

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

**11/30/2015 PUBLIC NOTICE OF PROPOSED AMENDMENT TO RHODE ISLAND
MEDICAID STATE PLAN**

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

**Reinventing Medicaid 2015:
Cedar Family Center Redesign**

As part of Governor Gina Raimondo's effort to reform Medicaid, the Working Group to Reinvent Medicaid issued an April report that recommended numerous initiatives to achieve financial savings in State Fiscal Year (SFY) 2016. The Governor introduced those recommendations in a budget article entitled, "The Reinventing Medicaid Act of 2015." The Rhode Island General Assembly passed the Reinventing Medicaid Act in June.

As a result of the Act's passage, EOHHS is seeking federal authority to implement several changes to the Medicaid program. This state plan amendment will redesign the Cedar Family Centers and refocus their efforts toward care management and coordination. This amendment will also update the payment methodology from 15-minute increments to a single case rate method.

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 December 31, 2015 to Darren J. McDonald, Executive Office of Health and Human Services, Hazard Building, 74 West Road, 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, 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.

iii. Provider Infrastructure

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.

Team of Health Care Professionals as described in Section 1945(h)(6)

iv. Service Definitions Comprehensive Care Management

Service Definition

OVERARCHING STATEWIDE DEFINITION: Comprehensive care management 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. 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. **Cedar HEALTH HOME SPECIFIC DEFINITION:** Comprehensive Care Management is provided by Cedar 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 Assessment and develop a Family Care Plan which will include functional and measurable outcomes meaningful to the family. Interventions and objectives identified in the Family Care Plan should map back to child and family's designated outcomes. The Family Care Plan must include; Action Steps, Timelines for Completion, the Party responsible for carrying out the Action Step and the Date the Action Step is achieved. The Family Care Plan shall be developed with the family and in coordination with existing community resources. The Family Care Plan is based on assessment information, the strengths and needs of the child and 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. The Family Care Plan can include a referral to direct treatment or support services (e.g., behavioral health, medical, social,) and Cedar direct supports/care coordination. The Family Care Plan should identify both natural and formal supports needed and incorporate services and supports. 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.

Ways Health IT Will Link

Cedar Family Centers 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

Family Care Plan o Facilitate cross-system coordination, integration and supports access to 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. oSubmit quarterly submission of enrollment data, with family notice and opportunity to opt out, to the RI Department of Health for the KIDSNET system. oCEDARRAccess 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

Care Coordination

Service Definition

OVERARCHING STATEWIDE DEFINITION; Care coordination is the implementation of the Family Care 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. Cedar HEALTH HOME 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. • 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.

Ways Health IT Will Link

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.

Health Promotion

Service 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 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).

Ways Health IT Will Link

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 format that is most appropriate for the child and families use, including multiple languages.

Comprehensive Transitional Care (including appropriate follow up, from Inpatient to other settings)
Service 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. 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). 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.

Ways Health IT Will Link

Individual and Family Support Services (including authorized representatives)

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. 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.

Ways Health IT Will Link

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 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.

Referral to Community and Social Support Services

Service Definition

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

Ways HealthIT Will Link

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 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.

v. Provider Standards

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/ProvidersPartners/GeneralInformation/ProviderDirectories/CEDARRRServices.aspx>
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vi. Assurances

A. The State assures that hospitals participating under the State plan or a waiver of such plan will establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated providers.

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

C. The State will report to CMS information submitted by health home providers to inform the evaluation and Reports to Congress as described in section 2703(b) of the Affordable Care Act, and as described by CMS.

vii. Monitoring

A. *Describe the State's methodology for tracking avoidable hospital readmissions, to include data sources and measure specifications.*

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

B. *Describe the State's methodology for calculating cost savings that result from improved, chronic care coordination and management achieved through this program, to include data sources and measure specifications.*

The State will 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.

C. *Describe the State's proposal for using health information technology in providing health home services under this program and improving service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider)*

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 or 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 Family Centers 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 Family Centers will also offer to enroll all clients into "CurrentCare" RI's electronic health information exchange.

3.1 - A: Categorically Needy View

Health Homes for Individuals with Chronic Conditions

Amount, Duration, and Scope of Medical and Remedial Care Services: Categorically Needy

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

viii. Quality Measures: Goal Based Quality Measures

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

Goal 1: Improve Care coordination

Clinical Outcomes

Measure

1. Direct contact between Physician and Health Home Team during Care Planning Process 2. Utilization of KidsNet Child Health Information System to access clinical information about the provision of required screenings, immunizations and other established developmental medical protocols. 3. Collaboration between Health Home and MCO

Data Source

1. Medicaid Claims 2. Kidsnet database report to Medicaid 3. Cedar Health Home Client Record Review (SO/o Sample)

Measure Specification

1. Percentage of Physician Consultation Claims per Family Care Plan Claims 2, Number of hits on the KidsNet System by Cedar Health Home staff per 1,000 enrollees 3. Percentage of HH enrollees who are MCO members where documented outreach to MCO has occurred.

How Health IT will be Utilized

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

Experience of Care

Measure

1. Participant and Family Experience Utilizing Cedar Services 2. Operational Performance of Cedar Health Home in the delivery of Care Coordination Services

Data Source

1. Annual Satisfaction Surveys 2. Cedar Health Home Quarterly Reporting to MEDICAID. Data obtained from Cedar Automated Care Coordination System

Measure Specification

1. Family Rating of satisfaction with care, accessibility of care, availability of care 2. Timeliness of service delivery: •Assessment within 45 days of referral • Family Care Plan completed within 45 days of referral.

How Health IT will be Utilized

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

Quality of Care

Measure

1. Increase in Families self-stated ability to understand and manage client's medical condition and advocate for the client 2. Decrease in Families self-stated level of stress related to the client's condition.

Data Source

Reports on responses to baseline and annual review of outcome questions submitted by Cedar Health Homes to Medicaid

Measure Specification

Annual performance measures reporting:

1. Assessment completed within 45 calendar days of initial referral
2. Family Care Plan completed within 45 calendar days from initial referral
3. Family Care Plan Goals Met
 - a. 50% of goals completed within 3 months
 - b. 75% of goals completed within 6 months
 - c. 100% of goals completed within 12 months
4. Family Care Plan coordination documented in the case record. % coordinated with:
 - a. Primary Care Provider
 - b. Health plans
 - c. Hospitals/inpatient facilities
5. Annual Family Satisfaction Surveys
6. 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
7. 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
8. Yearly review of immunizations, screenings and other clinical information contained in the KIDSNET Health Information System
9. # of Complaints and Resolutions and type of complaint

How Health IT will be Utilized

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

Goal 2: Improve Health Outcomes of Children and Youth with Special Health Care Needs (CYSHCN)

Clinical Outcomes

Measure

1. Provision of Community Based and Condition Specific Resources to Client and Family.
2. Parent/Guardian knowledge and understanding of client's condition

Data Source

1. Cedar Quality reporting to Medicaid. Data obtained from Cedar Automated Care Coordination System
2. Reports on responses to baseline and annual review of outcome questions submitted by Cedar Health Homes to Medicaid.

Measure Specification

Annual performance measures reporting:

10. Assessment completed within 45 calendar days of initial referral
11. Family Care Plan completed within 45 calendar days from initial referral
12. Family Care Plan Goals Met
 - a. 50% of goals completed within 3 months
 - b. 75% of goals completed within 6 months
 - c. 100% of goals completed within 12 months
13. Family Care Plan coordination documented in the case record. % coordinated with:
 - d. Primary Care Provider
 - e. Health plans
 - f. Hospitals/inpatient facilities
14. Annual Family Satisfaction Surveys
15. 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
16. 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
17. Yearly review of immunizations, screenings and other clinical information contained in the KIDSNET Health Information System
18. # of Complaints and Resolutions and type of complaint

How Health IT will be Utilized

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

Experience of Care Measure

Measure

1. Satisfaction with services
2. Operational Performance of Cedar Health Homes in Coordination of Home and Community Based Treatment Services

Data Source

1. Annual Satisfaction surveys
2. Cedar Health Home Quarterly Reporting to MEDICAID. Data obtained from Cedar Automated Care Coordination System

Measure Specification

1. Number of Referrals to Community Based resources per member/per year
2. Parent/Guardian self-rated measure of knowledge of condition

How Health IT will be Utilized

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

Quality of Care

Measure

1. Decrease in Families self-stated level of stress related to the client's condition.
2. Increase in ability of client to take part in age appropriate peer group activities
3. Increase in ability of family to take part in activities as a group

Data Source

1. Reports on responses to baseline and annual review of outcome questions submitted by Cedar Health Homes to Medicaid.
2. Reports on responses to baseline and annual review of outcome questions submitted by Cedar Health Homes to Medicaid.
3. Reports on response to baseline and annual review of outcome questions submitted by Cedar Health Homes to Medicaid.

Measure Specification

Annual performance measures reporting:

19. Assessment completed within 45 calendar days of initial referral
20. Family Care Plan completed within 45 calendar days from initial referral
21. Family Care Plan Goals Met
 - a. 50% of goals completed within 3 months
 - b. 75% of goals completed within 6 months
 - c. 100% of goals completed within 12 months
22. Family Care Plan coordination documented in the case record. % coordinated with:
 - d. Primary Care Provider
 - e. Health plans
 - f. Hospitals/inpatient facilities
23. Annual Family Satisfaction Surveys
24. 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
25. 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
26. Yearly review of immunizations, screenings and other clinical information contained in the KIDSNET Health Information System
27. # of Complaints and Resolutions and type of complaint

How Health IT will be Utilized

RI will use the Medicaid data Warehouse to collect and store historical Medicaid Claims and Encounter data. In addition, monitoring of progress towards identified Health Homes goals will be accomplished through the analysis of reports submitted on a regular basis by the Cedar Health Homes. Rhode Island will also use additional data sources to monitor the impact of its health home (HH) program on quality: through annual performance measures reporting; CEDARR; charts (either electronic or paper), and a client satisfaction survey. Rhode Island exercised prudence in selecting measures to not overburden Cedar or IT staff with new data

collection and analysis. We will use standard, validated measure specifications where they exist to increase our ability and CMS's to make comparisons across populations, programs, and states.

Goal 3: Decrease the occurrence of secondary conditions

Clinical Outcomes

Measure

1. Screening and follow-up for Obesity utilizing BMI measure
 2. Screening for Clinical Depression and Follow-Up Plan Data Source
1. Cedar Health Home Client Record Review (5% Sample)
 2. Cedar Health Home Client Record Review (5% Sample)

Measure Specification

1. Percentage of participants aged 6 years and older with a calculated BMI documented in the record AND if the most recent BMI is outside the parameters, a follow up plan is documented. Parameters age 18-64 BMI > or = 25, children 6-18 BMI >= 85th percentile. 2. Percentage of participants aged 12 years and older screened for clinical depression using a standardized tool and follow up documented

How Health IT will be Utilized

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

Experience of Care

1. Satisfaction with services

Data Source

1. Annual Satisfaction surveys

Measure Specification

% of Respondents providing positive rating(s)

How Health IT will be Utilized

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

Quality of Care

Measure

1. Reduction in the obesity rate of Cedar Health Homes participants
2. Clinical treatment for depression for those Cedar Health Homes clients who screened positive

Data Source

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

Measure Specification

1. Percent of clients who had a BMI outside the parameters who experienced a reduction in BMI in the subsequent year 2. Percent of clients who screened positive for depression who received an intervention to treat depression.

How Health IT will be Utilized

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

Goal 4: Decrease the use of Emergency Department and Inpatient Treatment for Ambulatory Sensitive Conditions

Clinical Outcomes

Measure

1. Ambulatory Care-Sensitive Condition Admissions 2. Preventable/Ambulatory care-sensitive emergency room visits

Data Source

1. Encounter Data (State will not have access to medical claims for those clients who have some form of Third Party Coverage, currently 38% of the Cedar population) 2. Encounter Data (State will not have access to medical claims for those clients who have some form of Third Party Coverage, currently 38% of the Cedar population)

Measure Specification

1. The State has established a set of diagnoses that can be appropriately treated in a lesser cost setting than Emergency Department or Inpatient Hospital These diagnoses include, but are not limited to; Asthma, Otitis Media and Upper Respiratory Infections. A complete list of Diagnoses Codes are available upon request.

How Health IT will be Utilized

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

Experience of Care

1. Satisfaction with services

Data Source

1. Annual Satisfaction Surveys

Measure Specifications

1. % of Respondents providing positive rating(s).

How Health IT will be Utilized

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

Quality of Care

Measure

1. Medical follow up within 7 days of ACS condition ED visit or admission for ACS condition.

Data Source

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

Measure Specification

1. % of cases who utilized the ED or were admitted for one or more ACS conditions as defined in Clinical Outcomes measurement for Goal #4, and who had a subsequent follow-up with a medical Professional within 7 days of discharge.

How Health IT will be Utilized

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

Goal 5: Improve the quality of Transitions from Inpatient/Residential Care to Community

Clinical Outcomes

Measure

1. Health Home Staff direct involvement with discharge planning process 2. Direct Contact between Health Home Team and client/family within 7 days of discharge 3. Hospital/Residential Care Re-Admission

Data Source

1. Claims and encounter data housed in Data Warehouse (State will not have access to medical claims for those clients who have some form of Third Party Coverage, currently 38% of the Cedar population) 2. Claims and encounter data housed in Data Warehouse (State will not have access to medical claims for those clients who have some form of Third Party Coverage, currently 38% of the Cedar population) 3. Claims and encounter data housed in Data Warehouse (State will not have access to medical claims for those clients who have some form of Third Party Coverage, currently 38% of the Cedar population)

Measure Specification

1. Percentage of Discharges for admissions of > 7 days with documented Health Home Staff collaboration with discharging facility 2. Percentage of Discharges with documented contact between client and Health Home Team member within 7 days of discharge. 3. Percent of Hospital/Residential discharges with Re-admission within 30 days with same diagnosis.

How Health IT will be Utilized

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

Experience of Care

Measure

1. Satisfaction with services

Data Source

1. Annual Satisfaction Surveys

Measure Specification

1. % of Respondents providing positive rating(s)

How HealthIT will be Utilized

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

Measure

Quality of Care

1 Clients are able to avoid readmissions for physical health conditions 2. Clients are able to avoid readmissions for psychiatric conditions

Data Source

1. Claims and encounter data housed in Data Warehouse (State will not have access to medical claims for those clients who have some form of Third Party Coverage, currently 38% of the Cedar population) 2. Claims and encounter data housed in Data Warehouse (State will not have access to medical claims for those clients who have some form of Third Party Coverage, currently 38% of the Cedar population)

Measure Specification

1. Percentage of clients readmitted for non-psychiatric conditions within 30 days of hospital discharge 2. Percentage of clients readmitted for psychiatric conditions within 30 days of hospital discharge

How Health IT will be Utilized

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

Payment Type: Bundled Payment Methodology with Incentive.
Provider Type

Certified Cedar Family Centers will be able to submit a claim upon completion of each individual Needs Assessment and Family Care Plan, contingent upon signature of an independently, Rhode Island licensed clinician. This fee will be paid no more than one time per 365 days from the date of the family signature on the Family Care Plan.

Rate = \$969

Infrastructure and Incentive Payments

EOHHS will provide an infrastructure payment to those organizations shifting from previous certification as a CEDARR Family Center to a new Certified Cedar Family Center in order to address transitional costs. This payment will be made in January 2016.

EOHHS will utilize CEDARR enrollment numbers from January 2015 and provide a payment of \$200 for 50% of January 2015 enrollment.

Incentive payments of up to \$200 per child will be available in 2018 for meeting performance expectations, which will be determined following collection of data on performance measures from 2016, and made available in 2017.