client's needs change, and advocate for the client's wishes, rights, and preferences.

☑ **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: 16-002 Supersedes Transmittal Number: RI-11-0007 Approved Effective Date: Jan 1, 2016 Approval Date: Jan 12, 2017

Transmittal Number: 16-002 Supersedes Transmittal Number: RI-11-0007 Approved Effective Date: Jan 1, 2016 Approval Date: Jan 12, 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 among eligible CMHO clients using the Medicaid health home.

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

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 Organizations (MCOs) for the 35% of the health home-eligible SPMI population enrolled in MCOs. The state is currently working with the MCOs to develop health utilization profiles minimally comprised of the components below. To the extent possible, similar profiles will be derived from the Medicaid data warehouse and other applicable sources for the remaining fee-for-service individuals who are dually eligible for Medicare and Medicaid. The state will work closely with the Centers for Medicare and Medicaid Innovation to obtain Medicare utilization and cost data, including: 1) Claims Data to Identify member's pattern of utilization based on previous 12 months: • #Emergency Room Visits. • Last ER Visit Date. • Last ER Visit Primary Diagnosis. • #Urgent Care Visits; 2) Claims data to identify member's primary care home: • #PCP Sites • PCP visits to current PCP Site • Last PCP visit date to current PCP Site • Current PCP Provider NPI • Last PCP visit to current PCP Site Provider NPI •#PCP visits to other Providers • Last PCP visit date to other Providers • Last PCP visit to other PCP Site Provider NP; 3) Health utilization profile developed by MCOs as part of the CMHO certification process. The state will query providers about the use of HIT in the delivery of care coordination services. The state may establish pilot tests of a subset of providers (e.g., those with EHRs and patient registries) to measure changes in health outcomes, experience of care and quality of care among clients.

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:

30 day readmission

Measure Specification, including a description of the numerator and denominator.
Measure: For members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.

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

Denominator: Count the number of Index Hospital Stays for each age, gender, and total combination
Data Sources:
Medicare and Medicaid Claims
Frequency of Data Collection:

○ **Monthly**
○ **Quarterly**

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

Measure:
Admission per 1000 member months for any diagnosis among health home enrollees.
Measure Specification, including a description of the numerator and denominator.
Admission per 1000 member months for any diagnosis among health home enrollees.
Data Sources:
Claims
Frequency of Data Collection:

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

Measure:
AMB-HH: Ambulatory Care – Emergency Department Visits
Measure Specification, including a description of the numerator and denominator.
Measure Specification:
Rate of emergency department (ED) visits per 1,000 enrollee months among Health Home enrollees.

Numerator: Number of ED visits that did not result in an inpatient hospitalization

Denominator: Total number of enrollee months among Health Home enrollees.
Data Sources:
Medicare and Medicaid Claims
Frequency of Data Collection:

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

Emergency Room Visits

Measure:
ED visits per 1000 member months for any diagnosis among health home enrollees.
Measure Specification, including a description of the numerator and denominator.
ED visits per 1000 member months for any diagnosis among health home enrollees.
Data Sources:
Claims
Frequency of Data Collection:

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

Measure:
IU-HH: Inpatient Utilization

Measure Specification, including a description of the numerator and denominator.
Measure Specification:
Rate of acute inpatient care and services (total, maternity, mental and behavioral disorders, surgery, and medicine) per 1,000 enrollee months among Health Home enrollees.

Numerator: Total acute inpatient stays and services (including maternity, mental and behavioral health disorders, surgeries, and medicine) with a discharge date during the measurement period.

Denominator: Total number of enrollee months among Health Home enrollees.
Data Sources:
Medicaid and Medicare claims
Frequency of Data Collection:

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

Measure:
Percent of patients with one or more ED visits for a mental health condition
Measure Specification, including a description of the numerator and denominator.
Numerator: Patients who had one or more visits for a mental health condition (ICD-9 code and DSM codes to be specified)

Denominator: All patients with an ED visit
Data Sources:
Medicaid and Medicare claims
Frequency of Data Collection:

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

Skilled Nursing Facility Admissions

Measure:
Admission per 1000 member months for any diagnosis among health home enrollees
Measure Specification, including a description of the numerator and denominator.
Admission per 1000 member months for any diagnosis among health home enrollees.
Data Sources:
Claims
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
The State will consolidate data from its Medicaid data warehouse which contains both FSS claims and managed care encounter data, to assess general and psychiatric hospital readmission rates of CMHO health home service users. The state

will calculate readmissions per 1000 member months among CMHO users. The state will track pre/post hospital readmission rates among health home participants. Rates will also be compared with clinically similar individuals not receiving CMHO health home services.

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

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

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

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

Assessment of Quality Improvements and Clinical Outcomes
The State will utilize quality process and outcome measures described in the prior section to assess quality improvements and clinical outcomes.

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.

Transmittal Number: 16-002 Supersedes Transmittal Number: RI-11-0007 Approved Effective Date: Jan 1, 2016 Approval Date: Jan 12, 2017

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-2 Health Home Services

Monitoring

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

8000

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

$ 4500000.00

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:
The annual savings projection was calculated based on the estimated total cost of care for those members receiving IHH/ACT services (estimated at $200M in FY14 based on combination of FFS activity and encounter data reported by the managed care plans). Based on analysis by BHDDH of other states' experiences, the targeted savings was projected to be 3%.

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		

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

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

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		
Improve Care Coordination [FOR PURPOSES OF CMHC HEALTH HOME QUALITY MEASURES, "PATIENT" REFERS TO ME...		
Improve management of chronic conditions [FOR PURPOSES OF CMHC HEALTH HOME QUALITY MEASURES, "PATIEN...		
Improve Transitions to CMHO Services [FOR PURPOSES OF CMHC HEALTH HOME QUALITY MEASURES, "PATIENT" R...		
Increase use of preventive services [FOR PURPOSES OF CMHC HEALTH HOME QUALITY MEASURES, "PATIENT" RE...		
Reduce Hospital Readmissions [FOR PURPOSES OF CMHC HEALTH HOME QUALITY MEASURES, "PATIENT" REFERS TO...		
Reduce preventable hospital emergency department (ED) visits [FOR PURPOSES OF CMHC HEALTH HOME QUALI...		

Health Homes Administrative Component: Goal Detail

Health Home Goal:

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

Measure		
Percentage of patients whose chart includes documentation of physical and behavioral health needs		
Percentage of patients with a regular source of health care		
Percentage of hospital-discharged patients with a follow-up visit within 14 days of hospital dischar...		
Percentage of hospital-discharged patients contacted by the CMHO hospital liaison or a member of the...		
Percentage of patients who had a physical exam in the past 12 months		

Health Homes Administrative Component: Measure Detail

Measure
Percentage of patients whose chart includes documentation of physical and behavioral health needs

○ **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 whose chart includes documentation of physical and behavioral health needs

Denominator: all patients

Data Sources:
Chart/EHR

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

Measure is related to:

◉ **Clinical Outcomes**

○ **Experience of Care**

○ **Quality of Care**

○ **Other**
Describe:

Health Homes Administrative Component: Measure Detail

Measure
Percentage of patients with a regular source of health 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 identifying a person or place they regularly get physical health care, other than a hospital emergency department

Denominator: All patients who complete Q1 on the RI OEI

Data Sources:
Rhode Island Outcomes Evaluation Instrument (RI OEI)

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 Organizations (MCOs) for the 35% of the health home-eligible SPMI population enrolled in MCOs. The state is currently working with the MCOs to develop health utilization profiles. To the extent possible, similar profiles will be derived from the Medicaid data warehouse and other applicable sources for the remaining fee-for-service individuals who are dually eligible for Medicare and Medicaid. The state will work closely with the Centers for Medicare and Medicaid Innovation to obtain Medicare utilization and cost data. Rhode Island will use 4 data sources to monitor the impact of its health home (HH) program on quality: claims; an intake survey of CMHO clients; charts (either electronic or paper), and; a client satisfaction survey. Rhode Island exercised prudence in selecting measures to not overburden CMHOs or IT staff with new data collection and analysis. We will use standard, validated measure specifications where they exist to increase our ability and CMS's to make comparisons across populations, programs, and states. We expect that Medicare claims for dual

eligibles will be available promptly as many measures examine the coordination between inpatient and outpatient care. We have not recommended meaningful use measures because they are unlikely to be available in the 8 quarter timeframe. In the first year, providers will be self-attesting to the presence of measures. If they become available quickly, they will be added. Chart sampling methodology to be developed collaboratively with CMHOs to achieve statistical validity. The state will also develop a plan in collaboration with the MMIS vendor to calculate and report measures associated with improving the management of chronic conditions.

Measure is related to:

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

Health Homes Administrative Component: Measure Detail

Measure
Percentage of hospital-discharged patients with a follow-up visit within 14 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: Patients with a clinician visit within 14 days of hospital discharge

Denominator: All patients with a hospital stay

Data Sources:

Medicare claims [hospitalization] and encounter data [visit to CMHO provider] or Medicaid claims [visit to PCP]

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

Measure is related to:

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

○ **Other**
Describe:

Health Homes Administrative Component: Measure Detail

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

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

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

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

Measure is related to:

○ **Clinical Outcomes**

○ **Experience of Care**

◉ **Quality of Care**

○ **Other**

Describe:

Health Homes Administrative Component: Measure Detail

Measure

Percentage of patients who had a physical exam in the past 12 months

○ **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 reporting they had a physical exam in the past 12 months

Denominator: All patients who complete Q3 on the RI OEI

Data Sources:
RI OEI

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 Organizations (MCOs) for the 35% of the health home-eligible SPMI population enrolled in MCOs. The state is currently working with the MCOs to develop health utilization profiles. To the extent possible, similar profiles will be derived from the Medicaid data warehouse and other applicable sources for the remaining fee-for-service individuals who are dually eligible for Medicare and Medicaid. The state will work closely with the Centers for Medicare and Medicaid Innovation to obtain Medicare utilization and cost data. Rhode Island will use 4 data sources to monitor the impact of its health home (HH) program on quality: claims; an intake survey of CMHO clients; charts (either electronic or paper), and; a client satisfaction survey. Rhode Island exercised prudence in selecting measures to not overburden CMHOs or IT staff with new data collection and analysis. We will use standard, validated measure specifications where they exist to increase our ability and CMS's to make comparisons across populations, programs, and states. We expect that Medicare claims for dual eligibles will be available promptly as many measures examine the coordination between inpatient and outpatient care. We have not recommended meaningful use measures because they are unlikely to be available in the 8 quarter timeframe. In the first year, providers will be self-attesting to the presence of measures. If they become available quickly, they will be added. Chart sampling methodology

to be developed collaboratively with CMHOs to achieve statistical validity. The state will also develop a plan in collaboration with the MMIS vendor to calculate and report measures associated with improving the management of chronic conditions.

Measure is related to:

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

Describe:

Health Homes Administrative Component: Goal Detail

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

Measure		
% of patients who are adherent to prescription medications for asthma and/or COPD.		
% of patients with diabetes (type 1 or type 2) who had HbA1c < 8.0%		
% of patients who are adherent to Meds – CVD and Anti-Hypertensive Meds		
% of patients using a statin medications who have a history of CAD (coronary artery disease).		
% of patients with a diagnosis of hypertension who have been seen for at least 2 office visits, w/ b...		
% of patients diagnosed with CAD with lipid level adequately controlled (LDL<100).		
% of patients identified as having persistent asthma & were appropriately prescribed medication (con...		

Health Homes Administrative Component: Measure Detail

Measure
% of patients who are adherent to prescription medications for asthma and/or COPD.

○ **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 members on medication for asthma/COPD in the past 90 days with medication possession ratio (MPR) > 80%

Denominator: number of all patients on medication for asthma/COPD in the past 90 days

Data Sources:
Medicare and Medicaid Claims

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 Organizations (MCOs) for the 35% of the health home-eligible SPMI population enrolled in MCOs. The state is currently working with the MCOs to develop health utilization profiles. To the extent possible, similar profiles will be derived from the Medicaid data warehouse and other applicable sources for the remaining fee-for-service individuals who are dually eligible for Medicare and Medicaid. The state will work closely with the Centers for Medicare and Medicaid Innovation to obtain Medicare utilization and cost data. Rhode Island will use 4 data sources to monitor the impact of its health home (HH) program on quality: claims; an intake survey of CMHO clients; charts (either electronic or paper), and; a client satisfaction survey. Rhode Island exercised prudence in selecting measures to not overburden CMHOs or IT staff with new data collection and analysis. We will use standard, validated measure specifications where they exist to increase our ability and CMS's to make comparisons across populations,

programs, and states. We expect that Medicare claims for dual eligibles will be available promptly as many measures examine the coordination between inpatient and outpatient care. We have not recommended meaningful use measures because they are unlikely to be available in the 8 quarter timeframe. In the first year, providers will be self-attesting to the presence of measures. If they become available quickly, they will be added. Chart sampling methodology to be developed collaboratively with CMHOs to achieve statistical validity. The state will also develop a plan in collaboration with the MMIS vendor to calculate and report measures associated with improving the management of chronic conditions.

Measure is related to:

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

Health Homes Administrative Component: Measure Detail

Measure
% of patients with diabetes (type 1 or type 2) who had HbA1c < 8.0%

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

Denominator : For a given 90-day period, number of patients identified as having diabetes and having a documented Hba1c in the previous 12 months

Data Sources:
Medicare and Medicaid Claims

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

Measure is related to:

◉ **Clinical Outcomes**

○ **Experience of Care**

○ **Quality of Care**

○ **Other**
Describe:

Health Homes Administrative Component: Measure Detail

Measure
% of patients who are adherent to Meds – CVD and Anti-Hypertensive Meds

○ **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 on that class of medication in the past 90 days with medication possession ratio (MPR) > 80%

Denominator: number of all patients on that class of medication in the past 90 days

Data Sources:
Medicare and Medicaid Claims

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

Measure is related to:

○ **Clinical Outcomes**

○ **Experience of Care**

◉ **Quality of Care**

○ **Other**
Describe:

Health Homes Administrative Component: Measure Detail

Measure
% of patients using a statin medications who have a history of CAD (coronary artery disease).

○ **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: for a given 90 day period number of patients identified as having coronary artery disease and a prescription for a statin

Denominator: for a given 90 day period number of patients coronary artery disease

Data Sources:
Medicare and Medicaid Claims

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

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Measure is related to:

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

Describe:

Health Homes Administrative Component: Measure Detail

Measure
% of patients with a diagnosis of hypertension who have been seen for at least 2 office visits, w/ blood pressure adequately controlled (BP < 140/90) during the measurement period

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

Denominator : for a given 90 day period number of patients identified as having hypertension who had two documented episodes of care in the previous 12 months

Data Sources:
Medicare and Medicaid Claims

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

Measure is related to:

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

○ **Other**
Describe:

Health Homes Administrative Component: Measure Detail

Measure
% of patients diagnosed with CAD with lipid level adequately controlled (LDL<100).

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

Denominator : for a given 90 day period number of patients identified as having cardiovascular disease

Data Sources:
Medicare and Medicaid Claims

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

Measure is related to:

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

Describe:

Health Homes Administrative Component: Measure Detail

Measure

% of patients identified as having persistent asthma & were appropriately prescribed medication (controller medication) during the measurement period.

○ **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 : for a given 90 day period number of patients identified as having asthma and a prescription for a controller medication

Denominator : for a given 90 day period number of patients identified as having asthma

Data Sources:
Medicare and Medicaid Claims

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 Organizations (MCOs) for the 35% of the health home-eligible SPMI population enrolled in MCOs. The state is currently working with the MCOs to develop health utilization profiles. To the extent possible, similar profiles will be derived from the Medicaid data warehouse and other applicable sources for the remaining fee-for-service individuals who are dually eligible for Medicare and Medicaid. The state will work closely with the Centers for Medicare and Medicaid Innovation to obtain Medicare utilization and cost data. Rhode Island will use 4 data sources to monitor the impact of its health home (HH) program on quality: claims; an intake survey of CMHO clients; charts (either electronic or paper), and; a client satisfaction survey. Rhode Island exercised prudence in selecting measures to not overburden CMHOs or IT staff with new data collection and analysis. We will use standard, validated measure specifications where they exist to increase our ability and CMS's to make comparisons across populations,

programs, and states. We expect that Medicare claims for dual eligibles will be available promptly as many measures examine the coordination between inpatient and outpatient care. We have not recommended meaningful use measures because they are unlikely to be available in the 8 quarter timeframe. In the first year, providers will be self-attesting to the presence of measures. If they become available quickly, they will be added. Chart sampling methodology to be developed collaboratively with CMHOs to achieve statistical validity. The state will also develop a plan in collaboration with the MMIS vendor to calculate and report measures associated with improving the management of chronic conditions.

Measure is related to:

- (selected) **Clinical Outcomes**
- **Experience of Care**
- **Quality of Care**
- **Other**
  Describe:

Health Homes Administrative Component: Goal Detail

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

Measure		
Mental health: percentage of discharges for members 6 years of age and older who were hospitalized f...		
Percentage of hospital-discharged patients contacted by the CMHO hospital liaison/or a member of the...		
Care transitions: percentage of patients, regardless of age, discharged from an inpatient facility t...		
Percentage of patients satisfied with their access to outpatient services and with the quality of th...		

Health Homes Administrative Component: Measure Detail

Measure
Mental health: percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health

disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge. http://qualitymeasures.ahrq.gov/content.aspx?id=14965

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

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

Data Sources:
Medicare and Medicaid claims

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 Organizations (MCOs) for the 35% of the health home-eligible SPMI population enrolled in MCOs. The state is currently working with the MCOs to develop health utilization profiles. To the extent possible, similar profiles will be derived from the Medicaid data warehouse and other applicable sources for the remaining fee-for-service individuals who are dually eligible for

Medicare and Medicaid. The state will work closely with the Centers for Medicare and Medicaid Innovation to obtain Medicare utilization and cost data. Rhode Island will use 4 data sources to monitor the impact of its health home (HH) program on quality: claims; an intake survey of CMHO clients; charts (either electronic or paper), and; a client satisfaction survey. Rhode Island exercised prudence in selecting measures to not overburden CMHOs or IT staff with new data collection and analysis. We will use standard, validated measure specifications where they exist to increase our ability and CMS's to make comparisons across populations, programs, and states. We expect that Medicare claims for dual eligibles will be available promptly as many measures examine the coordination between inpatient and outpatient care. We have not recommended meaningful use measures because they are unlikely to be available in the 8 quarter timeframe. In the first year, providers will be self-attesting to the presence of measures. If they become available quickly, they will be added. Chart sampling methodology to be developed collaboratively with CMHOs to achieve statistical validity. The state will also develop a plan in collaboration with the MMIS vendor to calculate and report measures associated with improving the management of chronic conditions

Measure is related to:

- (selected) **Clinical Outcomes**
- **Experience of Care**
- **Quality of Care**
- **Other**
  Describe:

Health Homes Administrative Component: Measure Detail

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

- **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 with a phone or in-person contact within 2 days of discharge

Denominator: all patients with a hospital visit

Data Sources:
CHMO chart review

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

Measure is related to:

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

Describe:

Health Homes Administrative Component: Measure Detail

Measure
Care transitions: percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge. http://qualitymeasures.ahrq.gov/content.aspx?id=15178

○ **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 for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge

Denominator:All patients, regardless of age, discharged from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self-care or any other site of care

Data Sources:
Medicare and Medicaid claims

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

Measure is related to:

○ **Clinical Outcomes**

○ **Experience of Care**

◉ **Quality of Care**

○ **Other**
Describe:

Health Homes Administrative Component: Measure Detail

Measure
Percentage of patients satisfied with their access to outpatient services and with the quality of those 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 location of services was convenient.
- Staff were willing to see me as often as I felt it was necessary.
- Staff returned my call within 24 hours.
- Services were available at times that were good for me.
- I was able to get all the services I thought I needed.
- I was able to see a psychiatrist when I wanted to.
- I like the services I received here.
- If I had other choices, I would still get services from this agency.
- I would recommend this agency to a friend or family member.

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

Data Sources:
RI OEI Survey

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 Organizations (MCOs) for the 35% of the health

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Measure is related to:

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

Health Homes Administrative Component: Goal Detail

Health Home Goal:
Increase use of preventive services [FOR PURPOSES OF CMHC HEALTH HOME QUALITY MEASURES, "PATIENT" REFERS TO MEDICAID BENEFICIARIES RECEIVING CMHO HEALTH HOME SERVICES.]

Measure		

Measure		
Age and gender appropriate use of pap test, mammogram, and colonoscopy, using HEDIS specifications.		
Percentage of adolescents and adults members with a new episode of alcohol or other drug (AOD) depen...		
Percentage of patients who report using illicit substances or abusing alcohol		
Percentage of members 18-74 years of age who had an outpatient visit and who had their body mass ind...		
Percentage of drug/alcohol abusers counseled and referred to drug/alcohol treatment		
Percentage of patients aged 18 years and older screened for clinical depression using a standardized...		
Percentage of patients having one or more well-visits/physical examination visits in 12 month period		
Percentage of patients who are satisfied with their access to outpatient services and with the quali...		
Percentage of smokers counseled and referred for smoking cessation		
Percentage of patients who report that they smoke		

Health Homes Administrative Component: Measure Detail

Measure
Age and gender appropriate use of pap test, mammogram, and colonoscopy, using HEDIS specifications.

○ **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 with timely receipt of mammogram, pap test, and colonoscopy

Denominator: patients eligible for screening, per HEDIS specifications

Data Sources:
Medicaid and Medicare claims

Frequency of Data Collection:

○ **Monthly**

○ **Quarterly**

○ **Annually**

○ **Continuously**

○ **Other**

How Health IT will be utilized
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Measure is related to:

◉ **Clinical Outcomes**

○ **Experience of Care**

○ **Quality of Care**

○ **Other**
Describe:

Health Homes Administrative Component: Measure Detail

Measure
Percentage of adolescents and adults members with a new episode of alcohol or other drug (AOD) dependence who received the following: (a) Initiation of AOD treatment (b) Engagement of AOD treatment

○ **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:Initiation of Alcohol and other Drug (AOD) Dependence Treatment: Members with initiation of AOD treatment through an inpatient admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of diagnosis. Engagement of Alcohol and other Drug (AOD) Treatment: Initiation of AOD treatment and two or more inpatient admissions, outpatient visits, intensive outpatient encounters or partial hospitalizations with any AOD diagnosis within 30 days after the date of the Initiation encounter (inclusive). Multiple engagement visits may occur on the same day, but they must be with different providers in order to be counted.

Denominator: Members 13 years of age and older as of December 31 of the measurement year with a new episode of alcohol or other drug (AOD) during the intake period, reported in two age stratifications (13-17 years, 18+ years) and a total rate. The total rate is the sum of the two numerators divided by the sum of the two denominators.

Data Sources:
Medicare and Medicaid Claims

Frequency of Data Collection:

○ **Monthly**

○ **Quarterly**

○ **Annually**

○ **Continuously**

○ **Other**

How Health IT will be utilized
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Measure is related to:

○ **Clinical Outcomes**

○ **Experience of Care**

◉ **Quality of Care**

○ **Other**
Describe:

Health Homes Administrative Component: Measure Detail

Measure
Percentage of patients who report using illicit substances or abusing alcohol

○ **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 reporting they use illicit drugs or abusing alcohol

Denominator: all patients completing the behavioral health assessment

Data Sources:
RI B-HOLD (Behavioral Health Online Dataset)

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 Organizations (MCOs) for the 35% of the health home-eligible SPMI population enrolled in MCOs. The state is currently working with the MCOs to develop health utilization profiles. To the extent possible, similar profiles will be derived from the Medicaid data warehouse and other applicable sources for the remaining fee-for-service individuals who are dually eligible for Medicare and Medicaid. The state will work closely with the Centers for Medicare and Medicaid Innovation to obtain Medicare utilization and cost data. Rhode Island will use 4 data sources to monitor the impact of its health home (HH) program on quality: claims; an intake survey of CMHO clients; charts (either electronic

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Measure is related to:

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

Health Homes Administrative Component: Measure Detail

Measure
Percentage of members 18-74 years of age who had an outpatient visit and who had their body mass index (BMI) documented during the measurement year or the year prior to the measurement year

- ( ) **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:Body mass index documented during the measurement year or the year prior to the measurement year

Denominator:Members 18-74 of age who had an outpatient visit

Data Sources:
RI B-HOLD

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

Measure is related to:

- ◉ **Clinical Outcomes**

○ **Experience of Care**

○ **Quality of Care**

○ **Other**
Describe:

Health Homes Administrative Component: Measure Detail

Measure
Percentage of drug/alcohol abusers counseled and referred to drug/alcohol treatment

○ **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 counseled and referred to care for alcohol abuse and illicit drug use

Denominator: illicit drug/alcohol abusers

Data Sources:
Chart review and screening assessment

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

Measure is related to:

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

Health Homes Administrative Component: Measure Detail

Measure
Percentage of patients aged 18 years and older screened for clinical depression using a standardized tool AND follow-up documented

○ **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.
1. Numerator:Total number of patients from the denominator who have follow-up documentation

Denominator: All patients 18 years and older screened for clinical depression using a standardized tool

Data Sources:
Medicare and Medicaid Claims

Frequency of Data Collection:

○ **Monthly**

○ **Quarterly**

○ **Annually**

○ **Continuously**

○ **Other**

How Health IT will be utilized
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Measure is related to:

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

Health Homes Administrative Component: Measure Detail

Measure
Percentage of patients having one or more well-visits/physical examination visits in 12 month period

- ○ **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 with a preventive or primary care visit

Denominator: all patients

Data Sources:
Medicare and Medicaid Claims

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

Measure is related to:

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

Health Homes Administrative Component: Measure Detail

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

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

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

Data Sources:
RI OEI Survey

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

Measure is related to:

○ **Clinical Outcomes**

◉ **Experience of Care**

○ **Quality of Care**

○ **Other**
Describe:

Health Homes Administrative Component: Measure Detail

Measure
Percentage of smokers counseled and referred for smoking cessation

○ **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: patient counseled and referred to care for smoking cessation

Denominator: smokers

Data Sources:
Chart review and screening assessment

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 Organizations (MCOs) for the 35% of the health home-eligible SPMI population enrolled in MCOs. The state is currently working with the MCOs to develop health utilization profiles. To the extent possible, similar profiles will be derived from the Medicaid data warehouse and other applicable sources for the remaining fee-for-service individuals who are dually eligible for Medicare and Medicaid. The state will work closely with the Centers for Medicare and Medicaid Innovation to obtain Medicare utilization and cost data. Rhode Island will use 4 data sources to monitor the impact of its health home (HH) program on quality: claims; an intake survey of CMHO clients; charts (either electronic or paper), and; a client satisfaction survey. Rhode Island exercised prudence in selecting measures to not overburden CMHOs or IT staff with new data collection and analysis. We will use standard, validated measure specifications where they exist to increase our ability and CMS's to make comparisons across populations, programs, and states. We expect that Medicare claims for dual

eligibles will be available promptly as many measures examine the coordination between inpatient and outpatient care. We have not recommended meaningful use measures because they are unlikely to be available in the 8 quarter timeframe. In the first year, providers will be self-attesting to the presence of measures. If they become available quickly, they will be added. Chart sampling methodology to be developed collaboratively with CMHOs to achieve statistical validity. The state will also develop a plan in collaboration with the MMIS vendor to calculate and report measures associated with improving the management of chronic conditions.

Measure is related to:

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

Health Homes Administrative Component: Measure Detail

Measure
Percentage of patients who report that they smoke

- ○ **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 who smoke

Denominator: all patients

Data Sources:
RI B-HOLD (Behavioral Health Online Dataset)

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

Measure is related to:

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

Health Homes Administrative Component: Goal Detail

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

Measure		
Ambulatory care sensitive conditions: age-standardized acute care hospitalization rate for condition...		
Percentage of hospital-discharged patients contacted by the CMHO hospital liaison or a member of the...		
For members 18 years of age and older, the number of acute inpatient stays during the measurement ye...		
Satisfaction with care, accessibility of care		
Percentage of hospital-discharged patients with a follow-up visit to a CMHO or medical provider with...		

Health Homes Administrative Component: Measure Detail

Measure
Ambulatory care sensitive conditions: age-standardized acute care hospitalization rate for conditions where appropriate ambulatory care prevents or reduces the need for admission to the hospital, per 100,000 population under age 75 years. http://www.guideline.gov/content.aspx?id=15067

- (●) **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

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

○ **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 contacted by the CMHO liaison by phone or in person within 2 days of discharge

Denominator: all patients with a hospital visit

Data Sources:
Chart Review

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 Organizations (MCOs) for the 35% of the health home-eligible SPMI population enrolled in MCOs. The state is currently working with the MCOs to develop health utilization profiles. To the extent possible, similar profiles will be derived from the Medicaid data warehouse and other applicable sources for the remaining fee-for-service individuals who are dually eligible for Medicare and Medicaid. The state will work closely with the Centers for Medicare and Medicaid Innovation to obtain Medicare utilization and cost data. Rhode Island will use 4 data sources to monitor the impact of its health home (HH) program on quality: claims; an intake survey of CMHO clients; charts (either electronic or paper), and; a client satisfaction survey. Rhode Island exercised prudence in selecting measures to not overburden CMHOs or IT

staff with new data collection and analysis. We will use standard, validated measure specifications where they exist to increase our ability and CMS's to make comparisons across populations, programs, and states. We expect that Medicare claims for dual eligibles will be available promptly as many measures examine the coordination between inpatient and outpatient care. We have not recommended meaningful use measures because they are unlikely to be available in the 8 quarter timeframe. In the first year, providers will be self-attesting to the presence of measures. If they become available quickly, they will be added. Chart sampling methodology to be developed collaboratively with CMHOs to achieve statistical validity. The state will also develop a plan in collaboration with the MMIS vendor to calculate and report measures associated with improving the management of chronic conditions.

Measure is related to:

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

  Describe:

Health Homes Administrative Component: Measure Detail

Measure

For members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.

- ◉ **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

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

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

Data Sources:
RI OEI Survey

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 Organizations (MCOs) for the 35% of the health home-eligible SPMI population enrolled in MCOs. The state is currently working with the MCOs to develop health utilization profiles. To the extent possible, similar profiles will be derived from the Medicaid data warehouse and other applicable sources for the

remaining fee-for-service individuals who are dually eligible for Medicare and Medicaid. The state will work closely with the Centers for Medicare and Medicaid Innovation to obtain Medicare utilization and cost data. Rhode Island will use 4 data sources to monitor the impact of its health home (HH) program on quality: claims; an intake survey of CMHO clients; charts (either electronic or paper), and; a client satisfaction survey. Rhode Island exercised prudence in selecting measures to not overburden CMHOs or IT staff with new data collection and analysis. We will use standard, validated measure specifications where they exist to increase our ability and CMS's to make comparisons across populations, programs, and states. We expect that Medicare claims for dual eligibles will be available promptly as many measures examine the coordination between inpatient and outpatient care. We have not recommended meaningful use measures because they are unlikely to be available in the 8 quarter timeframe. In the first year, providers will be self-attesting to the presence of measures. If they become available quickly, they will be added. Chart sampling methodology to be developed collaboratively with CMHOs to achieve statistical validity. The state will also develop a plan in collaboration with the MMIS vendor to calculate and report measures associated with improving the management of chronic conditions.

Measure is related to:

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

  Describe:

Health Homes Administrative Component: Measure Detail

Measure
Percentage of hospital-discharged patients with a follow-up visit to a CMHO or medical provider within 14 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: patients with a CMHO or medical provider visit within 14 days of discharge

Denominator: all patients with a hospital visit

Data Sources:
Medicare and Medicaid Claims

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

Measure is related to:

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

Describe:

Health Homes Administrative Component: Goal Detail

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

Measure		
Percent of patients with one or more ED visits for any conditions named in NYU ED methodology, avail...		
Percent of patients with one or more ED visits for a mental health condition		
Percentage of hospital-discharged patients contacted by the CMHO hospital liaison or a member of the...		
Satisfaction with care, accessibility of care		

Health Homes Administrative Component: Measure Detail

Measure
Percent of patients with one or more ED visits for any conditions named in NYU ED methodology, available at:
http://wagner.nyu.edu/ld.lpsr/lndex.html?p=61

- ◉ **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
Percent of patients with one or more ED visits for a mental health condition

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

- **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**
- (selected) **The measure is not included in the Health Homes State Plan**

Measure Specification, including a description of the numerator and denominator.
Numerator: patients with a phone or in-person contact within 2 days of discharge
Denominator: all patients with a hospital visit

Data Sources:
Chart review

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

Measure is related to:

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

Health Homes Administrative Component: Measure Detail

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

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

Data Sources:
RI OEI Survey

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 Organizations (MCOs) for the 35% of the health home-eligible SPMI population enrolled in MCOs. The state is currently working with the MCOs to develop health utilization profiles. To the extent possible, similar profiles will be derived from the Medicaid data warehouse and other applicable sources for the remaining fee-for-service individuals who are dually eligible for Medicare and Medicaid. The state will work closely with the

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Measure is related to:

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

PRA Disclosure Statement