STATE OF RHODE ISLAND
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

6/29/2018 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:

Health Homes for Children

EOHHS is seeking federal authority to move Cedar Family Center services into Managed Care, effective July 1, 2018. The services will be defined as Health Homes for Children, and will include the following services:

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

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 July 29, 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.

Submission - Summary

State Information

State/Territory Name: Rhode Island

Medicaid Agency Name: Executive Office of Health and Human Services

Submission Component

- ✓ State Plan Amendment
- ✓ Medicaid
- ○ CHIP

Submission Type

- ○ Official Submission Package
- ✓ Draft Submission Package

Allow this draft package to be viewable by other states?

- ○ **Yes**
- ✓ **No**

Key Contacts

Name	Title	Phone Number	Email
Lawrence, Melody	Health Services Manager	(401)462-6348	melody.lawrence@ohhs.ri.gov

Executive Summary

Summary Description Including Goals and Objectives

Dependency Description

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

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	**2016**	**$**
Second	**2017**	**$**

Federal Statute / Regulation Citation

Governor's Office Review

- o No comment
- o Comments received
- o No response within 45 days
- o Other

Submission - Medicaid State Plan

The submission includes the following:

- o Administration
- o Eligibility
- ✓ Benefits and Payments
  - ✓ Health Homes Program
    - o Create new Health Homes program
    - ✓ Amend existing Health Homes program
    - o Terminate existing Health Homes program

Submission - Public Comment

Name of Health Homes Program

Migrated_HH.CONVERTED Rhode Island Health Home Services - Amendment

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

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

Submission - Tribal Input

Name of Health Homes Program

Migrated_HH.CONVERTED Rhode Island Health Home Services - Amendment

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

- Yes
- No

Submission - Other Comment

SAMHSA Consultation

Name of Health Homes Program

Migrated_HH.CONVERTED Rhode Island Health Home Services - Amendment

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

Date of consultation

Program Authority

1945 of the Social Security Act

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

Name of Health Homes Program

Migrated_HH.CONVERTED Rhode Island Health Home Services - Amendment

Executive Summary

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

Data conversion from previous Medicaid Model Data Lab.

Supersedes Transmittal Number:11-006

Transmittal Number:16-0001

This State Plan Amendment is in Attachment 3.1-H(14) of the State Plan, except for the Payment Methodologies section, which is in Attachment 4.19-B(TN 09-004) of the State Plan.

Medicaid recipients under the age of 21 who meet the following criteria are eligible for Cedar Services: 1) Suspected of having a severe mental illness, or severe emotional disturbance, 2) Suspected of having two or more of the following chronic conditions Mental Health Condition, Asthma, Diabetes, Developmental

Disabilities, Down Syndrome, Mental Retardation, or Seizure Disorders; or 3) has one chronic condition listed previously and is at risk of developing a second.

Cedar Family Centers meeting the Health Homes criteria as established by the State in consultation with CMS will be certified by the State as Health Home providers. Eligible clients are free to choose from any Cedar Family Center to receive services. Cedar Family Centers are designed to provide a structured system for facilitating the assessment of need for, and the provision of high quality, evidence based medically necessary service that may be available for children pursuant to federal EPSDT requirements, and referrals to community based services and supports that benefit the child and family. Cedar Family Center Health Homes will operate as a "Designated Provider" of Health Home Services. The Cedar Health Home (CHH) Team may consist of any combination of a Licensed Clinician and/or a Family Service Coordinator dependent on the child and family needs. The CHH Team will consult, coordinate and collaborate on a regular basis with the child's Primary Care Physician/Medical Home and with other providers providing treatment services to that child. Cedar Family Centers, by Standard, provide all services in a patient and family centered manner.

General Assurances

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

Health Homes Geographic Limitations

- ✓ Health Homes services will be available statewide
- o Health Homes services will be limited to the following geographic areas
- o Health Homes Services will be provided in a geographic phased-in approach

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
- o Medically Needy Parents and Other Caretaker Relatives

Aged, Blind and Disabled

- o Medically Needy Aged, Blind or Disabled
- o 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

Specify the conditions included

- ✓ Mental Health Condition
- o Substance Use Disorder
- ✓ Asthma
- ✓ Diabetes
- o Heart Disease
- o BMI over 25
- ✓ Other (specify)

Name	Description
Developmental Disability	
Down Syndrome	
Mental Retardation	
Seizure Disorders	
Autism Spectrum Disorder	

- ✓ One chronic condition and the risk of developing another

Specify the conditions included

- ✓ Mental Health Condition
- o Substance Use Disorder
- ✓ Asthma
- ✓ Diabetes
- o Heart Disease

- BMI over 25
- ✓ Other (specify)

Name	Description
Developmental Disability	
Down Syndrome	
Mental Retardation	
Seizure Disorders	
Autism Spectrum Disorder	

Specify the criteria for at risk of developing another chronic condition

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

- Suspected of having a severe mental illness, or severe emotional disturbance
- Suspected of having two or more chronic conditions as listed below:
- Mental Health Condition
- Asthma
- Diabetes
- Developmental Disabilities
- Down Syndrome
- Mental Retardation
- Seizure Disorders
- Autism Spectrum Disorder
- Has one chronic condition listed above and is at risk of developing a second

✓ One serious and persistent mental health condition

Specify the criteria for a serious and persistent mental health condition

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

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

Describe the process used

Families may access a Cedar Family Center through self-referral or by other referral sources, including a Primary Care Physician, a Health Plan or other providers. When these sources initiate the referral, the Cedar Family Center must contact the family within ten (10) calendar days of referral. Cedar shall document attempts made to reach the family and response to the referral source.

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

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

Health Home Providers

- ✓ Designated Providers

  Indicate the Health Homes Designated Providers the state includes in its program and the provider qualifications and standards

  - o Physicians
  - o Clinical Practices or Clinical Group Practices
  - o Rural Health Clinics
  - o Community Health Centers
  - o Community Mental Health Centers
  - o Home Health Agencies
  - ✓ Case Management Agencies

  Describe the Provider Qualifications and Standards

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

Community/Behavioral Health Agencies

- Federally Qualified Health Centers (FQHC)
- Other (Specify)

- Teams of Health Care Professionals
- Health Teams

Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Home Services

Designated Providers as described in Section 1945(h)(5)

Cedar Family Centers meeting the Health Homes criteria as established by the State in consultation with CMS will be certified by the State as Health Home providers. Cedar family centers currently operate under Certification Standards established by the State. Certification Standards have been amended as required to ensure they meet Health Home requirements. Eligible clients are free to choose from any Cedar Family Center to receive services. Cedar Family Centers are designed to provide a structured system for facilitating the assessment of need for, and the provision of high quality, evidence based medically necessary service that may be available for children pursuant to federal Early and Periodic Screening Diagnosis and Treatment (EPSDT) requirements, as well as referrals to community based services and supports that benefit the child and family. Cedar Family Center Health Homes will operate as a "Designated Provider" of Health Home Services. All Cedar Family Centers employ independently licensed health care professional such as; Psychologists licensed Independent Clinical Social Workers Masters Level Registered Nurses, or licensed Marriage and Family Therapists; Cedar Family centers also employ staff trained to provide care coordination, individual and family support and other functions expected from a health home. The CHH Team 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.

Supports for Health Homes Providers

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

1. Provide quality-driven, cost-effective, culturally appropriate, and person- and family- centered Health Homes services
2. Coordinate and provide access to high quality health care services informed by evidence-based clinical practice guidelines
3. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders
4. Coordinate and provide access to mental health and substance abuse services
5. Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to

other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care

6. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families
7. Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services
8. Coordinate and provide access to long-term care supports and services
9. Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services
10. Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate
11. Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level

Description

Technical assistance is offered to providers minimally through monthly meetings and annual self-audits. Topics of discussion include: development of new informational materials-outreach efforts, code and diagnosis for billing, crisis plan development, Professional Development, , PCP and Health Plan coordination, Kidsnet- user roles and data sharing, hearings and complaints, FCCP/DCYF involved families, collaboration with direct service providers, performance measures/outcomes measures, and the Cedar Screening Tool.

Cedars are typically very proficient in utilizing HIT. Therefore, specific trainings on the adoption and use of HIT, such as integration with KIDSNET, will be provided on an ad hoc basis if there is a need. EOHHS assesses the Cedar Health Homes upon certification to determine readiness and identify any needs for additional training. The information that Cedar Health Homes are required to provide as part of their application for certification includes, but is not limited to; organization background information, organizational structure, description of program approach (including family centeredness, community focus, staff competency, organizational capacities, ability to demonstrate relationships with provider community, scope of practice), quality improvement plan, compliance processes and procedures, administrative and financial systems, independent audits, ownership and control interests, and mechanisms for data collection and reporting of outcome measures.

Other Health Homes Provider Standards

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

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

http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/ProviderManuals/CedarCertStds.pdf

Provider Standards

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

- Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered health home services;
- Coordinate high-quality health care services informed by evidence-based clinical practice guidelines;
- Coordinate preventive and health promotion services, including prevention of mental illness and substance use disorders;
- Coordinate mental health and substance abuse services;
- Coordinate 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;
- Coordinate chronic disease management, including self-management support to individuals and their families;
- Coordinate individual and family supports, including referral to community, social support, and recovery services;
- Coordinate long-term care supports and services;
- 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;
- Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate; and
- Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.

* Establish a protocol to gather, store and transmit to the State all data elements required to fulfill the reporting requirements of the Health Home Initiative.

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

The Cedars currently receive some admission/discharge notifications via fax, call or email from the medical/psychiatric inpatient facilities. To improve upon this process, the Cedars do active outreach to the

medical/psychiatric inpatient facilities to remind the facilities of their request to receive admission/discharge notifications in order to facilitate effective transitional care.

Name	Date Created

Health Homes Service Delivery Systems

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

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

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

- ✓ Yes
- ○ No

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

Contractor will provide family-centered, intensive care management and coordination services to children. These services include:

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

Contractor will deliver Health Home services to children within the following parameters:

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

- ○ 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

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

- ● Yes
- ○ No

Assurances

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

- ○ Other Service Delivery System

Health Homes Payment Methodologies

Payment Methodology

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

- ○ Fee for Service
- ○ PCCM (description included in Service Delivery section)
- ○ Risk Based Managed Care (description included in Service Delivery section)
- ✓ Alternative models of payment, other than Fee for Service or PMPM payments (describe below)
- ○ Tiered Rates based on

Assurances

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

Describe below how non-duplication of payment will be achieved

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

- 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

Health Home Services

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 is provided by Cedar Family Centers by working with the child and family to: assess current circumstances and presenting issues, identify strengths and needs, and identify resources and/or services to assist the child and family to address their needs
through the provision of an Assessment and development of a Family Care Plan.

A. Needs Assessment
The Needs Assessment is a face-to face meeting between the family and Cedar staff to determine the current needs of the child and family. The Assessment must be completed within forty-five (45) calendar days of initial request, or sooner, based upon the urgency of the child and family's needs. The family and the Cedar staff shall determine the most effective way to address their immediate concerns. Every effort should be made to include, or have the child present during a portion of the visit.

It is expected that Cedar staff will gather sufficient information during the Needs Assessment to complete a determination of the needs of the child and family and to develop a plan to address these needs. Additional information may be needed to make a determination about the efficacy of identified referrals. In these instances, the Cedar staff will identify as an action in the Family Care Plan.

B. Family Care Plan

The initial Family Care Plan must be completed within forty-five (45) calendar days from referral. Family Care Plans will be reviewed with the family and updated as needed. The Family Care Plan must be developed with and signed by the child's parent(s) or authorized guardian(s) as an agreement to work towards the action plan as indicted. A Family Care Plan must be reviewed and signed by an independently licensed clinician and may be in place for up to twelve (12) months.
General principles for the Care Plan include, but are not limited to:

C. Crisis Support Plan

Recognizing that families may experience a crisis that requires immediate support, Cedar Family Centers are authorized to assist the family in planning for potential crises and for linking them to supports and services in a timely manner. Crises include medical emergencies, behavioral health crises, food or housing problems, service delivery issues (provider coverage), etc. An important component of the assessment and care plan process is the development of a Crisis Support Plan as part of Crisis Intervention Support. The Crisis Support Plan should be completed as needed and a copy of the plan left with the family.

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

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

Scope of service

The service can be provided by the following provider types

- ✓ Behavioral Health Professionals

Description

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

- ○ Nurse Practitioner
- ○ Nurse Care Coordinators
- ○ Nurses
- ○ Medical Specialists
- ○ Physicians
- ○ Physician's Assistants
- ○ Pharmacists
- ○ Social Workers
- ○ Doctors of Chiropractic
- ○ Licensed Complementary and alternative Medicine Practitioners
- ○ Dieticians
- ○ Nutritionists
- ✓ Other (specify)

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

Care Coordination

Definition

Care Coordination is designed to be delivered in a flexible manner best suited to the family's preferences and to support goals that have been identified. This is achieved by developing linkages and skills to help families increase their independence in obtaining and accessing services. This includes:

- Provide and assist families in obtaining information about specific disorders, treatment and provider options, systems of support, services, assistance and legal rights available to Children with Special Health Care Needs and their families, resources beyond the scope of services covered by Medicaid, such as those which may be available from other

parents, family members, community-based organizations, service providers, grants, social programs, insurance plans, school-based services, faith based organizations, etc.
- Assistance in locating and arranging specialty evaluations as needed, in coordination with the child's Primary Care Provider and payer. This also includes follow-up and consultation with the evaluator as needed.
- Follow up with families, Primary Care provider, service providers and others involved in the child's care to ensure engagement of services and supports.

Primary Care Provider
Most children have a primary care provider (PCP). If a child does not have one, the Cedar Family Center should assist the family in linking with a PCP. The Cedar Family Center and the child's primary medical care provider should be active partners in coordinating care for the child. The Cedar Family Center is expected to develop procedures to ensure the coordination between the Cedar Family Center and the child's PCP. Documentation of this collaboration is required.

RIte Care Plans, Other Third Party Payers
Cedar Family Centers are required to coordinate efforts with a variety of payers as the insurance coverage status of children using the Cedar Family Center may vary. Cedar Family Centers are expected to be knowledgeable concerning the programmatic elements and eligibility rules of all publicly financed programs, and the requirements of all commercial payers' products and programs to enable it to support the family's need for information, and for it to make credible determinations as to financial responsibility for services identified in the family's Care Plan. It is not the intent of the Cedar Family Center or other State program to supplant other payers who have a fiscal or fiduciary responsibility for services or supports needed by the child or family.

- **Health Needs Coordination**

Health Needs Coordination (HNC) is a scope of services designed to support the enrolled child and family in addressing goals identified in a signed Cedar Family Care Plan. It is to be delivered in a flexible manner that is best suited to the family's current needs and preferences. The desired outcome of HNC is for the child and family to develop the linkages and skills needed in order for them to reach their full potential and increase their independence through the efficient integration of an array of medical and non-medical services and supports.

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

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

Scope of service

The service can be provided by the following provider types

✓ Behavioral Health Professionals or Specialists

Description

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

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

- o Nurse Practitioner
- o Nurse Care Coordinators
- o Nurses
- o Medical Specialists
- o Physicians
- 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)

Provider Type	Description
Family Service Coordinator	Family Service Coordinator demonstrating competency in strength-based family centered practice, community resources available to children and families, medical complexities and or legal issues experienced by families of children with special health care needs. • Provide and assist families in obtaining information about specific disorders, treatment and provider options, systems of support, services, assistance and legal rights available to Children

	with Special Health Care Needs and their families, resources beyond the scope of services covered by Medicaid, such as those which may be available from other parents, family members, community-based organizations, service providers, grants, social programs, insurance plans, school-based services, faith based organizations, etc. • Assistance in locating and arranging specialty evaluations as needed, in coordination with the child's Primary Care Provider and payer. This also includes follow-up and consultation with the evaluator as needed. • Follow up with families, Primary Care provider, service providers and others involved in the child's care to ensure engagement of services and supports.

Health Promotion

Definition

OVERARCHING STATEWIDE DEFINITION: Health promotion services encourage and support healthy ideas and concepts to motivate individuals to adopt healthy behaviors" The services also enable individuals to self-manage their health. Cedar HEALTH HOME SPECIFIC DEFINITION: Health Promotion assists children and families in implementing the 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).

Health Promotion is intended to provide an immediate support to children and families enrolled with a Cedar. The primary objective is for the Cedar and the family to work collaboratively to maximize the child's opportunity to succeed in the most natural, least restrictive environment.

Health Promotion will help to strengthen a family's ability to stabilize a situation and to maintain the child at home. It can assist the family while waiting for other therapeutic services or when they have an urgent issue. Health Promotion is not intended to replace, or duplicate other available therapeutic services that will meet the family's longer term needs.

Health Promotion is provided by competent Cedar staff who will:

- Work with the family to:
  - assess the most pressing needs of the child and family;
  - identify triggers and patterns linked with problems;
  - set individual goals for the child/family in the areas of self-management and skill acquisition
  - help develop specific intervention strategies that they will be able to carry out in the home environment to work toward the established goals

Health Promotion is achieved through regular consultation with the family and child through face to face visits or non-face to face contact or may include group intervention. Health Promotion is intended to support families and caregivers in their efforts to maintain Children with Special Health Care Needs at home. Health Promotion is intended to increase understanding of specific disabilities, increase understanding of the short and long-term impacts of disabilities on the lives of children and families, and strengthen families' ability to navigate the system and work effectively with service providers. Health Promotion groups can also provide information sharing or skill building for families and children.

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

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

Scope of service

The service can be provided by the following provider types

- ✓ Behavioral Health Professionals or Specialists

  Description

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

  Behavioral Health Professionals or Specialists work with the family to:

  - assess the most pressing needs of the child and family;
  - identify triggers and patterns linked with problems;
  - set individual goals for the child/family in the areas of self-management and skill acquisition
  - help develop specific intervention strategies that they will be able to carry out in the home environment to work toward the established goals

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

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

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

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

Definition

OVERARCHING STATEWIDE DEFINITION; Comprehensive transitional care services focus on the movement of individuals from any medical/psychiatric inpatient or other out-of-home setting into a community setting and between different service delivery models. Members of the health team work closely with the individual to transition the individual smoothly back in to the community and share information with the discharging organization in order to prevent any gaps in treatment that could result in a re-admission. Cedar HEALTH HOME SPECIFIC DEFINITION: Transitional Care will be provided by the Cedar Team to both existing clients who have been hospitalized or placed in other non-community settings as well as newly identified clients who are entering the community. Cedar Family Centers are not required to establish written protocols on the care transition process with hospitals or other institutions. The Cedar Team will collaborate with all parties involved including the facility, primary care physician, Health Plan (if enrolled) and community providers to ensure a smooth discharge into the community and

prevent subsequent re-admission(s). These services include providing access to and the coordination of long term services and supports. Transitional Care is not limited to Institutional Transitions but applies to all transitions that will occur throughout the development of the child and includes transition from Early Intervention into School based services and pediatric services to adult services. Cedar Family Centers have and continue to improve on their relationships with the health plan providers of their children and families in order to facilitate effective transitional care.

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

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

Scope of service

- ✓ Behavioral Health Professionals or Specialists

  Description

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

  Depending on the clinical necessity, licensed clinicians will collaborate with all parties involved with a family including the inpatient facility, primary care physician, Health Plan (if enrolled) and community providers to ensure a smooth discharge into the community and prevent subsequent re-admission(s). Transitional Care is not limited to Institutional Transitions and includes transition from pediatric services to adult services.
- Nurse Practitioner
- Nurse Care Coordinators
- Nurses
- Medical Specialists
- Physicians
- Physician's Assistants
- Pharmacists
- Social Workers
- Doctors of Chiropractic
- Licensed Complementary and alternative Medicine Practitioners
- Dieticians

- ○ Nutritionists
- ✓ Other (specify)

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

Individual and Family Support (which includes authorized representatives)

Definition

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

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

An electronic case management system will also be utilized to support the delivery of individual/family support by providing easy and immediate access to comprehensive information and tools (such as the Individual care plan, contact information, other involvements such as school, behavioral health and specialty care) that will assist the Cedar Team in meeting the needs of each child and family. In addition Cedar Family Centers provide their staff with access to a wide range of resource/educational material(s)

in multiple formats for use in supplementing and facilitating individual/family support activities. This information will be provided in a hard copy or electronic format that is most appropriate for the child and families use, including multiple languages.

Scope of service

The service can be provided by the following provider types

- ✓ Behavioral Health Professionals or Specialists

  Description

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

  Depending on the clinical necessity, licensed clinicians will 1) provide assistance to the family in accessing and coordinating services (these services include the full range of services that impact on Children with Special Health Care Needs and their families and may include, but are not limited to, health, behavioral health, education, substance abuse, juvenile justice and social and family support services), 2) actively integrate the full range of services into a comprehensive Family Care Plan, and 3) at the family's request, play the principal role as organizer, information source, guide, advocate, and facilitator for the family by helping the family to assess strengths and needs, identify treatment goals and services, and navigate agency and system boundaries.

- ○ Nurse Practitioner
- ○ Nurse Care Coordinators
- ○ Nurses
- ○ Medical Specialists
- ○ Physicians
- ○ Physician's Assistants
- ○ Pharmacists
- ○ Social Workers
- ○ Doctors of Chiropractic
- ○ Licensed Complementary and alternative Medicine Practitioners
- ○ Dieticians
- ○ Nutritionists
- ✓ Other (specify)

Provider Type	Description
Family Service Coordinator	Family Service Coordinator demonstrating competency in strength-based family centered practice, community resources available to children and families, medical complexities and or

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

Referral to Community and Social Support Services

Definition

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

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

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

This information will be provided in a hard copy or electronic format that is most appropriate for the child and families use, including multiple languages.

Scope of service

The service can be provided by the following provider types

- ✓ Behavioral Health Professionals or Specialists

  Description

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

  Depending on the clinical necessity, licensed clinicians will 1) refer to Community and Social Support Services which will include information about formal and informal resources beyond the scope of services covered by Medicaid, such as those which may be available from other parents, family members, community-based organizations, service providers, grants, social programs, insurance payers, school-based services, faith based organizations, etc., 2) whenever possible, families will be informed of opportunities and supports that are closest to home, that are the least restrictive and that promote integration in the home and community and 3) emphasize the use of informal, natural community supports as a primary strategy to assist children and families.
- ○ Nurse Practitioner
- ○ Nurse Care Coordinators
- ○ Nurses
- ○ Medical Specialists
- ○ Physicians
- ○ Physician's Assistants
- ○ Pharmacists
- ○ Social Workers
- ○ Doctors of Chiropractic
- ○ Licensed Complementary and alternative Medicine Practitioners
- ○ Dieticians
- ○ Nutritionists
- ✓ Other (specify)

Provider Type	Description
Family Service Coordinator	Family Service Coordinator demonstrating competency in strength-based family centered practice, community resources available to children and families, medical complexities and or legal issues experienced by families of children with special health care needs.

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

Health Homes Patient Flow

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

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

Name	Date Created

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

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

The state will phase-in the use of HIT to support health home services. Initially, providers will be supported in their delivery of health home services through data profiles supplied by Medicaid managed care plans for the 60% of the health home-eligible Cedar population enrolled in MCOs. The state is currently working with the MCOs to develop health utilization profiles minimally comprised of the components below.

1) Claims Data to identify member's pattern of utilization based on previous 12 months (#Emergency Room Visits, Last ER Visit Date,Last ER Visit Primary Diagnosis, #Urgent Care Visits).
2) Claims data to identify member's primary care home (#PCP Sites, #PCP visits to current PCP Site.
3) Prescription Drug information
4) Behavioral Health Utilization

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

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

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