STATE OF RHODE ISLAND
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

5/29/2018 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:

Integrated Health Homes

EOHHS is seeking federal authority to remove the 10% withhold in the reimbursement methodology for Integrated Health Homes (IHH) and Assertive Community Treatment (ACT) services, effective June 1, 2018. This amendment is expected to have no budgetary impact.

This proposed amendment is accessible on the EOHHS website (www.eohhs.ri.gov) or available in hard copy upon request (401-462-6348 or RI Relay, dial 711). Interested persons should submit data, views, or written comments by June 28, 2018 to Melody Lawrence, Executive Office of Health and Human Services, 3 West Rd, Cranston, RI, 02920, or Melody.Lawrence@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 fourteen (14) 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.

Summary

Executive Summary

Summary Description Including Goals and Objectives*

Response:

Integrated Health Home (IHH) – Rhode Island's Integrated Health Home is built upon the evidence-based practices of the patient-centered medical home (PCMH) model. IHH coordinates care for persons with Severe Mental Illness (SMI) and builds linkages with and among behavioral healthcare providers, primary care, specialty medical providers, and community and social supports. In addition to IHH services, EOHHS anticipates that 10% of the SMI population deemed eligible for IHH will meet the eligibility threshold for a supplemental set of services provided under Assertive Community Treatment (ACT).

The goals of IHH and ACT are to more effectively address the complex needs of persons with severe mental illness and co-occurring chronic conditions.
IHH is provided to community-based individuals by a team of professional and paraprofessional mental health staff in accordance with an approved
treatment plan to ensure the member's stability, improved medical
outcomes, and reduced reliance on more restrictive services, such as the emergency department, inpatient medical-surgical and psychiatric care. IHH teams coordinate care and ensure that medically
necessary interventions are provided to help the member manage the symptoms of their illness. The IHH team assists members, their providers, and their natural community supports to address social determinants affecting the member's health and well-being. Members receive assistance accessing medical, social, educational, and vocational services, as necessary.

ACT is a comprehensive and complementary set of services designed to meet all of a members' needs in a community setting. A multi-disciplinary
team provides the member enrolled in ACT with mental health outpatient services, care coordination, peer support, psychopharmacology, substance use disorder counseling, vocational training, and care management, with the goal of increasing community tenure.
ACT is not a linkage or brokerage case-management
program that connects individuals to mental health, housing, or rehabilitation programs —that is the role of the IHH staff layered onto the ACT teams. The ACT team delivers integrated clinical treatment, rehabilitation, and other supportive
services in community locations. Seventy-five percent or more of the services are provided outside of program offices in locations that are comfortable and convenient for members. ACT teams are available to provide necessary services 24 hours a day, seven days a week, 365 days a year. Research has shown that ACT services are successful in achieving outcomes and increasing community tenure for individuals with SMI and complex needs. Rhode Island's Integrated Health Home provides for ACT services for those identified to be in need, as established in a standardized level of care/functionality assessment. Members with a DLA score of 3.0 and under will be eligible for ACT. ACT programs will be reviewed by BHDDH using the Tool for Measurement of Assertive Community Treatment (TMACT) fidelity scale. EOHHS, through a collaboration with the MCOs and BHDDH, will monitor the clients receiving ACT as a subset of the IHH population.

Dependency Description

Description of any dependencies between this submission package and any other submission package undergoing review

Response: There are no dependencies.

Disaster-Related Submission

This submission is related to a disaster*:

Yes

No

Federal Budget Impact and Statute/Regulation Citation

Federal Budget Impact*

	Federal Fiscal Year	Amount
First	**FFY 18**	**$0**
Second	**FFY 19**	**$0**

Federal Statute/Regulation Citation*

Response: Section 2703 of the Patient Protection and Affordable Care of 2010

Governor's Office Review

Response: 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.

Public Comment

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

Public notice was not federally required and comment was not solicited

Public notice was not federally required, but comment was solicited

Public notice was federally required and comment was solicited

Indicate how public comment was solicited:

1) Newspaper Announcement
2) Publication in state's administrative record, in accordance with the administrative procedures requirements
3) Email to Electronic Mailing List or Similar Mechanism

Date of Email or other electronic notification*

Description of mailing list, in particular parties and organizations included, and, if not email, description of similar mechanism used:*

Response: Public notice is electronically emailed to EOHHS' list of interested parties. Such mailing list includes, but is not limited to providers, advocates, and other state agencies.

4) Website Notice

Select the type of website

Website of the State Medicaid Agency or Responsible Agency

Website for State Regulations

Other

5) Public Hearing or Meeting
6) Other method

Upload copies of public notices and other documents used

Upload with this application a written summary of public comments received

Indicate the key issues raised during the public comment period (and summarize the comments and the responses to each)

Access

Quality

Cost

Payment Methodology

Eligibility

Benefits

Service Delivery

Other Issue

Tribal Input

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

Yes

No

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

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

No

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

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

All Indian Health Programs

All Urban Indian Organizations

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

All Indian Tribes

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

Indicate the key issues raised during the public comment period (and summarize the comments and the responses to each)

Access

Quality

Cost

Payment Methodology

Eligibility

Benefits

Service Delivery

Other Issue

SAMHSA Consultation

[check box] The State provides assurance that it has consulted and coordinated with the Substance Abuse

Enter date of consultation: _____

Health Homes Intro

Executive Summary

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

Response:

The full integration of clients' medical and behavioral benefits into managed care creates new opportunities for further clinical integration across the continuum of care. This integration will allow integrated health homes (IHH) greater capacity to work with clients across all levels of care in order to achieve substantial clinical improvement. Services provided through IHHs and Assertive Community Treatment (ACT) are the fixed points of responsibility to coordinate and ensure the delivery of person-centered care, provide timely post-discharge follow-up, and improve patient health outcomes by addressing primary medical, specialist, and behavioral health care. Emphasis is placed on the monitoring of chronic conditions, preventative and educational services focused on self-care, wellness, and recovery.

This program is accountable for reducing health care costs, specifically preventable hospital admissions/readmissions and avoidable emergency room visits. These outcomes are achieved by adopting a whole-person approach to the consumer's needs and addressing the consumer's primary medical, specialist, and behavioral health care needs; and by providing the following timely and comprehensive services:

Comprehensive Care Management;
Care Coordination/Health Promotion;
Comprehensive Transitional Care;
Individual/Family Support Services; and
Chronic Condition Management/Population Management.
Clients eligible for IHH services will meet diagnostic and functional criteria established by the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH). The required diagnoses are as follows:
Schizophrenia
Schizoaffective Disorder
Schizoid Personality Disorder
Bipolar Disorder
Major Depressive Disorder, recurrent
Obsessive-Compulsive Disorder

Borderline Personality Disorder
Delusional Disorder
Psychotic Disorder

General Assurances [these are all checkboxes]

- The state provides assurance that eligible individuals will be given a free choice of Health Homes providers.
- The states provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services.
- The state provides assurance that hospitals participating under the state plan or a waiver of such plan will be instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Homes providers.
- The state provides assurance that FMAP for Health Homes services shall be 90% for the first eight fiscal quarters from the effective date of the SPA. After the first eight quarters, expenditures will be claimed at the regular matching rate.
- The state provides assurance that it will have the systems in place so that only one 8-quarter period of enhanced FMAP for each health homes enrollee will be claimed.
- The state provides assurance that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.

Health Homes Geographic Limitations

- ✓ Health Homes services will be available statewide
- Health Homes services will be limited to the following geographic areas

  If yes, specify the geographic limitations of the program

  By county:
  By region:
  By city/municipality:
  Other geographic area:
- Health Homes services will be provided in a geographic phased-in approach

  If yes, enter for each phase the title of phase, geographic area and implementation date:

Health Homes Population and Enrollment Criteria

Categories of Individuals and Populations Provided Health Homes Services

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

- ✓ Categorically Needy (Mandatory and Options for Coverage) Eligibility Groups
- ✓ Medically Needy Eligibility Groups

  Mandatory Medically Needy

  - ✓ Medically Needy Pregnant Women
  - ✓ Medically Needy Children under Age 18

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

  Families and Adults

  - Medically Needy Children Age 18 through 20
  - Medically Needy Parents and Other Caretaker Relatives

Aged, Blind and Disabled

- Medically Needy Aged, Blind or Disabled
- Medically Needy Blind or Disabled Individuals Eligible in 1973

Population Criteria

The state elects to offer Health Homes services to individuals with

- Two or more chronic conditions
- One chronic condition and the risk of developing another
  - ✓ One serious and persistent mental health condition

    Specify the criteria for a serious and persistent mental health condition:

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

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

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

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

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

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

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
- ✓ Referral and assignment to Health Homes provider with opt-out
- ○ Other (describe)

Describe the process used:

Response:

Providers must complete an enrollment form before enrollment is entered into the BHDDH portal. The member or the member's authorized representative must sign the form. Providers must provide a bi-annual attestation form to BHDDH to attest that enrollment forms have been completed for all members. The provider must retain the enrollment form in the member's record. The provider must also attach a roster of all IHH and ACT enrollees to each attestation form. BHDDH, EOHHS, and the MCOs reserve the right to request the enrollment form at any time.

Members will be determined eligible for IHH or ACT services based on the following criteria:

Members will qualify for IHH and ACT based, in part on their score on the Daily Living Assessment of Functioning (DLA). Average DLA scores are interpreted as follows:
5.1-6.0- Mild Impairments, minimal interruption in recovery
4.1-5.0-Moderate Impairments in functioning
3.1-4.0-Serious Impairment in functioning
2.1-3.0-Severe Impairment in functioning
2.0-Extremely severe impairments in functioning

Along with the established diagnostic categories, BHDDH has established the following guidelines for program assignment:
<3.0 - ACT
>3.0-5.0 – IHH

Individuals eligible for health home services but not currently engaged with an IHH may be identified through data provided by Medicaid managed care organizations (MCOs) and other Information from the state's Medicaid data warehouse. New members will be referred to a provider and assigned to IHH or ACT after they have met the diagnostic criteria and the provider has submitted a completed DLA to BHDDH. EOHHS and BHDDH reserve the right to review these documents at any time.

- ○ The state provides assurance that it will clearly communicate the individual's right to opt out of the Health Homes benefit or to change Health Homes providers at any time and agrees to submit to CMS a copy of any letter or communication used to inform the individuals of the Health Homes benefit and their rights to choose or change Health Homes providers or to elect not to receive the benefit

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
- Clinical Practices or Clinical Group Practices
- Rural Health Clinics
- Community Health Centers
- ✓ Community Mental Health Centers

  Describe the Provider Qualifications and Standards

  Response: CMHCs must be licensed as Community Mental Health Centers by BHDDH, certified as Health Home providers by BHDDH and currently providing Health Home services to the SMI population.
- Home Health Agencies
- Case Management Agencies
- Community/Behavioral Health Agencies
- Federally Qualified Health Centers (FQHC)
- Other (Specify)

- Teams of Health Care Professionals
- Health Teams

Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Home Services

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

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

Standards for CMHO health home providers specify that each health home indicate

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

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

Response: CMHOs will participate in a variety of learning supports, up to and including learning collaboratives (which are not mandatory), designed to instruct CMHOs to operate as health homes (HH) and provide care using a whole-person approach that integrates behavioral health, primary care and other needed services and supports. The following components will be addressed: Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered HH services; Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines, preventive and health promotion services, including prevention of mental illness and substance use disorders, mental health and substance abuse services, comprehensive care management, care coordination, and transitional care across settings (including appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care); Coordinate and provide access to chronic disease management, including self-management support to individuals and their families, individual and family supports, including

referral to community, social support, and recovery services, long-term care supports and services; Develop a person-centered treatment plan for each individual that coordinates and integrates all of clients' clinical and non-clinical health-care related needs and services; Demonstrate capacity to use HIT to link services, facilitate communication among team members and between the HH team and individual and family caregivers, and provide feedback to practices, and; Establish a continuous quality improvement program to collect and report on data that facilitates an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.

Other Health Homes Provider Standards

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

Response:

Comprehensive Care Management

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

1. Service capacity and team composition; roles and responsibilities meet staffing requirements.
2. A comprehensive and culturally appropriate health assessment is used that yields both subjective and objective findings regarding the consumer's health needs.
3. The consumer's treatment plan clearly identifies primary, specialty, community networks and supports to address identified needs; along with family members and other supports involved in the consumer's care.
4. A consumer's treatment plan reflects the consumer's engagement level in goal setting, issue identification, self-management action, and the interventions to support self-management efforts to maintain health and wellness.
5. Service coordination activities use treatment guidelines that establish integrated clinical care pathways for health teams to provide organized and efficient care coordination across risk levels or health conditions.
6. The Program functions as the fixed point of responsibility for engaging and retaining consumers in care and monitoring individual and population health status to determine adherence or variance from recommended treatment guidelines.
7. Routine/periodic reassessment, using the Daily Living Activities Scale (DLA), conducted every 6 months at a minimum, to include reassessment of the care management process and the consumer's progress towards meeting clinical and person-centered health action plan goals.
8. The Program assumes primary responsibility for psychotropic medications, including administration; documentation of non-psychotropic medications prescribed by physicians and any medication adherence, side effects, issues etc.
9. The Program uses peer supports (certified Peer Recovery Specialists) and self-care programs to increase the consumer's knowledge about their health care conditions and to improve adherence to prevention and treatment activities.
10. Evidence that the outcome and evaluation tools being used by the health care team uses quality metrics, including assessment and survey results and utilization of services to monitor and evaluate the impact of interventions.

Care Coordination and Health Promotion

The medical record shall provide evidence that:

1. Each consumer on the Program's team has a dedicated case manager who has overall responsibility and accountability for coordinating all aspects of the consumer's care.
2. A Program has a relationship with the community agencies in its local area. To that end it can provide evidence that the case managers can converse with these agencies on an as-needed basis when there are changes in a consumer's condition.
3. A Program facilitates collaboration through the establishment of relationships with all members of consumer's interdisciplinary health team.
4. Policies, procedures and accountabilities (contractual or memos of understanding agreements) have been developed to support and define the roles and responsibilities for effective collaboration between primary care, specialists, behavioral health, long-term services and supports and community-based organizations.
5. A psychiatrist or Advanced Practice Registered Nurse (APRN) /Nurse Practitioner provides medical leadership to the implementation and coordination of program's activities by developing and maintaining working relationships with primary and specialty care providers including various inpatient and long-term care facilities.
6. Protocol has been developed for priority appointments for Program's consumers to behavioral health providers and services, and within the Program's provider network to avoid unnecessary or inappropriate utilization of emergency room, inpatient hospital and institutional services.
7. The Program's provider has a system to track and share consumer's patient care information and care needs across providers and to monitor consumer's outcomes and initiate changes in care, as necessary, to address consumer needs.
8. 24 hours/seven days a week availability to provide information/emergency consultation services to the consumer.

Comprehensive Transitional Care

The consumer's medical record shall provide evidence that:

1. A Program's case manager is an active participant in all phases of care transition, including timely access to follow-up care and post-hospital discharge (see metrics).
2. The Program's provider has policies and procedures in place with local practitioners, health facilities including emergency rooms, hospitals, residential/rehabilitation settings, and community-based services, to help ensure coordinated, safe transitions in care.
3. A notification system is in place with Managed Care Organizations to notify the Programs of a consumer's admission and/or discharge from an emergency room, inpatient unit, nursing home or residential/rehabilitation facility.
4. The Program collaborates with physicians, nurses, social workers, discharge planners, pharmacists, and others to continue implementation of the treatment plan with a specific focus on increasing the consumer's ability to self-mange care and live safely in the community.
5. Care coordination is used when transitioning an individual from jail/prison into the community.

Individual and Family Support Services

The consumer's medical record shall:

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

2. Identify and refer to resources that support the consumer in attaining the highest level of health and functioning in their families and in the community, including ensuring transportation to and from medically necessary services.
3. Demonstrate communication and information shared with consumers and their families and other caregivers with appropriate consideration of language, activation level, literacy and cultural preferences.

Chronic Condition Management and Population Management

The consumer's medical record shall:

1. Identify available community-based resources discussed with consumers and evidence of actively managed appropriate referrals, demonstrate advocating for access to care and services, and include evidence of the provision of coaching for consumers to engage in self-care and follow-up with required services.
2. Reflect policies, procedures, and accountabilities (through contractual or memos of understanding, affiliation agreements or quality service agreements) to support effective collaboration with community-based resources, which clearly define roles and responsibilities.

Health Homes Service Delivery Systems

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

- ✓ Fee for Service
- o PCCM
- ✓ Risk Based Managed Care

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

- ✓ Yes
- o No

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

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

HHs are submitting HIPAA compliant claims data for services delivered under the IHH and ACT bundles.
For MCO enrollees active with IHH/ACT, the MCO will leverage the care management provided at the Health Home and will not duplicate services. The MCO will work collaboratively with Health Homes to ensure all the member's needs are met.

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

Name	Date Created	Type
No Items Available		

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

- ✓ Yes
- ✓ No

Assurances

- ✓ The State provides an assurance that at least annually, it will submit to the regional office as part of their capitated rate Actuarial certification a separate Health Homes section which outlines the following:
  - Any program changes based on the inclusion of Health Homes services in the health plan benefits
  - Estimates of, or actual (base) costs to provide Health Homes services (including detailed a description of the data used for the cost estimates)
  - Assumptions on the expected utilization of Health Homes services and number of eligible beneficiaries (including detailed description of the data used for utilization estimates)
  - Any risk adjustments made by plan that may be different than overall risk adjustments
  - How the final capitation amount is determined in either a percent of the total capitation or an actual PMPM
- ✓ The State provides assurance that it will design a reporting system/mechanism to monitor the use of Health Homes services by the plan ensuring appropriate documentation of use of services
- ✓
- ✓ The State provides assurance that it will complete an annual assessment to determine if the payments delivered were sufficient to cover the costs to deliver the Health Homes services and provide for adjustments in the rates to compensate for any differences found

- o Other Service Delivery System

Payment Methodology

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

- o Fee for Service
- o PCCM (description included in Service Delivery section)
- o Risked Based Managed Care (description included in Service Delivery section)
- ✓ Alternative models of payment, other than Fee for Service or PMPM payments (describe below)

- ✓ Tiered Rates based on
  - ○ Severity of each individual's chronic conditions
  - ✓ Capabilities of the team of health care professionals, designated provider, or health team
  - ○ Other

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

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

1. Providers must be Community Mental Health Centers or other private, not-for-profit providers of mental health services who are licensed by the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH).
2. All providers must conform to the requirements of the current Rules and Regulations for the Licensing of Behavioral Healthcare Organizations, and all other applicable state and local fire and safety codes and ordinances.
3. Providers must agree to contract and accept the rates paid by the Managed Care Organization as established with the Executive Office of Health and Human Service (EOHHS) and BHDDH as the sole and complete payment in full for services delivered to beneficiaries, except for any potential payments made from the beneficiary's applied income, authorized co-payments, or cost sharing spend down liability.
4. Providers must be enrolled in the RI Medicaid Program, have a contract with the Managed Care Organizations and agree to meet all requirements, such as, timely access to care and matching beneficiaries service needs.
5. The State will not include the cost of room and board or for non-Medicaid services as a component of the rate for services authorized by this section of the state plan.
6. The State will pay for services under this section on the basis of the methodology described in the section titled "Basis for IHH Methodology" of this document.
7. The amount of time allocated to IHH and ACT for any individual staff member is reflective of the actual time that staff member is expected to spend providing reimbursable IHH and ACT services to Medicaid recipients.
8. Providers are required to collect and submit complete encounter data for all IHH/ACT claims on a monthly basis utilizing standard Medicaid coding and units in an electronic format determined by EOHHS, BHDDH and Managed Care Organizations. The state will conduct an analysis of the data to develop recipient profiles, study service patterns, and analyze program costs vs. services received by recipients, for potential adjustments to the case rate as well as for consideration of alternative payment methodologies. Analysis will be conducted at least annually.
9. The State assures that IHH and ACT services under this submission will be separate and distinct and that duplicate payment will not be made for similar services available under other program authorities.
10. The base rates were set as of January 1, 2016 and are described below.

    Staffing Model and Rates for ACT
    ACT/High Acuity Team:
    12.75 FTE: v_PKG_1 Team Census
    FTE = 35 Hour Work Week
    Program Staff FTE Cost/FTE
    Total Cost
    Program Director (LICSW, LMHC, LMFT, LCDP, RN) 1 $68,000 $68,000

Registered Nurse 2 $66,000
$132,000
Master's Level Clinician 1 $60,000
$60,000
Vocational Specialist, Bachelor's level 1 $44,000
$44,000
Substance Abuse Specialist, Bachelor's level 2 $44,000
$88,000
CPST Specialist, Bachelor's level 4 $41,000
$164,000
Peer Specialist 1 $41,000 $41,000
Psychiatrist 0.75 $230,000
$172,500
Fringe at 30%
$230,850
Total Salaries & Fringe
$1,000,350

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

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

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

11. Basis for IHH Methodology for IHH:
The process is based on a CMS approved methodology that utilizes reliable estimates of the actual costs to the provider agencies for staff and operating/support and then feeding those costs into a fee model. The process also included the development of a standard core IHH team composition and suggested caseload based on estimates of available staff hours and client need. Flexibility is given to the providers for the costs of the entire team. Ten positions are noted as core expectations that consists of one (1) Master's level coordinator, two (2) registered nurses, one (1) hospital liaison, five (5) CPST specialists and one (1) peer specialist.
Agencies will also be able to flex staff by need to certain teams. Agencies are still accountable to the entire number of staff, cost and salaries for all positions for Health Homes of the agency. Any deviation from the model must have clinical and financial justification that is approved by BHDDH, the state Mental Health Authority. The goal is to give providers flexibility so that providers are able to manage the team to obtain the outcomes.
Staffing Model (per 200 clients):
Title
FTE
Master's Level Program Director
1
Registered Nurse
2
Hospital Liaison
1
CPST Specialist
5- 6
Peer Specialist
1
Medical Assistant
1 (optional)

IHH
OCCUPANCY
v_PKG_1.0%
CLIENTS
200
Program
Staff:
Qualifications: FTE
Cost/FTE Total Cost

Master's Level Coordinator
1.0 $78,817 $78,817

Registered Nurse
2.0 $81,500 $163,000

Hospital Liaison 1.0
$44,200 $44.200

CPST Specialist BA

6.0 $44,200 $265,200

Peer Specialist 1.0
$43,711.00 $43,711.00

Medical Assistant
1.0 $39,360 $39,360

$634,288

12.0
Fringe (Included in base cost)
0

Total base staff cost
$634,288

Total all staff cost
$634,288

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

Total all costs
$1,008,518

PMPM
$420.22

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

Providers not meeting performance targets shall submit corrective action plans describing how full compliance will be accomplished. BHDDH and EOHHS will monitor progress and compliance with corrective action plans. If improvement is not detected, these measures will be added to the following year's measures.

Flexibility is given to the providers for the costs of the entire team. Ten positions are noted as core expectations that consists of one (1) Master's level coordinator, two (2) registered nurses, one (1) hospital liaison, five (5) CPST specialists and one (1) peer specialist.

Agencies will also be able to flex staff by need to certain teams. Agencies are still accountable to the entire number of staff, cost and salaries for all positions for Health Homes of the agency.

Any deviation from the model must have clinical and financial justification that is approved by BHDDH, the state Mental Health Authority. The goal is to give providers flexibility so that providers are able to manage the team to obtain the outcomes.

Staffing Model (per 200 clients):

Title	FTE
Master's Level Program Director	1
Registered Nurse	2
Hospital Liaison	1
CPST Specialist	5- 6
Peer Specialist	1
Medical Assistant	1 (optional)

IHH

OCCUPANCY v_PKG_1.0%

CLIENTS 200

Program Staff:

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

Total base staff cost
$634,288

Total all staff cost
$634,288

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

Total all costs
$1,008,518

PMPM $420.22

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

Providers not meeting performance targets shall submit corrective action plans describing how full compliance will be accomplished. BHDDH and EOHHS will monitor progress and compliance with corrective action plans. If improvement is not detected, these measures will be added to the following year's measures.

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.

Assurances

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

  Describe below how non-duplication of payment will be achieved

  To avoid duplication of payment for similar services, the State has employed an on-line portal developed by Hewlett Packard Enterprises that validates the dates of enrollment in Health Home programs. Providers must enter client data into the on-line portal. If the client is already a client of another Health Home program, including Opiate Treatment Health Home or an Assertive Community Treatment program, the portal will give them an error message. This provides the State with assurances that duplicate programming and billing does not occur.

- o The state has developed payment methodologies and rates that are consistent with section 1902(a)(30)(A).
- ✓ The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule, unless otherwise described above.
- ✓ The State provides assurance that it shall reimburse providers directly, except when there are employment or contractual arrangements consistent with section 1902(a)(32).

Optional Supporting Material Upload

Name	Date Created	Type

Service Definitions

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

Comprehensive Care Management

Definition

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

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

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

Scope of service

The service can be provided by the following provider types

- ✓ Behavioral health Professionals or Specialists

  Description

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

assist patients in accessing other specialized care, encouraging patients to keep appointments and follow through with care recommendations.

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

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

- o Nurse Practitioner
- o Nurse Care Coordinator
- ✓ Nurses

Description

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

- o Medical Specialists
- ✓ Physicians

Description

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

- o Physician's Assistants
- o Pharmacists
- o Social Workers
- o Doctors of Chiropractic
- o Licensed Complementary and alternative Medicine Practitioners
- o Dieticians
- o Nutritionists

- Other (specify)

Care Coordination

Definition

Chronic Condition Management and Population Management

Service Definition:

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

- Assisting in the development of symptom self-management, communication skills, and appropriate social networks to assist clients in gaining effective control over their psychiatric symptoms;
- Provide health education, counseling, and symptom management to enable client to be knowledgeable in the oversight of chronic medical illness as advised by the client's primary/specialty medical team;
- Maintaining up-to-date assessments and evaluations necessary to ensure the continuing availability of required services;
- Assisting the client in locating and effectively utilizing all necessary medical, social, and psychiatric community services;
- Assisting in the development and implementation of a plan for assuring client income maintenance, including the provision of both supportive counseling and problem-focused interventions in whatever setting is required, to enable the client to manage their psychiatric and medical symptoms to live in the community. This includes:
- Provide a range of support services or direct assistance to ensure that clients obtain the basic necessities of daily life, including but not necessarily limited to: financial support and/or benefits counseling;
- Teach money-management skills (e.g. budgeting and bill paying) and assist client assessing financial services (e.g. payeeship etc.).
- Develop skills related to reliable transportation (help obtain driver's license, arrange for cabs, finds rides).
- Provide individual supportive therapy (e.g. problem solving, role playing, modeling and support), social skill development, and assertive training to increase client social and interpersonal activities in community settings) e.g. plan, structure, and prompt social and leisure activities on evenings, weekends, and holidays, including direct support and coaching.
- Assistance with other activities necessary to maintain personal and medical stability in a community setting and to assist the client to gain mastery over their psychiatric symptoms or medical conditions and disabilities in the context of daily living. For example:
- Support the client to consistently adhere to their medication regimens, especially for clients who are unable to engage due to symptom impairment issues.
- Accompanying clients to and assisting them at pharmacies to obtain medications.
- Accompany consumers to medical appointments, facilitate medical follow up.
- Provide direct support and coaching to help clients socialize - structure clients' time, increase social experiences, and provide opportunities to practice social skills and receive feedback and support.

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

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

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

Scope of Service

The service can be provided by the following provider types

- ✓ Behavioral Health Professionals or Specialists

  Description

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

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

- o Nurse Practitioner
- o Nurse Care Coordinators
- o Nurses

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

Health Promotion

Definition

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

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

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

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

Scope of Service

The service can be provided by the following provider types

- ✓ Behavioral Health Professionals or Specialists

  Description

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

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

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

- o Nurse Practitioner
- o Nurse Care Coordinators
- ✓ Nurses

  Description

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

- o Medical Specialists
- ✓ Physicians

  Description

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

- o *Physician's Assistants*
- o *Pharmacists*
- o *Social Workers*
- o *Doctors of Chiropractic*
- o *Licensed Complementary and alternative Medicine Practitioners*
- o *Dieticians*

- *Nutritionists*
- *Other (specify)*

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

Definition

Service Definition:

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

- Engage with the client upon admission to the hospital and ensure that the discharge plan addresses physical and behavioral health needs. For all medical and behavioral health inpatient stays, the IHH team conducts an on-site visit with client early in the hospital stay, participates in discharge planning, and leads the care transition until the client is stabilized.
- Upon hospital discharge (phone calls or home visit):
- Ensure that reconciliation of pre- and post-hospitalization medication lists is completed.
- Assist consumer to identify and obtain answers to key questions or concerns.
- Ensure the consumer understands their medications, can identify if their condition is worsening and how to respond, knows how to prevent a health problem from becoming worse, and has scheduled all follow-up appointments.
- Prepare the consumer for what to expect if another care site is required (i.e. how to seek immediate care in the setting to which they have transitioned).
- Identify linkages between long-term care and home and community-based services.

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

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

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

1. Program has structured information systems, policies, procedures, and practices to create, document, implement, and update a treatment plan for every consumer.
2. Health Home provider has a systematic process/system to follow-up on tests, treatments, services/referrals which is integrated into the consumer's treatment plan. Guidance: Programs have a system/process to identify, track, and proactively manage the consumers' care needs using

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

3. The program has a developed process and/or system which allows the consumer's health information and treatment plan to be accessible to the interdisciplinary provider team of providers, and which allows for population management/identification of gaps in care including preventative services.
4. Programs are committed to work with Rhode Island's health information exchange system (CurrentCare) and be in compliance with any future version of the Statewide Policy Guidance regarding information, polices, standards, and technical approaches, governing health information exchange. Guidance: Provider is committed to promote, populate, use, and access data through the statewide health information exchange system. Provider is to work with RI's Health Information Exchange to ensure they receive the technical assistance in regards to any of the above requirements.
5. Programs have the capability to share information with other providers and collect specific quality measures as required by EOHHS and CMS.
6. Program is able to use EOHHS and CMS quality measures as an accountability framework for assessing progress towards reducing avoidable health costs, specifically preventable hospital admissions/readmissions, avoidable emergency room visits, and providing timely post discharge follow-up care.

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

Scope of service

The service can be provided by the following provider types

- ✓ Behavioral Health Processionals or Specialists

Description

The Master's Level team leader will need to assess the consistency of the care plan(s) established in relation to the clinical treatment plan. This person will interact with other providers in addressing the patient's treatment and health needs while in another setting and work with the team to establish a transitional plan. The case manager will be responsible for the application of services in a transitional care plan. The case manager will be responsible for assuring the patient is able to follow through with transition plans and is assisted in doing so. The hospital liaison will work closely with the hospital staff, especially discharge planners, to assess the suitability of transition plans. Hospital liaisons will work with other long term facilities to plan for coordination of care during and after a residential stay.

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

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

- o Nurse Practitioner
- o Nurse Care Coordinators
- ✓ Nurses

Description

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

- o Medical Specialists
- ✓ Physicians

Description

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

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

Individual and Family Support (which includes authorized representatives)

Definition

Service Definition:

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

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

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

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

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

Scope of service

The service can be provided by the following provider types

- ✓ Behavioral health Professionals or Specialists

  Description

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

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

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

- o Nurse Practitioner

- o Nurse Care Coordinators
- ✓ Nurses

  Description

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

- o Medical Specialists
- ✓ Physicians

  Description

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

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

Referral to Community and Social Support Services

Definition

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

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

person in their social integration and social skill building; - Faith based organizations; - Access to employment and educational program or training; - Referral to community and social support services may be provided by any member of the CMHO health home team; however, CPST Specialists will be the primary practitioners providing referrals to community and social support services.

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

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

Scope of service

The service can be provided by the following provider types

- ✓ Behavioral Health Professionals or Specialists

  Description

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

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

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

- o Nurse Practitioners
- o Nurse Care Coordinators
- ✓ Nurses

  Description

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

- o Medical Specialists
- ✓ Physicians

  Description

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

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

Health Homes Patient Flow

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

Clients eligible for IHH services will meet diagnostic and functional criteria established by BHDDH. Individuals will also be assessed for eligibility using the Daily Living Activities (DLA) Functional Assessment. The DLA must be completed at admission and every 6 months after admission as well as after an IP admission or significant change in clinical presentation. The assessment tool identifies where interventions are needed for rehabilitation and recovery so clinicians can address those functional deficits on individualized treatment plans. Individuals who do not meet diagnostic criteria, but require IHH services due to significant functional impairment as measured by the DLA, may be admitted to the program through an exception process established by BHDDH in collaboration with MCOs. For all HH admissions, a BHDDH enrollment form must be completed and kept in the client's medical record. The Provider must submit a HH admission request via the HP web portal. The client's primary eligible diagnosis, the DLA score and the program (OTP, IHH or ACT) must be entered in the portal. In addition, CMHO will verify that client has signed an agreement to receive ACT/IHH services or needs this level of service and was unable/unwilling to sign. Staff at BHDDH will review and either approve or deny requests within 2 business days. A comprehensive and culturally appropriate health assessment is used. Each client will be assigned a service coordinator (case manager) who coordinates and monitors the activities of the client's individual treatment team and the greater IHH/ACT team. The primary responsibility of the service coordinator is to work with the client to develop the treatment plan, provide individual supportive counseling, offer options and choices in the treatment plan, ensure that immediate changes are made as the client's needs change, and advocate for the client's wishes, rights, and preferences.

Name	Date Created	Type

Health Homes Monitoring, Quality Measurement and Evaluation

Monitoring

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

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

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

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

Quality Measurement and Evaluation

- ✓ The state provides assurance that all Health Homes providers report to the state on all applicable quality measures as a condition of receiving payment from the state
- ✓ The state provides assurance that it will identify measurable goals for its Health Homes model and intervention and also identify quality measures related to each goal to measure its success in achieving the goals
- ✓ The state provides assurance that it will report to CMS information submitted by Health Homes providers to inform evaluations, as well as Reports to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS
- o The state provides assurance that it will track avoidable hospital readmissions and report annually in the Quality Measures report