Table of Contents

State/Territory Name: Rhode Island

State Plan Amendment (SPA) #:18-009

This file contains the following documents in the order listed:

1) Approval Letter
2) Summary Form (179-like)
3) Approved SPA Pages

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

October 22, 2018

Eric Beane, Secretary
Executive Office of Health and Human Services
State of Rhode Island and Providence Plantations
3 West Road
Cranston, RI 02920

Dear Secretary Beane:

On August 7, 2018, the Centers for Medicare and Medicaid Services (CMS) received Rhode Island State Plan Amendment (SPA) transmittal number 18-009 proposing to make CEDAR Health Home benefits available in the State's managed care delivery system.

Based on information that was provided, we are pleased to inform you that RI SPA 18-009 was approved on October 17, 2018 with an effective date of July 1, 2018. The approved state plan pages are enclosed.

If you have any questions regarding this matter you may contact Lynn DelVecchio (401) 380-5604 or by e-mail at Lynn.DelVecchio@cms.hhs.gov

Sincerely,

/s/

Richard R. McGreal
Associate Regional Administrator

Enclosure
Cc: Patrick Tigue, Medicaid Director
Melody Lawrence, Interdepartmental Project Manager

CMS-10434 OMB 0938-1188

Package Information

Package ID	RI2018MS0007O	**Submission Type**	Official
Program Name	CEDAR Health Homes	**State**	RI
SPA ID	RI-18-0009	**Region**	Boston, MA
Version Number	2	**Package Status**	Approved
Submitted By	Melody Lawrence	**Submission Date**	8/7/2018
Package Disposition		**Approval Date**	10/17/2018 3:02 PM EDT
Priority Code	P2		

Approval Notice

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

7500 Security Boulevard, Mail Stop S2-14-26

Baltimore, Maryland 21244-1850

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Date: 10/17/2018

Head of Agency: Elizabeth Roberts

Title/Dept : Secretary of Health and Human Services

Address 1: 74 West Road

Address 2:

City : Cranston

State: RI

Zip: 02920

MACPro Package ID: RI2018MS0007O

SPA ID: RI-18-0009

Subject

Approval Notification

Dear Elizabeth Roberts

This is an informal communication that will be followed with an official communication to the State's Medicaid Director.

The Centers for Medicare and Medicaid Services (CMS) is pleased to inform you that we are recommending approval for your request for

Approval

Reviewable Unit	Effective Date
Health Homes Intro	7/1/2018
Health Homes Geographic Limitations	7/1/2018
Health Homes Population and Enrollment Criteria	7/1/2018
Health Homes Providers	7/1/2018
Health Homes Service Delivery Systems	7/1/2018
Health Homes Payment Methodologies	7/1/2018
Health Homes Services	7/1/2018
Health Homes Monitoring, Quality Measurement and Evaluation	7/1/2018

For payments made to Health Homes providers under this new Health Homes Program submission package a medical assistance percentage (FMAP) rate of 90% applies to such payments for the period 7/1/2018 to 6/30/2020.

Corrections: Replace Elizabeth Roberts with Secretary Beane (State needs to update their system profile) and 90% FMAP is not available as this is not a new Health Homes SPA and has already used the full 8 quarters of enhanced match.

A full approval letter will be sent in hard copy under separate cover.

Sincerely,

Mike Nardone

Mr.

Approval Documentation

Name	Date Created

Name	Date Created	
No items available		

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | RI2018MS0007O | RI-18-0009 | CEDAR Health Homes

Package Header

Package ID RI2018MS0007O

SPA ID RI-18-0009

Submission Type Official

Initial Submission Date 8/7/2018

Approval Date 10/17/2018

Effective Date N/A

Superseded SPA ID N/A

State Information

State/Territory Name: Rhode Island

Medicaid Agency Name: Executive Office of Health and Human Services

Submission Component

- (selected) State Plan Amendment
- (selected) Medicaid
- ( ) CHIP

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | RI2018MS0007O | RI-18-0009 | CEDAR Health Homes

Package Header

Package ID RI2018MS0007O

SPA ID RI-18-0009

Submission Type Official

Initial Submission Date 8/7/2018

Approval Date 10/17/2018

Effective Date N/A

Superseded SPA ID N/A

SPA ID and Effective Date

SPA ID RI-18-0009

Reviewable Unit	Proposed Effective Date	Superseded SPA ID
Health Homes Intro	7/1/2018	
Health Homes Geographic Limitations	7/1/2018	
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Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | RI2018MS0007O | RI-18-0009 | CEDAR Health Homes

Package Header

Package ID RI2018MS0007O

SPA ID RI-18-0009

Submission Type Official

Initial Submission Date 8/7/2018

Approval Date 10/17/2018

Effective Date N/A

Superseded SPA ID N/A

Executive Summary

Summary Description Including Goals and Objectives

Cedar Health Homes are designed for Medicaid recipients under the age of 21 who meet the following criteria are eligible for Cedar Services: 1) Suspected of having a severe mental illness, or severe emotional disturbance, 2) Suspected of having two or more of the following chronic conditions Mental Health Condition, Asthma, Diabetes, Developmental Disabilities, Down Syndrome, Mental Retardation, or Seizure Disorders; or 3) has one chronic condition listed previously and is at risk of developing a second.
Cedar Family Centers are designed to provide a structured system for facilitating the assessment of need for, and referral to, evidence based medically necessary service that may be available for children pursuant to federal EPSDT requirements, and referrals to community based services and supports that benefit the child and family. Cedar Family Center Health Homes operate as "Designated Providers" of Health Home Services. The CHH Team will consult, coordinate and collaborate on a regular basis with the child's Primary Care Physician/Medical Home and with other providers providing treatment services to that child. Cedar Family Centers, by Standard, provide all services in a patient and family centered manner.

Cedar Family Centers aim to connect children and their families with appropriate, evidence based medically necessary services, and to empower and build a family's skills to successfully navigate systems of care and advocate for their child(ren) and family.

Beginning July 1, 2018, Cedar Family Services will be carved into the Managed Care contracts and will no longer be paid through FFS only. Cedar Family Services will now be available through both Fee-For Service and Managed Care Delivery Systems.

Federal Budget Impact and Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First	2018	$0
Second	2019	$0

Federal Statute / Regulation Citation

Section 2703 of the Patient Protection and Affordable Care Act of 2010

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | RI2018MS0007O | RI-18-0009 | CEDAR Health Homes

Package Header

Package ID RI2018MS0007O

SPA ID RI-18-0009

Submission Type Official

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Approval Date 10/17/2018

Effective Date N/A

Superseded SPA ID N/A

Governor's Office Review

- ○ No comment
- ○ Comments received
- ○ No response within 45 days
- ● Other

Describe This amendment has not been reviewed specifically with the Governor's Office. Under the Rhode Island Medicaid State Plan, the Governor has elected not to review the details of state plan materials. However, in accordance with Rhode Island law and practice, the Governor is kept apprised of major changes in the state plan.

Submission - Public Comment

MEDICAID | Medicaid State Plan | Health Homes | RI2018MS0007O | RI-18-0009 | CEDAR Health Homes

Package Header

Package ID RI2018MS0007O

SPA ID RI-18-0009

Submission Type Official

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Approval Date 10/17/2018

Effective Date N/A

Superseded SPA ID N/A

Name of Health Homes Program

CEDAR Health Homes

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

- ○ Public notice was not federally required and comment was not solicited
- ○ Public notice was not federally required, but comment was solicited
- ● Public notice was federally required and comment was solicited

Indicate how public comment was solicited:

- ☐ Newspaper Announcement
- ☐ Publication in state's administrative record, in accordance with the administrative procedures requirements
- ☐ Email to Electronic Mailing List or Similar Mechanism

Date of Email or other electronic notification: Jun 29, 2018

Description of mailing list, in particular parties and organizations included, and, if not email, description of similar mechanism used: Stakeholders, providers, and sister state agencies

- ☐ Website Notice

Select the type of website

- ☐ Website of the State Medicaid Agency or Responsible Agency

Date of Posting: Jun 29, 2018

Website URL: http://www.eohhs.ri.gov/ReferenceCenter/MedicaidStatePlanand1115Waiver/SPAand1115WaiverChanges.aspx

- ☐ Website for State Regulations
- ☐ Other
- ☐ Public Hearing or Meeting
- ☐ Other method

Upload copies of public notices and other documents used

Name	Date Created	
18-009 Interested Parties - Cedar In-Plan_6.29.18	8/7/2018 2:58 PM EDT	PDF
18-009 Notice to Public - Cedar In-Plan_6.29.18	8/7/2018 2:58 PM EDT	PDF

Upload with this application a written summary of public comments received (optional)

Name	Date Created	
No items available		

Indicate the key issues raised during the public comment period (optional)

- ☐ Access
- ☐ Quality
- ☐ Cost
- ☐ Payment methodology

- [ ] Eligibility
- [ ] Benefits
- [ ] Service delivery
- [ ] Other issue

Submission - Tribal Input

MEDICAID | Medicaid State Plan | Health Homes | RI2018MS0007O | RI-18-0009 | CEDAR Health Homes

Package Header

Package ID RI2018MS0007O

Submission Type Official

Approval Date 10/17/2018

Superseded SPA ID N/A

SPA ID RI-18-0009

Initial Submission Date 8/7/2018

Effective Date N/A

Name of Health Homes Program

CEDAR Health Homes

One or more Indian health programs or Urban Indian Organizations furnish health care services in this state

- (selected) Yes
- No

This state plan amendment is likely to have a direct effect on Indians, Indian health programs or Urban Indian Organizations

- (selected) Yes
- No

- [ ] The state has solicited advice from Indian Health Programs and/or Urban Indian Organizations, as required by section 1902(a)(73) of the Social Security Act, prior to submission of this SPA

Complete the following information regarding any solicitation of advice and/or tribal consultation conducted with respect to this submission:

Solicitation of advice and/or Tribal consultation was conducted in the following manner:

- [ ] All Indian Health Programs

Date of solicitation/consultation:	Method of solicitation/consultation:
6/29/2018	Email and USPS

- [ ] All Urban Indian Organizations

States are not required to consult with Indian tribal governments, but if such consultation was conducted voluntarily, provide information about such consultation below:

- [ ] All Indian Tribes

The state must upload copies of documents that support the solicitation of advice in accordance with statutory requirements, including any notices sent to Indian Health Programs and/or Urban Indian Organizations, as well as attendee lists if face-to-face meetings were held. Also upload documents with comments received from Indian Health Programs or Urban Indian Organizations and the state's responses to any issues raised. Alternatively indicate the key issues and summarize any comments received below and describe how the state incorporated them into the design of its program.

Name	Date Created	
18-009 Tribal Notification 18-010_6.29.18	8/7/2018 2:23 PM EDT	PDF

Indicate the key issues raised (optional)

- [ ] Access
- [ ] Quality
- [ ] Cost
- [ ] Payment methodology
- [ ] Eligibility
- [ ] Benefits
- [ ] Service delivery
- [ ] Other issue

Submission - Other Comment

MEDICAID | Medicaid State Plan | Health Homes | RI2018MS0007O | RI-18-0009 | CEDAR Health Homes

Package Header

Package ID	RI2018MS0007O	**SPA ID**	RI-18-0009
Submission Type	Official	**Initial Submission Date**	8/7/2018
Approval Date	10/17/2018	**Effective Date**	N/A
Superseded SPA ID	N/A		

SAMHSA Consultation

Name of Health Homes Program

CEDAR Health Homes

☐ 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
4/21/2011

Health Homes Intro

MEDICAID | Medicaid State Plan | Health Homes | RI2018MS0007O | RI-18-0009 | CEDAR Health Homes

Package Header

Package ID	RI2018MS0007O	**SPA ID**	RI-18-0009
Submission Type	Official	**Initial Submission Date**	8/7/2018
Approval Date	10/17/2018	**Effective Date**	7/1/2018
Superseded SPA ID	N/A		

Program Authority

1945 of the Social Security Act

The state elects to implement the Health Homes state plan option under Section 1945 of the Social Security Act.

Name of Health Homes Program

CEDAR Health Homes

Executive Summary

Provide an executive summary of this Health Homes program including the goals and objectives of the program, the population, providers, services and service delivery model used

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

Cedar Family Centers aim to connect children and their families with appropriate, evidence based medically necessary services, and to empower and build a family's skills to successfully navigate systems of care and advocate for their child(ren) and family.

Beginning July 1, 2018, Cedar Family Services will be carved into the Managed Care contracts and will no longer be paid through FFS only. Cedar Family Services will now be available through both Fee-For Service and Managed Care Delivery Systems.

General Assurances

- ☐ The state provides assurance that eligible individuals will be given a free choice of Health Homes providers.
- ☐ The states provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services.
- ☐ The state provides assurance that hospitals participating under the state plan or a waiver of such plan will be instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Homes providers.
- ☐ The state provides assurance that FMAP for Health Homes services shall be 90% for the first eight fiscal quarters from the effective date of the SPA. After the first eight quarters, expenditures will be claimed at the regular matching rate.
- ☐ 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.
- ☐ The state provides assurance that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.

Health Homes Geographic Limitations

MEDICAID | Medicaid State Plan | Health Homes | RI2018MS0007O | RI-18-0009 | CEDAR Health Homes

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Superseded SPA ID	N/A		

- (selected) Health Homes services will be available statewide
- ( ) Health Homes services will be limited to the following geographic areas
- ( ) Health Homes services will be provided in a geographic phased-in approach

Health Homes Population and Enrollment Criteria

MEDICAID | Medicaid State Plan | Health Homes | RI2018MS0007O | RI-18-0009 | CEDAR Health Homes

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Superseded SPA ID	N/A		

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 (Mandatory and Options for Coverage) Eligibility Groups

☐ Medically Needy Eligibility Groups

Mandatory Medically Needy

☐ Medically Needy Pregnant Women

☐ Medically Needy Children under Age 18

Optional Medically Needy (select the groups included in the population)

Families and Adults

☐ Medically Needy Children Age 18 through 20

☐ Medically Needy Parents and Other Caretaker Relatives

Aged, Blind and Disabled

☐ Medically Needy Aged, Blind or Disabled

☐ Medically Needy Blind or Disabled Individuals Eligible in 1973

Health Homes Population and Enrollment Criteria

MEDICAID | Medicaid State Plan | Health Homes | RI2018MS0007O | RI-18-0009 | CEDAR Health Homes

Package Header

Package ID RI2018MS0007O

SPA ID RI-18-0009

Submission Type Official

Initial Submission Date 8/7/2018

Approval Date 10/17/2018

Effective Date 7/1/2018

Superseded SPA ID N/A

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 Use Disorder

☐ Asthma

☐ Diabetes

☐ Heart Disease

☐ BMI over 25

☐ Other (specify)

Name	Description
Developmental Disability	Developmental Disability
Down Syndrome	Down Syndrome
Mental Retardation	Mental Retardation
Seizure Disorders	Seizure Disorders

☐ One chronic condition and the risk of developing another

Specify the conditions included

☐ Mental Health Condition

☐ Substance Use Disorder

☐ Asthma

☐ Diabetes

☐ Heart Disease

☐ BMI over 25

☐ Other (specify)

Name	Description
Developmental Disability	Developmental Disability
Down Syndrome	Down Syndrome
Mental Retardation	Mental Retardation
Seizure Disorders	Seizure Disorders

Specify the criteria for at risk of developing another chronic condition

Cedars will review medical records and collaborate with other service providers to assess if there is any evidence of risk factors present (such as meeting developmental milestones, activity level, weight, family history etc.). For individuals enrolled in managed care, designated care managers may also collaborate with Cedars, or refer children for assessment. Cedars look at the child's clinical and treatment history to get an idea of their overall progress and functioning as well as the child and family's ability to engage in treatment. Overall family functioning plays a major role in determining family and environmental risk factors that could play into future clinical needs. For instance, a family history of substance abuse or mental health needs may put the child at risk for other medical and behavioral health needs (i.e. a parent who struggles with their own mental health needs may have difficulty following through with OT recommendations which may lead to increased medical problems and the need for more involved therapy).

Medicaid recipients who meet the following criteria are eligible for Cedar Services:
o Suspected of having a severe mental illness, or severe emotional disturbance
o Suspected of having two or more chronic conditions as listed below:
o Mental Health Condition
o Asthma
o Diabetes
o Developmental Disabilities
o Down Syndrome
o Mental Retardation
o Seizure Disorders
o Has one chronic condition listed above and is at risk of developing a second

☐ One serious and persistent mental health condition

Specify the criteria for a serious and persistent mental health condition

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

Health Homes Population and Enrollment Criteria

MEDICAID | Medicaid State Plan | Health Homes | RI2018MS0007O | RI-18-0009 | CEDAR Health Homes

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Superseded SPA ID N/A

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

- (selected) Opt-In to Health Homes provider
- Referral and assignment to Health Homes provider with opt-out
- Other (describe)

Describe the process used

Families may access a Cedar Family Center through self-referral or by other referral sources, including a Primary Care Physician, a Health Plan or other providers. The enrollment process does not differ across delivery systems. For individuals enrolled in managed care, designated care managers may also collaborate with Cedars, or refer children for assessment. When these sources initiate the referral, the Cedar Family Center must contact the family within ten (10) calendar days of referral. Cedar shall document attempts made to reach the family and response to the referral source.

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

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

Health Homes Providers

MEDICAID | Medicaid State Plan | Health Homes | RI2018MS0007O | RI-18-0009 | CEDAR Health Homes

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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

☐ Clinical Practices or Clinical Group Practices

☐ Rural Health Clinics

☐ Community Health Centers

☐ Community Mental Health Centers

☐ Home Health Agencies

☐ Case Management Agencies

Describe the Provider Qualifications and Standards

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

☐ Community/Behavioral Health Agencies

☐ Federally Qualified Health Centers (FQHC)

☐ Other (Specify)

☐ Teams of Health Care Professionals

☐ Health Teams

Health Homes Providers

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Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Home Services

Designated Providers as described in Section 1945(h)(5)
Cedar Family Centers meeting the Health Homes criteria as established by the State in consultation with CMS will be certified by the State as Health Home providers. Cedar family centers currently operate under Certification Standards established by the State. Certification Standards have been amended as required to ensure they meet Health Home requirements. Eligible clients are free to choose from any Cedar Family Center to receive services. Cedar Family Centers are designed to provide a structured system for facilitating the assessment of need for, and the provision of high quality, evidence based medically necessary service that may be available for children pursuant to federal Early and Periodic Screening Diagnosis and Treatment (EPSDT) requirements, as well as referrals to community based services and supports that benefit the child and family. Cedar Family Center Health Homes will operate as a "Designated Provider" of Health Home Services. All Cedar Family Centers employ independently licensed health care professional such as; Psychologists licensed Independent Clinical Social Workers Masters Level Registered Nurses, or licensed Marriage and Family Therapists; Cedar Family centers also employ staff trained to provide care coordination, individual and family support and other functions expected from a health home. The CHH Team minimally consists of a Licensed Clinician and a Family Service Coordinator, The CHH Team will consult, coordinate and collaborate on a regular basis with the child's Primary Care Physician/Medical Home and with other providers providing treatment services to that child. Medical Specialists and other Medical professionals will be included on the CHH Team based on the unique needs of each enrolled child. Cedar Family Centers, by Standard, provide all services in a patient and family centered manner.

Health Homes Providers

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Supports for Health Homes Providers

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

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

Description

Technical assistance is offered to providers through monthly site visit meetings. Topics of discussion include: development of new informational materials-outreach efforts, code and diagnosis for billing, Kidsnet, billing segments, crisis plan development, Professional Development system (care coordination planning committee), RI Community Health Team collaboration, PCP and Health Plan coordination, Kidsnet- user roles and data sharing, hearings and complaints, FCCP/DCYF involved families, collaboration with direct service providers, performance measures/outcomes measures, and the Common Referral Tool.
The frequency of learning collaboratives vary, but are typically held at least twice annually. The learning collaboratives provide Cedars with an opportunity to learn best practices in various areas such as care coordination, integration of HIT, population health management, behavioral health, patient engagement, etc. Learning collaboratives are not mandatory, but providers are strongly encouraged to attend.
Cedars are typically very proficient in utilizing HIT. Therefore, specific trainings on the adoption and use of HIT, such as integration with KIDSNET, will be provided on an ad hoc basis if there is a need. EOHHS assesses the Cedar Health Homes upon certification to determine readiness and identify any needs for additional training. The information that Cedar Health Homes are required to provide as part of their application for certification includes, but is not limited to; organization background information, organizational structure, description of program approach (including family centeredness, community focus, staff competency, organizational capacities, ability to demonstrate relationships with provider community, scope of practice), quality improvement plan, compliance processes and procedures, administrative and financial systems, independent audits, ownership and control interests, and mechanisms for data collection and reporting of outcome measures.

Health Homes Providers

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Other Health Homes Provider Standards

The state's requirements and expectations for Health Homes providers are as follows

Rhode Island has established Certification Standards for Cedar Family Centers and will utilize those Standards as the basis to certify Health Home providers. The Standards can be found at: http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/ProviderManuals/CedarCertStds.pdf

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

Introduction

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

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

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

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

Provider Standards

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

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

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

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

Name	Date Created	
No items available		

Health Homes Service Delivery Systems

MEDICAID | Medicaid State Plan | Health Homes | RI2018MS0007O | RI-18-0009 | CEDAR Health Homes

Package Header

Package ID RI2018MS0007O
SPA ID RI-18-0009
Submission Type Official
Initial Submission Date 8/7/2018
Approval Date 10/17/2018
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Superseded SPA ID N/A

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

☐ Fee for Service

☐ PCCM

☐ Risk Based Managed Care

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

◉ Yes

○ No

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

Health Home Services:

The MCOs will be required to provide family-centered, intensive care management and coordination services to children. These services include the following:

• Comprehensive care management;
• Care coordination;
• Referral to community and social support services (formal and informal);
• Individual and family support services;
• Comprehensive transitional care; and
• Health promotion

Services will focus on providing enhanced guidance and psychoeducation to promote health and wellness by helping families understand their child's clinical needs, health conditions, medical needs, and/or risk and protective factors. Care coordination is required to include in-home, hands-on support and coaching to build a family's skills to successfully navigate systems of care and advocate for their child(ren) and family. Services must be delivered by providers who have experience in delivering health homes in a family's place of residence/community and are trusted members of the communities where members reside.

Network Adequacy:

MCOs are required to maintain and monitor a network of appropriate providers and to demonstrate their ability to provide the required covered services as outlined in the contract with EOHHS.

MCOs must consider the following when establishing and maintaining provider networks:
• Anticipated enrollment
• Ability to provide all enrolled Medicaid children a full continuum of behavioral health and substance use disorder services. This must include all levels of need.
• Expected utilization of services
• Numbers and types (in terms of training, experience, and specialization) of providers
• Numbers of providers who are not accepting new Medicaid patients
• Geographic location of providers and members, considering distance, travel time, and the availability of transportation
• Cultural Competency of providers and office staff.
• Disability Competency of providers and the physical accessibility of their offices.

Reporting Requirements:

The Health Plans are required to comply with all reporting requirements established by EOHHS. EOHHS develops and maintains a Managed Care Reporting Calendar that is shared with the MCOs and outlines all required reporting. Any Cedar reports will be included in the Managed Care Reporting Calendar.

Quality:

MCOs are contractually required to submit quality data as it pertains to EOHHS' quality strategy. Additionally, the Health Plans make available internal quality assurance reports, provide the results of quality improvement studies

and/or projects, and share Medicaid and CAHPS results with the state. The MCOs collect member satisfaction data at least annually.

☐ 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.

Name	Date Created	
No items available		

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

◉ Yes

○ No

Assurances

☐ 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

☐ Other Service Delivery System

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | RI2018MS0007O | RI-18-0009 | CEDAR Health Homes

Package Header

Package ID RI2018MS0007O

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Submission Type Official

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Payment Methodology

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

☐ Fee for Service

☐ PCCM (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 PMPM 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

☐ Other

Describe below

There are no tiered rates within the payment methodology.

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

FFS Payment Methodology: There are variations in payment based on individual care needs. Cedar Family Centers will receive an initial payment of $900.00 upon completion and submitted claims for the following deliverables: (1) An assessment of the family; and (2) Family Care Plan. Cedar Family Centers will then receive a Per Member Per Month (PMPM) of $25.00 upon submission of at least one claim per month totaling a minimum of one hour of child and/or family contact directly related to the achievement of action plan goals. Therefore, depending on the amount and/or frequency of care needed, the provider may receive additional monthly payments based on the individual's care needs.
Managed Care Payment Methodology: The state will include dollars for the Health Home payments in the Health Plan capitation rate. MCOs and qualified providers will develop a payment rate and methodology. EOHHS will monitor access to Health Home services in order to ensure that MCO rates are adequate to establish and maintain a robust provider network.

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

Cedar Family Centers will receive an initial payment of $900.00 upon completion and submitted claims for the following deliverables: (1) An assessment of the family; and (2) Family Care Plan. Cedar Family Centers will then receive a Per Member Per Month (PMPM) of $25.00 upon submission of

at least one claim per month totaling a minimum of one hour of child and/or family contact directly related to the achievement of action plan goals.

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

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

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | RI2018MS0007O | RI-18-0009 | CEDAR Health Homes

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Package ID	RI2018MS0007O	**SPA ID**	RI-18-0009
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Superseded SPA ID	N/A		

Assurances

☐ The State provides assurance that it will ensure non-duplication of payment for services similar to Health Homes services that are offered/covered under a different statutory authority, such as 1915(c) waivers or targeted case management.

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

☐ The state has developed payment methodologies and rates that are consistent with section 1902(a)(30)(A).

☐ The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule, unless otherwise described above.

☐ The State provides assurance that it shall reimburse providers directly, except when there are employment or contractual arrangements consistent with section 1902(a)(32).

Optional Supporting Material Upload

Name	Date Created	
No items available		

Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | RI2018MS0007O | RI-18-0009 | CEDAR Health Homes

Package Header

Package ID	RI2018MS0007O	**SPA ID**	RI-18-0009
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Service Definitions

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

Comprehensive Care Management

Definition

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

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

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

Scope of service

The service can be provided by the following provider types

☐ Behavioral Health Professionals or Specialists

Description

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

☐ Nurse Practitioner

☐ Nurse Care Coordinators

☐ Nurses

☐ Medical Specialists

☐ Physicians

☐ Physician's Assistants

☐ Pharmacists

☐ Social Workers

☐ Doctors of Chiropractic

☐ Licensed Complementary and alternative Medicine Practitioners

☐ Dieticians

☐ Nutritionists

☐ Other (specify)

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

Care Coordination

Definition

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

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

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

Scope of service

The service can be provided by the following provider types

☐ Behavioral Health Professionals or Specialists

Description

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

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

☐ Nurse Practitioner

☐ Nurse Care Coordinators

☐ Nurses

☐ Medical Specialists

☐ Physicians

☐ Physician's Assistants

☐ Pharmacists

☐ Social Workers

☐ Doctors of Chiropractic

☐ Licensed Complementary and alternative Medicine Practitioners

☐ Dieticians

☐ Nutritionists

☐ Other (specify)

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

Health Promotion

Definition

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

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

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

Scope of service

The service can be provided by the following provider types

☐ Behavioral Health Professionals or Specialists

Description

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

☐ Nurse Practitioner

☐ Nurse Care Coordinators

☐ Nurses

☐ Medical Specialists

☐ Physicians

☐ Physician's Assistants

☐ Pharmacists

☐ Social Workers

☐ Doctors of Chiropractic

☐ Licensed Complementary and alternative Medicine Practitioners

☐ Dieticians

☐ Nutritionists

☐ Other (specify)

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

Comprehensive Transitional Care from Inpatient to Other Settings (including appropriate follow-up)

Definition

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

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

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

Scope of service

The service can be provided by the following provider types

☐ Behavioral Health Professionals or Specialists

Description

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

☐ Nurse Practitioner

☐ Nurse Care Coordinators

☐ Nurses

☐ Medical Specialists

☐ Physicians

- [ ] Physician's Assistants
- [ ] Pharmacists
- [ ] Social Workers
- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [ ] Nutritionists
- [ ] Other (specify)

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

Individual and Family Support (which includes authorized representatives)

Definition

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

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

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

Scope of service

The service can be provided by the following provider types

- [ ] Behavioral Health Professionals or Specialists

Description

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

- [ ] Nurse Practitioner
- [ ] Nurse Care Coordinators
- [ ] Nurses
- [ ] Medical Specialists
- [ ] Physicians
- [ ] Physician's Assistants

☐ Pharmacists

☐ Social Workers

☐ Doctors of Chiropractic

☐ Licensed Complementary and alternative Medicine Practitioners

☐ Dieticians

☐ Nutritionists

☐ Other (specify)

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

Referral to Community and Social Support Services

Definition

OVERARCHING STATEWIDE DEFINITION: Referrals to community and social support services ensure that individuals have access to a myriad of formal and informal resources. Ideally, these resources are easily accessed by the individual in the service system and assists individuals in addressing medical1 behavioral, educational, and social and community issues. Cedar HEALTH HOME SPECIFIC DEFINITION: Referral to Community and Social Support Services will be provided by members of the Cedar Team and will include information about formal and informal resources beyond the scope of services covered by Medicaid, such as those which may be available from other parents, family members, community-based organizations, service providers, grants, social programs, funding options including the family's health coverage, school-based services, faith based organizations, etc. This includes providing access to and the coordination of long term services and supports. Whenever possible, families will be informed of opportunities and supports that are closest to home, that are the least restrictive and that promote integration in the home and community. Members of the Cedar Team will emphasize the use of informal, natural community supports as a primary strategy to assist children and families.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

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

Scope of service

The service can be provided by the following provider types

☐ Behavioral Health Professionals or Specialists

Description

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

☐ Nurse Practitioner

☐ Nurse Care Coordinators

☐ Nurses

☐ Medical Specialists

☐ Physicians

☐ Physician's Assistants

☐ Pharmacists

☐ Social Workers

☐ Doctors of Chiropractic

☐ Licensed Complementary and alternative Medicine Practitioners

☐ Dieticians

☐ Nutritionists

☐ Other (specify)

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

Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | RI2018MS0007O | RI-18-0009 | CEDAR Health Homes

Package Header

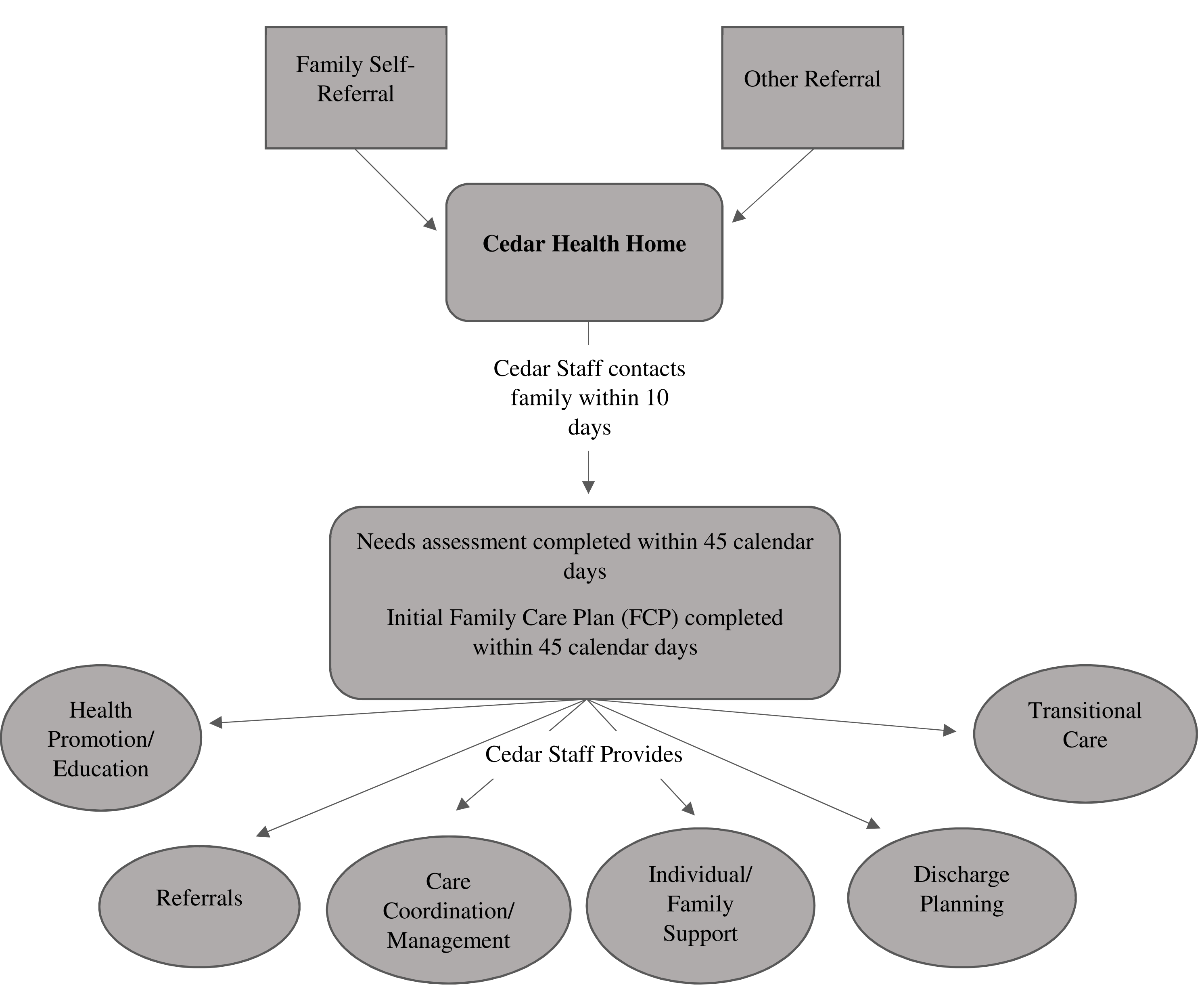
Package ID RI2018MS0007O
SPA ID RI-18-0009
Submission Type Official
Initial Submission Date 8/7/2018
Approval Date 10/17/2018
Effective Date 7/1/2018
Superseded SPA ID N/A

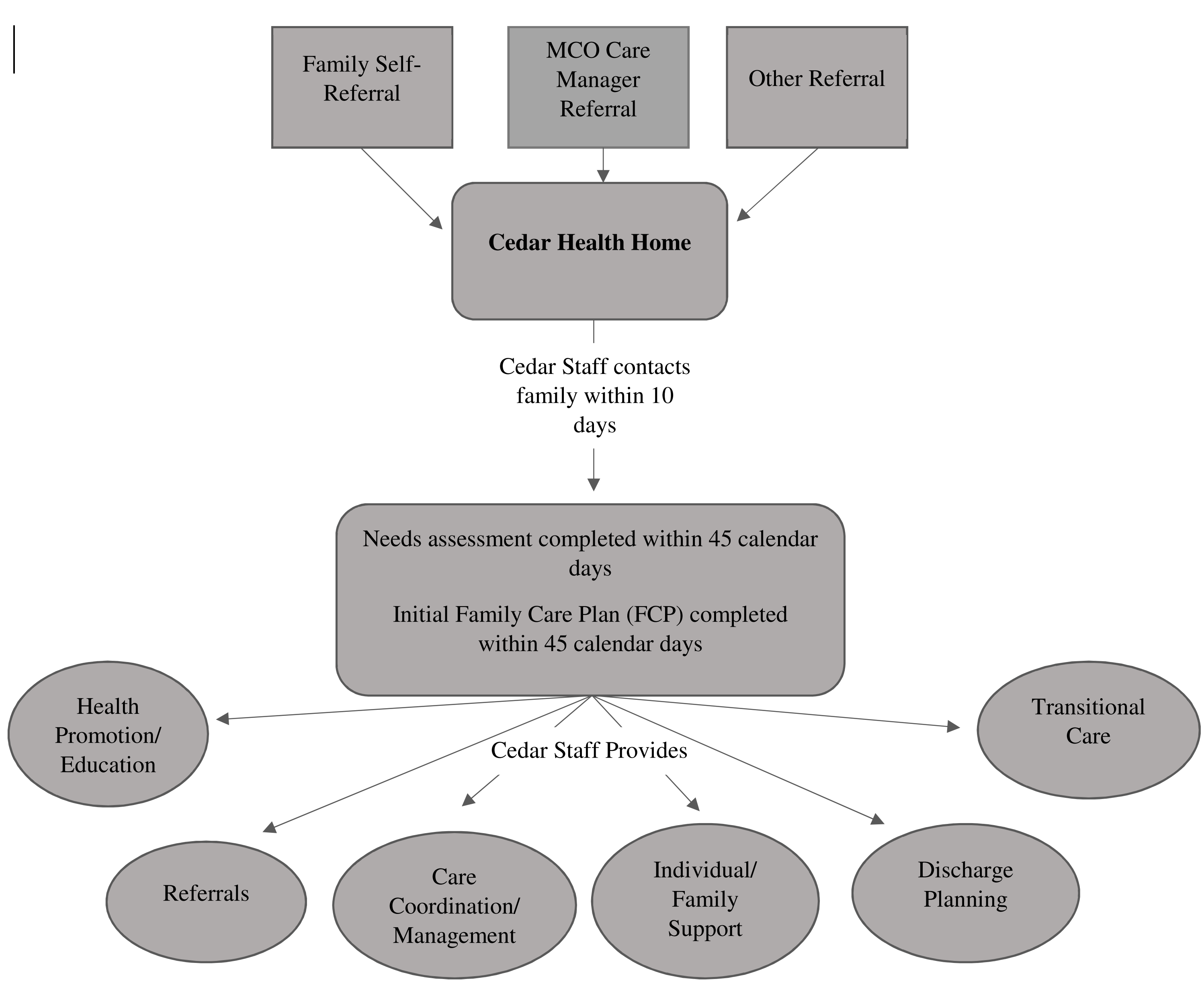
Health Homes Patient Flow

Describe the patient flow through the state's Health Homes system. Submit with the state plan amendment flow-charts of the typical process a Health Homes individual would encounter

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

Name	Date Created	
Cedar Health Home Patient Flow_final	8/7/2018 2:05 PM EDT	PDF
Cedar Health Home Patient Flow - Managed Care	9/26/2018 2:49 PM EDT	PDF


Family Self-Referral
Other Referral
Cedar Health Home
Cedar Staff contacts family within 10 days
Needs assessment completed within 45 calendar days
Initial Family Care Plan (FCP) completed within 45 calendar days
Health Promotion/ Education
Transitional Care
Cedar Staff Provides
Referrals
Care Coordination/ Management
Individual/ Family Support
Discharge Planning


Family Self-Referral
MCO Care Manager Referral
Other Referral
Cedar Health Home
Cedar Staff contacts family within 10 days
Needs assessment completed within 45 calendar days
Initial Family Care Plan (FCP) completed within 45 calendar days
Health Promotion/ Education
Transitional Care
Cedar Staff Provides
Referrals
Care Coordination/ Management
Individual/ Family Support
Discharge Planning

Health Homes Monitoring, Quality Measurement and Evaluation

MEDICAID | Medicaid State Plan | Health Homes | RI2018MS0007O | RI-18-0009 | CEDAR Health Homes

Package Header

Package ID	RI2018MS0007O	**SPA ID**	RI-18-0009
Submission Type	Official	**Initial Submission Date**	8/7/2018
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Superseded SPA ID	N/A		

Monitoring

Describe the state's methodology for calculating cost saving (and report cost savings annually in Quality Measure Report). Include savings that result from improved coordination of care and chronic disease management achieved through the Health Homes Program, including data sources and measurement specifications, as well as any savings associated with dual eligibles, and if Medicare data was available to the state to utilize in arriving at its cost-savings estimates

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

Describe how the state will use health information technology in providing Health Homes services and to improve service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider)

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

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

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

Health Homes Monitoring, Quality Measurement and Evaluation

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Quality Measurement and Evaluation

- [ ] The state provides assurance 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
- [ ] The state provides assurance that it will report to CMS information submitted by Health Homes providers to inform evaluations, as well as Reports to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS
- [ ] The state provides assurance that it will track avoidable hospital readmissions and report annually in the Quality Measures report

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