U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy

MEDICAID HEALTH HOMES IN RHODE ISLAND:

REVIEW OF PRE-EXISTING INITIATIVES AND STATE PLAN AMENDMENT(S) FOR THE STATE'S FIRST HEALTH HOMES UNDER SECTION 2703 OF THE AFFORDABLE CARE ACT

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Rhode Island's Health Home Program at a Glance		
	State Plan Amendment 1	**State Plan Amendment 2**
Health Home Eligibility Criteria	Serious Mental Illness (SMI) and evidence of need for supports to remain in the community	2 chronic conditions, 1 chronic condition and at risk of another, SMI
Qualifying Conditions	Mental health condition, with a history of intensive psychiatric treatment, no or limited employment, and poor social functioning	• Mental health condition • Asthma • Developmental disability • Diabetes • Down syndrome • Mental retardation • Seizure disorder
Enrollment*	6,772	2,855
Designated Providers	Community Mental Health Organizations (CMHO)	CEDARR Family Centers
Administrative/ Service Framework	Health home services are provided by 7 CMHOs and 2 specialty providers of mental health services	Health home services are provided by CEDARR Family Centers, operating at 4 sites and primarily serving children
Required Care Team Members	• Master's team coordinator • Psychiatrist • Registered nurse • Master's level clinician • Community psychiatric support and treatment (CPST) specialist • CPST specialist/hospital liaison • Peer specialist	• Licensed clinician • Family service coordinator
Payment System	Per member per month (PMPM) care management fee	Fee-for-service
Payment Level	Based on 9 staff hours PMPM	Fixed rates of $347, $366, or $397, depending on the service. Additional payments of either $9.50 or $16.63 made per quarter hour for 2 other services
Health Information Technology (HIT) Requirements	No HIT requirements. The state plans to phase-in HIT support to its health home providers and, in the interim, relies on the existing infrastructure	
* January 2014 data provided to the Centers for Medicare and Medicaid Services' Health Home Information Resource Center.		

Introduction

Rhode Island has two approved State Plan Amendments (SPAs); one for persons with serious and persistent mental illness (SPMI), and one for persons with SPMI and/or other disabling or chronic physical or developmental conditions (this latter group is *de facto* limited to children and youth by virtue of the providers designated in the SPA). Both SPAs were approved on November 23, 2011, and have a retroactive effective date of October 1, 2011. Health home services under the first SPA will be provided by seven community mental health organizations (CMHOs)--which provide behavioral health services to persons with SPMI, and predominantly serve Medicaid, Medicare, the dually eligible, and the uninsured--and two specialty providers of mental health services, Fellowship Health Resources, Inc., and Riverwood Mental Health Services.[1] The Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) oversees CMHOs and the specialty providers. Children and youth receive services through specialized providers known as CEDARR Family Centers (CEDARR stands for Comprehensive Evaluation, Diagnosis, Assessment, Referral, Re-evaluation). To be eligible for care at CEDARR centers, an individual must be eligible for Medical Assistance, under age 21, a Rhode Island resident, live at home, and have a disabling or chronic condition that is cognitive, physical, developmental and/or psychiatric.[2] The Rhode Island Department of Human Services (DHS) oversees the four CEDARR centers.

Implementation Context

Rhode Island's two SPAs were developed in the context of several ongoing initiatives aimed at reforming the health system so as to increase care management, develop the medical home model, and integrate care for those who are dually eligible for Medicare and Medicaid, with particular focus on high-cost, high-need populations. The state has characterized the health homes model as an opportunity to improve an existing system of care, develop new payment methodologies to accommodate activities such as community-based care coordination, and provide a consistent system of care for children with special health care needs as they transition to adulthood.[3] An important aspect of Rhode Island's reform is the five-year Global Consumer Choice Compact Waiver approved by the Centers for Medicare and Medicaid Services (CMS) in early 2009, under which Rhode Island operates its entire Medicaid program. Among other things, the waiver has allowed the state to mandate enrollment in either capitated or fee-for-service (FFS) managed care. The state also is participating in the Multipayer Advanced Primary Care Practice (MAPCP) Demonstration, through which CMS provides a monthly care management fee for Medicare enrollees in advanced primary care practices.[4] In addition, the state has received a Money Follows the Person grant to support efforts to help institutional residents return to health and supportive care in community settings and is working with CMS to implement models for integrating Medicare and Medicaid services and financing for persons dually eligible for the two programs in capitated or FFS managed care.[5] As part of the integration plan, the state

is considering creating a Community Health Care Team to focus on long-term services and supports (LTSS) for FFS participants and incorporating managed LTSS into the service package for managed care participants.

CEDARR Family Centers were selected as health home providers based on their experience managing care for children and youth with special health care needs. The centers, established in 2000, currently coordinate care for roughly 2,700 children and youth at any given time. These centers are responsible for assessment of need, referral to resources, and the integration of services provided through different systems (education, Medicaid FFS, Medicaid managed care, child welfare), oversight of Medicaid FFS specialized home and community-based services, and reassessment and adjustment of treatment plans on an annual basis. CEDARR centers also provide direct services, such as home-based therapeutic services, personal assistance services and supports, KIDS CONNECT therapeutic day care, and respite services. About 95% of CEDARR clients meet health home diagnostic criteria.[3]

CMHOs, which were established in 1964 and served about 20,000 persons in 2010, also have experience with care integration. Two of the seven CMHOs designated as health home providers received the Substance Abuse and Mental Health Services Administration primary care/behavioral health integration grants in September 2010.[6] Health homes will build on this existing infrastructure, which includes community hospital contracts with CMHOs to conduct emergency psychiatric assessments in emergency departments, and long-term relationships between some CMHOs and local federally qualified health centers and primary care practices (e.g., co-location and formal integrated care agreements). CMHO services also include 24-hour crisis intervention and stabilization, medication prescription and management, bio-psychosocial assessment, psychotherapy, counseling, psychiatric evaluation, community psychiatric supportive treatment specific to substance abuse and supported employment, rehabilitative residence, substance abuse treatment, supported housing/residential services, and two levels of intensive community-based treatment.[7] Basic mental health and substance abuse services are provided through managed care organizations (MCOs) for those enrolled; more extensive services for enrollees with SPMI are available on a FFS basis.[8]

Rhode Island has multiple programs intended to better coordinate and manage care for high-risk populations, including those with disabilities. Under its Section 1115 Global Consumer Choice Compact Waiver, the state has not only continued its efforts to increase access to community-based supports and services and reduce institutional care--a process which was begun in 2006 under a Real Choice Systems Transformation Grant--but has also expanded the scope of its health system reform.[9] As of fall 2009, Rhode Island adults age 21 and older who qualify for Medical Assistance must enroll in either Connect Care Choice (CCC), a FFS-based primary care case management (PCCM) program, or a capitated Medicaid MCO through Rhody Health Partners (RHP), both of which were initiated in 2007.[10] Children with special health care needs living outside of institutional settings (which include the target population for the CEDARR-based health home program) must enroll in a RIte Care managed care plan (MCP).[11]

UnitedHealthcare of New England and Neighborhood Health Plan of Rhode Island are the two participating plans for both RIte Care and RHP. In late 2008, the state launched a pilot program known as the Chronic Care Sustainability Initiative (CSI) which is a PCCM program focused on patients who suffer from diabetes, depression, and/or coronary artery disease (CAD). In 2011, the program was accepted for participation in the three-year CMS MAPCP Demonstration.[12] These programs are described in greater detail in the table found in the Appendix.

Implications for the Rhode Island Section 2703 Medicaid Health Homes Evaluation

The initiatives described above demonstrate that the state has made significant efforts toward expanding care coordination and management in its health system, integrating health services with community support services, and in planning additional expansions and models. The health homes initiative provides a vehicle for further system development for two particularly high-need subsets of the Medicaid population. Under the state's Section 1115 Global Waiver both children with special health care needs and adults with disabilities have been required to enroll in managed care for their physical health care--RIte Care MCPs in the case of children and CCC or RHP in the case of adults. Although both CEDARR Family Centers and the SPMI providers have experience with various aspects of health home structures, there appear to be significant differences in the level of development between the CEDARR and SPMI providers, and among the designated SPMI providers themselves. The two SPAs differ significantly in terms of service definition, level of training required, payment structure, and evaluation measures. The range of additional demonstrations and plans for care integration the state is undertaking may have implications for the availability of comparison groups for the evaluation, particularly for adults in the CMHO health homes. However, state materials relating to these integration efforts suggest that there are adults with SPMI outside of CMHOs who may be appropriate as comparisons. On the other hand, the progress of these additional care integration efforts may affect the validity of comparisons over time and will need to be monitored over the evaluation period.

Health home-type services have been provided by CEDARR centers for a number of years. Therefore, it will be particularly important to clearly identify and describe the structures and processes that are in place at baseline, and to characterize the changes that providers make to these structures and processes as a consequence of becoming health homes. It will also be necessary to adjust the analysis for both the participants' and providers' time in program.

The picture is more complex for CMHOs and the two specialty providers because some sites appear to have more experience with care integration and coordination than others. All, however, will require more substantial reorganization and training than the CEDARR centers to meet health home requirements. As in the CEDARR center evaluation, it will be necessary to clearly delineate the existing structure and processes,

but it will also be important to document variations between mental health provider sites and how the state is addressing the variations. The baseline site visits will be a critical tool for filling in gaps in our understanding of both provider groups.

Population Criteria and Provider Infrastructure

Table 1 summarizes the population criteria, the designated providers, and requirements regarding the minimum composition of the health home team for both health home initiatives. In the rest of the discussion, we denote the initiative targeting persons with SPMI as the CMHO-HH, and the second targeting special needs children and youth as the CEDARR-HH. The CMHO-HH SPA lists additional eligibility criteria aside from diagnostic category that limit those eligible to enroll to a highly impaired subset who have mental or emotional disorders that seriously impair daily functioning, but for whom long-term 24-hour care may be averted.[13] The CEDARR-HH population is also fairly narrowly focused by virtue of the eligibility criteria for receiving CEDARR services. Children and youth are eligible for health home services if they have a mental health condition, two chronic conditions, or one chronic condition and the risk of developing another. The conditions are a mental health condition, asthma, diabetes, Down syndrome, a developmental disability, mental retardation, or a seizure disorder.

CMHOs and CEDARR Family Centers have varying experience with health home-type services and have care teams that reflect both the extent to which they are already providing health home-like services and the different needs of their respective beneficiary populations. The required health home team for CEDARR-HH includes only two members, a licensed clinician and a family service coordinator, who will share responsibility for the core health home services. The required team for CMHO-HH includes at least seven members with behavioral, clinical, or social support expertise. However, the CEDARR-HH SPA states that the centers employ both licensed health professionals and staff trained to provide health home-type services, and that the two-person team is expected to collaborate regularly with the child's primary care provider (PCP).

Service Definitions and Provider Standards

Rhode Island has established both overarching and provider-specific definitions for the six health home services. (A full list of these services is provided in Table 5.) Overall, the differences between the provider-specific definitions between the CMHO-HH and the CEDARR-HH reflect the different characteristics and needs of their respective patient populations. Thus, for example, care coordination, transitional care, and referral to support services at CEDARR-HHs would potentially involve school-based services, whereas CMHO-HH services generally would not. Similarly, CMHO-HHs will focus more than CEDARR-HHs on ensuring adequate housing, social integration and functioning, substance abuse treatment, and vocational training. The assignment of service provision within the teams is flexible; although each service is assigned to a

provider who will have primary responsibility, many services for both CEDARR-HH enrollees and CMHO-HH enrollees may be performed by various members or combination of members of the health home team.

The information provided in the SPAs suggests that practice transformation requirements for the two provider groups will be somewhat different. CEDARR Family Centers already meet established state certification standards, which will serve as the basis for health home qualification and will be changed as necessary to meet any additional health home requirements.[14] Additional requirements for health home status have been added as an Appendix to the CEDARR Family Center Recognition Standards and include the requirement that health homes agree to perform the 11 health home functions identified by CMS in the November 16, 2010, State Medicaid Director (SMD) Letter on Section 2703.[15] CEDARR-HHs must also agree to establish a protocol to gather, store, and transmit to the state all required reporting data as part of their quality improvement plan. Additional reporting requirements are listed in Table 2.

The requirements for CMHO-HHs are more extensive. (See Table 2 for a detailed list.) In addition to meeting state licensure requirements for being behavioral health centers, CMHOs must submit a proposal demonstrating how they will structure team composition and member roles to meet health home goals, a requirement that is not included for CEDARR teams. CMHOs must also sign a certificate of agreement that outlines their roles and responsibilities as health homes and that includes requirements related to care organization, transitional care arrangements with hospitals, progress reports, and state evaluations. CMHOs must also agree to participate in statewide learning activities, which will focus on training providers to perform the 11 health home functions identified by CMS in the November 2010 SMD letter. Community support specialists are specifically required to undergo a 17-week training designed to improve their clinical and case management skills.

Use of Health Information Technology

Rhode Island plans to phase-in health information technology (HIT) support to its health home providers and, in the interim, will rely on the existing infrastructure used by CEDARR Family Centers and the state Medicaid MCOs, which cover 60% of CEDARR-HH participants and 35% of eligible CMHO-HH participants. The state is working with the MCOs to develop utilization profiles covering the last 12 months, including the number of emergency department and urgent care visits, date and diagnosis of most recent emergency department visit, PCP and number of visits, prescription drug information, and behavioral health utilization. To the extent possible, the state will develop similar profiles from the Medicaid data warehouse and other applicable sources for the remaining FFS individuals. For CMHO-HH participants who are dually eligible for Medicare and Medicaid, the state will work closely with the CMS Center for Medicare and Medicaid Innovation to obtain Medicare utilization and cost data. The state will query CMHO providers about the use of HIT in the delivery of care coordination services and may establish pilot tests of a subset of providers (e.g., those with

electronic health records [EHRs] and patient registries) to measure changes in health outcomes, experience of care, and quality of care among clients. The Rhode Island Behavioral Health Online Dataset (RI-BHOLD) also is cited as the source for some clinical outcome data, but is not otherwise described in the SPA.

CEDARR-HHs use an existing electronic case management system, which can support linkages of information from medical and human service providers and school programs, and the Rhode Island KIDSNET Child Health Information System, which provides access to information such as blood lead levels, immunizations, newborn developmental assessment, hearing assessment, the Special Supplemental Nutrition Program for Women, Infants, and Children participation, and early intervention participation. CEDARR-HHs also will offer to enroll all clients into "CurrentCare," Rhode Island's electronic health information exchange.

Payment Structure

The two types of health homes will have very different payment structures. CMHO-HHs are paid on a monthly case rate basis, with the rate reflecting personnel costs and staffing ratios based on estimates of client need. The estimated staff needs, for a team serving 200 clients, is 11.25 full-time equivalent, or approximately nine staff hours per member per month (PMPM). CMHO-HHs are required to submit detailed encounter data to the state. After six months, and annually thereafter, the state will consider whether to adjust the case rate or consider alternate payment methodologies, based on analysis of program costs versus services received by recipients.

CEDARR-HHs are paid on a FFS basis. Three existing CEDARR activities, with established rates, are defined to be the "comprehensive care management" component of a health home. These are initial family intake and needs assessment, family care plan development following initial needs assessment, and annual family care plan review. Fixed rates for each of these three services are in the $350-$400 range. All the other health home services are mapped to two established CEDARR services: health needs coordination and therapeutic consultation. The skill mix associated with each health home service is specified in the SPA. Care coordination, comprehensive transitional care, individual and family support services, and referral to community and social support services are considered to be health needs coordination. Health promotion is considered to be therapeutic consultation. Payment rates per quarter hour for each type of professional are established hourly rates, and billing is by quarter-hour units of time actually spent on each service. There is no stated plan for revision of the payment system for CEDARR-HHs.

Quality Improvement Goals and Measures

There are five quality improvement goals for CEDARR-HHs and six for CMHO-HHs, summarized in Table 3 below, along with the quality measures that will be used.

There is little overlap in either the goals or the measures used, in part because of the very different participant populations for the two types of providers. Both SPAs list "improved care coordination" as the first goal, but the measures diverge, with CEDARR-HH measures focusing on physician consultations, use of Rhode Island KIDSNET, and communication with MCO PCPs, while those for CMHO-HHs focus on chart documentation of physical and behavioral health needs and post-hospitalization follow-up visits. Other goals are similar in concept, but have very different measures. For example, goals for CEDARR centers include "decrease occurrence of secondary conditions," "decrease ED use and preventable admissions," and "improve quality of transitions from inpatient/residential care to community," while CMHO goals include "increase use of preventive services," "reduce preventable ED use," and "improve transitions to CMHO care." There are only a few overlaps in measures (e.g., documentation of BMI and depression screening). Both patient groups will be surveyed on their satisfaction with service access and quality.

Data sources also vary, though both evaluations will use claims and encounter data as well as chart/record review and client surveys. The CEDARR data sources also will include KIDSNET, and CMHO data sources will include the Rhode Island Outcomes Evaluation Instrument, and RI-BHOLD.

Evaluation Measures and Methods

The evaluation measures and methodology described in the CMHO-HH and CEDARR-HH SPAs are reproduced in Table 4 and are different in both content and evaluation methodology for the two provider groups.

The CEDARR-HH evaluation strategy is limited to an entirely pre/post design for all data collected from practices and for cost savings estimates. Based on the detailed information provided for the cost savings estimation, the intent is to consider the "pre" period to be the single quarter preceding the effective date of October 1, 2011 (the first quarter of the state's fiscal year 2012), and the "post" period to be the eight subsequent quarters over which the enhanced federal match for health home services is in effect. No comparison group of beneficiaries or practices is specified. Hospital admission rates and length of stay, and the number of emergency department visits and skilled nursing facility admissions will be computed bi-annually.

The CMHO-HH strategy for evaluating chronic disease management, coordination of care, assessment of program implementation, and processes and lessons learned, and assessment of quality improvements and clinical outcomes, does not specify either a pre/post design or a comparison group, apparently relying on change over time after implementation. For hospital admission rates (to be measured per 1,000 member months), both a pre/post analysis of rates for CMHO-HH participants and a comparison with rates for clinically similar individuals not receiving CMHO-HH services are envisioned. It is not made clear whether the intent is to examine rates pre/post for both participants and comparison group, which is the preferred approach. For savings

estimations, the state proposes to estimate baseline total costs for Medicare and Medicaid beneficiaries who would have been eligible for CMHO health home services at any time during the fourth quarter of state fiscal year 2011 (April 2011-June 2011), presuming they can obtain appropriate Medicare claims data for dual eligible clients. Cost savings will be estimated annually by comparing those baseline estimates with costs for the same beneficiaries one year and two years later. Assessments also will include performance measures, which we interpret as the clinical outcome measures shown in Table 3, and targeted areas of cost in addition to total costs.

<table>
<tr><th colspan="3">TABLE 1. Target Population and Designated Providers--Rhode Island</th></tr>
<tr><th></th><th>SPA 1</th><th>SPA 2</th></tr>
<tr><td>SPA Approval (Effective Date)</td><td>November 23, 2011
(October 1, 2011)</td><td>November 23, 2011
(October 1, 2011)</td></tr>
<tr><td>Designated Provider(s)</td><td>CMHOs; 2 specialty mental health providers</td><td>CEDARR Family Centers</td></tr>
<tr><td>Health Home Team Composition</td><td>Required:
• Master's team coordinator
• Psychiatrist
• Registered nurse
• Master's level clinician
• Community psychiatric support and treatment (CPST) specialist
• CPST specialist/hospital liaison
• Peer specialist

Optional:
• PCP
• Pharmacist
• Substance abuse specialist
• Vocational specialist
• Community integration specialist</td><td>Required:
• Licensed clinician
• Family service coordinator

Optional:
• Other medical providers as necessary</td></tr>
<tr><td>Target Population and Qualifying Chronic Conditions</td><td>Beneficiaries must have SMI, be Medicaid eligible and:
1. Have either undergone psychiatric treatment more intensive than outpatient care more than once, experienced a single episode of continuous, supportive residential care other than hospitalization for at least 2 months, or have impaired role functioning.
2. Meet at least 2 of the following criteria, on a continuing or intermittent basis for at least 2 years:
– If employed, is employed in a sheltered setting, or has markedly limited skills or a poor work history.
– Requires public financial assistance for out-of-hospital maintenance and may be unable to procure such assistance without help.
– Shows inability to establish or maintain a personal social support system.
– Requires help in basic living skills.
– Exhibits inappropriate social behavior which results in demand for intervention by the mental health and/or judicial system</td><td>Beneficiaries must have:
• 2 chronic conditions
• 1 chronic condition and the risk of developing another
• SPMI

Qualifying chronic conditions include:
• Mental health condition
• Asthma
• Diabetes
• Developmental disability
• Down syndrome
• Mental retardation
• Seizure disorder</td></tr>
</table>

TABLE 2. Provider Qualifications--Rhode Island
CEDARR Qualifications
• Agree to perform the 11 health home functions identified by CMS in the November 10 SMD Letter. • Establish a protocol to gather, store and transmit to the state all required reporting data. • Perform yearly outreach to the child's PCP and Medicaid MCP (if applicable). • Perform yearly Body Mass Index (BMI) Screening for all children 6 years of age or older. If this is not clinically indicated, reason must be documented. • Perform documented yearly depression screening for all children 12 years of age or older. If this is not clinically indicated, reason must be documented. • Conduct a yearly review of immunizations, screenings and other clinical information contained in the KIDSNET Child Health Information System.
CMHO Qualifications
1. Each CMHO health home provider must sign a certification agreement that outlines CMHO's roles and responsibilities, which will minimally require: • Have psychiatrists/nurse specialists assigned to the health home team, and available 24/7 for all services that address whole-person needs;. • Conduct wellness interventions as indicated based on individuals' level of risk. • Agree to participate in any statewide learning sessions that may be implemented for health home providers. • Within 3 months of health home service implementation, have developed a contract or memorandum of understanding with regional hospitals or system(s) to ensure a formalized structure for transitional care planning, as well as maintain a collaboration to identify individuals seeking emergency department services that might benefit from connection with a CMHO health home provider. • Agree to convene internal health home team meetings with all relevant providers to plan and implement practice transformation. • Agree to participate in CMS and state-required evaluation activities. • Agree to develop required reports describing CMHO health home activities, efforts and progress in implementing health home services. • Maintain compliance with all of the terms and conditions as a CMHO health home provider or face termination as a provider of those services. 2. Each CMHO health home must develop and submit to BHDDH for approval its approach for conducting health home services. Proposals must include: • An overview of the provider's health home approach (e.g., discussion of a care management model, etc.). • A description of the health team, including team member roles and functions. • Local hospitals with which the CMHO health home will establish transitional care agreements. • A description of the health home's processes for integrating physical and behavioral health care, including coordinating care with PCP. • A list of primary care practices with which the CMHO will develop referral agreements. • An overview of how each of the 6 health home service components will be carried out by the CMHO health home, and, if applicable: – A description of the provider's use of EHRs or patient registries; – A description of the providers use of HIT to support care management (e.g., care management software); – A list and description of quality measures currently collected and tracked by the CMHO, and, if applicable; – An overview of embedded or collected primary care services delivered at the CMHO health home provider. Community support professionals will also undergo a 17-week Community Support Professional Certification Training Program funded by BHDDH and administered by the Rhode Island Council of Community Mental Health Organizations (RICCMHO).

TABLE 3. Health Home Goals and Quality Measures--Rhode Island	
Shared Goal: Improve Care Coordination	
CEDARR	Clinical outcome measures: • Percent of physician consultation claims to the number of care plans developed and renewed • Number of hits on the KIDSNET Child Health Information System per 1,000 enrollees • Percent of MCO enrollees with outreach to MCO documented in the CEDARR record Experience of care measures: • Satisfaction with services, accessibility of services, availability of services • Percent of initial assessment appointment dates offered within 30 days of request • Percent of care plans completed within 30 days of completion of the initial assessment • Percent of care plans reviews completed prior to expiration of current care plan Quality of care measures: • Percent of clients who have adequate or higher level of knowledge of condition • Percent of clients who indicate having a high level of stress caused by condition(s)
CMHO	Clinical outcome measures: • Percent of patients whose chart includes documentation of physical and behavioral health needs • Percent of hospital-discharged patients with a follow-up visit within 14 days of hospital discharge Experience of care measures: • Percent of patients with a regular source of health care • Percent of patients who had a physical exam in the past 12 months Quality of care measures: • Percent of hospital-discharged patients contacted by the health home team by phone or in person within 2 days of discharge
CEDARR Goals	
Improve Health Outcomes of Children and Youth with Special Health Care Needs	Clinical outcome measures: • Percent of clients who indicate having adequate or higher level of knowledge of condition • Number of referrals to community-based resources per member per year Experience of care measures: • Satisfaction with services, accessibility of services, availability of services • Percent of community-based service treatment plans reviewed within 30 days of submission to the health home Quality of care measures: • Percent of clients who indicate having a high level of stress caused by condition(s) • Parent/guardian self-rating of child's ability to take part in age appropriate community and social activities
Decrease the Occurrence of Secondary Conditions	Clinical outcome measures: • Yearly BMI is calculated for all clients 6 years of age and older with documented intervention if <85th percentile • Yearly screening for depression for all clients 12 years of age or above Experience of care measures: • Satisfaction with services, accessibility of services, availability of services Quality of care measures: • Reduction of clients with a BMI >85th percentile • Clients who screened positive for depression who received further treatment or evaluation

<table>
<tr><th colspan="2">TABLE 3 (continued)</th></tr>
<tr><td colspan="2">CEDARR Goals (continued)</td></tr>
<tr><td>Decrease Emergency Department and Inpatient Treatment for Ambulatory Sensitive Conditions (ASCs)</td><td><u>Clinical outcome measures</u>:
• Percent of patients with 1 or more emergency department visits for any conditions appearing in a state-defined list of diagnoses that can be treated in a nonemergency department setting
• Percent of patients with 1 or more admissions for any conditions appearing in a state list of diagnoses that can be avoided through preventive care

<u>Experience of care measures</u>:
• Satisfaction with care, accessibility of care

<u>Quality of care measures</u>:
• Medical follow-up within 7 days of ASC admission
• Medical follow-up within 7 days of ASC emergency department visit</td></tr>
<tr><td>Improve the Quality of Transitions from Inpatient/Residential Care to Community</td><td><u>Clinical outcome measures</u>:
• Percent of discharges for admissions >7 days in length with active participation of health home staff
• Percent of discharges for admissions >7 days in length who are contacted by health home staff within 7 days of discharge
• Percent of clients re-admitted or utilizing emergency department within 30 days of discharge with same diagnosis as admission

<u>Experience of care measures</u>:
• Satisfaction with care, accessibility of care

<u>Quality of care measures</u>:
• Percent of clients with nonpsychiatric admissions within 30 days of hospital discharge
• Percent of clients with a psychiatric admission within 30 days of psychiatric hospital discharge</td></tr>
<tr><td colspan="2">CMHO Goals</td></tr>
<tr><td>Reduce Preventable Emergency Department Visits</td><td><u>Clinical outcome measures</u>:
• Percent of patients with 1 or more emergency department visits for any conditions named in the New York University emergency department methodology
• Percent of patients with 1 or more emergency department visits for a mental health condition

<u>Experience of care measures</u>:
• Satisfaction with care, accessibility of care

<u>Quality of care measures</u>:
• Percent of hospital-discharged patients contacted by the health home team by phone or in person within 2 days of discharge</td></tr>
<tr><td>Reduce Hospital Readmissions</td><td><u>Clinical outcome measures</u>:
• Hospitalization rate for conditions where appropriate ambulatory care prevents or reduces the need for admission, per 100,000 under age 75
• Number of acute inpatient stays followed by all-cause readmission within 30 days and the predicted probability of an acute readmission

<u>Experience of care measures</u>:
• Satisfaction with care, accessibility of care

<u>Quality of care measures</u>:
• Percent of hospital-discharged patients with a follow-up visit to a CMHO or medical provider within 14 days of hospital discharge
• Percent of hospital-discharged patients contacted by health home team member by phone or in person within 2 days of discharge</td></tr>
</table>

TABLE 3 (*continued*)	
CMHO Goals (*continued*)	
Increase Use of Preventive Services	Clinical outcome measures: • Percent of patients who report that they smoke • Percent of patients who report using illicit substances or abusing alcohol • Percent of members 18-74 years of age who had an outpatient visit and who had their BMI documented • Age and gender appropriate use of pap test, mammogram, and colonoscopy, using HEDIS specifications Experience of care measures: • Percent of patients who are satisfied with their access to outpatient services and with the quality of those services Quality of care measures: • Percent of patients aged 18 years and older screened for clinical depression using a standardized tool AND follow-up documented • Percent of members with a new episode of alcohol or other drug (AOD) dependence who received initiation or engagement of AOD treatment • Percent of patients having 1 or more well-visits/physical examination visits in 12 month period • Percent of smokers counseled and referred for smoking cessation • Percent of drug/alcohol abusers counseled and referred to drug/alcohol treatment
Improve Management of Chronic Conditions	Clinical outcome measures: • Percent of patients with diabetes (type 1 or type 2) who had HbA1c <8.0% • Percent of patients identified as having persistent asthma and were appropriately prescribed controller medication • Percent of patients with a diagnosis of hypertension who have been seen for at least 2 office visits, with blood pressure controlled at <140/90 • Percent of patients diagnosed with CAD with lipid level adequately controlled (LDL <100) Quality of care measures: • Percent of patients who are adherent to prescription medications for asthma and/or chronic obstructive lung disease • Percent of patients who are adherent to medication--cardiovascular disease and anti-hypertensive medication • Percent of patients using a statin medication who have a history of CAD
Improve Transitions to CMHO Services	Clinical outcome measures: • Percent of discharges for members 6 years of age and older who were hospitalized for selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge Experience of care measures: • Percent of patients satisfied with their access to outpatient services and with the quality of those services Quality of care measures: • Percent of hospital-discharged patients contacted by health home team member by phone or in person within 2 days of discharge • Percent of patients discharged from inpatient facility for whom a transition record was transmitted to health home for follow-up care within 24 hours

TABLE 4. Evaluation Methodology--Rhode Island		
	CEDARR-HH	**CMHO-HH**
Hospital Admission Rates	Comparison of claims and encounter data pre/post-implementation of health homes.	The state will consolidate data from its Medicaid data warehouse which contains both FSS claims and managed care encounter data, to assess general and psychiatric hospital readmission rates of CMHO health home service users. The state will calculate readmissions per 1,000 member months among CMHO users. The state will track pre/post-hospital readmission rates among health home participants. Rates will also be compared with clinically similar individuals not receiving CMHO health home services.
Chronic Disease Management	Comparison of claims and encounter data pre/post-implementation of health homes.	For new individuals of CMHO health home services, the state will track hospital referrals and/or hospital liaison encounters as well as track face-to-face follow-up by a health team member within 2 days after hospitalization discharge. The state will also monitor the number of referrals/post-discharge follow-up contacts that resulted in the development of a care plan.
Coordination of Care for Individuals with Chronic Conditions	Comparison of claims and encounter data pre/post-implementation of health homes.	The state will monitor updates to RI-BHOLD to track changes in psychiatric diagnoses, determine individuals' difficulty with Axis N diagnoses (e.g., housing problems, problems with access to health care services) and track individuals' self-reported co-occurring physical health conditions.
Assessment of Program Implementation	Comparison of claims and encounter data pre/post-implementation of health homes.	The state will monitor implementation through processes developed for regularly occurring meetings of DHS, BHDDH, RICCMHO, MCOs and PCCMs.
Processes and Lessons Learned	CEDARR-HH survey to be developed.	The state and RICCMHO will develop tools to elicit feedback from CMHOs to understand any operational barriers of implementing CMHO health home services.
Assessment of Quality Improvements and Clinical Outcomes	Comparison of quarterly and annual data pre/post-implementation of health homes. The state will utilize quality process and outcome measures described in the prior section to assess quality improvements and clinical outcomes.	
Estimates of Cost Savings	The state will analyze Medicaid and Medicare claims cost and utilization data in order to conduct the cost savings methodology. 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 fourth quarter of state fiscal year 2011 (April 2011-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 1 year and 2 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.	

TABLE 5. Health Home Service Definitions--Rhode Island	
Comprehensive Care Management	
Overarching State Definition	Comprehensive care management services are conducted with an individual and involve the identification, development, and implementation care plan that addresses the needs of the whole-person. Family/peer supports can also be included in the process. The service involves the development of a care plan based on the completion of an assessment. A particular emphasis is the use of the multidisciplinary team including medical personnel who may or may not be directly employed by the provider of the health home. The recipient of comprehensive care management is an individual with complex physical and behavioral health needs.
CEDARR Definition	Comprehensive care management is provided by CEDARR health homes by working with the child and family to: assess current circumstances and presenting issues, identify continuing needs, and identify resources and/or services to assist the child and family to address their needs through the provision of an Initial Family Intake and Needs Determination; develop a Family Care (or Treatment) Plan which will include child specific goals, treatment interventions and meaningful functional outcomes; and regular review and revision of the Family Care Plan to determine efficacy of interventions and emerging needs. Integral to this service is ongoing communication and collaboration between the CEDARR health homes team and the clients PCP/medical home MCO, behavioral health and institutional/long-term care providers. This service will be performed by the licensed clinician with the support of the family service coordinator.
CMHO Definition	Comprehensive care management services are conducted with beneficiaries, their families and supporters to develop and implement a whole-person oriented treatment plan and monitor the individual's success in engaging in treatment and supports. Comprehensive care management services are carried out through use of a bio-psychosocial assessment of each individual's physical and psychological status and social functioning. The assessment determines an individual's various needs and expectations, and may be conducted by a psychiatrist, registered nurse or a licensed and/or master's prepared mental health professional. Based on the bio-psychological assessment, a goal-oriented, person-centered care plan is developed, implemented and monitored by a multidisciplinary team in conjunction with the individual served. Comprehensive care management services may be provided by any member of the CMHO health home team; however, Master's Level Health Home Team Coordinators will be the primary practitioners providing comprehensive care management services.
Care Coordination	
Overarching State Definition	Care coordination is the implementation of the treatment plan developed to guide comprehensive care management in a manner that is flexible and meets the need of the individual receiving services. The goal is to ensure that all services are coordinated across provider settings, which may include medical, social and, when age appropriate, vocational educational services. Services must be coordinated and information must be centralized and readily available to all team members. Changes in any aspect of an individual's health must be noted, shared with the team, and used to change the care plan as necessary. All relevant Information is to be obtained and reviewed by the team.

TABLE 5 (*continued*)	
Care Coordination (*continued*)	
CEDARR 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 includes: • Follow-up with family, providers, and others involved in the child's care to ensure the efficient provision of services. • Provide information to families about specific disorders, treatment and provider options, systems of support, services, assistance and legal rights available, and resources beyond the scope of services covered by Medicaid, such as those which may be available from other parents, family members, community-based organizations, school-based services, etc. • Service delivery oversight and coordination to ensure that services are being delivered in a satisfactory manner. • Assistance in locating and arranging specialty evaluations as needed, in coordination with the child's PCP. This also includes follow-up and ongoing consultation with the evaluator as needed. This service will be performed by the licensed clinician or the family service coordinator depending on the exact nature of the activity.
CMHO Definition	Care coordination is the implementation of the individualized treatment plan (with active involvement of the individual served) for attainment of the individuals' goals and improvement of chronic conditions. Care 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. • Coordinating with other providers to monitor individuals' health status, medical conditions, medications and side effects. Care coordination services may be provided by any member of the CMHO health home team; however, CPST Specialists will be the primary practitioners providing care coordination services.
Health Promotion	
Overarching State Definition	Health promotion services encourage and support healthy ideas and concepts to motivate individuals to adopt healthy behaviors. The services also enable individuals to self-manage their health.
CEDARR Definition	Health Promotion assists children and families in implementing the Family Care Plan and in developing the skills and confidence to independently identify, seek out and access resources that will assist in managing and mitigating the child's condition(s), preventing the development of secondary or other chronic conditions, addressing family and child engagement, promoting optimal physical and behavioral health, and addressing and encouraging activities related to health and wellness. This service will include the provision of health education, information, and resources with an emphasis on resources easily available in the families' community and peer group(s). This service will be performed by the licensed clinician.

TABLE 5 (*continued*)	
Health Promotion (*continued*)	
CMHO 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**. Health promotion services may be provided by any member of the CMHO health home team. Health promotion activities place a strong emphasis on self-direction and skills development for monitoring and management of chronic health conditions. Health promotion assists individuals to take a self-directed approach to health through the provision of health education. Specific health promotion services may include, but are not limited to, providing or coordinating assistance with: • Promoting individuals' health and ensuring that all personal health goals are included in person-centered care plans. • Promotion of substance abuse prevention, smoking prevention and cessation, nutritional counseling, obesity reduction, and increased physical activity. • Providing health education to individuals and family members about chronic conditions. • Providing prevention education to individuals and family members about health screening and immunizations. • Providing **self-management** support and development of self-management plans and/or relapse prevention plans so that individuals can attain personal health goals. • Promoting **self-direction** and skill development in the area of independent administering of medication. Health promotion services may be provided by any member of the CMHO health home team; however, psychiatrists and nurses will be the primary practitioners providing health promotion services.
Comprehensive Transitional Care	
Overarching State Definition	Comprehensive transitional care services focus on the movement of individuals from any medical/psychiatric inpatient or other out-of-home setting into a community setting, and between different service delivery models. Members of the health team work closely with the individual to transition the individual smoothly back into the community and share information with the discharging organization in order to prevent any gaps in treatment that could result in a readmission.
CEDARR Definition	Transitional care will be provided by the CEDARR health homes team to both existing clients who have been hospitalized or placed in other noncommunity settings as well as newly identified clients who are entering the community. The CEDARR health homes team will collaborate with all parties involved including the facility, PCP, health plan (if enrolled) and community providers to ensure a smooth discharge into the community and prevent subsequent readmission(s). Transitional care is not limited to Institutional transitions but applies to all transitions that will occur throughout the development of the child and includes transition from early intervention into **school-based services** and pediatric services to adult services. This service will be performed by the licensed clinician with the support of the family service coordinator.

TABLE 5 (*continued*)	
Comprehensive Transitional Care (*continued*)	
CMHO Definition	Comprehensive transitional care services focus on the transition of individuals from any medical, psychiatric, long-term care or other out-of-home setting into a community setting. Designated members of the health home team work closely with the individual to transition the individual smoothly back into the community and share information with the discharging organization in order to prevent any gaps in treatment that could result in a readmission. To facilitate timely and effective transitions from inpatient and long-term settings to the community, all health home providers will maintain collaborative relationships with hospital emergency departments, psychiatric units of local hospitals, long-term care and other applicable settings. In addition, all health home providers will utilize hospital liaisons to assist in the discharge planning of individuals, existing CMHO clients and new referrals, from inpatient settings to CMHOs. Care coordination may also occur when transitioning an individual from a **jail/prison setting** into the community. Hospital liaisons, community support professionals and other designated members of the team may provide transitional care services. The team member collaborates with physicians, nurses, social workers, discharge planners and pharmacists within the hospital setting to ensure that a treatment plan has been developed and works with family members and community providers to ensure that the treatment plan is communicated, adhered to and modified as appropriate. Comprehensive transitional care services may be provided by any member of the CMHO health home team; however, hospital liaisons will be the primary practitioners providing comprehensive transitional care services.
Individual and Family Support Services	
Overarching State Definition	Individual and family support services assist individuals to accessing services that will reduce barriers to treatment and improve health outcomes. Family involvement may vary based on the age, ability, and needs of each individual. Support services may include advocacy, information, navigation of the treatment system, and the development of self-management skills.
CEDARR Definition	The CEDARR health homes team is responsible for providing assistance to the family in accessing and coordinating services. These services include the full range of services that impact on children with special health care needs and include, but are not limited to, health, behavioral health, education, substance abuse, **juvenile justice** and social and **family support** services. The CEDARR health homes team will actively integrate the full range of services into a comprehensive program of care. At the family's request, the CEDARR team can play the principal role as organizer, information source, guide, advocate, and facilitator for the family by helping the family to assess strengths and needs, identify treatment goals and services, and navigate agency and system boundaries. This service will be performed by the licensed clinician or the family service coordinator depending on the exact nature of the activity.
CMHO Definition	Individual and family support services are provided by community support professionals and other members of the health team to reduce barriers to individuals' care coordination, increase skills and engagement and improve health outcomes. Individual and family support services may include, but are not limited to: • Providing assistance in accessing needed **self-help** and peer support services. • Advocacy for individuals and families. • Assisting individuals to identify and develop **social support networks**. • Assistance with **medication** and treatment management and adherence. • Identifying resources that will help individuals and their families reduce barriers to their highest level of health and success. • Connection to peer advocacy groups, wellness centers, the National Alliance on Mental Illness (NAMI) and family psycho-educational programs. Individual and family support services may be provided by any member of the CMHO health home team; however, CPST Specialists will be the primary practitioners providing individual and family support services.
Referral to Community and Social Support Services	
Overarching State Definition	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.

TABLE 5 (*continued*)	
Referral to Community and Social Support Services (*continued*)	
CEDARR Definition	Referral to Community and Social Support Services will be provided by members of the CEDARR health homes team and will include information about formal and informal resources beyond the scope of services covered by Medicaid, such as those which may be available from **other parents, family members, community-based organizations**, service providers, grants, social programs, funding options, school-based services, faith-based organizations, etc. Whenever possible, families will be informed of opportunities and supports that are closest to home, that are the least restrictive and that promote integration in the home and community. Members of the CEDARR Health Homes Team will emphasize the use of informal, natural community supports as a primary strategy to assist children and families. This service will be performed by the licensed clinician or the family service coordinator depending on the exact nature of the activity.
CMHO Definition	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: • PCPs 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, Mental Health Consumer Advocates of Rhode Island (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. • 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. CPST Specialists will be the primary practitioners providing referrals to community and social support.

APPENDIX: Pre-Existing Initiatives in Rhode Island		
	CCC/RHP	**CSI**
Timeline	The programs were implemented in September 2007; now include all Medicaid beneficiaries.	Pilot began in October 2008, and the initiative is currently operating as part of the 3-year CMS MAPCP Demonstration program.
Geographic Area	Statewide	Statewide
Sponsors	State	Center for Health Care Strategies provided a grant to the Rhode Island Office of the Health Insurance Commissioner for the pilot; the program is now part of the Medicare MAPCP demonstration.
Scope	• Both the CCC and RHP programs serve Rhode Island adults age 21 and older who qualify for Medicaid and are not covered by Medicare or private insurance.[16] • CCC participants enroll in a PCP, which provides case management services, and have access to all specialists who accept Medicaid FFS payments.[16] • RHP participants enroll in a capitated managed care health plan, which provides all care, except for a few services (e.g., dental care) that continue to be covered on a FFS basis.[17]	• The medical home multi-payer pilot program in Rhode Island covered 76% of the states' residents who have health insurance at implementation. • The acceptance of the program into the CMS MAPCP Demonstration added Medicare as a payer and increased eligibility to 98% of insured residents. • The pilot aims to cover Rhode Island residents who suffer from diabetes, depression, and/or CAD.[18] • Originally began with 5 primary care practices, but in April 2010 an additional 8 sites were included in the pilot. • By October 2010 there were 13 sites, 55 providers, 46,000 lives, and 28 Family Medicine residents were participating in the pilot.[19]
Goals	• The CCC program is intended to improve access to primary care, provide links to social services, enable more coordinated care, and facilitate improvement in self-managed care.[16] • RHP has the goal of improving access to care, the quality of care, and health outcomes while containing costs.[20]	• To align the quality improvement and financial incentives to provide better and more efficient primary care for people who suffer from chronic illnesses. • To prioritize the "whole-person" approach to medicine by more effectively coordinating care and integrating community supports with the beneficiary's personal physician team.[18] • Enhance payment to PCPs so they are able to achieve recognition as medical homes and provide high-quality chronic illness care.[18]

APPENDIX (*continued*)			
	CCC/RHP		CSI
Payment Approach	CCC: • Participating practices receive monthly care coordination fees, which are adjusted to account for time spent caring for patients with complex health care needs. • Practices that care for moderate to high-risk CCC members and employ a nurse care manager receive an additional \$35-\$40 PMPM.[12]	RHP: • Medicaid contracts with private plans to provide managed health care. • Participating plans are UnitedHealthcare of New England and Neighborhood Health Plan of Rhode Island.[17]	• The payment structure is effectively enhanced FFS, with capitated payment (PMPM) and support for services in kind.[18] • Medicaid MCOs, PCCM, and FFS programs pay \$3 PMPM, and health plans supply funding for nurse care managers who work at each practice. • Participating practices receive a PMPM care coordination fee, and receive subsidies for hiring on-site nurse care manager.[12] • Purchasers include Care New England and Lifespan, 2 of the largest private sector employers, Rhode Island Medicaid, state employees--health benefits program, Rhode Island Business Group on Health.[18]
Technical Assistance (TA)	No information found		• Training is provided by the Rhode Island Department of Health and Rhode Island Quality Improvement organization, which also has technical experts whom practices may contact for assistance.[21] • Assistance includes on-site practice assistance, statewide learning sessions, mentoring, monthly best practice sharing meetings, nurse care manager training, and sponsorship at national conferences.[21]
HIT Use	No information found		Some medical homes are receiving HIT support through the Beacon Community program, as well as ongoing data feedback. It is unclear how many of the pilot sites are receiving this support, however.

APPENDIX (*continued*)		
	CCC/RHP	**CSI**
Evaluation Methods	• Externally funded third-party evaluations will track several key clinical measures focusing on cost, return on investment, quality improvements, and patient/provider satisfaction. • An evaluation of Rhode Island's Global Consumer Choice Compact Waiver included CCC and RHP.[9] • Analyses included a comparison of expenditures for FFS and CCC/RHP programs and changes in medical care service utilization. • The report concludes that managed care programs were cost-effective and improved access to physician services.	• Practices report clinical quality data each quarter, which are shared with other demonstration practices, health insurance providers involved in the pilot, convening organizations, practice transformation consultants, and a stakeholder coalition.[19] • The practices provide clinical quality data related to treatment for diabetes, CAD, and depression, while health plans are reporting inpatient hospitalization and emergency department use to practices.[19] • Claims data will be utilized to assess clinical quality, patient experience, provider experience, cost and quality measures.[21] • Data on provider experience and satisfaction will be collected from interviews and surveys of providers, and patient satisfaction will be measured through a patient experience survey upon the pilot's completion.[19] • Evaluators from the Harvard School of Public Health will collect qualitative data to assess the process of practice transformation, the changes in patient outcomes, and the patient experiences of care.[12]

Endnotes

1. Rhode Island Council of Community Mental Health Organizations. "Building a Recovery-Oriented, Integrated System of Care for Persons with Serious Mental Illness: Rhode Island's Proposal for Medicaid Health Homes." Presentation to IACP, February 2012. Available from: http://nationalblockgrantconference.com/presentations/2011/Elizabeth%20Earls.pdf. Accessed April 4, 2012.

2. Rhode Island Department of Health and Human Services website. "CEDARR Family Centers." Available from: http://www.dhs.ri.gov/ChildrenwithSpecialNeeds/CEDARRFamilyCenters/tabid/795/Default.aspx.

3. Rhode Island Health Home Initiative. "Presentation to the RI Global Waiver Task Force by Paul Choquette, RI Executive Office of Health and Human Services (EOHHS)." December 19, 2011. Available from: http://www.eohhs.ri.gov/documents/documents11/Health_Homes_Initiative_presentation.pdf. Accessed December 4, 2012.

4. CMS Innovations Center. "Advanced Primary Care Initiative." Presentation. Available from: http://www.innovations.cms.gov/Files/slides/Comprehensive-Primary-Care-Initiative-Open-Door-Forum-Slides.pdf. Accessed December 4, 2012.

5. Rhode Island Executive Office of Health and Human Services. "CMS Proposal to Integrate Care for Medicare and Medicaid Beneficiaries." Available from: http://www.eohhs.ri.gov/documents/documents12/CMS_Demonstration_Proposal_042612.pdf. Accessed December 4, 2012.

6. Substance Abuse and Mental Health Services Administration. "HHS Awards $26.2 million to Expand Primary Care to Individuals with Behavioral Health Disorders." News release, September 24, 2010. Available from: http://www.samhsa.gov/newsroom/advisories/1009245435.aspx. Accessed December 4, 2012.

7. Rhode Island Executive Office of Health and Human Services. "Final Operational Protocols for Collaboration Between Health Plans and Health Homes." Available from: http://www.chcs.org/usr_doc/Health_Home-MCO_protocols_FINAL_090111.pdf. Accessed December 4, 2012.

8. Substance Abuse and Mental Health Services Administration. "State Profiles of Mental Health and Substance Abuse Services in Medicaid: Rhode Island." Data as of July 2003. Available from: http://store.samhsa.gov/shin/content//NMH05-0202/NMH05-0202-RI.pdf. Accessed December 4, 2012.

9. Lewin Group. "An Independent Evaluation of Rhode Island's Global Waiver." December 6, 2011. Available from: http://www.ohhs.ri.gov/documents/documents11/Lewin_report_12_6_11.pdf. Accessed December 4, 2012.

10. Rhode Island Department of Human Services website. Available from: http://www.dhs.ri.gov/AdultswithDisabilities/HealthMedicalServices/MedicalAssistanceFeeForService/tabid/350/Default.aspx.

11. Rhode Island Department of Human Services website. Available from: http://www.dhs.ri.gov/Portals/0/Uploads/Documents/Public/Children%20w%20Spec%20Needs/CSHCN_enroll_hp_FAQ.pdf.

12. National Association for State Health Policy website. Available from: http://www.nashp.org/med-home-states/rhode-island.

13. According to information on the Rhode Island BHDDH website, these criteria plus the additional requirements shown in Table 1 are the eligibility criteria for receiving community support services, defined as case management services and supportive assistance to individuals in order to attain the goals of their behavioral health treatment plan, as well as access to medical, social, educational and other services essential to meeting basic human needs. Available from: http://www.bhddh.ri.gov/MH/eligibility.php, http://www.bhddh.ri.gov/MH/description.php.

14. The certification standards are available from: http://www.dhs.ri.gov/Portals/0/Uploads/Documents/Public/Children%20w%20Spec%20Needs/CEDARR_cert_stds.pdf.

15. Centers for Medicare and Medicaid Services. "Health Homes for Enrollees with Chronic Conditions." State Medicaid Director Letter #10-024. Available from: http://www.cms.gov/smdl/downloads/SMD10024.pdf.

16. Rhode Island Department of Human Services. "Connect Care Choice Fact Sheet." Available from: http://www.dhs.ri.gov/Portals/0/Uploads/Documents/Public/ConnectCareChoice/ccc_fact_sheet.pdf.

17. Rhode Island Department of Human Services. "Rhody Health Partners Fact Sheet." Available from: http://www.dhs.ri.gov/Portals/0/Uploads/Documents/Public/Rhody%20Health%20Partners/rhp_fact_sheet.pdf.

18. Office of the Health Insurance Commissioner. "CSI Rhode Island: The Chronic Care Sustainability Initiative." Available from: http://www.ohic.ri.gov/documents/Committees/CSI%201st%20annual%20forum/1_Genesis%20of%20the%20RI%20Chronic%20Care%20Sustainability%20Initiative.pdf.

19. Patient-Centered Primary Care Collaborative website. Available from: http://www.pcpcc.net/pilot/rhode-island-chronic-care-sustainability-initiative. Accessed December 4, 2012.

20. See http://www.eohhs.ri.gov/documents/documents11/2011_performance_goal_program_10_27_11_final.pdf.

21. Patient-Centered Primary Care Collaborative. "Patient-Centered Medical Home: Building Evidence and Momentum." 2008. Available from: http://www.pcpcc.net/content/pcpcc_pilot_report.pdf.

This paper is an attachment to the U.S. Department of Health and Human Services (HHS), Office of the Assistant Secretary for Planning and Evaluation (ASPE) report "***Evaluation of the Medicaid Health Home Option for Beneficiaries with Chronic Conditions: Annual Report - Year Two***". The full report is available at: http://aspe.hhs.gov/daltcp/reports/2014/HHOption2.cfm.

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EVALUATION OF THE MEDICAID HEALTH HOME OPTION FOR BENEFICIARIES WITH CHRONIC CONDITIONS:
Annual Report - Year Two

Files Available for This Report

Full Report (including state appendices)
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