

**STATE OF RHODE ISLAND
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES**

10/24/2014 PUBLIC NOTICE OF PROPOSED AMENDMENT TO EOHHS STATE PLAN

In accordance Rhode Island General Laws (RIGL) 42-35, notice is hereby given that the Executive Office of Health and Human Services (EOHHS) proposes to amend the following section of the Rhode Island State Plan under Title XIX of the Social Security Act:

Health Homes for Individuals with Chronic Conditions

EOHHS intends to submit to the federal Centers for Medicare and Medicaid Services (CMS) an amendment to Rhode Island's Medicaid State Plan relative to health homes for individuals with chronic conditions. Specifically, this change will enhance the provision of Care Coordination activities by the CEDARR Team by shifting from an encounter based, fee-for-service payment methodology, to a per member per month payment system for participating CEDARR Centers, enabling staff to focus more closely on service delivery rather than service claims documentation. EOHHS does not anticipate increased expenses as a result of the new payment methodology; CEDARR's fiscal impact to the state should remain the same.

This proposed amendment is accessible on the EOHHS website (www.eohhs.ri.gov) or available in hard copy upon request (401 462-1965 or RI Relay, dial 711). Interested persons should submit data, views, or written comments by November 24, 2014 to Darren J. McDonald, Office of Policy and Innovation, R.I. Executive Office of Health and Human Services, Louis Pasteur Building, 57 Howard Avenue, Cranston, RI 02920 or darren.mcdonald@ohhs.ri.gov.

In accordance with the Rhode Island General Laws 42-35-3, an oral hearing will be granted on the proposed State Plan Amendment if requested by twenty-five (25) persons, or an agency, or by an association having at least twenty-five (25) members. A request for an oral hearing must be made within thirty (30) days of this notice.

The Executive Office of Health and Human Services does not discriminate against individuals based on race, color, national origin, sex, gender identity or expression, sexual orientation, religious belief, political belief, or handicap in acceptance for or provision of services or employment in its programs or activities.

Health Home State Plan Amendment

OMB Control Number: 0938-1148

Expiration date: 10/31/2014

Transmittal Number: RI-14-0015 Supersedes Transmittal Number: RI-11-0006 Proposed Effective Date: Oct 1, 2014 Approval Date:
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.

RI-14-0015

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-11-0006

- The State elects to implement the Health Homes State Plan option under Section 1945 of the Social Security Act.

Name of Health Homes Program:

CONVERTED Rhode Island Health Home Services - in process

State Information

State/Territory name:

Rhode Island

Medicaid agency:

Executive Office of Health & Human Services

Authorized Submitter and Key Contacts

The authorized submitter contact for this submission package.

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Title:

Telephone number:

Email:

The tertiary contact for this submission package.

Name:

Title:

Telephone number:

Email:

Proposed Effective Date

(mm/dd/yyyy)

Executive Summary

Summary description including goals and objectives:
 Data conversion from previous Medicaid Model Data Lab.
 Supersedes Transmittal Number: 11-0006
 Transmittal Number: 14-0015
 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.

Federal Budget Impact

Federal Fiscal Year		Amount
First Year	<input type="text" value="2014"/>	\$ <input type="text" value="0.00"/>
Second Year	<input type="text" value="2015"/>	\$ <input type="text" value="0.00"/>

Federal Statute/Regulation Citation

Governor's Office Review

No comment.

Comments received.

Describe:

No response within 45 days.

Other.

Describe:

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

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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:

(mm/dd/yyyy)

Website URL:

Website for State Regulations

Date of Posting:

(mm/dd/yyyy)

Website URL:

Other

Public Hearing or Meeting

Other method

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

Access

Summarize Comments

Summarize Response

Quality

Summarize Comments

Summarize Response

Cost

Summarize Comments

--

Summarize Response

--

Payment methodology

Summarize Comments

--

Summarize Response

--

Eligibility

Summarize Comments

--

Summarize Response

--

Benefits

Summarize Comments

--

Summarize Response

--

Service Delivery

Summarize Comments

[Empty text box]

Summarize Response

[Empty text box]

Other Issue

Transmittal Number: RI-14-0015 Supersedes Transmittal Number: RI-11-0006 Proposed Effective Date: Oct 1, 2014 Approval Date:

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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 Health Programs**
- Urban Indian Organization**

Indicate the key issues raised in Indian consultative activities:

Access

Summarize Comments

[Empty text box]

Summarize Response

[Empty text box]

Quality

Summarize Comments

--	--

Summarize Response

--	--

Cost

Summarize Comments

--	--

Summarize Response

--	--

Payment methodology

Summarize Comments

--	--

Summarize Response

--	--

Eligibility

Summarize Comments

--	--

Summarize Response

--	--

Benefits

Summarize Comments

[Empty text box for summarizing comments]

Summarize Response

[Empty text box for summarizing response]

Service delivery

Summarize Comments

[Empty text box for summarizing comments]

Summarize Response

[Empty text box for summarizing response]

Other Issue

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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	
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Transmittal Number: RI-14-0015 Supersedes Transmittal Number: RI-11-0006 Proposed Effective Date: Oct 1, 2014 Approval Date:

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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	
Developmental Disability	
Down Syndrome	
Mental Retardation	
Seizure Disorders	

Additional description of other chronic conditions:

One chronic condition and the risk of developing another

Specify the conditions included:

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

Other Chronic Conditions	
Developmental Disability	
Down Syndrome	
Mental Retardation	
Seizure Disorders	

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

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:

Geographic Limitations

Health Homes services will be available 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):

[Empty rectangular box]

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:

[Empty rectangular box]

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

Describe the process used:

[Empty rectangular box]

- 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:

[Empty rectangular box]

- The State provides assurance that eligible individuals will be given a free choice of Health Homes providers.**
- The State provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services.**
- The State provides assurance that hospitals participating under the State Plan or a waiver of such plan will be instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Homes providers.**
- The State provides assurance that it will have the systems in place so that only one 8-quarter period of enhanced FMAP for each Health Homes enrollee will be claimed. Enhanced FMAP may only be claimed for the first eight quarters after the effective date of a Health Homes State Plan Amendment that makes**

Health Home Services available to a new population, such as people in a particular geographic area or people with a particular chronic condition.

- The State assures that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.

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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:

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- Clinical Practices or Clinical Group Practices

Describe the Provider Qualifications and Standards:

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- Rural Health Clinics

Describe the Provider Qualifications and Standards:

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- Community Health Centers

Describe the Provider Qualifications and Standards:

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- Community Mental Health Centers

Describe the Provider Qualifications and Standards:

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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:

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Nutritionists

Describe the Provider Qualifications and Standards:

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Social Workers

Describe the Provider Qualifications and Standards:

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Behavioral Health Professionals

Describe the Provider Qualifications and Standards:

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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:

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Nurses

Describe the Provider Qualifications and Standards:

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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:

Please see description under Provider Standards

Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Homes Services.

CEDARR 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. CEDARR family centers (Health Homes) currently operate under Certification Standards established by the State. Certification Standards will be amended as required to ensure they meet Health Home requirements. Eligible clients are free to choose from any CEDARR Family Center (Health Home) to receive services.

CEDARR Family Centers are designed to provide a structured system for facilitating the assessment of need for, and the provision of high quality, evidenced based Medically Necessary services 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.

CEDARR Family Center Health Homes will operate as a "Designated Provider" of Health Home Services. All CEDARR 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; CEDARR 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. CEDARR Family Centers, by Standard, provide all services in a patient and family centered manner.

The State assures that health homes services will be separate and distinct and duplicate payment will not be made for similar services available under other program authorities.

Provider Standards

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

Rhode Island has established Certification Standards for CEDARR Family Centers and will utilize those Standards as the basis to certify Health Home providers. The Standards can be found at:

http://www.dhs.ri.gov/Portals/0/Uploads/Documents/Public/Children%20w%20Spec%20Needs/CEDARR_cert_stds.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 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 CEDARR Family Centers as Health Homes for Children and Youth with Disabilities and Chronic conditions.

The design of the CEDARR System of Care and the CEDARR 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 CEDARR 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 CEDARR Family Centers will be required to abide by these requirements, in addition to the existing CEDARR Certification Standards as revised in 2009.

Health Homes Requirements

Population Criteria

Medicaid recipients who meet the following criteria are eligible for CEDARR Health Home services:

- o Has a severe mental illness, or severe emotional disturbance
- o Has 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

Provider Standards

As previously mentioned, the current CEDARR certification standards, under which all CEDARR Family Centers operate will be utilized as the Provider Standards for CEDARR 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.

Health Home Services

Health Homes are required to provide the following services to all eligible individuals.

o Comprehensive Care Management- Comprehensive Care Management is provided by CEDARR Family Centers by working with the child and family to: assess current circumstances and presenting issues, identify continuing needs, and identify resources and/or services to assist the child and family to address their needs through the provision of an Initial Family Intake and Needs Determination; develop a Family Care (or Treatment) Plan which will include child specific goals, treatment interventions and meaningful functional outcomes; and regular review and revision of the Family Care Plan to determine efficacy of interventions and emerging needs. Integral to this service is ongoing communication and collaboration between the CEDARR Team and the clients Primary Care Physician/Medical Home. CEDARR staff (Licensed Clinician and Family Service Coordinator) shall utilize the Initial Family Intake and Needs Determination (IFIND), Family Care Plan (FCP) and Family Care Plan Review (FCPR) to provide Comprehensive Care Management.

o Care coordination is the implementation of the treatment plan developed to guide comprehensive care management in a manner that is flexible and meets the need of the individual receiving services. The goal is to ensure that all services are coordinated across provider settings, which may include medical, social and, when age appropriate, vocational educational services. Services must be coordinated and information must be centralized and readily available to all team members. Changes in any aspect of an individual's health must be noted, shared with the team, and used to change the care plan as necessary. All relevant information is to be obtained and reviewed by the team.

CHH Specific Definition:

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.
- Service delivery oversight and coordination to ensure that services are being delivered in the manner that satisfies the requirements of the individual program(s) and meet the needs of the child and family.
- Monitor for unmet needs through review of records, contact with family and other service and support

providers, and review of claims and encounter data.

- Assistance in locating and arranging specialty evaluations as needed, in coordination with the child's Primary Care Provider. This also includes follow-up and ongoing consultation with the evaluator as needed.

Care Coordination will be performed by the member of the CEDARR Team (Licensed Clinician or Family Service Coordinator) that is most appropriate based upon the issue that is being addressed.

Health Promotion- Health Promotion assists children and families in implementing the Family Care 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). CEDARR staff (Licensed Clinician) shall utilize Therapeutic Counseling and Group Intervention to provide Health Promotion.

Comprehensive Transitional Care- Transitional Care will be provided by the CEDARR 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. The CEDARR 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). 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. CEDARR staff (Licensed Clinician and Family Service Coordinator) shall utilize Health Needs Coordination (HNC) to provide Comprehensive Transitional Care.

Individual and Family Support Services- The CEDARR 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. The CEDARR Team will actively integrate the full range of services into a comprehensive program of care. At the family's request, the CEDARR 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. CEDARR staff (Licensed Clinician and Family Service Coordinator) shall utilize Health Needs Coordination (HNC) to provide Individual and Family Support Services.

Referral to Community and Social Support Services- Referral to Community and Social Support Services will be provided by members of the CEDARR 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, school-based services, faith based organizations, etc. 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 CEDARR Team will emphasize the use of informal, natural community supports as a primary strategy to assist children and families. CEDARR staff (Licensed Clinician and Family Service Coordinator) shall utilize Health Needs Coordination (HNC) to provide Referral to Community and Social Supports.

Additional Requirements

To fully achieve the goals of the Health Homes initiative, certain actions which were previously viewed as suggested are now required and subject to EOHHS performance review requirements. Those include:

- o Documented yearly outreach to the child's Primary Care Physician and Medicaid Managed Care Plan (if applicable)
- o Documented yearly Body Mass Index (BMI) Screening for all children 6 years of age or older. If BMI screen is not clinically indicated, reason must be documented

- o Documented yearly Depression Screening utilizing the Center for Epidemiological Studies Depression Scale for Children (CES-DC) (or equivalent) for all children 12 years of age or older. If depression screening is not clinically indicated, reason must be documented
- o Yearly review of immunizations, screenings and other clinical information contained in the KIDSNET Health Information System

In order for an entity to be certified as a CEDARR Health Home they must agree, in writing, to abide by both the existing CEDARR Certification Standards as well as the Health Home addendum and Appendix.

The CEDARR Family Center shall maintain a complete confidential case record which complies with established clinical documentation requirements and adheres to the most current standards of confidentiality, for each child and family. All records must be maintained for the period of time dictated by State or Federal record retention policy.

The record must include but is not limited to:

- Initial Family Contact intake form
- Date of initial contact with CEDARR Family Center
- All assessment related materials, including delineation of problems and strengths and involvement of key parties
- Family Work Plan
- Family Crisis Support Plan
- Family Care Plan, including goals, objectives, goals and objectives attainment summary, treatment modalities, service scope and duration, performing provider (by name), time-frame
- CEDARR Family Center Direct Services (HBTS, PASS, Kids Connect, Respite) contacts, plan approvals, review sheets and progress reports
- Progress notes, notation of involvement with family, others (e.g., Early Intervention, Special Education)
- Clinical specialty evaluation recommendations
- Case conference summaries
- Recommendations for treatment plan modification, continuance and discharge
- Ongoing progress reports

Site visits for record reviews to all CEDARR Family Centers will be conducted by EOHHS program staff and the CEDARR Interdepartmental Team on a periodic basis. The interval between compliance site visits shall not exceed three (3) years.

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Health Homes Service Delivery Systems

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

Fee for Service

PCCM

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

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

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

Fee for Service

Alternative Model of Payment (describe in Payment Methodology section)

Other

Description:

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

If yes, describe how requirements will be different:

Risk Based Managed Care

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

The current capitation rate will be reduced.

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

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

Other

Describe:

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

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

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

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

Yes

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

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

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

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

No

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

- Fee for Service**
- Alternative Model of Payment (describe in Payment Methodology section)**
- Other**
Description:

[Empty rectangular box]

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:

[Empty rectangular box]

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:

[Empty rectangular box]

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:

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Other: Describe below.

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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.

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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.

Health Needs Coordination will be reimbursed on a PMPM which covers the following services:

- Care Coordination
- Comprehensive Transitional Care
- Individual and Family Support Services
- Referral; to Community and Social Support Services

Whereas, Comprehensive Care Management is achieved by the Health Home team through the provision of the following three services:

1. Initial Family Intake and Needs Assessment (IFIND); this is performed by the Health Home team during the Admission process. It is designed to be a global assessment of the child's functioning, the family's needs and initial goals. It is performed only once during the members enrollment history and occurs during a face to face visit with the family and child.
2. Family Care Plan Development (FCP) This service involves the drafting and formulation of the comprehensive care plan and involves communication and collaboration with a wide range of collaterals (i.e. Primary Care Physician, School personnel, Medicaid Managed Care Plan, etc.). It is during this time that Goals and Objectives are identified and defined and a plan of care is agreed upon. This also occurs only once during a child's enrollment history with the health home.
3. Family Care Plan Review (FCPR) this involves a formal review and updating of the plan of care. It is during this time that goals are reviewed and updated and new needs and issues as well as goals are established. This service is provided annually as long as there is enrollment.

These services are paid on a fee for service basis, on a Fixed Rate basis upon completion of the activity and not. The rate for each service is determined by establishing an average length of time need to

complete all required activities for each service and determining a level of involvement for each member of the Health Home team in the delivery of each service.

Incentive payment reimbursement

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

PCCM Managed Care (description included in Service Delivery section)

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

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

Tiered Rates based on:

- Severity of each individual's chronic conditions
- Capabilities of the team of health care professionals, designated provider, or health team.

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

Rate only reimbursement

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

All rates are derived from the development of a market based; hourly rate (base rate) for each Health Home team member which considers the salary and benefit costs for staff with comparable qualifications and their associated employment costs including:

- Prevailing wages for comparable personnel (Licensed Clinician, Master's Degree or above and Family Service Coordinator, less than a Master's Degree)
- Adjustments to direct wages to recognize payroll taxes, fringe benefits, productivity standards (direct client service hours as a percentage of total work hours), and administrative overhead

This base rate is then used to derive all subsequent re-imbursement rates for Health Home services (fixed rates and PMPM rates).

Per Member per Month:

Care Coordination services will be reimbursed on a per member per month case rate basis. The reimbursement will be the same regardless of the frequency or intensity of services provided during the month, except that the health home providers will be required to provide, at a minimum, one (or more) allowable activity during the billable month.

Allowable Care Coordination activities include:

- Care Coordination and Monitoring for unmet need
- Health Promotion
- Comprehensive Transitional Care
- Individual and family support services
- Referral to Community and social support services
- Activities related to updating the care plan and documenting contacts

The state considered the following factors in developing the case rate:

- The participation rate for each health home team member in the provision of the service
- The intensity of the services provided in the past, minimum required service levels and required collaborations per the certification standards

The following steps were used to determine the Monthly Case Rate

1. The Base Hourly rate for each Health Home Team member (Licensed Clinician and Family Service Coordinator) was established utilizing the same process that was used to determine the Fixed Rates.
2. Claims information and encounter data relating to the provision of the covered services for the period 1/1/2011 through 12/31/2012 for all enrollees was collected and analyzed to determine:
 - a. Average per member per enrollment day (PMPD) utilization of services by unique user
 - b. Average participation rate of each Health Home team member in the provision of those services
3. Per member per day average was multiplied by 303 to determine average number of units per year (303 days is 365 days minus holidays and weekend days, when Health Home services are not delivered).
4. The staff participation rate was then applied to the average units per year to determine the average number of units provided by each Health Home team member (Licensed Clinician 45% and Family Service Coordinator 55%).
5. Average units per year for each billing level was multiplied by the base rate for each level, the results were combined and then divided by 12 to determine the monthly case rate.

EOHHS intends to implement the PMPM payment methodology upon approval from CMS.

Alternate Payment Methodology:

Comprehensive Care Management is achieved by the Health Home team through the provision of the following three services:

1. Initial Family Intake and Needs Assessment (IFIND); this is performed by the Health Home team during the Admission process. It is designed to be a global assessment of the child's functioning, the family's needs and initial goals. It is performed only once during the members enrollment history and occurs during a face to face visit with the family and child.
2. Family Care Plan Development (FCP) This service involves the drafting and formulation of the comprehensive care plan and involves communication and collaboration with a wide range of collaterals (i.e. Primary Care Physician, School personnel, Medicaid Managed Care Plan, etc.). It is during this time that Goals and Objectives are identified and defined and a plan of care is agreed upon. This also occurs only once during a child's enrollment history with the health home.
3. Family Care Plan Review (FCPR) this involves a formal review and updating of the plan of care. It is during this time that goals are reviewed and updated and new needs and issues as well as goals are established. This service is provided annually as long as there is enrollment.

These services are provided by the Health Home Team (Licensed Clinician and Family Service Coordinator) and are paid on a Fixed Rate basis upon completion of the activity. The rate for each service is determined by establishing an average length of time need to complete all required activities for each service and determining a level of involvement for each member of the Health Home team in the delivery of each service. These assumptions were initially established in 2010 utilizing an analysis of service delivery practices established during the previous years. In 2013 the State conducted a new analysis of these rates and the assumptions upon which they are based and have made adjustments to both level of effort and participation rate assumptions, which are summarized in Attachment A.

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.

Care Coordination services will be reimbursed on a per member per month case rate basis to the member's primary assigned CEDARR Center. The reimbursement will be the same regardless of the frequency or intensity of services provided during the month, except that the health home providers will be required to provide, at a minimum, one (or more) allowable activity during the billable month.

Allowable Care Coordination activities include:

- Care Coordination and Monitoring for unmet need
- Health Promotion
- Comprehensive Transitional Care
- Individual and family support services
- Referral to Community and social support services
- Activities related to updating the care plan and documenting contacts

The state considered the following factors in developing the case rate:

- The participation rate for each health home team member in the provision of the service
- The intensity of the services provided in the past, minimum required service levels and required collaborations per the certification standards

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)
<p>Category of Individuals CN individuals</p>
<p>Service Definitions</p>

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

Comprehensive Care Management

Definition:

OVERARCHING STATEWIDE DEFINITION: Comprehensive care management services are conducted with an individual and involves the identification, development, and implementation care plan that addresses the needs of the whole person. Family/Peer Supports can also be included in the process. The service involves the development of a care plan based on the completion of an assessment. A particular emphasis is the use of the multi-disciplinary team 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. **CEDARR HEALTH HOME SPECIFIC DEFINITION:** Comprehensive Care Management is provided by CEDARR Health Homes by working with the child and family to: assess current circumstances and presenting issues, identify continuing needs, and identify resources and/or services to assist the child and family to address their needs through the provision of an Initial Family Intake and Needs Determination; develop a Family Care (or Treatment) Plan which will include child specific goals, treatment interventions and meaningful functional outcomes; and regular review and revision of the Family Care Plan to determine efficacy of interventions and emerging needs. Integral to this service is ongoing communication and collaboration between the CEDARR Health Homes Team and the clients Primary Care Physician/Medical Home Managed Care Organization, Behavioral Health and Institutional/Long Term Care providers. This service will be performed by the Licensed Clinician with the support of the Family Service Coordinator.

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

CEDARR Health Homes utilize a secure HIPPA 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

- o Integrating the information into the treatment planning process.
- o Developing the child specific treatment plan
- o Facilitate cross-system coordination, integration and supports access to specific service interventions to address the medical, social, behavioral and other needs of the child
- o 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

CEDARR Family Centers also access RI KIDSNET Child Health Information System which provides access to information vital to the provision of Comprehensive Care Management. This information includes:

- o Blood Lead levels
- o Immunizations
- o Newborn Developmental Assessment
- o Hearing Assessment
- o WIC and Early Intervention participation

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

Scope of benefit/service

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

Behavioral Health Professionals or Specialists

Description

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Nurse Care Coordinators

Description

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Nurses

Description

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Medical Specialists

Description

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Physicians

Description

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Physicians' Assistants

Description

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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:

Care coordination is the implementation of the treatment plan developed to guide comprehensive care management in a manner that is flexible and meets the need of the individual receiving services. The goal is to ensure that all services are coordinated across provider settings, which may include medical, social and, when age appropriate, vocational educational services. Services must be coordinated and information must be centralized and readily available to all team members. Changes in any aspect of an individual's health must be noted, shared with the team, and used to change the care plan as necessary. All relevant information is to be obtained and reviewed by the team.

CHH Specific Definition:

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.
- Service delivery oversight and coordination to ensure that services are being delivered in the manner that satisfies the requirements of the individual program(s) and meet the needs of the child and family.
- Monitor for unmet needs through review of records, contact with family and other service and support providers, and review of claims and encounter data.
- Assistance in locating and arranging specialty evaluations as needed, in coordination with the child's Primary Care Provider. This also includes follow-up and ongoing consultation with the evaluator as needed.

Care Coordination will be performed by the member of the CEDARR 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 CEDARR Health Homes Team in meeting the needs of each child and family.

Scope of benefit/service

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

Behavioral Health Professionals or Specialists

Description

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Nurse Care Coordinators

Description

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Nurses

Description

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Medical Specialists

Description

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Physicians

Description

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Physicians' Assistants

Description

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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:

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. CEDARR HEALTH HOME SPECIFIC

DEFINITION: Health Promotion assists children and families in implementing the Family Care 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). This service will be performed by the Licensed Clinician.

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

See Care Coordination description above. In addition CEDARR Health Homes 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 format that is most appropriate for the child and families use, including multiple languages.

Scope of benefit/service

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

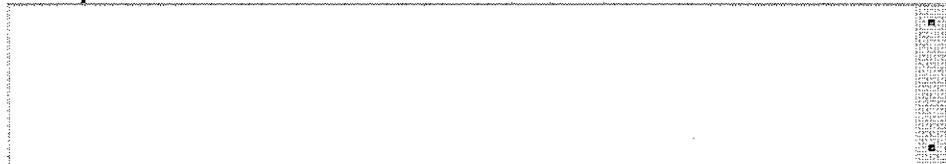
Behavioral Health Professionals or Specialists

Description



Nurse Care Coordinators

Description



Nurses

Description

Medical Specialists

Description

Physicians

Description

Physicians' Assistants

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Pharmacists

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Social Workers

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Doctors of Chiropractic

Description

[Empty text box]

Licensed Complementary and Alternative Medicine Practitioners

Description

[Empty text box]

Dieticians

Description

[Empty text box]

Nutritionists

Description

[Empty text box]

Other (specify):

Name

[Empty text box]

Description

[Empty text box]

Health Homes Services (2 of 2)

Category of Individuals
CN individuals

Service Definitions

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

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

Definition:

OVERARCHING STATEWIDE DEFINITION: Comprehensive transitional care services focus on the movement of individuals from any medical/psychiatric inpatient or other out-of-home setting into a community setting, and between different service delivery models. Members of the health team work closely with the individual to transition the individual smoothly back into the community and share information with the discharging organization in order to prevent any gaps in treatment that could result in a re-admission. **CEDARR HEALTH HOME SPECIFIC DEFINITION:** Transitional Care will be provided by the CEDARR Health Homes 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. The CEDARR Health Homes 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). 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. This service will be performed by the Licensed Clinician with the support of the Family Service Coordinator.

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

See Care Coordination description above. In addition CEDARR Health Homes 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 format that is most appropriate for the child and families use, including multiple languages.

Scope of benefit/service

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

Behavioral Health Professionals or Specialists

Description

[Empty text box for description of Behavioral Health Professionals or Specialists]

Nurse Care Coordinators

Description

[Empty text box for description of Nurse Care Coordinators]

Nurses

Description

Medical Specialists

Description

Medical Specialists

Description

Physicians

Description

Physicians

Description

Physicians' Assistants

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Physicians' Assistants

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Pharmacists

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Pharmacists

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Social Workers

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Social Workers

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Doctors of Chiropractic

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Doctors of Chiropractic

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Licensed Complementary and Alternative Medicine Practitioners

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Dieticians

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Nutritionists

Description

Other (specify):

Name

Description

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. CEDARR HEALTH HOME SPECIFIC DEFINITION: The CEDARR Health Homes 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. The CEDARR Health Home Team will actively integrate the full range of services into a comprehensive program of care. At the family's request, the CEDARR 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. This service will be performed by the Licensed Clinician or the Family Service Coordinator depending on the exact nature of the activity.

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

See Care Coordination description above. In addition CEDARR Health Homes provide their staff with access to a wide range of resource/educational material(s) in multiple formats for use in supplementing and facilitating Individual and Family Support activities. This information will be provided in a format that is most appropriate for the child and families use, including multiple languages.

Scope of benefit/service

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

Behavioral Health Professionals or Specialists

Description

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Nurse Care Coordinators

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Nurses

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Medical Specialists

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Physicians

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Physicians' Assistants

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Pharmacists

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Social Workers

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Doctors of Chiropractic

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Licensed Complementary and Alternative Medicine Practitioners

Description

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Dieticians

Description

Nutritionists

Description

Other (specify):

Name

Description

Referral to community and social support services, if relevant

Definition:

OVERARCHING STATEWIDE DEFINITION: Referrals to community and social support services ensure that individuals have access to a myriad of formal and informal resources. Ideally, these resources are easily accessed by the individual in the service system and assist individuals in addressing medical, behavioral, educational, social and community issues. **CEDARR HEALTH HOME SPECIFIC DEFINITION:** Referral to Community and Social Support Services will be provided by members of the CEDARR Health Homes 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, school-based services, faith based organizations, etc. 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 CEDARR Health Homes Team will emphasize the use of informal, natural community supports as a primary strategy to assist children and families. This service will be performed by the Licensed Clinician or the Family Service Coordinator depending on the exact nature of the activity.

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

See Care Coordination description above. In addition CEDARR 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 format that is most appropriate for the child and families use, including multiple languages.

Scope of benefit/service

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

Behavioral Health Professionals or Specialists

Description

[Empty description box for Behavioral Health Professionals or Specialists]

Nurse Care Coordinators

Description

[Empty description box for Nurse Care Coordinators]

Nurses

Description

[Empty description box for Nurses]

Medical Specialists

Description

[Empty description box for Medical Specialists]

Physicians

Description

[Empty description box for Physicians]

Physicians' Assistants

Description

[Empty description box for Physicians' Assistants]

Pharmacists

Description

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Social Workers

Description

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Doctors of Chiropractic

Description

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Licensed Complementary and Alternative Medicine Practitioners

Description

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Dieticians

Description

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Nutritionists

Description

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Other (specify):

Name

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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:
Not Applicable

 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.**

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Health Homes Monitoring, Quality Measurement and Evaluation

Monitoring

Describe the State's methodology for tracking avoidable hospital readmissions, including data sources and measurement specifications:

The state will measure re-admissions per 1000 member months for any diagnosis using a pre/post-period comparison among eligible CEDARR Health Home clients. The data source will be claims and encounter data available in the Medicaid data warehouse.

Describe the State's methodology for calculating cost savings that result from improved coordination of care and chronic disease management achieved through the Health Homes program, including data sources and measurement specifications.

The State will annually perform an assessment of cost savings using a pre/post-period comparison of CEDARR 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 CEDARR 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 CEDARR 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.

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

Quality Measurement

- The State provides assurance that it will require that all Health Homes providers report to the State on all applicable quality measures as a condition of receiving payment from the State.**
- The State provides assurance that it will identify measureable goals for its Health Homes model and intervention and also identify quality measures related to each goal to measure its success in achieving the goals.**

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

Evaluations

- The State provides assurance that it will report to CMS information submitted by Health Homes providers to inform the evaluation and Reports to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS.**

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

Hospital Admissions

Measure: Not Applicable Measure Specification, including a description of the numerator and denominator. Not Applicable Data Sources: Not Applicable Frequency of Data Collection: <input checked="" type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Annually	
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<input type="checkbox"/> Continuously <input checked="" type="checkbox"/> Other Not Applicable	
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Emergency Room Visits

Measure: Not Applicable Measure Specification, including a description of the numerator and denominator. Not Applicable Data Sources: Not Applicable Frequency of Data Collection: <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Annually <input type="checkbox"/> Continuously <input checked="" type="checkbox"/> Other Not Applicable	
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Skilled Nursing Facility Admissions

Measure: Not Applicable Measure Specification, including a description of the numerator and denominator. Not Applicable Data Sources: Not Applicable Frequency of Data Collection: <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Annually <input type="checkbox"/> Continuously <input checked="" type="checkbox"/> Other Not Applicable	
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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

Comparison of Claims and Encounter data pre and post implementation of health homes

Chronic Disease Management

Comparison of Claims and Encounter data pre and post implementation of health homes

Coordination of Care for Individuals with Chronic Conditions

Comparison of quarterly and annual data pre and post implementation of health homes

Assessment of Program Implementation

Comparison of quarterly and annual data pre and post implementation of health homes

Processes and Lessons Learned

CEDARR Health Homes survey to be developed

Assessment of Quality Improvements and Clinical Outcomes

Comparison of quarterly and annual data pre and post implementation of health homes

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.

Rhode Island Medicaid total spend (all services) on CEDARR enrolled children for SFY 2010 was \$2,553 per member per month (PMPM). The predicted PMPM trend increase used in the actuarially certified rates is 7.2%. Using this trend increase, projected total spend (all services) on CEDARR enrolled children for SFY 2011 is \$2,736 PMPM. RI Medicaid estimates that the Health Home intervention will reduce this trend by 5% - to a trend of 6.84%.

Assuming that the Health Home intervention begins on October 1, 2011, one quarter of SFY 2012 will not have the "Health Home effect". Three quarters of SFY 2012 will. All four quarters of SFY 2013 will see the "Health Home effect". Assuming enrollment of 2440 children, using this methodology, savings for SFY 2012 is \$79.44 PMPM (\$2,325,908.10 total). Using this methodology, savings for SFY 2013 is \$95.43 PMPM or \$2,794,253.24. Total aggregate savings over this period is \$5,120,161.34.

SFY 2010 = \$2553 PMPM

SFY 2011 = \$2736.82 PMPM(7.2% increase over SFY 2010)

SFY 2012 do nothing scenario = \$2,933.87 PMPM (7.2% increase over SFY 2011)

SFY 2012 Health Home scenario = \$2854.43 PMPM (one quarter of 1.8% increase, and 3 quarters of 5.13% increase)

Savings in SFY 2012 = \$2933- \$2854.43 = \$79.44 PMPM

\$79.44 PMPM x 2440 children x 12 months = \$2,325,908.10

SFY 2013 do nothing scenario = \$3145.11 PMPM

SFY 2013 Health Home scenario = \$3049.67 PMPM

Savings in SFY 2013 = \$3145.11 - \$3049.67 = \$95.43 PMPM

95.43 PMPM x 2440 children x 12 months = \$2,794,253.24

Total two-year savings = \$2,325,908.10 + \$2,794,253.24 = \$5,120,161.34

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PRA Disclosure Statement

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