

**ATTACHMENT H - Accountable Entities Certification Standards – Comprehensive AE  
(Program Year 3)**

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## **I. Certification Standards Overview and Purpose**

This Accountable Entity (AE) Certification Standards Document was submitted by the RI EOHHS, as the single state Medicaid agency in Rhode Island, to CMS for review and approval in accordance with Special Term and Condition (STC) 43 of the Rhode Island Comprehensive 1115 Demonstration Waiver. The purpose of this document is to formalize the Certification Standards for Accountable Entities. Interested parties are invited to submit applications for certification and participation in the program. The issuance of AE Certification Standards, as well as the application and approval process, through the various stages, is managed directly by EOHHS.

The AE Certification standards and the corresponding application and approval process are intended to promote the development of new forms of organization, care integration, payment, and accountability. Successful organizations are multi-disciplinary in composition, interdisciplinary in practice and focused on population health, with programs tailored to address varying levels and types of needs. Participants are demonstrably engaged in a common enterprise with incentives to work together to do a better job meeting the needs of attributed populations. There is a strong emphasis on integration of behavioral health and social determinants of health.

Certification standards may be updated annually, and modifications may be required during implementation to ensure that best practices and lessons that are learned throughout implementation can be leveraged and incorporated into the program design. Any such revisions shall be formally posted on the EOHHS website and shall allow for a 30-day public comment period prior to implementation.

## II. Background and Context

The Rhode Island Executive Office of Health and Human Services (EOHHS), is implementing the RI Medicaid Accountable Entity (AE) Program **through its contracted Medicaid Managed Care Organizations (MCOs)**. This program is intended to break through the financing and delivery system disconnects, to build partnerships across payment systems, delivery systems and medical/social support systems that effectively align financial incentives and quality to more effectively meet the real life needs of individuals and their families.

EOHHS intends for Certified AEs to be the central platform for transforming the structure of the delivery system as envisioned in the Final Report of the Reinventing Medicaid Working Group that was convened by Governor Raimondo in March of 2015. The core objectives of the AE program include:

- Substantially transition away from fee-for-service models
- Define Medicaid-wide population health targets, and, where possible, tie them to payments
- Maintain and expand on our record of excellence in delivering high quality care
- Deliver coordinated, accountable care for high-cost/high-need populations
- Ensure access to high-quality primary care
- Shift Medicaid expenditures from high-cost institutional settings to community-based settings

Certified Accountable Entities are responsible for coordinating a full continuum of health care services for defined populations. An effective AE must be able to meet the needs of the full population but must also have distinct competencies to recognize and address the special needs of high risk and “rising risk” sub groups. Applicants who are designated as “Certified” will immediately be eligible to enter into a contractual arrangement with the Medicaid MCOs to manage a population of Medicaid members under a total cost of care arrangement.

EOHHS recognizes that potential applicants may have differing stages of readiness. To that end AEs are certified annually, and EOHHS recognizes that most AEs will be **“Certified with Conditions”**. Deficiencies need to be addressed in accordance with an agreed upon project plan for the AE to continue to be eligible for incentive funds. AEs who demonstrate that all the domain requirements are fully met are designated as “Fully Certified”.

**Certified Accountable Entities who commit to the AE Program requirements are eligible to participate in the Medicaid Infrastructure Incentive Program**, which is intended to support Accountable Entities in building the capacity – the processes and technology -- required for effective system transformation.

Note that EOHHS does not contract directly with Certified Accountable Entities. The intent of the designation of Certified AEs is to provide program requirements for the Medicaid MCOs, as they transition to value-based purchasing models and accountable care. As such, these requirements are reflected in EOHHS arrangements with the Medicaid Managed Care organizations.

### **Certification Period and Continued Compliance with Certification Standards**

Certification is on an annual basis, in compliance with CMS requirements. AEs are required to comply with all standards and requirements throughout the certification period. A certified AE is to provide notification to EOHHS of any potential changes that may impact performance or represent material modifications to the AE in relation to their certification and associated approval for participation in the AE program (e.g. change in ownership; change in contracted status with a MCO; change in the AE's legal or financial status such as but not limited to changes due to a merger, acquisition, or any other change in legal status; withdrawal or change in legal status of key partners; requests to add additional partners, or other material change.) Upon notice, and with reasonable opportunity for the AE to address identified deficiencies, EOHHS reserves the right to suspend or terminate certification.

The AE shall not assign or transfer any right, interest, or obligation under this certification to any successor entity or other entity without the prior written consent of EOHHS.

### **III. Public Input Process**

The process for developing these Certification Standards includes substantive public input. EOHHS recognizes the value of ongoing stakeholder engagement, collaboration and consensus building and is committed to ensuring a transparent and open public process. EOHHS has and will continue to meet with stakeholders, including MCOs and Accountable Entities, providers, and other community and advocacy groups to receive comments/feedback on upcoming guidance documents.

### **IV. Certification Standards: Comprehensive Accountable Entity**

EOHHS' expectation is that the AE shall be structured and organized to assure its commitment to the objectives and requirements of an EOHHS certified Accountable Entity and demonstrate its ability to provide care for each population it proposes to serve. Applicants are required to identify the populations they propose to serve – children, adults, or both. Certification by EOHHS is based on the qualifications to meet requirements for each population.

#### **Summary of Domains for Certification:**

1. Breadth and Characteristics of Participating Providers<sup>1</sup>
2. Corporate Structure and Governance
3. Leadership and Management
4. IT Infrastructure – Data Analytic Capacity and Deployment
5. Commitment to Population Health and System Transformation
6. Integrated Care Management
7. Member Engagement and Access
8. Quality Management

Within each of the domains considerable attention is given to the integration of activities focused on behavioral health and social determinants of health. AEs are expected to work directly with partner organizations to address both needs within a care plan.

For each requirement, applicants must either demonstrate specific compliance or identify how they will achieve compliance and a timeline for doing so. In the several domains for certification, the AE is expected to demonstrate the ability to address the requirements. It is not necessarily the case the AE will itself have that capacity. For example, the performance requirements may be partially met by an engaged partner, such as an MCO. EOHHS application

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<sup>1</sup> Participating Providers are all providers within an AE network including but not limited to medical, behavioral health and social service providers.

will demonstrate an effective and robust partnership between the AE and MCO to leverage the capabilities that each brings to the relationship and to avoid duplication.

A major objective of this initiative is that participants can define methods of care for people with high-end needs, including co-occurring chronic conditions, and persons with co-occurring physical and behavioral health needs. A certified AE must be able to recognize and address high risk and rising risk individuals and improve care at points of transition from higher levels of care to mild levels of care.

## 1. Breadth and Characteristics of Participating Providers

An AE needs to have a critical mass of providers that are inter-disciplinary with core expertise/direct service capacity in primary care and in behavioral health, inclusive of substance use services. The AE further needs to demonstrate defined relationships with providers of social services.

For each population (children and/or adults) that is to be attributed to the AE, the applicant must demonstrate that it has the capability to address and coordinate the needs of populations at all levels and the ability to coordinate and direct a significant portion of care for those populations. AEs should not only have a strong foundation in primary care but also be able to effectively coordinate care beyond the scope of primary medical care. An application needs to identify participating behavioral health and social service partners and the role and expectation of such organizations as provider partners in the AE delivery system. Total costs of care calculations are based on the full range of benefits and services included within EOHHS's contract with managed care organizations. Note, for reference, Appendix A provides excerpts from the contracts between EOHHS and the MCOs that describe the scope of benefits covered within the managed care contracts, including required areas of behavioral health services coverage for children and adults.

Primary care (PCP) capacity is evidenced through health services provided by a Rhode Island licensed, board-certified, or board eligible general practitioner, family practitioner, pediatrician or internal medicine physician, primary care geriatrician or through a licensed Advanced Practice Certified Nurse Practitioner, and/or Physician Assistant. Such clinicians shall have demonstrated core expertise in primary care and will serve as the member's initial and critical point of interaction. PCP responsibilities must include at a minimum:

- ❖ Serving as the member's Primary Care Provider (PCP) and medical home
- ❖ Willing and able to provide the level of care and range of services necessary to address the medical and behavioral needs of members, including those members with chronic conditions
- ❖ Provide overall clinical direction and serve as the central point for the integration and coordination of care
- ❖ Make and track referrals for specialty care, other medically necessary services, and services to address social determinants of health.

Whether located directly in the primary care provider setting or through direct coordination with arrangements made with or by the AE entity, the primary care provider shall also have the demonstrated capacity to provide integrated care management, particularly for complex need individuals, through nurse care manager or other specified care management support.

Mental Health and Substance Use Disorder (Behavioral health (BH) capacity must be demonstrated through evidence of Provider Partnerships with BH Service providers. The AE's governance structure should include a representative from a community-based licensed behavioral health provider.

Behavioral health capacity shall be commensurate with the size and needs of the attributed population and based on a geographic analysis conducted by the AE. An AE may identify specific gaps and needs in care that inform the enhancement and referral arrangements of their AE network. BH service capacity shall include, through direct service provision or through established relationships with other providers, the ability to ensure that a broad range of treatment options representing a continuum of care is available to members of each population for which certification is sought (children, adults, older adults, perinatal and postpartum women etc.).

Direct service capacity within the AE shall be evidenced by the participation of Rhode Island licensed providers. This can include programs licensed by the Office of Facilities and Program Standards within the R.I. Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH) for the provision of services to individuals who are developmentally disabled and/or experiencing a mental health and/or substance use disorder and can include programs licensed by the Department of Children, Youth, and Families.

AEs serving individuals 16 years of age and older adults at risk for or diagnosed with an opioid use disorder must make available community-based treatment utilizing all federally approved Medication Assisted Therapies, Opioid Treatment Program (OTP) Health Homes and American Society of Addiction Medicine (ASAM) levels 3.1, 3.3, 3.5 and 3.7 of SUD residential treatment. These programs are provided by organizations licensed by BHDDH. Direct services for substance use treatment can also be demonstrated through the participation of treatment providers licensed by the Rhode Island Department of Health who are permitted to practice and bill Medicare or Medicaid autonomously, whether in a private practice or in association with a private agency or institution. Direct service capacity can also be demonstrated through the participation of Licensed Chemical Dependency Professionals who are permitted to practice under approved licensed provider agencies.

AEs serving individuals with or at risk for having a serious mental illness (SMI) or serious and persistent mental illness (SPMI) must ensure that Assertive Community Treatment (ACT) and Integrated Health Home (IHH) services are available to their members directly or through a Provider Partnership with a Community Mental Health Center (CMHC). CMHCs are licensed by BHDDH. Direct service capacity can also be demonstrated through the participation of BH providers who are licensed by the Rhode Island Department of Health and who are permitted to practice and bill Medicare or Medicaid autonomously, whether in private practice or in

association with a private agency or institution. This can include but is not limited to licensed psychologists, psychiatrists, licensed psychiatric nurses, and licensed mental health counselors (LMHC), licensed marriage and family therapists (LMFT), and licensed independent clinical social workers (LICSW). Approved licensed provider agencies may expand their BH capacity through clinical supervision to a defined staff of BH practitioners not otherwise licensed to perform at the independent level.

Physical and behavioral health providers are responsible for forming and maintaining partnerships to ensure overall wellness of AE members. In addition, BH practitioners will adhere to guidelines that incorporate dignity and worth of the individuals served, cultural awareness, diversity, as well as the individual's right to self-determination. Practitioners must adhere to Rhode Island General Law including Mental Health Law Chapter 40.1-5.

Social determinants capacity – Social factors can play crucial roles in the health status and health outcomes. These include unstable housing, food insecurity, and exposure to safety risks and domestic violence, as well as many other factors. These examples raise stress levels, impact the progression of health conditions, impact one's ability to mitigate health risks, or to access basic health care. A core feature of the AE initiative is to advance the systematic integration of social determinants of health into an individuals' total care. The applicant must identify three key domains of social need for each population for which certification is being sought (children, adults) and identify arrangements in place for the provision of pertinent services. EOHHS identifies two priority domains that would be expected areas of attention. However, based on the needs of the population served, an AE may propose different areas of focus for consideration. The two priority domains identified by EOHHS are:

- Housing Insecurity
- Food insecurity

Services to help mitigate these needs can take a variety of forms (e.g. tenant/landlord mediation; legal supports; assisting members to access related services that they are entitled to, employment supports, other).

Social determinants capacity shall be evidenced by the participation of providers of pertinent social supports within the AE. This may be through defined relationships with community-based organizations or through in-house social supports capacity within a single entity AE. It is not required that an AE be able to provide the full range of social supports that may be appropriate to meet the needs of the attributed population. An AE may demonstrate in-house capacity and/or defined affiliations and working arrangements with Community-Based Organization (CBOs) that fill in the gaps, such as Health Equity Zone participants, to address identified social contexts impacting health and outcomes.

## **1.1. Provider Base**

- 1.1.1. Critical Mass for attribution. For the purposes of these certification standards provider is differentiated from individual clinicians and is defined as a corporate entity with an identifiable tax identification number for services to patients based on the work of individual clinicians working with or for the corporate entity.

1.1.1.1. Attribution: A comprehensive AE must have a base attributable Medicaid population of 5,000 members in accordance with EOHHS Total Cost of Care requirements.

1.1.2. Population specific AE application: Delineation of capacity by population served: Children, adults

1.1.2.1 Population specific primary care and behavioral health capacity to serve children, including adequate pediatricians, family practice clinicians, and advanced nurse practitioners, physician assistants, and pediatric behavioral health providers.

1.1.2.2 Population specific primary care and behavioral health capacity to serve adults, including adequate internists, family practice clinicians, primary care geriatricians, and/or APRNs/PAs and adult behavioral health providers.

1.1.2.3 Population specific substance use service capacity

1.1.2.4 Population specific social determinants service capacity

AEs will identify social determinants for the populations they serve. AEs will identify three critical areas of need for social supports for each population served and have defined in-house capacity and/or defined relationships with providers of social supports to address those needs. For illustration, the community-based services that can have critical impacts in promoting improved health outcomes may include the following:

- Housing stabilization and support services
- Housing search and placement;
- Utility assistance;
- Food security;
- Support for attributed members who have experienced violence.

AEs may identify other areas deemed to be of critical impact. Note that incentive funds through the HSTP program are available to help strengthen these relationships.

## **1.2. Relationship of Providers to the AE**

1.2.1. Certification that all AE participating providers have agreed to participate in, and be accountable for health care transformation efforts, as set forth in these certification standards, including use of a total cost of care based Alternative Payment Methodology, in accordance with EOHHS APM requirements.

1.2.2. Description of types of member providers and clinicians and their relationship to the Entity: Note that clinicians employed by a participating provider entity are by definition deemed to be participating in, and accountable for health care transformation efforts of their employer.

1.2.2.1. Providers (primary care, behavioral health, and community based) are the core organizational and corporate partners in the AE, with voting rights on the AE Board of Directors, who participate in shared savings, movement to risk, participate in written mutual requirements and protocols for collaborative practice (e.g. data sharing, care management) to promote and support integrated care, as applicable.

1.2.2.2. Primary care providers are recognized providers in attribution methodologies. Although not necessarily represented as voting

members of the AE, PCPs provide the direct core capacity the AE brings to the organization of care, have meaningful direct and contractually defined participation in shared savings arrangements and progression to risk, and participate in written mutual requirements and protocols for collaborative practice (e.g. data sharing, care management) to promote and support integrated care.

- 1.2.2.3. Most specialty and community-based providers have established referral and working relationships with AE but do not provide a basis for attribution. These include, but are limited to, arrangements to fulfill the “breadth of provider base” requirements related to providers of behavioral health, substance use services, or social supports to address social determinants of health. Relationships with such providers are essential to demonstrate the ability to coordinate care for the full continuum of needs for attributed populations, particularly rising and high-risk individuals. Depending on the nature of the agreement between the parties the AE may or may not have shared savings or incentive arrangements with those providers.

### **1.3. Ability to coordinate for All Levels of Need for any Attributed population**

- 1.3.1. Demonstrate that the AE can meet all AE requirements to deliver the full continuum of needs for attributed populations by either providing services directly or through accountable care management to ensure smooth transitions. (For reference, see Attachment A)
  - 1.3.1.1. Physical Health: service delivery/coordination capacity beyond the scope of PCP medical care, including specialty and inpatient care.
  - 1.3.1.2. Behavioral Health: meet preventive, routine, and high-end behavioral health needs.
  - 1.3.1.3. Integrated PH/BH: Evidence of direct participation of identified working relationships with a full continuum of BH providers as shown in Attachment A, including recognized CMHO providers
  - 1.3.1.4. Integrated SUD treatment, across the spectrum of need including opioid addiction services
  - 1.3.1.5. Social Determinants: Community Health Team and/or Social Service Organization (SSO) CBO partner addressing targeted social determinant area (e.g. focus on housing/housing security).
- 1.3.2. Develop and implement agreed upon protocols that guide the interaction between providers across the continuum of care and to integrate care delivery.

### **1.4. Defined Methods to Care for People with Complex Needs**

- 1.4.1. Ability to identify and address rising risk, high risk populations
- 1.4.2. Improve care at points of transition from low to intensive levels of care
- 1.4.3. Ability to work effectively at key points of life transition or impact, as appropriate for the population served, such as discharge from corrections, engagement with DCYF protective custody, risk of loss of housing, homelessness, substance use, domestic violence/sexual violence
- 1.4.4. Ability to care for people with co-occurring chronic conditions, especially BH

**1.5. Able to Ensure Timely Access to Care**

Minimally - Able to Demonstrate Compliance with all pertinent MCO Access requirements, as specified in the MCO contract and documented below

1.5.1. Assuring timely (within 30 minutes) after-hours phone access

1.5.1.1. Minimum Access Standards:

<i>Appointment</i>	<i>Access Standard</i>
After Hours Care Contact (Telephone, text, email)	24 hours 7 days a week
Urgent Care Appointment	Within 24 hours
Routine Care Appointment	Within 30 calendar days
New Member Appointment	30 calendar days
Physical Exam	180 calendar days
EPSDT appointment	Within 6 weeks
Non-emergent, non-urgent mental health or substance use condition	Within ten (10) business days for diagnosis or treatment

**2. Corporate Structure and Governance**

A fundamental EOHHS objective is to develop a new type of organization in Rhode Island Medicaid to promote a population health focused and person-centered system of care. Such an organization must meet a core set of corporate requirements set forth in these requirements. The intent of these requirements include: (1) To ensure multi-disciplinary providers are actively engaged in a shared enterprise and have a stake in both financial opportunities and decision-making of the organization; (2) to ensure that assets and resources intended to support RI Medicaid are appropriately allocated, protected, and retained in Rhode Island; (3) to ensure that the mission and goals of the new entity align with the goals of EOHHS and the needs of the Medicaid population; (4) to ensure a structured means of accountability to the population served.

A qualified AE applicant must demonstrate its ability to meet the requirements of these certification standards including corporate structure and governance. A qualified applicant must be a legal entity incorporated within Rhode Island and with a federal tax identification number. The AE applicant may be formed by two or more entities joining together for the purpose of forming an AE, or it may be a single entity that includes all required capabilities of an AE.

If two or more parties form the AE applicant, it must be a distinct corporation and meet all the requirements for corporate structure and governance. It must have an identifiable governing body with authority to execute the functions and make final decisions on behalf of the AE. The governing body must be separate and unique to the AE and must not be the same as the governing body of any other entity participating in the AE.

If the applicant is a single entity the AE's board of directors may be the same as that of the single entity. However, the single entity applicant must establish a Governing Committee with distinct obligations and authorities in management of the AE program. The composition of the Governing Committee must include participation of various constituencies as set forth below. The Governing Committee must have authority to make binding decisions regarding the distribution of any shared savings or losses to providers (primary, behavioral health & social service), or other contracted parties, as applicable.

Whether the applicant is a single-entity or a multiple entity AE:

- There shall be an established means for shared governance that provides all AE Providers participating in savings and/or risk arrangements with an appropriate, meaningful proportionate participation in the AE's decision-making processes. The structure of the AE must ensure that Governing Board or Governing Committee members have shared and aligned incentives to drive efficiencies, improve health outcomes, work together to manage and coordinate care for Medicaid beneficiaries, and share in savings and in risk.
- The AE must have a mission statement that aligns with EOHHS goals – a focus on population health, a commitment to an integrated and accountable system of care, a primary concern for the health outcomes of attributed members, the progressive use of outcome-based metrics, and particular concern for those with the most complex set of medical, behavioral health, and social needs.
- Governing Board of Directors or Governing Committee shall meet regularly, not less than quarterly

These requirements are further defined in sections 2.1 -2.4. For each requirement, new applicants must either demonstrate specific compliance or propose an approach and timeline not to exceed nine months from the date of provisional certification to come into full compliance.

## **2.1 Multiple and Single Entity Applicants**

- 2.1.1. By-Laws/ charter that sets forth Membership on the Board of Directors with voting rights that is inclusive of the minimum requirements set forth by EOHHS
- 2.1.2. Inclusion of Board Level Governing Committees with a distinct focus on Medicaid, and inclusive of an Integrated Care Committee, a Quality Oversight Committee, and a Finance Committee
- 2.1.3. Include quarterly progress dashboards to monitor quality and cost effectiveness to support the MCO's and AE's ability to monitor and improve performance.
- 2.1.4. A Compliance Officer with an unimpeded line of communication with the Board and who is not the legal counsel for the Board
- 2.1.5. Community Advisory Committee (CAC)
  - 2.1.5.1. CAC consisting of at least four persons who are attributed Medicaid beneficiaries or who are appropriate family representatives of those beneficiaries and who are representative of the populations served by the AE.
  - 2.1.5.2. CAC shall include at least one representative from a Health Equity Zone organization
- 2.1.6. Fiduciary and Administrative Responsibility Resides with BOD.

- 2.1.6.1. The AE’s administration must report exclusively to the governing Board through the AE’s chief executive officer
- 2.1.7. Defined conflict of interest provisions that
  - 2.1.7.1. Require each member of the governing body, sub-committees, employees and consultants to disclose relevant financial interests
  - 2.1.7.2. Provide a procedure to determine whether a conflict of interest exists and set forth a process to address any conflicts that arise.
  - 2.1.7.3. Address remedial action for members of the governing body that fail to comply with the policy

**2.2. Governing Board or Governing Committee Members: Inter-Disciplinary Partners Joined in a Common Enterprise**

**2.2.1. Core Premises**

Shared governance provides all AE participants with an appropriate, meaningful proportionate control over the AE’s decision-making processes, including oversight of the quality of the AE’s services to attributed members, providing guidance in decisions related to program design and implementation, and with authority to make binding decisions regarding the distribution of any shared savings or losses to Providers (primary care, behavioral health, and social service) or other contracted partners, as applicable.

- 2.2.1.1. Multi-disciplinary in composition and inter-disciplinary in practice.
- 2.2.1.2. Defined, transparent structure ensuring partners have shared and aligned incentives
- 2.2.1.3. Leverage strengths of partners toward an integrated person-centered system of care

**2.2.2. Board or Governing Committee Membership**

- 2.2.2.1. Most voting members of the Board or the Governing Committee shall be primary care providers (i.e. representatives appointed by the respective provider) behavioral health providers (i.e. representatives appointed by the respective provider) from participating provider organizations, provided that at least three members shall be primary care providers and three members shall be behavioral health providers. The meaning of the term provider is as set forth in Section 1.1.1
- 2.2.2.2. Minimal representation requirements, for each population certified to serve
  - 2.2.2.2.1. **Children:** Pediatric primary care provider, Pediatric BH provider, Pediatric representative member of Consumer Advisory Committee, CBO provider of age appropriate social supports (i.e. representatives appointed by the respective provider)
  - 2.2.2.2.2. **Adults:** Internal Medicine primary care provider, Adult BH provider, Adult representative member of Consumer Advisory Committee, CBO provider of age appropriate social supports (i.e. representatives appointed by the respective provider)

### **2.3. Compliance**

- 2.3.1. Provisions for assuring compliance with State, Federal law re: Medicaid, Medicare.
- 2.3.2. Policies and Procedures related to debarred providers, discrimination, protection of privacy, use of electronic records.
- 2.3.3. Policies and procedures for compliance with anti-trust rules and regulations
- 2.3.4. AE compliance program includes a designated compliance official who is not legal counsel and a mechanism to identify and address compliance problems including fraud, waste, and abuse.
- 2.3.5. Compliance Officer. A single entity AE may use an existing Corporate Compliance Officer in this role provided that the Compliance Officer's scope of activities includes compliance with AE program requirements and at least twice annual reporting to the Governing Body/Committee.

### **2.4. Required - an Executed Contract with a Medicaid Managed Care Organization**

- 2.4.1. Required for attribution, shared savings/risk contract, and to be eligible for Health System Transformation Program (HSTP) incentive funds.
- 2.4.2. Comport with EOHHS defined delegation rules re: AE/MCO distribution of functions.

## **3. Leadership and Management**

### **3.1. Leadership Structure**

There must be a single, unified vision and leadership structure, with commitment of senior leaders, backed by the required resources to implement and support the vision. The AE shall describe how its current structure meets these requirements or set forth a defined plan with fixed dates and deliverables as to how compliance will be progressively achieved. This includes:

- 3.1.1. For a multiple or single entity AE, a Chief Executive and/or a Medicaid AE Program Director responsible to the BOD and for AE operations.
- 3.1.2. Management structure/staffing profile describing how the various component parts of the AE will be integrated into a coordinated system of care. This may include specific management services agreements with MCOs or subcontracts under the direction of the AE. Pertinent areas include:
  - 3.1.2.1. Integrated Care Management
  - 3.1.2.2. IT Infrastructure/Data Analytics
  - 3.1.2.3. Quality Assurance and Tracking
  - 3.1.2.4. Finance - Description of infrastructure for
    - 3.1.2.4.1. Unified financial leadership and systems
    - 3.1.2.4.2. Financial modeling capabilities and indicators
    - 3.1.2.4.3. Designing incentives that encourage coordinated, effective, efficient care
- 3.1.3. Defined approach to manage care under a total cost of care (TCOC) approach. Total cost of care calculation is based on the full scope of benefits that are included within the MCO contract with EOHHS. Although the AE may not have direct

responsibility for providing that full scope of services, it must have a defined, disciplined approach for impacting the total scope of services needed by attributed members.

- 3.1.4. In addition to general program certification requirements, certification of AEs entering into downside risk contracts with MCOs will additionally be required to obtain a Risk Bearing Provider Organization certification from the Office of the Health Insurance Commissioner. Such OHIC certification will require AEs to document how they plan to cover downside losses and demonstrate the financial capacity to bear an estimated amount of downside risk.

## 4. IT Infrastructure – Data Analytic Capacity and Deployment

IT infrastructure and data analytic capabilities are widely recognized as critical to effective AE performance. The high performing AE must make use of comprehensive health assessment and evidence-based decision support systems based on complete patient information and clinical data across life domains. This data will be used to inform and facilitate Integrated Care Management across disciplines, including strategies to address social determinants of health care.

It is not necessary that an AE use limited resources to independently invest in and develop “big data” capabilities. There are many efforts underway in Rhode Island to standardize data collection and take advantage of emerging technologies, to build all payer data systems, to enable access to an up-to-date comprehensive clinical care record across providers (e.g. CurrentCare & IMAT), and to forge system connections that go beyond traditional medical claims and eligibility systems (e.g. SNAP, homelessness, census tract data on such factors as poverty level, percent of adults who are unemployed, percent of people over age 25 without a high school degree). MCOs have long established administrative claims data and eligibility files. **As such, many of these required capacities and capabilities might best be achieved in partnerships with MCOs and others to avoid duplicative infrastructure.**

A successful AE will be able to draw upon and integrate multiple information sources that use validated and credible analytic profiling tools to conduct regular risk stratification/predictive modeling to segment the population into risk groups and to identify those beneficiaries who would benefit most from care coordination and management. The goal of analytical tools is to define processes to advance population health, to support risk segmentation to better target efforts to rising risk and high-risk groups, to critical points of transition, to strengthen clinical practice, to promote evidence-based care, to report on quality and cost measures, and to better coordinate care.

### 4.1. Core Data Infrastructure and Provider and Patient Portals

- 4.1.1. Able to receive, collect, integrate, utilize person specific clinical and health status information.
  - 4.1.1.1. Able to ensure data quality, completeness, consistency of fields, definitions
  - 4.1.1.2. EHR capacity: Ability to share information with providers and partner organizations.

- 4.1.1.2.1. Achieve “State 2 Meaningful Use” requirements based on CMS EHR Incentive program or equivalent standard subject to EOHHS approval. Use EHR systems to document medical, behavioral, and social needs in one common medical record that can be shared across the network within HIPAA guidelines. Complies with enhanced certification standards or EHRs promoted through CMS EHR incentive Payment Program that require EHRs to capture clinical data necessary for quality measurement as part of care delivery and calculate and report electronic clinical quality for all patients treated by individual providers.
- 4.1.1.3. Patient registries – shared patient lists (e.g. PCP, BH provider, Care management) to ensure providers are aware of patient engagements.
- 4.1.1.4. Demonstrate that at least 60% of AE patients are enrolled in CurrentCare and/or document a plan to increase CurrentCare enrollment.
- 4.1.1.5. 4.1.1.4 AE provider participants must contribute data from their EHRs to CurrentCare (AE office-based providers will send encounter data in a Clinical Care Document Format (CCD) via “Direct” secure messages). AE provider participants must have the ability to receive data from CurrentCare or CurrentCare enrolled patients in at least one of the following ways: Through bi-directional interfaces with CurrentCare, or where RIQI and AE provider participants’ EHR vendor capacity exists, ensure staff have appropriate access to CurrentCare viewer or CurrentCare data within their EHR.

#### **4.2. Using Data Analytics for Population Segmentation, Risk stratification, Predictive Modeling**

Able to draw upon and integrate multiple information sources to conduct regular risk stratification/predictive modeling to segment the population into risk groups, identify the specific people that will benefit the most from care coordination and management. Such tools should incorporate social risk factors. (e.g. housing, family supports into risk profiling, by population)

- 4.2.1. Identified methodology and tools for attributed member risk stratification:
  - Highest complexity, rising/imminent risk groups
- 4.2.2. By population groups included in certification: Children, adults,
- 4.2.3. Incorporating social determinants (e.g. housing, family support systems) into risk profiling, by population
- 4.2.4. Able to identify the use of validated, effective, credible tools for analytic profiling

#### **4.3. Reshaping workflows by Deploying Analytic Tools – Business Process Support Systems & Metrics**

Development of defined strategic focus on the AE processes and outcomes that impact costs.

- 4.3.1. Defined set of business process metrics meaningfully targeted to both operational and total cost of care efficiency.
- 4.3.2. Actions to Enhance Ability to Manage Care processes. Reshaping workflows for: availability and access, high impact interventions, reduce variance in quality/outcomes
- 4.3.3. Defined tools in place for tracking and monitoring level of performance in meeting contact and follow up objectives in implementation of the care model; established protocols for review of performance and feedback loops for quality improvement.

#### **4.4. Integrating Analytic work with Clinical Care and Care Management Processes**

- 4.4.1. HIT tools to provide clinical decision support to providers to help ensure they follow the evidence-based care pathways
- 4.4.2. Define processes to promote evidence-based medicine, report on quality and cost measures, and coordinate care.
- 4.4.3. Provision of actionable information to providers within the system
  - 4.4.3.1. Analysis of gaps, needs, risks based on evidence-based practice. Gaps in care reports based on deviations from evidence-based practice.
  - 4.4.3.2. To help enhance, help direct care coordination/care management. E.g. medication management.
- 4.4.4. Early warning system
  - Established methods to alert, engage the care management team to critical changes in utilization. Alerted before bearing the full burden of costs.
  - 4.4.4.1. Employ a Care Management Dashboard (real time dashboard of patient-admissions and discharges to EDs and hospitals)
  - 4.4.4.2. Employ Care Management Alerts (ADT notification via direct messaging of ED and hospital admissions and discharges)

#### **4.5. Staff Development – Training**

- 4.5.1. Training in, and expectation for, using data systems effectively, using data to manage patients care.
- 4.5.2. Ongoing aggregate reporting with individual/team drill-downs re: Conformance with accepted standards of care, deviations from best practice, identified breakdowns in process

### **5. Commitment to Population Health and System Transformation**

Defined, integrated strategic plan for population health that sets out its theory of action as to how the entity proposes to organize resources and actions to impact care and health outcomes for attributed populations. Central to the AE is progression to a systematic population health model that works to improve the health status of the entire attributed population while systematically segmenting subpopulation risk groups with complex needs in order to implement focused strategies to improve their health status. An effective system recognizes interrelated conditions and factors that influence the health of populations over the life course, identifies systematic variations in their patterns of occurrence, and develops a road map to address social determinants

of health based on recognized best practices locally and nationally. Along with clinical and claims data, the entity identifies population needs in collaboration with state and local agencies using publicly available data to develop a plan.

## **5.1. Key Population Health Elements**

An applicant will describe its approach to population health management inclusive of the following:

- 5.1.1. Population Based
- 5.1.2. Data driven
- 5.1.3. Evidence based
- 5.1.4. Client centered: Strength based individual and family support
- 5.1.5. Recognizes/Addresses the determinants of health. Creates programmatic interventions by sub-population.
- 5.1.6. Team based, including Care management and care coordination, effectively manages transitions of care, Community Health Workers as integral partners
- 5.1.7. Integration of BH and PH/primary care, including the identification of modifiable, non-modifiable risk factors for poor behavioral health outcomes.

## **5.2. Social Determinants of Health**

5.2.1. Recognizes and seeks methods to approach key social determinants of health. These can include social factors such as housing, food security, safety, transportation, and domestic violence.

5.2.2. Population Health and SDOH Assessment

Evaluate the social needs of their members and take actions to maximize the degree that Attributed Members receive appropriate care and follow-up based on their identified social needs.

5.2.2.1. Together with partner MCOs, develop, implement, and maintain procedures for completing an initial SDOH Care Needs Screening for Attributed Members based on a defined protocol. The protocol shall identify what triggers a screening and may be based on such factors as diagnosis, care utilization pattern or patient self-identification. Procedures shall address approach to completing an initial SDOH Care Needs Screening for persons with a primary care visit.

5.2.2.2. The SDOH Care Needs Screening shall be an instrument defined by the AE and reviewed by EOHHS. The screening shall evaluate Attributed Members' health-related social needs in order to determine the need for social service intervention. Such services shall include but not be limited to:

- Housing stabilization and support services;
- Housing search and placement;
- Food security;
- Support for Attributed Members who have experience of violence.
- Utility assistance;

- 5.2.2.3. Evaluate Attributed Members' SDOH screening needs through regular analysis of available claims, encounter, & clinical data on diagnoses and patterns of care, in partnership with participating MCOs;
  - 5.2.2.4. Develop reporting or claiming mechanism to allow social needs diagnostic codes to be provided to MCO.
- 5.2.3. Tracking and Follow-up Referrals. Ensure that Attributed Members receive warm-transfers for appropriate care and follow-up based on their identified SDOH needs. May be done in direct coordination with MCOs.
- 5.2.3.1. Develop a standard protocol for referral for social needs using evidence and experience-based learning and for tracking referrals and follow-up. Social needs assistance shall include:
    - Referring to providers, social service agencies, or other community-based organizations that address the Attributed Member's needs
    - Providing support to maximize successful referrals, which may include:
      - Actions to maximize the outcome that the Member attends the referred appointment or activity, including activities such as coordinating transportation assistance & following up after missed appointments;
      - The Attributed Member's PCP or care team member communicating and sharing records with the provider being referred to, as appropriate to coordinate care;
      - The Attributed Member's PCP or care team member directly introduces the Attributed Member to the service provider, if co-located, during a medical visit (i.e., a "warm hand-off");
      - Providing information and navigation to the Attributed Member regarding community providers of social services that address the Attributed Member's health-related social needs, as appropriate;
      - Providing the Attributed Member with information and counseling about available options; and
      - Coordinating with community providers of social services to improve integration of care.

- 5.2.3.2. AE should have a documented plan for the tracking and reporting of referrals for social needs to MCO. The plan should include:
  - Standardized protocol for referral to social service provider
  - Methods for tracking referrals
  - Development of metrics to define a successful referral
  - Development of reporting of metrics and referral information to MCO

### **5.3. System Transformation and the Healthcare Workforce**

In consideration of the essential role that AEs will play in RI's health system transformation, AEs will be expected to partner with EOHHS, DLT, URI, RI College, CCRI, and other education and training providers to support RI's workforce transformation efforts. Such efforts shall include, but not be limited to, the following activities:

- 5.3.1. Healthcare workforce transformation planning
  - 5.3.1.1. Participate on EOHHS, DLT, or other committees as requested to provide ongoing assessment of healthcare workforce transformation needs and strategies.
  - 5.3.1.2. Participate in periodic employer surveys of healthcare workforce development needs and opportunities
- 5.3.2. Healthcare workforce transformation programming
  - 5.3.2.1. Collaborate with URI, RIC, CCRI and/or other education and training providers to assist in educational planning, curriculum development, instruction, clinical training, research, and/or other educational activities related to healthcare workforce transformation.
  - 5.3.2.2. Develop partnerships with URI, RIC, CCRI and/or other education and training providers to expand clinical rotations and/or internships to prepare health professional students with knowledge and skills needed to achieve RI's health system transformation goals.
  - 5.3.2.3. Develop partnerships with URI, RIC, CCRI and/or other education and training providers to expand continuing education for current employees of AE partners to acquire the knowledge and skills needed to achieve RI's health system transformation goals.
  - 5.3.2.4. Develop partnerships with secondary schools, public workforce development agencies, and/or community-based organizations to develop career pathways that prepare culturally and linguistically-diverse students and adults for entry level jobs leading to career advancement in health-related employment.

## **6. Integrated Care Management**

The AE shall create an organizational approach to care integration and document such approach in a plan that defines a strategy to integrate person-centered medical, behavioral, and social services for individuals at risk for poor outcomes and avoidable high costs. The integration approach will be developed in collaboration with providers across the care continuum and

incorporate evidence-based strategies into practice. An effective AE must have a systematic process to target the top 1% - 5% most complex patients in each relevant subpopulation for care management and support. The AE will have tools to systematically track and coordinate care across specialty care, facility-based care and community organizations. The AE will also demonstrate the ability to rapidly and effectively respond to changes in a condition with interventions and care plan refinements as needed to enable such individuals to remain in the community. Such entities shall demonstrate protocols and/or defined strategies to work collaboratively with providers across the continuum of services.

An AE should have a care coordination team with specialized expertise pertinent to the characteristics of each targeted population. The goal is to create interdependence among institutions and practitioners and to facilitate collaboration and information sharing with a focus on improved clinical outcomes and efficiencies.

Care coordination for high-risk members should include an individualized person-centered care plan based on a comprehensive assessment of care needs, including plans to mitigate impacts of social determinants of health. Person centered care plans reflect the patient's priorities and goals, ensures that the member is engaged in and understands the care he/she will receive, and includes empowerment strategies to achieve those goals.

#### **6.1. Systematic Processes to Identify Patients for Care Management**

Electronic systems to support effective care management, targeted care coordination for top 1% - 5% in each relevant subpopulation, including:

- 6.1.1. Systematically utilizes analytics, risk segmentation to identify/target individuals for more hands-on, individual care management. May include indicators such as poly-pharmacy, behavioral health diagnosis, limits to physical mobility, release from corrections, neighborhood stress index, depression, hospitalization, clinical indicators (e.g. diabetes), gaps in care.
- 6.1.2. Tools to systematically track & coordinate care across specialty care, facility-based care and community organizations
- 6.1.3. Referral Tracking and Follow-Up
- 6.1.4. Ability to rapidly recognize and effectively respond to changes in a condition to activate care coordination and help avoid use of unnecessary services, particularly emergency department visits or hospitalizations

#### **6.2. Defined Care Management Team with Specialized Expertise Pertinent to Characteristics of Rising Risk and High-Risk Target population**

- 6.2.1. Care Management Team – with evidence of ability, tools to manage care
  - 6.2.1.1. Deliver evidence-based care management to individuals at high risk for poor outcomes based on identified core principles and related processes specified in the care.
  - 6.2.1.2. Develop and implement a transitions of care approach for individuals who are moving between health care settings, including care transition protocols to proactively address the needs of individuals in transition according to evidence based practices whenever possible.

- 6.2.1.3. May include participants from multiple organizations with delineation of roles.
- 6.2.1.4. Greatest impact and member benefit if care (handoffs) remain *within* the network of participating providers where possible – to promote coordination, accountability and efficiency.
- 6.2.2. Specialized expertise and staff for work with distinct sub-populations
  - 6.2.2.1. Integration of BH (including SUD) and Medical care – children, adults,
  - 6.2.2.2. Coordination of care for persons with chronic diseases including medical management, coordinating transitions of care (ED, hospital, home, SNF)
  - 6.2.2.3. Coordination of care for persons requiring home and community-based services
  - 6.2.2.4. Coordination of care for persons requiring supporting social services

**6.3. Individualized Person-Centered Care Plan - Care Management for Rising Risk, High-Risk Targeted Members**

- 6.3.1. Comprehensive assessment of care needs and gaps: symptom severity, functional status, potentially avoidable hospital readmission strategies and improvement plan
- 6.3.2. Individual Care Plans: Culturally and linguistically appropriate care management. Based on assessment, develop a care plan that considers: gaps in care, functional status, behavioral health and social service needs, managing transitions, increased patient medication adherence and use of medication therapy
- 6.3.3. Incorporates mitigation strategies for social determinants of health  
E.g., Housing security, Nutrition, Food security, Physical /activity and Nutrition, Safety, safe environment; Involvement with criminal justice, parole
- 6.3.4. Inter-disciplinary care plan across providers
  - 6.3.4.1. Care Plan coordinates efforts of medical, behavioral and social support providers.
  - 6.3.4.2. Entity has established methods to promote access, engagement, and accountability.
  - 6.3.4.3. Engagement with CBOs and providers of social support services as part of the implementation of the care plan.
  - 6.3.4.4. Specific attention to transitions of care (between settings, between youth/adult services)
  - 6.3.4.5. Person Centered Care plan developed in collaboration with the member or caregiver and is driven by the member’s priorities, motivations, and goals, ensures that the member is engaged in and understands the care she will receive. The Care Plan is readily available to the member
  - 6.3.4.6. Processes for working closely with members, family members and caregivers.
  - 6.3.4.7. Encourage patient and/or family health education and promotion; and

- 6.3.4.8. Leverage Home-based services, and telephonic and web-based communications, group care, and the use of culturally and linguistically appropriate care.
- 6.3.5. Educates and trains providers across the full continuum of care regarding the care integration strategy and provider requirements for participation.

## 7. Member Engagement

An AE must have defined strategies to maximize effective member contact and engagement, including the ability to effectively outreach to, and connect with, hard-to-reach high need target populations. The best strategies will use evidence-based and culturally appropriate engagement methods to actively develop a trusting relationship with patients. A successful AE will make use of new technologies for member engagement and health status monitoring. Social media applications and telemedicine can be used to promote adherence to treatment and for support and monitoring of physiological and functional status of older adults.

Recognizing that many of these new technologies for health status monitoring and health promotion are not currently covered benefits, EOHHS anticipates that successful AEs will begin by promoting such products and encouraging their use and anticipates that infrastructure investments (including HSTP incentive funds) may be utilized to develop such capacities.

### 7.1. Defined Strategies to Maximize Effective Member Contact and Engagement

Able to effectively outreach to and connect with hard-to-reach high need target populations.

- 7.1.1. Communication approach that recognizes highly complex, multi-condition high cost members. Recognizes that the roots of many problems are based in childhood trauma; that many of the highest need individuals have a basic mistrust of the health care system. Often does not have a primary existing affiliation with a PCP.
- 7.1.2. Identified population specific strategies, methods to actively develop a trusting relationship through evidence-based and patient-centered engagement methods.
  - 7.1.2.1. Use culturally competent communication methods and materials with appropriate reading level and communication approaches. Tools are understandable, and culturally and linguistically appropriate.
  - 7.1.2.2. Uses methods adapted to recognize that compliance with patient notification requirements is not the same as effective communication with members

### 7.2. Implementation, Use of New technologies for Member Engagement, Health Status Monitoring, and Health Promotion

- 7.2.1. Established capabilities to educate members/promote the use of technologies for member engagement. This includes technologies that may not be covered by Medicaid but might support/enable people to be better able to manage health conditions.
  - 7.2.1.1. Demonstrated use of Products that support monitoring and management of an individual's physiological status and mental

- health (e.g. vital sign monitors, activity/sleep monitors, mobile PERS with GPS)
- 7.2.1.2. Demonstrated use of Products that support monitoring and maintaining the functional status of vulnerable adults in their homes (Fall detection technologies, environmental sensors, video monitoring)
- 7.2.1.3. Technologies, products that support both informal and formal caregivers providing timely, effective assistance.
- 7.2.2. Established capabilities to leverage relevant, cost effective technologies including, but not limited to:
  - 7.2.2.1. Social media applications to promote adherence to treatment
  - 7.2.2.2. Use of technologies that enable vulnerable adults to stay socially connected (Social communication/PC mobile apps for remote caregivers, cognitive gaming & training, social contribution)
  - 7.2.2.3. Demonstrated use of telemedicine
  - 7.2.2.4. Patient Portals to enhance engagement, awareness, and self-management opportunities.

## 8. Quality Management

### 8.1. Quality Committee and Quality Program

The AE will maintain an ongoing Quality Committee that reports to the Governing Board or to the Governing Committee. The AE shall have a defined Quality Program overseen by qualified healthcare professional responsible for the AE's quality assurance and improvement program. Members of the AE Quality Committee will minimally include an identified board certified physician licensed in the State of Rhode Island who is an AE participating clinician, a behavioral health clinician at the independent practice level who is licensed in Rhode island and who is an AE participating clinician, and an individual from a community based service organization that provides key social supports to attributed members of the AE.

### 8.2. Methodology for the Integration of Medical, Behavioral, and Social Supports

AE will develop defined methods and processes to advance the integration of medical, behavioral, and social supports for AE members. Methods and processes to advance integration will be evidenced through executed Policies and Procedures and Operational Protocols. The AE will be able to identify how it will require AE participants and providers/suppliers to comply with and implement each process, including the remedial processes and penalties (including the potential for expulsion) applicable to AE participants and AE providers/suppliers for failure to comply with and implement the required process; and explain how it will employ its internal assessments of cost and quality of care to continuously improve-the AE's care practices

### 8.3. Clinical Pathways, Care Management Pathways, and Evidence Based Practice

AE will identify a method for (a) promoting evidence-based practice and (b) integration and review of clinical pathways, care management pathways based on evidence-based practice. The minutes of, and reports to, the Quality Committee as to the performance of

the Quality Program will report on implementation and tracking of defined strategies for promoting the introduction and utilization of evidence-based practices in clinical and care management pathways.

#### **8.4. Quality Performance Measures**

The AE shall identify and report on a set of core quality metrics that enable the AE to monitor performance, emerging trends, quality of care, and to use these results to improve care over time. AE will have the ability to track and report on key performance metrics. Performance metrics shall include consumer reported quality measures.

In accordance with 42 CFR §438.6(c)(2)(ii)(B) 2, AE quality performance must be measured and reported to EOHHS using the Medicaid Comprehensive AE Common Measure Slate. These measures shall be used to inform the distribution of any shared savings.

For QPY3, MCOs are responsible for reporting performance on all AE Common Measure Slate measures to EOHHS. All Admin measures must be generated and reported by the MCO. AEs and MCOs must work together to establish clinical data exchange capabilities.

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<sup>2</sup> [https://www.ecfr.gov/cgi-bin/text-idx?SID=85dc983b09de39869ece9ee0d34d0a09&mc=true&node=se42.4.438\\_16&rgn=div8](https://www.ecfr.gov/cgi-bin/text-idx?SID=85dc983b09de39869ece9ee0d34d0a09&mc=true&node=se42.4.438_16&rgn=div8)

**Appendix A: Excerpts from the EOHHS Contracts with Managed  
Care Organizations Regarding Scope of Benefits**

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**ATTACHMENT A  
SCHEDULE OF IN-PLAN BENEFITS**

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## ATTACHMENT A SCHEDULE OF IN-PLAN BENEFITS

Services below are covered for all members based on medical necessity criteria. Contractor is responsible for ensuring access and quality of care to services listed in **ATTACHMENT A**. The Contractor will provide services which increase the member’s opportunities to remain at home and out of an institutional setting. The Contractor is authorized to offer alternative services and value add services/equipment where such services are cost effective and clinically appropriate, including interventions intended to address social determinants of health.

The Contractor will recognize that services in entitled “scope of benefits” are provided as examples and do not represent an all-inclusive list of benefits.

Some services are subject to stop loss provisions as defined in **ATTACHMENT N**, Special Terms & Conditions, Section 12 and 13.

<b>SERVICE</b>	<b>SCOPE OF BENEFIT (ANNUAL)</b> <b>Including but not limited to:</b>
<b>Inpatient Hospital Care</b>	As medically necessary. EOHHS will be responsible for inpatient admissions or authorizations while Member was in Medicaid fee-for-service, prior to Member’s enrollment in Health Plan. The Contractor will be responsible for inpatient admissions or authorizations, even after the Member has been disenrolled from the Contractor’s Health Plan and enrolled in another Health Plan or re- enrolled into Medicaid fee- for-service, until the management of the Member’s care is formally transferred to the care of another Health Plan, another program option, or fee-for-service Medicaid.
<b>Outpatient Hospital Services</b>	Covered as needed, based on medical necessity. Includes physical therapy, occupational therapy, speech therapy, language therapy, hearing therapy, respiratory therapy, and other Medicaid covered services delivered in an outpatient hospital setting.
<b>Therapies</b>	Covered as medically necessary, includes physical therapy, occupational therapy, speech therapy, hearing therapy, respiratory therapy and other related therapies.
<b>Physician/Provider Services</b>	Covered as needed, based on medical necessity, including primary care, specialty care, obstetric and newborn care.

<b>SERVICE</b>	<b>SCOPE OF BENEFIT (ANNUAL)</b> <b>Including but not limited to:</b>
<b>Family Planning Services</b>	Enrolled female members have freedom of choice of providers for family planning services. Covered to receive three hundred sixty-five (365) days of prescription contraception of F.D.A. approved drugs and devices which will require a prescription dispensed as a single prescription.
<b>Prescription Drugs</b>	Covered when prescribed by a Health Plan physician/provider. Generic substitution only unless provided for otherwise as described in the <i>Managed Care Pharmacy Benefit Plan Protocols</i> .
<b>Non-Prescription Drugs</b>	Covered when prescribed by a Health Plan physician/provider. Limited to non-prescription drugs, as described in the <i>Medicaid Managed Care Pharmacy Benefit Plan Protocols</i> . Includes nicotine cessation supplies ordered by a Health Plan physician. Includes medically necessary nutritional supplements ordered by a Health Plan physician.
<b>Laboratory Services</b>	Covered when ordered by a Health Plan physician/provider including urine drug screens.
<b>Radiology Services</b>	Covered when ordered by a Health Plan physician/provider.
<b>Diagnostic Services</b>	Covered when ordered by a Health Plan physician/provider.

<b>SERVICE</b>	<b>SCOPE OF BENEFIT (ANNUAL)</b> <b>Including but not limited to:</b>
<b>Mental Health and Substance Use –Outpatient&amp; Inpatient</b>	Covered as needed for all members, as defined in <b>ATTACHMENT O &amp; ATTACHMENT P</b> , including residential substance use treatment for youth. Covered services include a full continuum of Mental Health and Substance Use Disorder treatment, including but not limited to, community-based narcotic treatment, methadone, and community detox. Covered residential treatment includes therapeutic services but does not include room and board, except in a facility accredited by the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO"). Covered Services subject to limitations described in <b>ATTACHMENT O &amp; ATTACHMENT P</b> Also includes, DCYF ordered administratively necessary days (See Attachments O & P for further details), or hospital-based detox, MH/SUD residential treatment (including minimum 6 month SSTAR birth residential services), Mental Health Psychiatric Rehabilitative Residence (MHPRR), psychiatric rehabilitation day programs, Community Psychiatric Supportive Treatment (CPST), Crisis Intervention for individuals with severe and persistent mental illness (SPMI) enrolled in the Community Support Program (CSP), Opioid Treatment Program Health Homes (OTP), Assertive Community Treatment (ACT), Integrated Health Home (IHH), and services for individuals at CMHCs.
<b>Home Health Services</b>	Covered services include those services provided under a written plan of care authorized by a physician/provider including full-time, part-time, or intermittent skilled nursing care and certified nursing assistant services as well as physical therapy, occupational therapy, respiratory therapy and speech-language pathology, as ordered by a health plan physician. This service also includes medical social services, durable medical equipment and medical supplies for use at home. Home Health Services do not include respite care, relief care or day care.

<b>SERVICE</b>	<b>SCOPE OF BENEFIT (ANNUAL)</b> <b>Including but not limited to:</b>
<b>Home Care Services</b>	Covered services include those provided under a written plan of care authorized by a physician/provider including full-time, part-time or intermittent care by a licensed nurse or certified nursing assistant as well as; physical therapy, occupational therapy, respiratory therapy and speech therapy. Home care services include laboratory services and private duty nursing for a patient whose medical condition requires more skilled nursing than intermittent visiting nursing care. Home care services include personal care services, such as assisting the client with personal hygiene, dressing, feeding, transfer and ambulatory needs. Home care services also include homemaking services that are incidental to the client's health needs such as making the client's bed, cleaning the client's living areas such as bedroom and bathroom, and doing the client's laundry and shopping. Home care services do not include respite care, relief care or day care.
<b>Preventive Services</b>	Covered when ordered by a health plan physician/provider. Services include homemaker services, minor environmental modifications, physical therapy evaluation and services, and personal care services.
<b>EPSDT Services</b>	Provided to all children, pregnant women, unborn children, and young adults up to age 21(described in greater detail in Section D). Includes tracking, follow-up and outreach to children for initial visits, preventive visits, and follow-up visits. Includes inter-periodic screens as <i>medically</i> indicated. Includes multi-disciplinary evaluations and treatment, including, PT/OT/ST, for children with significant disabilities or developmental delays.
<b>Emergency Room Service and Emergency Transportation Services</b>	Covered both in- and out-of-State, for Emergency Services or when authorized by a Health Plan Provider, or in order to assess whether a condition warrants treatment as an emergency service.

<b>SERVICE</b>	<b>SCOPE OF BENEFIT (ANNUAL)</b> <b>Including but not limited to:</b>
<b>Nursing Home Care and Skilled Nursing Facility Care</b>	Covered when ordered by a Health Plan physician/provider. All skilled and custodial care covered. For Rhody Health Partners/Expansion members, the Contractor payments are limited to thirty (30) consecutive days. The Contractor is responsible for notifying the State to begin disenrollment process.
<b>School-Based Clinic Services</b>	Covered for RItE Care members as Medically Necessary at all designate sites.
<b>Services of Other Practitioners</b>	Covered if referred by a Health Plan physician. Practitioners certified and licensed by the State of Rhode Island including nurse practitioners, physicians' assistants, social workers, licensed dietitians, psychologists and licensed nurse midwives.
<b>Court-ordered mental health and substance use services – criminal court</b>	<p>Covered for all members. Treatment must be provided in totality, as directed by the Court or other State official or body (i.e. a Probation Officer, The Rhode Island State Parole Board). If the length of stay is not prescribed on the court order, the Health Plans may conduct Utilization Review on the length of stay. The Managed Care Organizations must offer appropriate transitional care management to persons upon discharge and coordinate and/or arrange for in-plan medically necessary services to be in place after a court order expires. The following are examples of Criminal Court Ordered Benefits that must be provided in totality as an in-plan benefit:</p> <p>Bail Ordered: Treatment is prescribed as a condition of bail/bond by the court.</p> <p>Condition of Parole: Treatment is prescribed as a condition of parole by the Parole Board.</p> <p>Condition of Probation: Treatment is prescribed as a condition of probation</p> <p>Recommendation by a Probation State Official: Treatment is recommended by a State official (Probation Officer, Clinical social worker, etc.).</p> <p>Condition of Medical Parole: Person is released to treatment as a condition of their parole, by the Parole Board.</p> <p>Exclusions are presented in <b>ATTACHMENT B</b>.</p>

<b>SERVICE</b>	<b>SCOPE OF BENEFIT (ANNUAL)</b> <b>Including but not limited to:</b>
<b>Court-ordered mental health and substance use treatment – civil court</b>	<p>All Civil Mental Health Court Ordered Treatment must be provided in totality as an in-plan benefit. All regulations in the State of Rhode Island and Providence Plantations, Title 40.1, Behavioral Healthcare, Developmental Disabilities and Hospitals, Chapter 40.1- 5, Mental Health Law, Section 40.1-5.5 must be followed. If the length of stay is not prescribed on the court order, the Health Plans may conduct Utilization Review on the length of stay. The Managed Care Organizations must offer appropriate transitional care management to persons upon discharge and coordinate and/or arrange for in-plan medically necessary services to be in place after a court order expires. Note the following are facilities where treatment may be ordered: The Eleanor Slater Hospital, Our Lady of Fatima Hospital, Rhode Island Hospital (including Hasbro), Landmark Medical Center, Newport Hospital, Roger Williams Medical Center, Butler Hospital (including the Kent Unit), Bradley Hospital, Community Mental Health Centers, Riverwood, and Fellowship. Any persons ordered to Eleanor Slater Hospital for more than 7 calendar days, will be dis-enrolled from the Health Plan at the end of the month, and be re-assigned into Medicaid FFS. Civil Court Ordered Treatment can be from the result of:</p> <ul style="list-style-type: none"> <li>a) Voluntary Admission</li> <li>b) Emergency Certification</li> <li>c) Civil Court Certification</li> </ul> <p>Court-ordered treatment that is not an in-plan benefit or to a non-network provider, is not the responsibility of the Contractor. Court ordered treatment is exempt from the 14-day prior authorization requirement for residential treatment as defined in SECTION 2.12.03.02.</p>

<b>SERVICE</b>	<b>SCOPE OF BENEFIT (ANNUAL)</b> <b>Including but not limited to:</b>
<b>Court Ordered Treatment for Children</b>	All Court Ordered Treatment must be provided in totality as an in-plan benefit including treatments which are ordered by the court to be provided by a non-network provider. If the length of stay is not prescribed on the court order, the Health Plans may conduct Utilization Review on the length of stay. The Managed Care Organizations must offer appropriate transitional care management to persons upon discharge and coordinate and/or arrange for in-plan medically necessary services to be in place after a court order expires.
<b>Podiatry Services</b>	Covered as ordered by Health Plan physician/provider.
<b>Optometry Services</b>	<p><i>For children under 21:</i> Covered as medically necessary with no other limits.</p> <p><i>For adults 21 and older:</i> Benefit is limited to examinations that include refractions and provision of eyeglasses if needed once every two years. Eyeglass lenses are covered more than once in 2 years only if medically necessary. Eyeglass frames are covered only every 2 years. Annual eye exams are covered for members who have diabetes. Other medically necessary treatment visits for illness or injury to the eye are covered.</p>
<b>Oral Health</b>	<p><i>Inpatient:</i> The Contractor is responsible for operating room charges and anesthesia services related to dental treatment received by a Medicaid beneficiary in an inpatient setting.</p> <p><i>Outpatient:</i> The Contractor is responsible for operating room charges and anesthesia services related to dental treatment received by a Medicaid beneficiary in an outpatient hospital setting.</p> <p><i>Oral Surgery:</i> Treatment covered as medically necessary. As detailed in the <i>Schedule of In-Plan Oral Health Benefits updated January 2017.</i></p>

<b>SERVICE</b>	<b>SCOPE OF BENEFIT (ANNUAL)</b> <b>Including but not limited to:</b>
<b>Hospice Services</b>	Covered as ordered by a Health Plan physician/provider. Services limited to those covered by Medicare.
<b>Durable Medical Equipment</b>	Covered as ordered by a Health Plan physician/provider as medically necessary.
<b>Adult Day Health</b>	Day programs for frail seniors and other adults who need supervision and health services during the daytime. Adult Day Health programs offer nursing care, therapies, personal care assistance, social and recreational activities, meals, and other services in a community group setting. Adult Day Health programs are for adults who return to their homes and caregivers at the end of the day.
<b>Children's Evaluations</b>	Covered as needed, child sexual abuse evaluations (victim and perpetrator); parent child evaluations; fire setter evaluations; PANDA clinic evaluations; and other evaluations deemed medically necessary.
<b>Nutrition Services</b>	Covered as delivered by a registered or licensed dietitian for certain medical conditions and as referred by a Health Plan physician.
<b>Group/Individual Education Programs</b>	Including childbirth education classes, parenting classes, wellness/weight loss and tobacco cessation programs and services.
<b>Interpreter Services</b>	Covered as needed.
<b>Transplant Services</b>	Covered when ordered by a Health Plan physician.
<b>HIV/AIDS Non-Medical Targeted Case Management for People Living with HIV/AIDS (PLWH/As) and those at High Risk for acquiring HIV</b>	This program may be provided for people living with HIV/AIDS and for those at high risk for acquiring HIV (see provider manual for distinct eligibility criteria for beneficiaries to qualify for this service). These services provide a series of consistent and required "steps" such that all clients are provided with and Intake, Assessment, Care Plan. All providers must utilize an acuity index to monitor client severity. Case management services are specifically defined as services furnished to assist individuals who reside in a

<b>SERVICE</b>	<b>SCOPE OF BENEFIT (ANNUAL)</b> <b>Including but not limited to:</b>
	<p>community setting or are transitioning to a community setting to gain access to needed medical, social, educational and other services, such as housing and transportation. Targeted case management can be furnished without regard to Medicaid's state-wideness or comparability requirements. This means that case management services may be limited to a specific group of individuals (e.g., HIV/AIDS, by age or health/mental health condition) or a specific area of the state. (Under EPSDT, of course, all children who require case management are entitled to receive it.)</p> <p>May include:</p> <p>Benefits/entitlement counseling and referral activities to assist eligible clients to obtain access to public and private programs for which they may be eligible</p> <p>All types of case management encounters and communications (face-to-face, telephone contact, other)</p> <p>Categorical populations designated as high risk, such as, transitional case management for incarcerated persons as they prepare to exit the correctional system; adolescents who have a behavioral health condition; sex workers; etc.</p> <p>A series of metrics and quality performance measures for both HIV case management for PLWH/s and those at high risk for HIV will be collected by providers and are required outcomes for delivering this service.</p> <p>Note: Does not involve coordination and follow up of medical treatments.</p>
<b>AIDS Medical Case Management</b>	<p>Medical Case Management services (including treatment adherence) are a range of client – centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments are components of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and</p>

<b>SERVICE</b>	<b>SCOPE OF BENEFIT (ANNUAL)</b> <b>Including but not limited to:</b>
	<p>personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include 1) initial assessment of service needs; 2) development of a comprehensive, individualized service plan; 3) coordination of services required to implement the plan; 4) monitoring the care; 5) Periodic re-evaluation and adaptation of the plan as necessary over the time client is enrolled in services.</p> <p>It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other form of communication.</p>
<b>Treatment for Gender Dysphoria</b>	Comprehensive benefit package.
<b>Early Intervention</b>	Covered for RIte Care members as included within the Individual Family Service Plan (IFSP), consistent with the 2005 Article 22 of the General Laws of Rhode Island
<b>Rehabilitation Services</b>	Physical, Occupational and Speech therapy services may be provided with physician orders by RI DOH licensed outpatient Rehabilitation Centers. These services supplement home health and outpatient hospital clinical rehabilitation services when the individual requires specialized rehabilitation services not available from a home health or outpatient hospital provider. See also EPSDT.
<b>Value Add Services</b>	Services/equipment which are not in the State Plan but are cost effective, improve health and clinically appropriate.
<b>Neonatal Intensive Care Unit (NICU)</b>	Covered under the following circumstances: Admitted to Women and Infants (W&I) from home after discharge, admitted to W&I NICU from home after discharge from W&I Normal Newborn Nursery, Admission to non-W&I level 2 Nursery, Admission to W&I NICU from home following delivery at and discharge from non-W&I facility or discharge from

<b>SERVICE</b>	<b>SCOPE OF BENEFIT (ANNUAL)</b> <b>Including but not limited to:</b>
	non-W&I NICU with admission to W&I for continued care.
<b>Health Homes for Children</b>	<ul style="list-style-type: none"> <li>• comprehensive care management;</li> <li>• care coordination;</li> <li>• referral to community and social support services (formal and informal);</li> <li>• individual and family support services;</li> <li>• comprehensive transitional care; and</li> <li>• health promotion</li> </ul>
<b>Complementary Alternative Medicine Services</b>	Treatment from a chiropractor, acupuncturist, and massage therapist for the treatment of chronic pain as specified in section 2.06.01.11
<b>Institutes for Mental Disease Exclusion for Substance Use Disorder treatment up to 30 Days</b>	The Contractor must offer appropriate transitional care management to members upon discharge and coordinate and/or arrange for in-plan medically necessary services. The Contractor will ensure that members discharged from an IMD after 15 days receive appropriate clinical treatment in a non-IMD facility for as many days as medically necessary. Additionally, the Contractor will recognize cases in which member are subject to a court ordered length of stay longer than 15 days. The Contractor will ensure that the length of stay for members is in compliance with the court order. While EOHHS requires that Contractor comply with all State and Federal regulations, Contractor should exercise its judgement with regard to clinical decisions

“In lieu of services” are in-plan alternative services in a setting that is not included in the state plan or otherwise covered by the contract but are medically appropriate, cost-effective substitutes for state plan services included within a contract. EOHHS identifies the following services as those services which the Contractor may provide to members without obtaining prior approval from EOHHS. If the Contractor seeks to provide cost-effective alternative services not listed below, it must obtain prior written approval from EOHHS.

<b>SERVICES APPROVED BY EOHHS AS IN LIEU OF SERVICES:</b>	<b>SERVICE FOR WHICH THE IN LIEU OF SERVICE IS OFFERED AS AN ALTERNATIVE:</b>
<ul style="list-style-type: none"> <li>• Chiropractic Services</li> <li>• Acupuncture</li> <li>• Massage Therapy</li> <li>• Yoga</li> <li>• Meditation classes for purpose of pain management</li> </ul>	<ul style="list-style-type: none"> <li>• Medications for treating pain.</li> <li>• Invasive procedures including surgical procedures.</li> </ul>
<ul style="list-style-type: none"> <li>• Medication management services which include: <ul style="list-style-type: none"> <li>○ Ensuring compliance with medication regime</li> <li>○ Prepacking medication boxes</li> <li>○ Creating reference guide describing medications and dosages.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Extended Skilled Nursing Services.</li> </ul>
<ul style="list-style-type: none"> <li>• Nutritional Programs which include: <ul style="list-style-type: none"> <li>○ Weight Reduction Programs for Obesity</li> <li>○ Therapeutic counseling</li> <li>○ Group support programs.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Gastric By-pass Surgery</li> <li>• Weight Reduction Medications prescribed by a licensed provider</li> </ul>
<ul style="list-style-type: none"> <li>• Meals on Wheels-Meal delivery for persons who are in danger of malnutrition and/or have limited mobility or access to transportation.</li> </ul>	<ul style="list-style-type: none"> <li>• Preventive homecare services.</li> <li>• Homemaking services up to 6 hrs/wk.</li> </ul>
<ul style="list-style-type: none"> <li>• Home care hours greater than 6 hours to prevent increases in level of care or institutionalization</li> </ul>	<ul style="list-style-type: none"> <li>• Long Term Care placements</li> </ul>
<ul style="list-style-type: none"> <li>• Medically appropriate smart phone applications</li> </ul>	<ul style="list-style-type: none"> <li>• Face to Face MD office visit with a licensed provider</li> </ul>
<ul style="list-style-type: none"> <li>• Therapeutic Light Boxes</li> </ul>	<ul style="list-style-type: none"> <li>• Antidepressant medication management for seasonal depression</li> </ul>

**ATTACHMENT O**  
**MENTAL HEALTH, SUBSTANCE USE AND DEVELOPMENTAL DISABILITY**  
**SERVICES FOR CHILDREN**

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**ATTACHMENT O:  
MENTAL HEALTH, SUBSTANCE USE AND DEVELOPMENTAL DISABILITY  
SERVICES FOR CHILDREN----**

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The Contractor requirements for mental health and substance use services as set forth in **ATTACHMENT A** is described below.

**MENTAL HEALTH PARITY**

The Contractor will comply with the Mental Health Parity Addiction Equity Act (MHPAEA). Requirements include:

- Treatment limitations that are applied to mental health or substance use disorder benefits are no more than the predominant treatment limitations that are applied to substantially all medical/surgical benefits.
- There are no separate treatment limitations that apply only to mental health or substance use disorder benefits.
- Medical management techniques used by the Contractor must be comparable to and applied no more stringently than the medical techniques that are applied to medical/surgical benefits.

In addition, the contractor agrees that its non-quantitative treatment limits for behavioral health services will not be more restrictive, nor applied more stringently, than the plan's non-quantitative treatment limits for its commercial population. This includes policies and procedures for medical necessity determination, prior approval, and concurrent and retrospective review.

**MENTAL HEALTH AND SUBSTANCE USE SERVICES**

The Contractor commits to providing children a full continuum of mental health and substance use services. The Contractor's services will address all levels of need. These include but are not limited to:

**ACUTE SERVICES:**

Acute Services represent the highest level of service intensity based on the member's need for either a locked or staff secured 24-hour clinical setting that offers full behavioral health management. These services are represented within a continuum of care including services such as Inpatient, Acute Residential Treatment Services (ARTS), Observation/Crisis Stabilization/Holding Bed, and Emergency Service Intervention.

1. **Emergency Service Intervention:** 24 hour/7 days a week, face-to-face care management and intervention of an individual experiencing a behavioral health crisis. Such crises include an imminent, real, and significant risk of serious harm to self or others that requires immediate treatment. The activities are conducted by a licensed behavioral health provider in a hospital emergency room, residential placement setting, the individual's home, police station, or other community setting that the family and the child-family competent clinician agree is safe and clinically suitable to resolve the mental health crisis.
  - When a member is clinically assessed in an Emergency Room Setting and is not admitted to an inpatient level of care, the health plan will ensure that the member has a follow up appointment within three (3) business days of discharge from the Emergency Room. The health plan may fulfill this requirement by contract with their providers; or by utilizing the health plans care manager for outreach; or another care coordination entity in the community. The health plan must demonstrate compliance to this requirement within ninety (90) days of the execution of this amendment.
  - The discharge plan will be shared with the member's pediatrician within three (3) business days of the Emergency Room discharge. If a member is involved with a care coordinating entity, it is recommended that the discharge plan is shared within (3) business days of the emergency room discharge.
  - The health plan must demonstrate compliance to this requirement within ninety (90) days of the execution of this amendment".

The plan will work with the hospital delivery system to ensure coordination of integrated care for members who may present with primary medical condition who have an underlying BH issue including but not limited to:

- - 1. Alcohol Related Disorders
  - 2. Anxiety Disorders
  - 3. Mood Disorders
2. **Observation/Crisis Stabilization/Holding Bed:** A secure and protected, medically staffed, psychiatrically supervised program designed for those individuals who, as a result of a psychiatric disorder, are an acute and significant danger to themselves or others, or who are acutely and significantly disabled and cannot meet their basic needs and functions, and who require extended observation in order to determine the most appropriate level of care and to avoid acute inpatient hospitalization.
  3. **Inpatient Acute Hospitalization:** Services provided in a hospital- or freestanding detoxification facility staffed by licensed physicians (including psychiatrists) with 24-hour skilled nursing in a structured treatment milieu for the treatment of individuals with a mental health or substance use disorder of sudden onset and short, severe course who cannot be safely or effectively treated in a less intensive level of care.

4. **Acute Residential Treatment:** A community based short-term service or hospital step- down that provides comprehensive multidisciplinary behavioral health evaluation and treatment in a staff setting offering high levels of supervision, structure, restrictiveness and intense treatment on a 24-hour basis. The treatment should include individual, family, and group clinical therapy, crisis management, & medication evaluation and management.

Acute Residential Treatment requires:

- The provider to be licensed as a Residential Treatment provider
- Available licensed physician on staff or on call, 24 hours per day, 7 days per week to adjust medications as needed or to address members in crisis.
- RN on staff or an RN available to meet member's needs.
- 24/7 availability of certified clinical staff adequate to meet the member's medical and psychological needs
- Program structure includes therapeutic treatment services, modalities and intensity as appropriate to meet family and member's needs. It is recommended that the structure includes at minimum 4 hours/ day Monday- Friday and 4 hours/day on weekends. Recreational and educational activities do not count toward therapeutic treatment.

#### **INTERMEDIATE SERVICES:**

Acute Services represent the highest level of service intensity based in the member's need for either a locked or staff secured 24-hour clinical setting that offers full behavioral health management. These services are represented within a continuum of care including services such as Inpatient, Acute Residential Treatment Services (ARTS), Observation/Crisis Stabilization/Holding Bed, and Emergency Service Intervention.

1. **Partial Hospitalization (PHP):** A short term, comprehensive, multidisciplinary behavioral health program that promotes and maintains a therapeutic milieu/community. The PHP is an alternative to or step-down from inpatient care. PHP is designed to provide stabilization of acute, severe, mental illness, substance use disorders, or dual diagnosis.

A PHP requires daily psychiatric evaluation and treatment comparable to that provided by an inpatient setting. A PHP may be provided by both hospital-based and freestanding facilities and available 6-9 hours per day at minimum 5 days per week. For children and adolescents, a PHP provides services similar to hospital level care for members who have a supportive environment to return to in the evening. As the child's symptoms improve and a transition plan effectively transitions the child back to family, community and school setting. The PHP consults and coordinates the member's care with the child's parent/guardian, other treating providers and community supports. The PHP implements behavior plans, monitors, manages, and administers medication, and has 24/7 physician availability for emergencies.

Minimum program requirements include:

- Members receive clinical treatment & scheduled programming based on member's clinical needs. It is recommended that this is provided at least twenty (20) hours per week for BH and/or SUD
  - Individualized treatment plan, assessment, medication and evaluation, individual, family, & group counseling; crisis intervention, and activity therapies or psychoeducation, when determined to be clinically appropriate to meet the needs of the member.
  - Members must be able to tolerate and participate in the PHP program.
  - A licensed practitioner responsible to supervise program and staff and a treatment plan will be provided for each member.
  - The Contractor will be responsible for ensuring that the provider has a treatment plan for each member and that the treatment plan includes member goals and a method for measuring these goals.
2. **Day/Evening Treatment:** A structured program focused on enhancing current levels of functioning and skills while maintaining community living. Children and adolescents who no longer require active medically based services may have significant residual symptoms that require extended interventions to address recovery. The goal of day/evening treatment is to assist members with behavioral health disorders to achieve and maintain their highest level of functioning and work toward appropriate development goals. The services provided include: individual and family behavioral health therapies; psychosocial and adjunctive treatment modalities including rehabilitative, pre-vocational and life skill services to enable the individual to attain adequate functioning in the community.
3. **Intensive Outpatient Treatment (IOP):** A clinically structured outpatient program for individuals similar to a Day Treatment offering short-term day, evening, or combination which consists of intensive treatment within a stable therapeutic milieu for those individuals who can be safely treated in a less intense setting than a partial, day or evening program but require a higher level of intensity than that available in outpatient therapy. IOP's primary treatment modality is group therapy which supports positive and safe communication and interactions in a supportive therapeutic milieu which is an essential component for member recovery.

Minimum program requirements include:

- Members receive clinical treatment based on the member's clinical needs. It is recommended that the clinical services are provided at least 3 hours per day, 3 times/week for BH and/or SUD.
- Individualized treatment plan, assessment, medication and evaluation, group, individual, and family, counseling; crisis intervention, and activity therapies or psychoeducation, when determined to be clinically appropriate based on the member's needs.
- Licensed physician on staff or on call that can adjust and evaluate medication if needed. Alternatively, designated program clinical staff will coordinate, collaborate, and/or link a member to a prescriber, if needed.

- A licensed practitioner responsible to supervise program and staff and a treatment plan will be provided for each member.
4. **Enhanced Outpatient Services (EOS):** Home/community based clinical services provided by a team of specialized licensed therapists and case managers. (Some examples of EOS clinical specialists include providers with expertise in the treatment of Developmental Disabilities, Sexual Abuse, and Post Traumatic Stress Disorder). The goal of EOS is to offer an effective and clinically supported transition of care from an inpatient or residential setting or to avoid an inpatient or residential admission for high risk members.

Providers offer prompt access to this service and are able to provide varying levels of service intensity (multiple times per day and tapering to multiple times per week) to meet the unique needs of children and their families. This service may be used to assist a child transitioning from an inpatient stay or to prevent an admission.

Minimum program requirements include:

- Home/community based clinical services provided to meet the member’s clinical needs. It is recommended that services are provided for up to 5 days per weeks.
- Services are provided to the member based on the member’s need. It is recommended that this includes 4 hours per day of service by a multi-disciplinary clinical team.

## **OUTPATIENT SERVICES:**

### **1. Traditional outpatient services, including:**

- Diagnostic evaluation
- Developmental evaluations
- Psychological testing
- Individual therapy
- Family therapy
- Group therapy
- Medication management

### **2. Home and Community Based Services for Individuals under Age 21 Years of Age (as described below):**

#### **1. Background and Overview**

Home Based Treatment Services (HBTS), Personal Assistance Services & Supports (PASS), Respite, Evidence Based Practices (EBP) and Adolescent Residential Substance Use Treatment are designed for children with complex health needs. These services intended for children with complex health needs have historically been accessible outside of the MCO’s scope of benefits through Medicaid Fee- For- Services (FFS). EOHHS intends to integrate all home and community-based services for children and adolescents in an effort to meet Rhode Island’s goals of the Triple Aim and to provide continuity and appropriate service delivery to children and their families. It is intended that the Contractor will further expand the service array available for children enrolled in the Contractor’s Health Plan and fully manage the health care of the whole

child within the context of their families. The Contractor must provide these services to any Medicaid member under age 21, per Federal EPSDT regulation. Services are not specific to any particular product line or population but are intended to meet the needs of children with serious or chronic health needs to attain their fullest potential and to remain as independent as possible within their communities. The Contractor will assess members for medical necessity criteria, based on the guidelines outlined below.

**2. Goals**

Specialized programs for children with complex health needs should be provided in a holistic, person and family centered way. Services should be provided to improve member outcomes by integrating social, behavioral health, and physical health needs. For some, selective services will be provided over extended periods of time, to assist with chronic condition management and prevent acute inpatient admissions and transitions to higher costs settings. The overarching goals of these services follow the Triple Aim approach:

<b>Improve Care and Access</b>	<ul style="list-style-type: none"> <li>• Improve overall health and quality of life of children and families</li> <li>• Improve family ability to manage symptoms/behaviors in the home</li> <li>• Improve ability for children to thrive in their communities</li> </ul>
<b>Reduce Cost</b>	<ul style="list-style-type: none"> <li>• Decrease utilization of the ER</li> <li>• Decrease utilization of higher costs settings such as hospitals or residential placements</li> <li>• Encourage alternative payment methodologies for these services</li> </ul>
<b>Improve Quality</b>	<ul style="list-style-type: none"> <li>• Promote evidence-based practices</li> <li>• Encourage provider incentives to improve quality of care</li> </ul>

**3. Program Description by Service**

**A. Home Based Treatment Services (HBTS):**

HBTS is an intensive home or community-based service for children and adolescents who have chronic, moderate, or severe cognitive, developmental, medical/neurological, and/or psychiatric conditions whose level of functioning is significantly compromised. HBTS is a phased system approach that includes in person, high frequency, specialized treatment (including Applied Behavioral Analysis discrete trial interventions) and supervision of direct care staff. HBTS is administered routinely with the child/adolescent and parents/guardians engaged in treatment. Children may require up to 20 hours per week, or more as clinically indicated. Key goals of this treatment are person/family centered and could include: a) Increased ability of caregiver to meet the needs of their child/adolescent; b) increased language and communication skills; c) improved attention to tasks; d) enhanced imitation; e) generalized social behaviors; f) developing skills for independence; g) decreased aggression and other maladaptive behaviors; and h) improved learning and problem-solving skills. The Contractor is responsible for contracting with providers to provide the level of service indicated in this section and ensure timely and needed access to these services per EOHHS Practice Standards.

## **Core Components:**

HBTS is composed of various service components, including:

### Assessment and Treatment Planning

1. Assessment of the functional needs of the child and family, utilization of all referral and collateral information (i.e., IEP, IFSP, contact with providers/teachers, review relevant medical or behavioral health evaluations/records), and maintaining ongoing parent/caregiver/guardian communication.
2. Identification and prioritization of treatment goals and objectives that are written to be clear to families, specific and measurable. Interventions will be clearly defined, and research based. The level of parent participation will be clear and consistent. Parents/Caregivers/Guardians must sign all proposed Treatment Plans.
  - i. **HBTS Treatment Consultation Services**  
Treatment Consultation is intended to bring specific expertise and direction to the treatment team (i.e., Clinical Supervisor and home-based worker). It can be offered on a broad basis or by using Specialty Consultations from licensed Occupational Therapists (OT), Physical Therapists (PT), Psychologist, or Speech and Language Pathologists (SLP). HBTS Treatment Consultation is available before direct services begin (i.e., Pre-Treatment), during a course of HBTS care (Treatment Consultation and Specialty Consultation), and at the conclusion of HBTS (Post- Treatment).
  - ii. **Treatment Coordination**  
Treatment Coordination represents activities by a team member on behalf of a specific child receiving HBTS services to ensure coordination and collaboration with parents, providers, the medical home, and other agencies (e.g., school, Early Intervention, DCYF or FCCP) including the referral source. Collaboration and communication is ongoing throughout a child's course of HBTS.
  - iii. **HBTS Direct Services**  
HBTS consists of Specialized Treatment and Treatment Support. These services can only be provided to a child by a home-based worker in accordance with an approved Treatment Plan, and under the supervision of a licensed healthcare professional.
  - iv. **HBTS Specialized Treatment**  
Specialized Treatment is intensive evidence-based intervention that may take place in the child's home, center, and/or community setting, and requires the participation of parents/guardians. For some children/adolescents, HBTS Specialized Treatment may be ABA discrete trial interventions through approved ABA provider-agencies.

HBTS Specialized Treatment is provided on a continuous basis for an approved number of hours per week. The focus of treatment can include: increasing

language and communication skills, improving attention to tasks, enhancing imitation, generalizing social behaviors, developing independence skills, decreasing aggression or other maladaptive behaviors, and improving learning and problem-solving skills (e.g., organization, conflict resolution, and relaxation training). It addresses the development of behavior, communication, social, and functional - adaptive skills, and may reinforce skills included in a child's Individual Educational Plan (IEP) or Individualized Service Plan (IFSP). Goals and objectives are defined, written, and tied to specific methods of intervention and measurement of progress. HBTS is not intended to replace or substitute for educational services.

v. HBTS Treatment Support

For some children and adolescents with moderate to severe functional impairments, the frequency and intensity of Specialized Treatment may become too taxing and result in limited benefits such that Treatment Support is indicated. Treatment Support does not represent a minimization of therapeutic effort and is not equivalent to Respite care. Treatment Support uses a portion of HBTS hours for the purposes of providing structure, guidance, supervision, and redirection for the child.

The inclusion of Treatment Support is intended to facilitate a child's ability to remain at home, maintain activities of daily living, participate in the community, and transition into young adulthood. It encourages and promotes the practice of daily living skills by providing structure, supervision, guidance, and redirection while engaging in cognitive, physical, and social activities that would be typical for a child his/her age. The rationale for using Treatment Support must be clearly articulated and linked to one or more of the following domains:

1. The child's ability to acquire and use information.
2. The child's ability to attend and complete tasks.
3. The child's ability to interact and relate with others.
4. The child's ability to care for him or herself.
5. The child's ability to maintain health and physical well-being, which includes participation in community activities.

vi. Applied Behavior Analysis (ABA) Services

ABA discrete trial interventions are highly specialized and a distinct form of basic behavior therapy principles. It is intended that all children and adolescents be considered eligible for ABA services if it is clinically appropriate. It can be overseen by a Board-Certified Behavior Analyst (BCBA) or a licensed trained professional (e.g., Psychologist). The use of ABA discrete trial intervention can require additional hours of material preparation, planning, directing and supervising of direct service staff. This may include more hours for Clinical Supervision and Lead Therapy. These additional supports can only be provided for ABA recognized providers.

vii. Lead Therapy (for ABA only)

Lead therapy is regarded as an administrative support for ABA services. It provides for the development and updating of instructional materials, providing support to families in applying instructional strategies, and gathering and managing treatment data.

viii. Child Specific Orientation for Newly Assigned Home-Based Worker

Child specific orientation provides the newly assigned home-based worker with detailed information about a child's condition, treatment goals and objectives, methods of intervention, and other related aspects of care such as observing the child and/or other staff working with the child and family. It is provided by the Treatment Consultant or Clinical Supervisor and with an experienced home-based worker, when applicable, to prepare new staff to work with a child and family already receiving care.

ix. Clinical Supervision of Specialized Treatment and Treatment Support Workers

The Clinical Supervisor is responsible for the duties and actions of direct service staff. Clinical Supervision serves to ensure effective development, implementation, modification, and oversight of the Treatment Plan. It is the responsibility of the provider-agency to maintain clinical supervision throughout a period of treatment authorization. Additionally, the Clinical Supervisor must educate the home-based staff on issues of domestic violence, substance use and risk to child welfare, harassment of home-based staff or any other serious circumstances that may compromise or interfere with treatment. Specific functions of clinical supervision include:

- Observe worker in the home with the child implementing the Treatment Plan on a monthly basis
- Model techniques for staff and/or work with the child
- Instruct workers on proper implementation of treatment interventions
- Analyze treatment data and assess efficacy of treatment
- Address clinical issues and challenging behaviors including a functional behavioral analysis for providing direction to the home-based worker
- Assist in development/revisions of the Treatment Plan and writing of goals and objectives
- Communication and collaboration with others (e.g., school personnel, OT, PT, SLP consultants) regarding treatment
- Attend IEP or IFSP meetings, when indicated, in order to maintain or modify Treatment Plan
- In person consultation to home-based worker and family
- Provide group supervision when there are two or more home-based workers treating a child. Group supervision is necessary to maintain optimal communication and ensure consistent implementation of treatment

At a minimum, the Contractor is responsible for ensuring that all above components are available to its members and are part of the continuum of care offered by the Contractor.

x. Treatment Intensity and Therapeutic Approach

Treatment intensity refers to the number of direct service hours in an approved Treatment Plan. Upon referral, the provider-agency will assess the child and family's current treatment needs and determine the treatment intensity required. Treatment is to be individualized based upon the clinical needs being addressed and done in collaboration with the child's family and all relevant parties involved in developing a plan of care for the child and family.

Treatment intensity must take into account the following factors:

- a. The child's age.
- b. The child and family's ability to engage in sustained treatment (e.g., span of attention, stamina, developmental level, etc.) and expectations for progress.
- c. Type, nature, and course of presenting condition and diagnosis.
- d. Severity of presenting behaviors.
- e. Other treatment or educational services being received.
- f. Impact on family functioning.
- g. Presence of co-existing conditions.
- h. Presence of biological or neurological abnormalities.
- i. Current functional capacities of the child.
- j. Family factors (e.g., parenting skills, living environment, and psycho-social problems).
- k. Interaction with other agencies or providers.

xi. Staffing

HBTS is provided by for a variety of different staff persons, all of whom must successfully pass a BCI and CANS screening, including the following:

1. Home-Based Specialized Treatment Worker:
  - a. At least 19 years of age
  - b. High school diploma/equivalent and two years' experience or currently enrolled in not less than 6 semester hours of relevant undergraduate coursework at accredited college or university
2. Home-Based Treatment Support Worker:
  - a. At least 19 years of age
  - b. High school diploma/equivalent and one-year experience or Associate's degree in human service field.
3. Clinical Supervisor:
  - a. Rhode Island licensed health care professional with established competency working with children with special health care needs.

Master's or Doctoral degree.

4. Treatment Consultant:
  - a. Rhode Island licensed health care professional in one of the following categories: BCBA, licensed independent clinical social worker, licensed clinical social worker, marriage and family therapist, mental health counselor, psychologist, physical therapist, Occupational Therapist, or Speech and Language Pathologist
5. Treatment Coordinator:
  - a. Bachelor's degree at minimum
6. Lead Therapist: (for ABA)
  - a. At least 19 years of age
  - b. High school diploma/equivalent and two years' experience or an Associate degree in human service field.

At a minimum, the Contractor is responsible for ensuring that adequate provider access is available for all levels of staffing listed above.

xii. Level of Care Criteria

The Contractor is responsible for designing level of care/ utilization management criteria for this service. In order to assure comparability between the Contractors and Fee for Service (FFS) Medicaid, the criteria must be submitted to EOHHS for review and approval, prior to the Contractor's implementation.

xiii. Payment Methodology

The Contractor is responsible for designing an innovative payment method for the core components of HBTS. Methodology must be submitted to EOHHS for review and approval, prior to the Contractor's implementation.

xiv. Quality/Outcome Metrics and Reporting

The Contractor is responsible for providing EOHHS with reporting specific to HBTS at intervals defined by EOHHS. Within six months of the executed contract, the State and the Contractor will collaboratively identify reportable quality outcome metrics.

xv. Provider Network

The Contractor is responsible for maintaining a robust provider network to provide this service. At the minimum, the Contractor must contract with the following providers:

Access Point RI (HBTS and ABA Program)  
Bradley Hospital (ABA Program)  
CBS Therapy (ABA Program)  
Family Behavior Solutions, Inc. (ABA Program)  
Frank Olean Center (HBTS)  
Groden Center (HBTS and ABA Program)  
J. Arthur Trudeau (HBTS and ABA Program)  
Looking Upwards, Inc. (HBTS)

Momentum, Inc. (ABA Program)  
Northeast Behavioral Associates (HBTS and ABA Program)  
Ocean State Behavioral (HBTS)  
Ocean State Community Resources, Inc. (HBTS)  
Perspectives Youth and Family Services (HBTS and ABA Program)  
proAbility (HBTS)  
Seven Hills (HBTS and ABA Program)  
TIDES (HBTS)  
United Cerebral Palsy of RI (HBTS)

The Contractor is responsible for contacting each provider agency and providing education on managed care contracting and managed care billing procedures to the provider, if applicable.

**B. Evidence Based Practices (EBP):**

EBP are Home and Community Based Treatment modalities that include an array of services to meet the continuum of care a child, adolescent, and family needs.

**Core Components:**

At a minimum, the Contractor is responsible for ensuring that evidenced based practices, such as the services identified above are available to its members and are part of the continuum of care offered by the Contractor.

i. Staffing

At a minimum, the Contractor is responsible for ensuring that adequate provider contracts are available for all levels of staffing needed for the specific EBP.

ii. Level of Care Criteria

The Contractor is responsible for designing level of care/ utilization management criteria for this service. In order to assure comparability between the Contractors and FFS, the criteria must be submitted to EOHHS for review and approval, prior to the Contractor's implementation.

iii. Payment Methodology

The Contractor is responsible for designing an innovative payment method for these services. Methodology must be submitted to EOHHS for review and approval, prior to the Contractor's implementation.

iv. Quality/Outcome Metrics and Reporting

The Contractor is responsible for providing EOHHS with reporting specific to the EBP at interval defined by EOHHS. Within six months of the executed contract, the State and the Contractor will collaboratively identify reportable quality outcome metrics.

v. Provider Network

The Contractor is responsible for maintaining a robust provider network to provide this service.

**C. Adolescent Residential Substance Use Treatment:**

**Core Components:**

Individualized treatment is determined through comprehensive assessment using ASAM criteria and clinical collaboration. Treatment is strength-based, solution focused utilizing Motivational Interviewing, Cognitive-Behavioral Therapy and evidence-based modalities including Dialectical Behavior Therapy and Aggression Replacement Therapy. Programming combines recreation, life skills curriculums and opportunities for 12-step recovery work with the individual, group and family work each client receives. Treatment is specific to maintaining abstinence and relapse prevention while promoting effective functioning in society with medication prescribing and monitoring where indicated. Referrals are received via hospitals, physicians, call centers, treatment programs, RI Family and Drug Courts, Probation and Parole, DCYF and local school systems.

i. Staffing

Clinical Director, Program Director, counselors/clinicians, education coordinator, recreation coordinator and residential support staff.

At a minimum, the Contractor is responsible for ensuring that adequate provider contracts are available for all levels of staffing listed above.

ii. Payment Methodology

The Contractor is responsible for designing an innovative payment method for these services. Methodology must be submitted to EOHHS for review and approval, prior to the Contractor's implementation.

iii. Quality/Outcome Metrics and Reporting

The Contractor is responsible for providing EOHHS with reporting specific to adolescent substance use residential programming at intervals defined by EOHHS. The Contractor is responsible for identifying reportable quality outcome metrics.

iv. Provider Network

The Contractor is responsible for maintaining a robust provider network to provide this service. At the minimum, the Contractor must contract with the following providers:

**Caritas ARTS Program.**

The Contractor is responsible for contacting each provider and providing education on managed care contracting and managed care billing procedures to the provider, if applicable.

**D. Personal Assistance Services & Supports (PASS):**

PASS is a comprehensive integrated program that includes intermittent, limited, or extensive one- to-one personal assistance services needed to support, improve or maintain functioning in age appropriate natural settings. These specialized consumer-directed services are available to

children who have been diagnosed with certain physical, developmental, behavioral or emotional conditions living at home. PASS Services are designed to assist children and youth with attaining goals and identifying objectives within three areas: activities of daily living, making self-preserving decisions, and participating in social roles and social settings. The goals of the services provided are to support the family in helping the child participate as fully and independently as possible in natural community settings and to reach his or her full potential.

This is achieved through maximizing control and choice over specifics of service delivery and the child's family assumes the lead role in directing support services for their child.

### **Core Components:**

PASS is composed of various service components, including:

i. Assessment and Service Planning

PASS Agency coordinator works with the family to assure families have the requisite information and/or tools to participate in a consumer-directed approach and to manage the services. The PASS Agency coordinator assesses the family's ability to effectively participate in the delivery of PASS services throughout an authorized period of care. The Service Plan begins with an assessment of the needs and activities of the child and family based upon their daily routines. From the assessment, flows the identification of goals and objectives with details of Service Plan Implementation and monitoring. Service Plans constitute a written agreement for all involved parties and identify roles and responsibilities of each party (i.e. PASS families, direct service worker(s) and PASS Agency). All goals and objectives in the Service Plan and in the scope of the Direct Service Worker activities must be focused in at least one of the three PASS domains: activities of daily living, making self-preserving decisions, and participating in social roles and social settings.

ii. Direct Services

Direct Services are one-to-one personal assistance services provided by a Direct Service Worker under the direction of the parent/caregiver/guardian in accordance with an individualized approved Service Plan. Under Direct Services, designated family supervisor(s) will direct the scope, content and schedule of worker activities and evaluate their performance.

iii. Service Plan Implementation

PASS Agency supports family in recruitment, screening, hiring and training of Direct Service Workers and their ongoing employment through payroll administration.

iv. Clinical Consultation

Provides family, Direct Service Workers, and the child with clinical guidance through reviews of goals and objectives, observations of a child's progress, providing recommendations for effective strategies and approaches and for methods for monitoring and tracking progress.

v. Treatment Intensity

Treatment intensity refers to the number of direct service hours in an approved Service Plan. It is the PASS Agency's responsibility to determine the level of treatment intensity necessary to promote the achievement of treatment objectives. Treatment intensity is based on the individual needs of a child. Collaboration with the child's family and all

relevant parties involved in developing an individualized plan of care for the child is required and will be maintained throughout a period of treatment (e.g., HBTS, behavioral health, physician, school personnel, or other agencies). Arriving at a level of treatment intensity must take into account the following factors:

1. The child's age.
2. Ability to engage in sustained treatment (e.g., span of attention, stamina, developmental level, etc.) and expectations for progress.
3. Type, nature, and course of presenting condition and diagnosis.
4. Severity of presenting behaviors.
5. Other treatment or educational services being received.
6. Impact on family functioning.
7. Presence of co-existing conditions.
8. Presence of biological or neurological abnormalities.
9. Current functional capacities of the child.
10. Family factors (e.g., parenting skills, living environment, and psycho-social problems).
11. Interaction with other agencies or providers.

At a minimum, the Contractor is responsible for ensuring that all above services are available to its members and are part of the continuum of care offered by the Contractor.

vi. Staffing

PASS is provided by for a variety of different staff persons, all of whom must successfully pass a BCI and CANTS screening, including the following:

1. Direct Service Worker
  - a. At least 18 years of age
  - b. High school diploma/equivalent
  - c. No financial responsibility for child and does not live in household
  - d. Demonstrated ability to carry out specific tasks outlined in service plan
2. PASS Agency Coordinator
  - a. Bachelor's Degree in human services or related field
  - b. One-year minimum experience
  - c. Demonstrated competency working with families of children with special health care needs
3. Clinical Consultant: Rhode Island licensed health care professional with minimum two years' experience working with children with special health care needs

- a. Licensed independent clinical social worker
- b. Licensed clinical social worker
- c. Board Certified Behavior Analyst
- d. Registered nurse with Master's Degree
- e. Psychologist
- f. Physical therapist, occupational therapist, or speech and language pathologist
- g. Mental health counselor
- h. Marriage and family therapist

At a minimum, the Contractor is responsible for ensuring that adequate provider contracts are available for all levels of staffing listed above.

vii. Level of Care Criteria

After the PASS transition period, the Contractor is responsible for designing level of care/ utilization management criteria for this service. In order to assure comparability between the Contractors and Fee for Service (FFS) Medicaid, the criteria must be submitted to EOHHS for review and approval, prior to the Contractor's implementation.

viii. Payment Methodology

The Contractor is responsible for designing an innovative payment method for the core components of PASS. Methodology must be submitted to EOHHS for review and approval, prior to the Contractor's implementation.

ix. Quality/Outcome Metrics and Reporting

The Contractor is responsible for providing EOHHS with reporting specific to PASS at interval defined by EOHHS. Within six months of the executed contract, the State and the Contractor will collaboratively identify reportable quality outcome metrics.

x. Provider Network

The Contractor is responsible for maintaining a robust provider network to provide this service. At the minimum, the Contractor must contract with the following providers:

- Access Point RI
- Frank Olean Center
- Groden Center
- J. Arthur Trudeau Memorial Center
- Looking Upwards, Inc.
- Momentum, Inc.
- Northeast Behavioral Associates
- Ocean State Behavioral
- Ocean State Community Resources, Inc.
- Perspectives Youth and Family Services
- proAbility
- Seven Hills
- United Cerebral Palsy of RI

The Contractor is responsible for contacting each provider agency and providing education on managed care contracting and managed care billing procedures to the provider.

**E. Respite:**

Respite services are family directed caregiving supports available for families of children (birth-21) that meet an institutional level of care criteria. Families who are eligible receive an annual allotment of at least 100 hours of respite services. Additional hours may be utilized to prevent the need for more intensive services and supports. Respite agencies manage, hire, and provide payment to respite workers. Respite workers are chosen by the family and the hours may be utilized as determined by the family. The Contractor must offer the family at least 100 hours of respite services, per year.

**Core Components:**

Respite is composed of two service components, including:

- i. Assessment of Safety/Service Plan  
Respite agency conducts a brief assessment of child's preferred and allowable activities, methods for communicating, health and safety issues for development of a service and safety plan.
- ii. Respite Service  
Respite Agency supports family in recruitment, screening, hiring and training of Direct Service Workers and their ongoing employment through payroll administration.

At a minimum, the Contractor is responsible for ensuring that all above components are available to its members and are part of the continuum of care offered by the Contractor.

- iii. Staffing  
Respite is provided by the following staff persons, including:
- iv. Respite Program Coordinator  
Minimum Associates Degree and one-year experience working with families of children with special health care needs or at least three years' experience working with families of children with special health care needs.
- v. Respite Worker  
At least 18 years of age with no financial responsibility for child and does not live in household. At a minimum, the Contractor is responsible for ensuring that adequate provider contracts are available for all levels of staffing listed above.
- vi. Level of Care Criteria  
After the Respite transition period, the Contractor is responsible for designing level of care/ utilization management criteria for this service. This criterion must be submitted to EOHHS for review and approval, prior to the Contractor's implementation.
- vii. Payment Methodology

The Contractor is responsible for designing an innovative payment method for these services. Methodology must be submitted to EOHHS for review and approval, prior to the Contractor's implementation.

viii. **Quality/Outcome Metrics and Reporting**

The Contractor is responsible for providing EOHHS with reporting specific to Respite at interval defined by EOHHS. Within six months of the executed contract, the State and the Contractor will collaboratively identify reportable quality outcome metrics.

ix. **Provider Network**

The Contractor is responsible for maintaining a robust provider network to provide this service. At the minimum, the Contractor must contract with the following providers:

- The Autism Project
- Access Point RI
- The Groden Center
- J. Arthur Trudeau Memorial Center
- Northeast Behavioral Associates
- Ocean State Behavioral
- Ocean State Community Resources, Inc.
- Seven Hills Rhode Island

The Contractor is responsible for contacting each provider and providing education on managed care contracting and managed care billing procedures to the provider.

**4. EOHHS Certification Standards**

EOHHS has designed certification standard for its Medicaid FFS providers. The Contractor will use these certification standards as a guideline in designing the Contractors' programs. To assure comparability, the Contractors programs will not deviate substantially from the EOHHS Certification standards. All of the Contractors program standards and guidelines must be provided to EOHHS for review and approval.

**5. Services with Existing Referral Lists**

There is an existing referral list for HBTS (including ABA services). The Contractor will continually evaluate all individuals on the referral list and provide them with suitable services which address their unique clinical needs. The Contractor will be responsible for reporting to EOHHS monthly until such time that no members remain on the referral list.

**6. Reductions in Savings:**

EOHHS has assumed savings for children's behavioral health programs in the current rates and contracts. Saving estimates have been reduced to ensure timely access to services and increase provider participation. The Contractor will insure appropriate reimbursement adjustments to children's Home-Based Therapeutic Services (HBTS) and Applied Behavior Analysis (ABA) providers. It is the expectation that the Contractor provides services to all children currently on the waitlist as described in the section above.



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**ATTACHMENT P**  
**BEHAVIORAL HEALTH AND SUBSTANCE USE SERVICES FOR ADULTS**

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**ATTACHMENT P**  
**BEHAVIORAL HEALTH AND SUBSTANCE USE SERVICES FOR ADULTS**

The following provides a description of the Integrated Health Home Program (IHH) and the Assertive Community Treatment Programs (ACT). These services are specific to individuals with serious mental illness. The second part of the document refers to the continuum of mental health and substance use services. These services will be provided to any adult member, based on need. EOHHS, BHDDH, and the Contractor will work together to transition these services from Fee-for-Service into managed care. EOHHS recognizes as this transition occurs, the program and service features may change. EOHHS will continue to hold the Contractor responsible for ensuring all members with need receive appropriate and timely access to care.

**1. Overview**

Adults with serious mental illness require specialized programs that deliver recovery-oriented care, addressing all clinical needs both behavioral and medical. These specialized programs are responsible for ensuring integration of care which includes coordinating the recipient's comprehensive health care needs including physical health, mental health, substance use and social supports. The performance of these programs will be measured, and the goal is improved access to high quality community-based services and decreased costs.

The specialized programs will be for adults with a range of serious mental health illness identified based on diagnostic characteristics. The specialized programs described in this document which will be carried out by the Community Mental Health Organizations (CMHOs) licensed by BHDDH are referred as: Assertive Community Treatment (ACT) and Integrated Health Homes (IHH). Program monitoring and evaluation by the Contractor is required to ensure validity to the model and the effective implementation of responsibilities and functions by the Managed Care Organizations and the CMHOs. The program will be supported by BHDDH regulations.

It is the State's expectation that for those members who are active with a Health Home, the care manager on site at the Health Home will be the Lead Care Manager for that member. Contractor's care management staff will coordinate between the Health Home and any necessary physical health care a member may need. The Contractor will have a designated Lead Care Coordinator or Care Manager to work directly with the CMHO and OTP Health Homes. The Contractor will employ predictive modeling tools that identify and stratify members at risk. If an at-risk member is identified, they will be referred to a Health Home.

The Contractor will have policies and procedures that document how the Contractor will conduct transitions of care and hospital discharge activities, to ensure all appropriate medical, social, and behavioral health needs are met when a member transitions back to the community.

**2. Goals**

The specialized programs for adults with serious mental illness will be a holistic, person-centered care model that aims to improve member outcomes and takes into account behavioral (mental health and substance use) and primary medical and specialist needs in order to strengthen the connection these high-risk patients have to the comprehensive health care system. Emphasis is placed on the monitoring of chronic conditions, timely post inpatient discharge follow-up and preventative and education services focused on self-care, wellness and recovery. This program is accountable for reducing health care costs, specifically preventable hospital admissions/readmissions and avoidable emergency room visits. The programs will meet the Triple Aim of improving care and access, reducing cost, and improving quality.

<p><b>Improve care and access</b></p>	<ul style="list-style-type: none"> <li>• Person-centered approach (whole person care)</li> <li>• Commitment to recovery/resiliency focused services</li> <li>• Coordinate care across medical, mental health and substance use system</li> <li>• Expand capacity of and access to high quality community-based services</li> </ul>
<p><b>Reduce cost</b></p>	<ul style="list-style-type: none"> <li>• Ensure that a sufficient range of community-based services are available to decrease ER and inpatient utilization</li> <li>• Decrease total cost of care for highest utilizers</li> <li>• Alignment of incentives to support providers in sharing accountability for the cost of care</li> </ul>
<p><b>Improve quality</b></p>	<ul style="list-style-type: none"> <li>• Continuous quality improvement</li> <li>• Promote clinical and service excellence through evidence-based practices</li> <li>• Alignment of incentives to promote increased quality</li> </ul>

**3. Mental Health Parity**

The Contractor will comply with the Mental Health Parity Addiction Equity Act (MHPAEA). Requirements include:

- Treatment limitations that are applied to mental health or substance use disorder benefits are no more than the predominant treatment limitations that are applied to substantially all medical/surgical benefits.
- There are no separate treatment limitations that apply only to mental health or substance use disorder benefits.
- Medical management techniques used by the Contractor must be comparable to and applied no more stringently than the medical techniques that are applied to medical/surgical benefits.

In addition, the contractor agrees that its non-quantitative treatment limits for behavioral health services will not be more restrictive, nor applied more stringently, than the plan’s non-

quantitative treatment limits for its commercial population. This includes policies and procedures for medical necessity determination, prior approval, and concurrent and retrospective review.

## **Program Description**

### **Target Populations**

Eligible participants in ACT or IHH must be 18 years or older and are actively enrolled in the following Medicaid product lines: RItE Care, Medicaid Expansion, and Rhody Health Partners (RHP).

Participants are initially defined by their diagnostic characteristics, specifically a primary DSM V/ICD-10 mental health diagnosis. To be eligible for ACT and IHH participants must also meet the appropriate level of acuity as defined by the State approved standardized assessment tool Daily Living Activities Functional Assessment (DLA).

- ACT participants must have a DSM V/ICD-10 mental health diagnosis and an impaired functional level score based on the DLA.
- IHH participants must have a DSM V/ICD-10 mental health diagnosis and an impaired functional level score based on the DLA.
- Individuals who do not meet diagnostic criteria but require IHH services due to significant functional impairment as measured by the state approved standardized assessment tool, may be admitted to the program through an appeals process established by the State.

### **Core CMHO Functions and Responsibilities**

The CMHOs will carry out the following functions under both ACT and IHH Programs:

- Identify participants eligible for specialized programs (based on Target Population parameters)
- Complete a comprehensive risk assessment using the standardized tool, DLA, to identify participant.
- Based on Assessment score, determine and place individual in appropriate specialized program level of service: IHH or ACT. Individuals that do not meet IHH or ACT will not be assigned to the programs and but remain eligible for services and care management in the community.
- Develop a person-centered, individualized Care Plan
- For all Health Home admissions, discharges and transfers, a State approved enrollment form must be completed and kept in the client's medical record. If a client is already enrolled in a Health Home program it is up to the Provider to coordinate with the client's current Health Home Provider

- Carry out treatment and recovery services with fidelity to the ACT model of care
- Carry out treatment and recovery services in the IHH model of care
- Actively use Current Care for communication between medical and BH settings, especially for inpatient and ER alerts, for clients that opt into the Current Care program
- Participate in active discharge planning with medical and BH/SU inpatient, acute care and other facilities
- Collaborate to create new delivery system capacity as needed through on-going evaluation of the needs of the system.
- Work with the Contractor’s care management staff to facilitate access to the member’s PCP and specialty medical providers.
- Work with the Contractor’s utilization review staff to ensure timely access to follow-up care, post inpatient psychiatric hospitalization, including medication reconciliation.
- Submit required the Contractor and EOHHS metric reporting and data exchange
- Coordinate with the Opioid Treatment Provider (OTP) Health Home Program to avoid duplication of services. Members can only be enrolled in one specialized program at a time and cannot be simultaneously enrolled in ACT, IHH and OTP Health Home
- Notify the Contractor and BHDDH of staffing changes impacting the CMHO’s ability to provide the services required for IHH or ACT within 14 calendar days. Providers will submit a monthly staffing census to BHDDH/MCO that will be reviewed and evaluated for provision of services.
- Provide primary medical, specialist and behavioral health care through direct provision, or through contractual or collaborative arrangements with appropriate service providers of comprehensive, integrated services.

### **Program Elements**

The ACT and IHH specialized programs both use a multi-disciplinary team model where medical care coordination staff and behavioral health treatment staff work together to meet the comprehensive health and wellness needs of assigned participants. The team is responsible for coordinating the medical, behavioral and substance use care of all participants. Care is provided with fidelity to the evidence-based practices of ACT and IHH. The model of care promotes recovery, hope, dignity and respect with the belief that all consumers can recover from mental illness. Active treatment and supports are provided with cultural competence.

### **Program Definitions**

Assertive Community Treatment (ACT) Services provided through RI Integrated Health Homes (IHH) have the responsibility to coordinate and ensure the delivery of person-centered care; provide timely post discharge follow-up, and improve patient health outcomes by addressing primary medical, specialist and behavioral health care through direct provision, or through

contractual or collaborative arrangements with appropriate service providers of comprehensive, integrated services. Emphasis is placed on the monitoring of chronic conditions, and preventative and education services focused on self-care, wellness and recovery.

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

- Comprehensive care management;
- Care coordination and health promotion;
- Comprehensive transitional care from inpatient to other settings, including follow-up;
- Individual and family support, which includes authorized representatives of the consumer;
- Referral to community and social support services, if relevant; and
- The use of health information technology to link services, as feasible and appropriate.

The ACT team is available to provide services 24 hours per day seven days per week, 365 days per year. An ACT team is best conceptualized as continuous care team that functions as a vehicle to provide an array of clinical services or practical needs a person requires. As the provider of most of the services, the continuous care team assures that the services are integrated and provided in the context of the client's current needs, with all activities directed toward helping the client to live a stable life of quality in the community. A major focus of the team is to help the client to gain the skills and confidence needed to move toward greater degrees of independence.

**Integrated Health Home (IHH)** is built upon the evidence-based practices of the patient-centered medical home model. IHH builds linkages to other community and social supports, and enhances coordination of primary medical, specialty and behavioral healthcare, (including Addiction care) in keeping with the needs of persons with multiple chronic illnesses. IHH is a service provided to community-based clients by professional behavioral health staff in accordance with an approved treatment plan for the purpose of ensuring the client's stability and continued community tenure. IHH teams monitor and provide medically necessary interventions to assist in the enhancement of health, management of symptoms of illness, as well as overall life situations, including accessing needed medical, social, educational and other services necessary to meeting basic human needs. IHH uses a team-based approach for care coordination, mental health and physical health chronic condition management, health promotion and peer/family support.

IHH activities are focused in four areas:

### **1. Care coordination and health promotion**

Each client will be assigned a primary case manager who coordinates and monitors the activities of the individual treatment team and has primary responsibility to write the person-centered treatment/care coordination plan, ensure plans are revised and updated as clients' needs change and advocate for client rights and preferences. In addition, collaborate with primary and specialty care providers as required and provide education about medical medications (e.g. educating through written materials, etc.). The Health Home team is responsible for managing clients' access to other healthcare providers and to act as a partner in encouraging compliance with care plans established by these providers. Health promotion activities are delivered by the team to engage clients in addressing healthy lifestyles and include but are not limited to: smoking cessation; nutrition; increasing activity levels; relaxation strategies; and stress management.

### **2. Chronic condition management and population management**

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

- Assisting in the development of symptom self-management, communication skills and appropriate social networks to assist clients in gaining effective control over their psychiatric symptoms and their life situations, including minimizing social isolation and withdrawal brought on by mental illness, to increase client opportunities for leading a normal, socially integrated life;
- Provide health education, counseling and symptom management challenges to enable client to be knowledgeable in the prevention and management of chronic medical illness as advised by the client's primary/specialty medical team.
- Maintaining up-to-date assessments and evaluations necessary to ensure the continuing availability of required services;
- Assisting the client in locating and effectively utilizing all necessary community services in the medical, social and psychiatric areas and ensuring that services provided in the mental health area are coordinated with those provided through physical health care professionals;
- Assisting in the development and implementation of a plan for assuring client income maintenance, including the provision of both supportive counseling and problem-focused interventions in whatever setting is required, to enable the client to manage the symptoms of their psychiatric and medical issues to live in the community. This includes:
  - Provide a range of support services or direct assistance to ensure that clients obtain the basic necessities of daily life, including but not necessarily limited to: financial support and/or benefits counseling (e.g., SSI, SSDI, Food Stamps, Section 8, Home Energy Assistance; Social Services; Transportation and Legal advocacy).

- Find housing which is safe, of good quality and an affordable place to live- apartment hunting, finding a roommate, landlord negotiations, cleaning, furnishing and decorating and procuring necessities (i.e. telephone, etc.).
- Provide ongoing assessment, problem solving, side-by-side services, skill training, supervision (e.g. prompts, assignments, monitoring, and encouragement) and environmental adaption to assist support client to maintain housing).
- Teach money-management skills (e.g. budgeting and bill paying) and assist client assessing financial services.
- Develop skills related to reliable transportation (help obtain driver's license, use of mass transit, arrange for cabs).
- Provide individual supportive therapy (e.g. problem solving, role playing, modeling and support), social skill development, and assertive training to increase client 's social and interpersonal activities in community settings) e.g. Plan, structure, and prompt social and leisure activities on evenings, weekends, and holidays, including side-by-side support and coaching.
- Assistance with other activities necessary to maintain personal and medical stability in a community setting and to assist the client to gain mastery over their psychiatric symptoms or medical conditions and disabilities in the context of daily living. For example:
  - Support the client to consistently adhere to their medication regimens (e.g. daily scheduling, delivering and supervision of medication regime, telephone prompting, Motivational interviewing, etc.), especially for clients who are unable to engage due to symptom impairment issues.
  - Accompanying clients to and assisting them at pharmacies to obtain medications.
  - Accompany consumers to medical appointments, facilitating medical follow up.
  - Provide side-by-side support and coaching to help clients socialize (e.g. going with a client to a baseball game, etc.) - structure clients' time, increase social experiences, and provide opportunities to practice social skills and receive feedback and support.

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

### **3. Comprehensive transitional care**

The IHH team will ensure consumers are engaged by assuming an active role in discharge planning. The IHH team will communicate and ensure collaboration between consumers, professionals across sites of care and the Contractor's care management and utilization review staff potentially reducing medical errors, missed appointments, and dissatisfaction with care. Specific functions include:

- a. Engage with the client upon admission to the hospital and ensure that the discharge plan addresses physical and behavioral health needs.
- b. Upon hospital discharge (phone calls or home visit):
  - i. Ensure that reconciliation of pre-and post-hospitalization medication lists is completed.
  - ii. Assist consumer to identify key questions or concerns.
  - iii. Ensure Consumer understands medications; potential side-effects; is knowledgeable about indications if their condition is worsening and how to respond; how to prevent health problem becoming worse; has scheduled all follow- up appointments.
  - iv. Prepare consumer for what to expect if another next level of care site is required (i.e. how to seek immediate care in the setting to which they have transitioned).
  - v. The Contractor’s care management and utilization review staff will work with the IHH team to review transition care goals, relevant transfer information (i.e. all scheduled follow-up appointments; any barriers preventing making appointments), function as resource to IHH consumers – to clarify all outstanding questions.
- c. Identify and facilitate linkages between long-term care and home and community-based services.

#### **4. Individual and Family support services**

IHH team will provide practical help and support, advocacy, coordination, side-by-side individualized support with problem solving, direct assistance, helping clients to obtain medical and dental health care. Services include individualized psycho-education about the client’s illness and the role of the family and their significant people in the therapeutic process. Also, to assist clients with children regarding service coordination (e.g. services to help client fulfill parenting responsibilities; services to help client restore relationship with children, etc.).

IHH peer support specialists will help IHH consumers utilize support services in the community and encourage them in their recovery efforts by sharing their lived experience and perspective. Peer support serves to validate clients’ experiences, guide and encourage clients to take responsibility for and actively participate in their own recovery. In addition, offer peer support services to:

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

#### **Assessment**

The CMHOs are expected to use a single, standardized assessment tool approved by the State. Assessments based on other tools will not be accepted.

Assessment Frequency

- An assessment will be administered at the time of initial engagement and every 6 months or more frequently when a significant change is identified.
- A reassessment with the standardized tool will be conducted within 48 hours of a discharge from a hospital or nursing home.

**Plan of Care**

A comprehensive Plan of Care must address behavioral health needs, medical and social needs with measurable, realistic and time sensitive goals. The following are required:

- Plan of care developed within thirty (30) days of completion of the assessment.
- Plan of care developed with and agreed to by the member or caregiver, or those chosen by the member to participate in the care plan. (verbal or written acceptance)
- Reviewed at least every 6 months and when a significant change is identified

**Reporting**

A complete listing of quality and monitoring measures is listed below. The State reserves the right to make modifications to required data elements and aggregate reports.

**5. Assertive Community Treatment (ACT) and IHH Requirements**

The requirements of ACT and IHH have several shared requirements but differ in the characteristics of the participants and the level of service intensity, as determined by the functional level score. ACT and IHH participants must have a DSM V/ICD-10 mental health diagnosis and an impaired functional level score based on the DLA.

**Service Requirements**

Participants are outreached by members of the ACT Team continually to engage in care to the maximum extent necessary to achieve individual goals. If a member refuses care or declines participation for ninety (90) days, the CMHO must notify the Contractor to review the Care Plan.

Participants are outreached and engaged by members of the IHH Team over the course of each month. The IHH Team members must be flexible and available to meet more frequently when needed. The IHH Team Leader is available 24 hours/day 7 days a week if needed.

The ACT and IHH Teams provides or coordinates the following services:

• Crisis Stabilization Services 24/7
• Housing Assistance, Tenancy Supports and Activities of Daily Living Supports
• Medication Management Medication administration, monitoring and reconciliation
• Individual, Group and Family Therapy
• Medical and Substance Use Treatment Coordination Activities
• Recovery and Rehabilitation Skills
• Substance Use Treatment (for ACT participants only)

• Supported Employment/Schooling Assessment and Assistance
• Care Transition – hospital, incarceration or nursing home to home
• Outreach and engagement
• Identification and engagement of natural supports and Social relationships
• Peer Support and IADL Support Services
• Education, Support, and Consultation to Clients’ Families and Other Major Supports

**A. Service Coordination/Care Management**

Each client will be assigned a service coordinator (care manager) who coordinates and monitors the activities of the client’s individual treatment team and the greater ACT/IHH team. The primary responsibility of the service coordinator is to work with the client to develop the treatment plan, provide individual supportive counseling, offer options and choices in the treatment plan, ensure that immediate changes are made as the client’s needs change, and advocate for the client’s wishes, rights, and preferences. The service coordinator is the first staff person called upon when the client is in crisis and is the primary support person and educator to the individual client’s family. Members of the client’s individual treatment team share these tasks with the service coordinator and are responsible to perform the tasks when the service coordinator is unavailable. Service coordination also includes coordination with community resources, including consumer self-help and advocacy organizations that promote recovery.

**B. Crisis Stabilization**

Crisis stabilization will be available and provided 24 hours per day, seven days per week. Crisis intervention response must be provided in a timely manner.

These services will include telephone and face-to-face contact. The Contractor will make available a current listing of all subcontractors engaged for this service.

**A. Therapy**

This will include but is not limited to the following:

1. Ongoing comprehensive assessment of the client’s mental illness symptoms, accurate diagnosis, and response to treatment.
2. Individual and family Psychoeducation regarding mental illness and the effects and side effects of prescribed medications
3. Symptom-management efforts directed to help client identify/target the symptoms and occurrence patterns of his or her mental illness and develop methods (internal, behavioral, or adaptive) to help lessen the effects.
4. Individual, group and family supportive therapy
5. Psychological support to clients, both on a planned and as-needed basis, to help them accomplish their personal goals, to cope with the stressors of day-to-day living, and to facilitate recovery.

- B. Medication Prescription, Administration, Monitoring and Documentation  
The ACT/IHH team psychiatrist or registered nurse will provide education about medication, benefits and risks, obtain informed consent and assess and document the client's mental illness symptoms and behavior in response to medication. Team members will monitor and document medication side effects and provide supportive services. This clinical team will also assist the client with medication adherence strategies for all psychiatric and medical prescriptions.
- C. Dual Diagnosis Substance Use Disorder Services  
Provision of a stage-based treatment model that is non-confrontational, considers interactions of mental illness and substance use, and has client-determined goals. This will be provided by an addiction specialist and include but is not be limited to individual and group interventions in:
1. Engagement (e.g., empathy, reflective listening, avoiding argumentation)
  2. Assessment (e.g., stage of readiness to change, client-determined problem identification)
  3. Motivational enhancement (e.g., developing discrepancies, psych education)
  4. Active treatment (e.g., cognitive skills training, community reinforcement)
  5. Continuous relapse prevention (e.g., trigger identification, building relapse prevention action plans).
- D. Supportive Employment-Related Services  
Work-related services to help clients value, find, and maintain meaningful employment in community-based job sites and services to develop jobs and coordinate with community-based employers. The principles of the evidence-based practice Individual Placement and Support (IPS) will be used to find employment. Services Include but are not limited to:
- a. Assessment of job-related interests and abilities through a complete education and work history assessment as well as on-the-job assessments in community-based jobs.
  - b. Assessment of the effect of the client's mental illness on employment with identification of specific behaviors that interfere with the client's work performance and development of interventions to reduce or eliminate those behaviors and find effective job accommodations.
  - c. Development of an ongoing employment rehabilitation plan to help each client establish the skills necessary to find and maintain a job.
  - d. Individual supportive counseling to assist clients to identify and cope with mental illness symptoms that may interfere with their work performance.
  - e. On-the-job or work-related crisis intervention.

- f. Work-related supportive services, such as assistance with grooming and personal hygiene, securing of appropriate clothing, wake-up calls, and transportation, if needed.
  - g. Job Development
  - h. On-site supports as needed
  - i. Coordination of supports through in collaboration with the Office of Rehabilitation Services (ORS)
  - j. Job coaching
- E. Activities of Daily Living/ADL's  
Services to support activities of daily living in community-based settings include individualized assessment, problem solving, sufficient side-by-side assistance and support, skill training, ongoing supervision (e.g. prompts, assignments, monitoring, encouragement), and environmental adaptations to assist clients to gain or use the skills required to:
- a. Find housing which is safe, of good quality, and affordable (e.g., apartment hunting; finding a roommate; landlord negotiations; cleaning, furnishing, decorating; and procuring necessities such as telephones, furnishings, linens)
  - b. Perform household activities, including house cleaning, cooking, grocery shopping, and laundry
  - c. Carry out personal hygiene and grooming tasks, as needed
  - d. Develop or improve money-management skills
  - e. Use available transportation
  - f. Have and effectively use a personal physician and dentist
- F. Natural Supports and Social/Interpersonal Relationship Identification  
Services to support social/interpersonal relationships and leisure-time skill training include supportive individual therapy (e.g., problem solving, role-playing, modeling, and support); social skill teaching and assertiveness training; planning, structuring, and prompting of social and leisure-time activities; side-by-side support and coaching; and organizing individual and group social and recreational activities to structure clients' time, increase social experiences, and provide opportunities to practice social skills and receive feedback and support required to:
- a. Improve communication skills, develop assertiveness, and increase self-esteem
  - b. Develop social skills, increase social experiences, and develop meaningful personal relationships

- c. Plan appropriate and productive use of leisure time
- d. Relate to landlords, neighbors, and others effectively
- e. Familiarize themselves with available social and recreational opportunities and increase their use of such opportunities

G. Peer Support Services

Services to validate clients' experiences and to guide and encourage clients to take responsibility for and actively participate in their own recovery. In addition, services to help clients identify, understand, and combat stigma and discrimination against mental illness and develop strategies to reduce clients' self-imposed stigma. Services include:

1. Peer counseling and support
2. Introduction and referral to consumer self-help programs and advocacy organizations that promote recovery

H. Instrumental Activities of Daily Living Support Services (IADL)

Support services or direct assistance to ensure that clients obtain the basic necessities of daily life, including but not limited to:

1. Medical and Dental services
2. Safe, clean, affordable housing
3. Financial support and/or benefits counseling (e.g., SSI, SSDI, Food Stamps, Section 8, Home Energy Assistance)
4. Social services
5. Transportation
6. Legal advocacy and representation

I. Education, Support, and Consultation to Clients' Families and Other Major Supports

Services provided regularly under this category to clients' families and other major supports with client agreement or consent, include:

- 1) Individualized psycho education about the client's illness and the role of the family and other significant people in the therapeutic process
- 2) Intervention to restore contact, resolve conflict, and maintain relationships with family and or other significant people
- 3) Ongoing communication and collaboration, face-to-face and by telephone, between the ACT/IHH team and the family

- 4) Introduction and referral to family self-help programs and advocacy organizations that promote recovery
- 5) Assistance to clients with children (including individual supportive counseling, parenting training, and service coordination) including but not limited to:
  - a) Services to help clients throughout pregnancy and the birth of a child
  - b) Services to help clients fulfill parenting responsibilities and coordinate services for the child/children
  - c) Services to help clients restore relationships with children who are not in the client's care and custody

#### J. Care Transitions

The ACT/IHH team will ensure consumers are engaged by assuming an active role in discharge planning. The team will communicate and ensure collaboration between consumers, professionals across sites of care, potentially reducing medical errors, missed appointments, and dissatisfaction with care. Specific functions include:

1. Engage with the client upon admission to the hospital and ensure that the discharge plan addresses physical and behavioral health needs.
2. Upon hospital discharge (phone calls or home visit):
  - Ensure that reconciliation of pre- and post-hospitalization medication lists is completed.
  - Assist consumer to identify key questions or concerns.
  - Ensure the client understands medications; potential side-effects; is knowledgeable about indications if their condition is worsening and how to respond; how to prevent worsening of health conditions and facilitate the scheduling of all follow-up appointments.
  - Review transition care goals with the team, provide relevant follow up and transfer information, function as resource to the client on all matters related to transition.
3. Identify and educate on linkages between primary and specialty medical care, behavioral healthcare, long-term care and home and community-based services.

### **Team Composition and Staffing Levels**

The Team Lead for an ACT team must be a licensed clinician. The Team Lead for an IHH team can be licensed as a Registered Nurse or have a Master's in Social Work. The assignment of the appropriate type of Lead CM is based on the level member's level of needs. In addition to the Team Lead, the ACT Team and IHH teams are expected to have a staff as defined in the *IHH Provider Manual*.

**Reimbursement Arrangement**

The provider is reimbursed based on a bundled rate for their ACT or IHH participants and MCO Fee for Service for selected services.

Billing for ACT will be a bundled rate. Providers will be required to submit encounter data/shadow claims to the MCOs for MCO clients and for the State for Medicaid FFS clients. If a service provided for in the bundle is billed separately from the bundle, by the ACT provider or another provider, the claim will deny.

Individuals involved in the MHPRR program are not able to enroll in ACT. ACT billing is not allowed for persons in institutionalized settings. Refer to the *Integrated Health Home (IHH) and Assertive Community Treatment (ACT) Provider Billing Manual*, for detailed information on billing. For any individual that is in a residential setting for more than thirty (30) days, the provider will report to the Contractor, BHDDH, and EOHHS on these members for the State to make a determination if this person is still appropriate for this level of service.

Billing for IHH will consist of the specified IHH code as well as other clinical services provided apart from the bundle. The IHH bundled rate is for care coordination activities only and does not include any clinical services. IHH can be billed while an individual is in an institutionalized setting. Refer to the *Integrated Health Home (IHH) and Assertive Community Treatment (ACT) Provider Billing Manual*, for detailed information on billing. For any individual that is in a residential setting for more than thirty (30) days, the provider will report to the Contractor, BHDDH, and EOHHS on these members for the State to make a determination if this person is still appropriate for this level of service.

ACT Bundled Services	ACT MCO Fee for Service
<ul style="list-style-type: none"> <li>• Crisis Stabilization Services including 24/7 access</li> </ul>	<ul style="list-style-type: none"> <li>• Clubhouse</li> </ul>
<ul style="list-style-type: none"> <li>• Housing Assistance, Tenancy Supports and Activities of Daily Living Supports</li> </ul>	<ul style="list-style-type: none"> <li>• Methadone</li> </ul>
<ul style="list-style-type: none"> <li>• Recovery &amp; Rehabilitation skills</li> </ul>	
<ul style="list-style-type: none"> <li>• Supported Employment/Schooling assessment and assistance</li> </ul>	
<ul style="list-style-type: none"> <li>• Case Management- Identification and engagement of natural supports and Social relationships</li> </ul>	
<ul style="list-style-type: none"> <li>• Care Coordination- Outreach and engagement</li> <li>• Medical and Substance Use Treatment Coordination Activities</li> </ul>	
<ul style="list-style-type: none"> <li>• Team Rounding</li> </ul>	

ACT Bundled Services	ACT MCO Fee for Service
<ul style="list-style-type: none"> <li>Peer Support and IADL Support Services</li> </ul>	
<ul style="list-style-type: none"> <li>Care Transition – hospital, incarceration or nursing home to home</li> </ul>	
<ul style="list-style-type: none"> <li>Outpatient Clinical services provided at the CMHO including: Medication Management Medication administration, monitoring and reconciliation, Individual, Group and Family Therapy</li> </ul>	
<ul style="list-style-type: none"> <li>Medication management including reconciliation</li> </ul>	
<ul style="list-style-type: none"> <li>Substance Use Treatment (for ACT participants only)</li> </ul>	

In general, the IHH program billing will encompass:

<ul style="list-style-type: none"> <li>Crisis Stabilization Services including 24/7 access</li> </ul>	<ul style="list-style-type: none"> <li>Residential Treatment</li> <li>Substance Use Treatment</li> </ul>
<ul style="list-style-type: none"> <li>Housing Assistance, Tenancy Supports and Activities of Daily Living Supports</li> </ul>	<ul style="list-style-type: none"> <li>Outpatient Clinical services provided at the CMHO and in community- Medication Management Medication administration, monitoring and reconciliation, Individual, Group and Family Therapy</li> </ul>
<ul style="list-style-type: none"> <li>Recovery &amp; Rehabilitation skills</li> </ul>	<ul style="list-style-type: none"> <li>Clubhouse</li> </ul>
<ul style="list-style-type: none"> <li>Case Management- Identification and engagement of natural supports and Social relationships</li> </ul>	<ul style="list-style-type: none"> <li>Supported Employment/Schooling assessment and assistance</li> </ul>

<ul style="list-style-type: none"> <li>Care Coordination-Care Transition – hospital, incarceration or nursing home to home</li> </ul>	
<ul style="list-style-type: none"> <li>Medical and Substance Use Treatment Coordination Activities</li> </ul>	
<ul style="list-style-type: none"> <li>Team Rounding</li> </ul>	
<ul style="list-style-type: none"> <li>Care Transition – hospital, incarceration or nursing home to home</li> </ul>	

### **Contractor Responsibility:**

The Contractors will support the following:

- Provide CMHOs with reporting to facilitate the coordination of medical and behavioral health care.
- The Contractor will use utilization data (inpatient admissions, readmissions, ER visits, and Pharmacy reports) along with predictive models to identify members with new health risks to share with CMHOs.
- The Contractor will be responsible for oversight to ensure contract requirements are being met.
- The Contractor will assist the CMHOs with identifying necessary components of metric reporting.
- The Contractor will adhere to the reporting date requirements as specified by EOHHS.
- The Contractor will adhere to a quality performance payment methodology and process that could include recoupments or withholds, as specified by EOHHS.
- Continuity of care requirements, including maintenance of relationships between members and treating providers. This includes beneficiaries transitioning into the managed care organization.
- The Contractor will hold the member harmless.
- The Contractor will ensure that the CMHO's are submitting HIPAA compliant claims data for services delivered under the IHH and ACT bundles.

### **Integration with Rehabilitation Practices**

Additional services not mentioned above for ACT/ IHH will integrate clinical treatment, services, and Rehabilitation practices including:

- Integrated Dual Diagnosis Treatment (substance use and mental illness), an evidence-based practice
- Mental Health Psychiatric Rehabilitation Residences (MHPRR)

### **Value-based Purchasing & Monitoring**

The Contractor will adhere to a quality performance payment methodology and process that may include recoupments or withholds, as specified by EOHHS.

The information collected from each measure will be used for program monitoring and must be provided based on the parameters. These measures will be routinely reviewed and modified, based on industry trends.

## **6. In Plan Benefits**

### **1. MENTAL HEALTH AND SUBSTANCE USE SERVICES**

The Contractor commits to providing all Medicaid managed care adults a full continuum of mental health and substance use services. The Contractor's services will address all levels of need. The Contractor will have a robust network of providers that meet the needs of the community. Providers should be a mix of CMHCs and community-based providers. All services should be provided to any adult member, as needed.

Services are not restricted to a specific pay level or category (such as an SPMI designation). The following provides an example of services that a CMHC or equivalent provider should provide. These include but are not limited to:

#### **A. ACUTE SERVICES:**

Acute Services represent the highest level of service intensity based on the member's need for either a locked or staff secured 24-hour clinical setting that offers full behavioral health management. These services are represented within a continuum of care including services such as Inpatient, Acute Residential Treatment Services (ARTS), Observation/Crisis Stabilization/Holding Bed, and Emergency Service Intervention.

##### **1. Emergency Service Intervention:**

24 hour/7 days a week, face-to-face care management and intervention of an individual experiencing a behavioral health crisis. Such crises include an imminent, real, and significant risk of serious harm to self or others that requires immediate treatment. The activities are conducted by a licensed behavioral health provider in a hospital emergency room, residential placement setting, the individual's home, police station, or other community setting that the family and the child-family competent clinician agree is safe and clinically suitable to resolve the mental health crisis.

- When a member is clinically assessed in an Emergency Room Setting and is not admitted to an inpatient level of care, the health plan will ensure that the member has a follow up appointment within three (3) business days of discharge from the Emergency Room. The health plan may fulfill this requirement by contract with their providers; or by utilizing the health plans care manager for outreach; or another care coordination entity in the community. The health plan must demonstrate compliance to this requirement within ninety (90) days of the execution of this amendment.
- The discharge plan will be shared with the member's physician within three (3) business days of the Emergency Room discharge. If a member is involved with a care coordinating entity, it is recommended that the discharge plan is shared within (3) business days of the emergency room discharge.

- The Contractor must demonstrate compliance to this requirement within ninety (90) days of the execution of this amendment”.

The plan will work with the hospital delivery system to ensure coordination of integrated care for members who may present with primary medical condition who have an underlying BH issue including but not limited to:

- Alcohol Related Disorders
- Anxiety Disorders
- Mood Disorders

## **2. Observation/Crisis Stabilization/Holding Bed:**

A secure and protected, medically staffed, psychiatrically supervised program designed for those individuals who, as a result of a psychiatric disorder, are an acute and significant danger to themselves or others, or who are acutely and significantly disabled and cannot meet their basic needs and functions, and who require extended observation and treatment in order to determine the most appropriate level of care and to avoid acute inpatient hospitalization.

## **3. Inpatient Acute Hospitalization:**

Services provided in a hospital- or freestanding detoxification facility staffed by licensed physicians (including psychiatrists) with 24-hour skilled nursing in a structured treatment milieu for the treatment of individuals with a mental health or substance use disorder of sudden onset and short, severe course who cannot be safely or effectively treated in a less intensive level of care.

## **4. Acute Residential Treatment:**

A community based short-term service or hospital step- down that provides comprehensive multidisciplinary behavioral health evaluation and treatment in a staff setting offering high levels of supervision, structure, restrictiveness and intense treatment on a 24-hour basis. The treatment should include individual, family, and group clinical therapy, crisis management, & medication evaluation and management.

Acute Residential Treatment requires:

- The provider to be licensed as a Residential Treatment provider
- Available licensed physician on staff or on call, 24 hours per day, and 7 days per week to adjust medications as needed or to address members in crisis.
- RN on staff or an RN available to meet member’s needs.
- 24/7 availability of certified clinical staff adequate to meet the member’s medical and psychological needs
- Program structure includes therapeutic treatment services, modalities and

intensity as appropriate to meet family and member's needs. It is recommended that the structure includes at minimum 4 hours/ day Monday- Friday and 4 hours/day on weekends. Recreational and educational activities do not count toward therapeutic treatment.

## **B. INTERMEDIATE SERVICES and OUTPATIENT**

Acute Services represent the highest level of service intensity based in the member's need for either a locked or staff secured 24-hour clinical setting that offers full behavioral health management. These services are represented within a continuum of care including services such as Inpatient, Acute Residential Treatment Services (ARTS), Observation/Crisis Stabilization/Holding Bed, and Emergency Service Intervention.

### **1. Partial Hospitalization (PHP):**

A short term, comprehensive, multidisciplinary behavioral health program that promotes and maintains a therapeutic milieu/community. The PHP is an alternative to or step-down from inpatient care. PHP is designed to provide stabilization of acute, severe, mental illness, substance use disorders, or dual diagnosis.

A PHP requires daily psychiatric evaluation and treatment comparable to that provided by an inpatient setting. A PHP may be provided by both hospital-based and freestanding facilities and available 6-9 hours per day at minimum 5 days per week. For adults, a PHP provides services similar to hospital level care for members who have a supportive environment to return to in the evening. As the adult's symptoms improve and a transition plan effectively transitions the adult back to the community. The PHP consults and coordinates the member's care with other treating providers, and community supports. The PHP implements behavior plans, monitors, manages, and administers medication, and has 24/7 physician availability for emergencies.

Minimum program requirements include:

- Members receive clinical treatment & scheduled programming based on member's clinical needs. It is recommended that this is provided at least 20 hours per week for BH and/or SUD
- Individualized treatment plan, assessment, medication and evaluation, individual, family, & group counseling; crisis intervention, and activity therapies or psycho education, when determined to be clinically appropriate to meet the needs of the member.
- Members must be able to tolerate and participate in the PHP program.
- A licensed practitioner responsible to supervise program and staff and a treatment plan will be provided for each member.
- The Contractor will be responsible for ensuring that the provider has a treatment plan for each member and that the treatment plan includes member goals and a method for measuring these goals.

## **2. Day/Evening Treatment:**

A structured program focused on enhancing current levels of functioning and skills while maintaining community living. Adults who no longer require active medically based services may have significant residual symptoms that require extended interventions to address recovery. The goal of day/evening treatment is to assist members with behavioral health disorders to achieve and maintain their highest level of functioning and work toward appropriate development goals. The services provided include: individual and family behavioral health therapies; psychosocial and adjunctive treatment modalities including rehabilitative, pre-vocational and life skill services to enable the individual to attain adequate functioning in the community.

## **3. Intensive Outpatient Treatment (IOP):**

A clinically structured outpatient program for individuals similar to a Day Treatment offering short-term day, evening, or combination which consists of intensive treatment within a stable therapeutic milieu for those individuals who can be safely treated in a less intense setting than a partial, day or evening program but require a higher level of intensity than that available in outpatient therapy. IOP's primary treatment modality is group therapy which supports positive and safe communication and interactions in a supportive therapeutic milieu which is an essential component for member recovery.

Minimum program requirements include:

- Members receive clinical treatment based on the member's clinical needs. It is recommended that the clinical services are provided at least 3 hours per day, 3 times/week for BH and/or SUD.
- Individualized treatment plan, assessment, medication and evaluation, group, individual, and family, counseling; crisis intervention, and activity therapies or psycho education, when determined to be clinically appropriate based on the member's needs.
- Licensed physician on staff or on call that can adjust and evaluate medication if needed. Alternatively, designated program clinical staff will coordinate, collaborate, and/or link a member to a prescriber, if needed.
- A licensed practitioner responsible to supervise program and staff and a treatment plan will be provided for each member.

#### **4. ACT & IHH:**

Integrative behavioral and physical health care management model. Assessment, evaluation to identify member's behavioral and physical health needs. Care plan developed based on members identified needs with the goal of client stability and long-term community tenure. Coordination through regular contact and correspondence with primary care, social support, family, and treatment providers the member is involved with. Assist member in accessing social supports, vocational training and support, medical and behavioral health treatment, education training and support as identified through members' assessment and care plan. Case Manager must assist a member with transition from any 24-hour level of care or to prevent an admission. Case Management is delivered by adequately trained agency staff in accordance with applicable program specifications, State certification or licensing requirements, in addition to applicable MCO credentialing requirements.

The Contractor will reimburse these services in a manner defined by the State.

#### **5. Peer Support/Recovery Coach:**

A personal guide and mentor for people seeking or in recovery. The peer support/Recovery Coach assists to remove barriers and obstacles and links the recovering person to the recovery activities and supports.

#### **6. Clubhouse:**

The Clubhouse International model has been recognized by SAMHSA as an Evidence Base Practice for those with severe and persistent mental illness. Clubhouse has community structure, evidence-based practice, led by peers, recovery model with a focus on employment, wellness, and development of a community support network.

The Contractor will reimburse these services in a manner defined by the State. Clubhouse services should include a minimum of three (3) hours per service, at least 1 time per week. At a program level, twenty-five percent (25%) of all members in the program must have an employment outcome of either supported employment, transitional employment or independent employment.

#### **7. Integrated Dual Diagnosis Treatment for Substance Use Disorders:**

Care management services provided in accordance with an approved treatment plan to ensure members with primary substance use maintain and build stability, recovery capital, and continued community tenure.

#### **8. General Outpatient:**

Clinical services inclusive of individual, group, family, crisis intervention, diagnostic evaluation, psychological testing, and medication evaluation and management. Treatment can be conducted in an office, home-based or community setting. Member

has access to full continuum of Behavioral Health and Substance Use benefits offered by the Contractor (PHP, IOP, etc.) Clinical services are delivered by adequately trained behavioral health professionals in accordance with applicable program specifications, State licensing requirements, in addition to applicable Contractor.

**9. Center of Excellence Program (COE):**

Through the work of the Governor’s Opioid Overdoes Prevention and Intervention Task Force, BHDDH will certify providers that meet the established COE certification standards. EOHHS will work with CODAC, and future providers who become certified, to ensure that proper arrangements are in place to allow COE providers to bill medication via J-codes or other methods that will allow them to dispense medication to members at their facility rather than prescribe to the member for self-management, under a point of sale system.

The program is reimbursed by fee for service for managed care members, with the exception of the medications (table or films) which is currently in the formulary of the Contractor and is a benefit for their members.

**C. LONG TERM RESIDENTIAL PROGRAMS**

Long Term SUD Residential Services:

The Contractor is required to contract with and support the SSTAR Birth Residential Program. This requirement includes but is not limited to a minimum six (6) month length of stay for the family unit. EOHHS reserves the right to review and approve any prior authorization process required by the Contractor.

Services must meet ASAM Level 3.5, Level 3.3, or 3.1

**A. ASAM Level 3.5 Clinically Managed High- Intensity Residential:**

Level 3.5 provides a structured, therapeutic community environment focused on addressing member life skills, reintegration into the community, employment, education, and recovery.

Minimum Requirements:

- Member meets at least all 3.5 ASAM level criteria.
- Capacity to address the medical needs of the member.
- Medication and evaluation.
- It is recommended that at least 12 clinical services per week including individual, group, & family, based on the member’s need.

**B. ASAM Level 3.3 Short- Term Clinically Managed- Medium Intensity:**

Level 3.3 is a non- acute residential level of care that focuses on member stabilization, integration, employment, education, and recovery. A component of member treatment may focus on habilitation due to immediate service delivery needs for continuity of services (e.g. medications, assistive medical technology or supplies, ongoing relationships with providers, potential needs for prior authorizations or special arrangements to assure continuity with current providers, and potential met and unmet needs for assistance in accessing services and/or identifying to discharge from institutional level of care).

Minimum Requirements:

- Member meets all 3.3 ASAM level criteria.
- Capacity to address the medical needs of the member.
- Medication and evaluation.
- It is recommended that at least 12 clinical services per week including individual, group, & family, based on the member’s need.

**C. ASAM Level 3.1 Clinically Managed Low- Intensity Residential Services:**

Minimum Requirements:

- Member meets at all 3.1 ASAM level criteria.
- Capacity to address the medical needs of the member.
- Medication and evaluation.
- It is recommended that at least 5 clinical services (1 hour per week of clinical treatment and 4 group and/or family sessions) per week including individual, group, & family, based on the member’s need.

Mental Health Psychiatric Rehabilitative Residential (Group Home and Supportive Housing)

**A Mental Health Psychiatric Rehabilitative Residence (MHPRR):** is a licensed residential program that provides 24-hour staffing for a sub-population of the Integrated Health Home clients.

A physician must authorize all MHPRR services.

The “24-hour staffing” requirement means that the Provider must provide staff coverage 24 hours a day, 7 days a week as long as there are clients physically present in the living quarters of a program. Staff is on site for these programs.

The service elements offered by a residential program include to the following based on each resident’s individualized recovery-focused treatment plan:

- Mental health therapeutic and rehabilitative services for the resident to attain recovery
- Medication prescription, administration, education, cueing and monitoring
- Educational activities (appropriate to age and need)

- Menu planning, meal preparation and nutrition education
- Skill training regarding health and hygiene
- Budgeting skills training and/or assistance
- Community and daily living skills training
- Community resource information and access
- Transportation
- Social skills training and assistance in developing natural social support networks
- Cultural/Spiritual Activities
- Limited temporary physical assistance, as appropriate

In addition, each residential program provides the following for its residents:

- A homelike and comfortable setting
- Opportunities to participate in activities not provided within the residential setting
- Regular meetings between the residents and program personnel
- A daily schedule of activities
- Sleeping arrangements based on individual need for group support, privacy, or independence, as well as, the individual's gender and age.
- Provisions for external smoking areas, quiet areas, and areas for personal visits

**Supervised Apartments:** A Supportive Mental Health Psychiatric Rehabilitative Residence Apartments (MHPRR-A) is a licensed residential program which provides 24-hour staffing for IHH clients in which the clients receive a wide range of care management, treatment, psychiatric rehabilitation and individual care services. Beds may be designated as Intensive, Specialty, Basic, Crisis/Respite, or any combination thereof.

Specific services may include, but are not limited to:

- a) Medication: Education, administration and monitoring;
- b) Social casework: Client-based advocacy; linkage to outside service providers; monitoring the use of outside services; individualized treatment planning and skill teaching; income maintenance; and medical care assistance
- c) Limited physical assistance as required: Mobility; assistance with non-injectable medications; dressing; range-of-motion exercises; transportation; and household services;
- d) Skill assessment and development: Personal hygiene; health care needs; medication compliance; use of community resources; social skills development and assistance; support in the development of appropriate behaviors to allow the residents to participate, to the fullest extent possible, in normalized community activities.

The “24-hour staffing” requirement is interpreted to mean that the Provider must provide staff coverage 24-hours a day, 7 days a week as long as there are clients physically present in the living quarters of a program. Staff will be on site. Due to the complexity of these populations, staffing ratios are expected to be greater than traditional MHPRR settings. In addition, group home rules and expectations, levels of supervision and unaccompanied off-site travel will be specifically designed to address the needs of the population.

### Target Population:

Services are for adults with complex mental illness who are stable and require specialized rehabilitation services versus basic MHPRR services, in order to continue on their recovery journey. Need indicators for placement will be based on:

- History of Risk of harm to self to others
- Unpredictable behavior and likelihood of relapse
- Motivation and capacity in the areas of self-management
- Socialization
- Mental Health Court Order for residential services.

The Contractor will reimburse MHPRR facilities at a rate defined by EOHHS.

### Quality/Outcome:

Through chart audits at the CMHC, members in MHPRR should routinely attend all care management and integrated BH and medical services.

#### I. LEVEL OF CARE CRITERIA BASED UPON MEDICAL NECESSITY

The Contractor will provide descriptions of services and treatment settings. The criteria for medical necessity must be compliant with the medical necessity definition contained in Section **Error! Reference source not found.** of the Contract and include admission, continuing stay and discharge criteria for each.

#### II. EARLY IDENTIFICATION AND ACCESS

The Contractor will have defined methods to promote access to care and for early identification of adults with behavioral health needs, including:

1. Identification of members who may be in an inpatient setting and who will require intensive outpatient services following and to facilitate discharge,
2. Direct referral by a family member or other health care provider.

#### III. ACCESSIBILITY, AVAILABILITY, REFERRAL AND TRIAGE

The behavioral health program will have defined performance criteria for accessibility, availability, referral and triage that meet and/or-exceed NCQA standards.

#### IV. PROVIDER NETWORK AND NETWORK ADEQUACY

The Contractor will develop and monitor behavioral health provider network standards, subject to review by the Department, to ensure the full continuum of behavioral health needs is met on a timely basis and to promote geographic accessibility.

## V. TRANSITION PLAN

1. The Contractor is required to honor all prior authorizations for the period of the authorization and with the provider authorized.
2. The Contractor will complete a readiness process approved by the state prior to IHH program implementation
3. The Contractor will complete a review and identify and report to EOHHS on:
  - a. IHH
  - b. ACT
  - c. A Community Health Team (CHT)
  - d. Patient Medical Centered Medical Home (PCMH)

### **The Opioid Treatment Program Health Home Program Description**

The following provides a description of the Opioid Treatment Program Health Home (OTP HH). These services are specific to individuals with opiate dependence disorders who have or are at risk of chronic physical illnesses. The second part of the document refers to the continuum of mental health and substance use services. These services will be provided to any adult member, based on need. EOHHS will continue to hold the Contractor responsible for ensuring all members with need receive appropriate and timely access to care.

#### **1. Overview**

### **The Opioid Treatment Program Health Home Program**

The Opioid Treatment Program (OTP) Health Home (HH) initiative is a state-wide collaborative model designed to decrease stigma and discrimination, monitor chronic conditions, enhance coordination of physical care and treatment for opioid dependence, and promote wellness, self-care, and recovery through preventive and educational services. It is the fixed point of responsibility in the provision of person-centered care; providing timely post-discharge follow-up, and improving consumer health outcomes by addressing primary medical, specialist and behavioral health care through direct provision, or through contractual or collaborative arrangements with appropriate service providers.

**OTP Health Home(s):** as the fixed point of responsibility to coordinate and ensure the delivery of **person-centered care**, the OTP Health home staff ensure and provide timely post discharge follow-up and coordination with other behavioral health providers and primary care providers in the delivery of medical services to the member. The OTP Health Home places emphasis on the monitoring of chronic conditions, and preventative and education services focused on self-care, wellness and recovery. This program is accountable for reducing health care costs, specifically preventable hospital admissions/readmissions, avoidable emergency room visits and better alignment with standards of care for chronic medical conditions such as Hepatitis C, HIV, Diabetes, Asthma, and COPD.

**Patient Eligibility**

Opioid Dependent Medicaid recipients who are currently receiving or who meet criteria for Medication Assisted Treatment and have or are at risk of another chronic health condition are eligible for the OTP Health Home. The OTP Health Home will provide documentation of such risk by completing the OTP Health Home Eligibility checklist form developed by the Rhode Island Office of Behavioral Health, Developmental Disabilities and Hospitals (BHDDH).

**Provider Eligibility**

The Rhode Island Office of Behavioral Health, Developmental Disabilities and Hospitals (BHDDH) licenses Opiate Treatment Programs and OTP Health Homes.

**2. Goals of OTP HH**

The specialized programs for adults with opioid dependence and co-occurring chronic conditions or risk of chronic conditions will be a holistic, person-centered care model that aims to improve member outcomes and takes into account behavioral (mental health and substance use) and primary medical and specialist needs in order to strengthen the connection these high-risk patients have to the comprehensive health care system. Emphasis is placed on the monitoring of chronic conditions, timely post inpatient discharge follow-up and preventative and education services focused on self-care, wellness and recovery. This OTP Health Home program is accountable for reducing health care costs, specifically preventable hospital admissions/readmissions and avoidable emergency room visits. The programs will meet the Triple Aim of improving care and access, reducing cost, and improving quality.

<b>Improve care and access</b>	<ul style="list-style-type: none"> <li>• Person-centered approach (whole person care)</li> <li>• Commitment to recovery/resiliency focused services</li> <li>• Coordinate care across medical, mental health and substance use system</li> <li>• Expand capacity of and access to high quality community-based services</li> </ul>
<b>Reduce cost</b>	<ul style="list-style-type: none"> <li>• Ensure that a sufficient range of community-based services are available to decrease ER and inpatient utilization</li> <li>• Decrease total cost of care for highest utilizers</li> <li>• Alignment of incentives to support providers in sharing accountability for the cost of care</li> </ul>
<b>Improve quality</b>	<ul style="list-style-type: none"> <li>• Continuous quality improvement</li> <li>• Promote clinical and service excellence through evidence-based practices</li> <li>• Alignment of incentives to promote increased quality</li> </ul>

### **3. Program Description**

#### **Patient Eligibility**

Opioid Dependent Medicaid recipients who are currently receiving or who meet criteria for Medication Assisted Treatment and have or are at risk of another chronic health condition are eligible for the OTP Health Home. The OTP Health Home will provide documentation of such risk by completing the OTP Health Home Eligibility checklist form developed by the Rhode Island Office of Behavioral Health, Developmental Disabilities and Hospitals (BHDDH).

#### **Core Functions and Responsibilities of OTP Health Home Providers**

The OTP Health Homes will carry out the following functions:

- Identify participants eligible for specialized programs (based on Target Population parameters)
- Complete a comprehensive risk assessment using the BHDDH-approved OTP Eligibility Checklist form. Based on the finding on the checklist and a bio-psychosocial assessment, the provider will determine and place the individual in the OTP Health Home. Develop a person-centered, individualized Care Plan
- Carry out treatment and recovery services in the OTP Health Home OTP HH model of care
- Actively use CurrentCare for communication between medical and BH settings, especially for inpatient and ER alerts, for clients that opt into the CurrentCare program
- Participate in active discharge planning with medical and BH/SU inpatient, acute care and other facilities
- Submit required metric reporting and data exchange to the Health Home Administrative Coordinator
- Coordinate with the Integrated Health Home and ACT program to avoid duplication of services. Members can only be enrolled in one specialized program at a time and cannot be simultaneously enrolled in ACT, OTP HH and OTP Health Home
- Notify the Contractor and BHDDH of staffing changes impacting the OTP Health Home's ability to provide the services required for OTP Health Home OTP HH within 14 calendar days. Providers will submit a monthly staffing census to BHDDH/MCO that will be reviewed and evaluated for provision of services.
- Provide primary medical, specialist and behavioral health care through direct provision, or through contractual or collaborative arrangements with appropriate service providers of comprehensive, integrated services.

## **Program Elements**

The OTP Health Home is a OTP HH specialized program that uses a multi-disciplinary team model where medical care coordination staff and behavioral health treatment staff work together to meet the comprehensive health and wellness needs of assigned participants. The team is responsible for coordinating the medical, behavioral and substance use care of all participants. The OTP HH model of care promotes recovery, hope, dignity and respect with the belief that all consumers can recover from addiction and lead healthier lives and manage their other chronic conditions. Active treatment and supports are provided with cultural competence.

## **Program Definitions**

The OTP Health Home services are defined below:

- Comprehensive care management;
- Care coordination and health promotion;
- Comprehensive transitional care from inpatient to other settings, including follow-up;
- Individual and family support, which includes authorized representatives of the consumer;
- Referral to community and social support services, if relevant; and
- The use of health information technology to link services, as feasible and appropriate.

**The OTP Health Home** (OTP HH) is built upon the evidence-based practices of the patient-centered medical home model. The OTP Health Home builds linkages to other community and social supports, and enhances coordination of primary medical, specialty and behavioral healthcare, (including mental health treatment) in keeping with the needs of persons with a primary diagnosis of opioid dependence and multiple chronic illnesses or who is at risk of chronic illnesses. OTP Health Home is a service provided to community-based clients by professional behavioral health staff in accordance with an approved treatment plan for the purpose of ensuring the client's stability and continued community tenure. OTP Health Home teams monitor and provide medically necessary interventions to assist in the enhancement of health, management of symptoms of illness, as well as overall life situations, including accessing needed medical, social, educational and other services necessary to meeting basic human needs. OTP Health Home uses a team-based approach for care coordination, mental health and physical health chronic condition management, health promotion and peer/family support.

### **OTP HH activities are focused in four areas:**

#### **1. Care coordination and health promotion**

Each client will be assigned a primary case manager who coordinates and monitors the activities of the individual treatment team and has primary responsibility to write the person-centered treatment/care coordination plan, ensure plans are revised and updated as clients' needs change and advocate for client rights and preferences. In addition, the primary care

manager will collaborate with primary and specialty care providers as required and provide education about medications (e.g. educating through written materials, etc.). The OTP Health Home team is responsible for managing clients' access to other healthcare providers and to act as a partner in encouraging compliance with care plans established by these providers. Health promotion activities are delivered by the team to engage clients in addressing healthy lifestyles and include but are not limited to: smoking cessation; nutrition; increasing activity levels; relaxation strategies; and stress management.

## **2. Chronic condition management and population management**

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

- Assisting in the development of symptom self-management, communication skills and appropriate social networks to assist clients in gaining effective control over their opiate addictions and their life situations;
- Provide health education, counseling and symptom management challenges to enable client to be knowledgeable in the prevention and management of their opiate addiction and other chronic medical illnesses as advised by the client's primary/specialty medical team.
- Assisting the client in locating and effectively utilizing all necessary community services to address the client's medical, social and psychiatric needs and ensuring that services provided are coordinated with those provided through physical health care professionals;
- Assisting in the development and implementation of a plan for assuring client income maintenance, including the provision of both supportive counseling and problem-focused interventions in whatever setting is required, to enable the client to address their symptoms of addiction. Activities include:
- Provide a range of support services or direct assistance to ensure that clients obtain the basic necessities of daily life, including but not necessarily limited to: financial support and/or benefits counseling (e.g., SSI, SSDI, Food Stamps, Section 8, Home Energy Assistance; Social Services; Transportation and Legal advocacy).
- Find housing which is safe, of good quality and an affordable place to live- apartment hunting, finding a roommate, landlord negotiations, cleaning, furnishing and decorating and procuring necessities (i.e. telephone, etc.).
- The OTP HH team will conduct the necessary analysis related to how well they are managing entire populations, based on measurable health outcomes and utilization. This information helps OTP HH's improve their care delivery system, to the benefit of each OTP HH clients receiving care.

### **3. Comprehensive transitional care**

The OTP HH team will ensure consumers are engaged by assuming an active role in discharge planning. The OTP HH team will communicate and ensure collaboration between consumers, professionals across sites of care, potentially reducing medical errors, missed appointments, and dissatisfaction with care. Specific functions include:

- Engage with the client upon admission to the hospital and ensure that the discharge plan addresses physical and behavioral health needs.
- Upon hospital discharge (phone calls or home visit):
- Ensure that reconciliation of pre- and post-hospitalization medication lists is completed.
- Assist consumer to identify key questions or concerns.
- Ensure Consumer understands medications; potential side-effects; is knowledgeable about indications if their condition is worsening and how to respond; how to prevent health problem becoming worse; has scheduled all follow-up appointments.
- Prepare consumer for what to expect if another next level of care site is required (i.e. how to seek immediate care in the setting to which they have transitioned).
- Review with the OTP HH team transition care goals, relevant transfer information (i.e. all scheduled follow-up appointments; any barriers preventing making appointments), function as resource to OTP HH consumers – to clarify all outstanding questions.
- Identify and facilitate linkages between long-term care and home and community-based services.

### **4. Individual and Family support services**

OTP HH team will provide practical help and support, advocacy, coordination, side-by-side individualized support with problem solving, direct assistance, helping clients to obtain medical and dental health care. Services include individualized substance use education about the client's opiate addiction and other chronic illnesses and the role of the family and their significant people in the therapeutic process.

OTP HH recovery support specialists will help OTP HH consumers utilize support services in the community and encourage them in their recovery efforts by sharing their lived experience and perspective. Recovery support services will validate clients' experiences, guide and encourage clients to take responsibility for and actively participate in their own recovery. In addition, offer peer support services to:

- Help clients establish a link to primary health care and health promotion activities.
- Assist clients in reducing high- risk behaviors and health risk factors such as smoking, poor illness self-management, inadequate nutrition, and infrequent exercise.

- Assist clients in making behavioral changes leading to positive lifestyle improvement.
- Help clients set and achieve a wellness or health goal using standardized programs such as Whole Health Action Maintenance (WHAM).

**Assessment**

The OTP Health Home Providers will use the BHDDH-designed checklist to assess clients’ needs for OTP Health homes.

**Assessment Frequency**

- An assessment will be administered at the time of initial engagement and every 6 months or more frequently when a significant change is identified.
- A reassessment with the standardized tool will be conducted within 48 hours of a discharge from a hospital or detoxification program.

**Plan of Care**

A comprehensive Plan of Care must address behavioral health needs, medical and social needs with measurable, realistic and time sensitive goals. The following are required:

- Plan of care developed within thirty (30) days of completion of the assessment.
- Plan of care developed with and agreed to by the member or caregiver, or those chosen by the member to participate in the care plan. (verbal or written acceptance)
- Reviewed at least every 6 months and when a significant change is identified

**5. OTP HH Reporting Requirements**

The OTP HH Reporting Requirements are managed by the OTP Health Home Administrator and coordinated with BHDDH and the OTP HH providers. All reports must be submitted to EOHHS at a frequency defined by EOHHS.

**6. Service Delivery and Coordination**

The OTP HH Teams provide or coordinate the following services:

• Housing Assistance, Tenancy Supports and Activities of Daily Living Supports
• Individual, Group and Family Therapy
• Medical and Substance Use Treatment Coordination Activities
• Recovery and Rehabilitation Skills
• Care Transition – hospital, incarceration or nursing home to home
• Outreach and engagement
• Identification and engagement of natural supports and Social relationships
• Education, Support, and Consultation to Clients’ Families and Other Major Supports

## **7. Service Coordination/Care Management**

Each client will be assigned a service coordinator (care manager) who coordinates and monitors the activities of the client's individual treatment team and other members of the OTP HH team. The primary responsibility of the service coordinator is to work with the client to develop the treatment plan, provide individual supportive counseling, offer options and choices in the treatment plan, ensure that immediate changes are made as the client's needs change, and advocate for the client's wishes, rights, and preferences. The service coordinator is the first staff person called upon when the client is in crisis and is the primary support person and educator to the individual client's family. Members of the client's individual treatment team share these tasks with the service coordinator and are responsible to perform the tasks when the service coordinator is unavailable. Service coordination also includes coordination with community resources, including consumer self-help and advocacy organizations that promote recovery.

## **8. Therapy**

This will include but is not limited to the following:

1. Ongoing comprehensive assessment of the client's opiate addiction and response to treatment.
2. Individual and family education regarding opiate addiction and the effects and side effects of prescribed medications
3. Addiction management efforts directed to help client identify/target the symptoms and occurrence patterns of his or her opiate addiction and develop methods (internal, behavioral, or adaptive) to help lessen the effects.
4. Individual, group and family supportive therapy
5. Psychological support to clients, both on a planned and as-needed basis, to help them accomplish their personal goals, to cope with the stressors of day-to-day living, and to facilitate recovery.

## **9. Medication Prescription, Administration, Monitoring and Documentation**

The OTP HH team psychiatrist or registered nurse will provide education about medication, benefits and risks, obtain informed consent and assess and document the client's mental illness symptoms and behavior in response to medication. Team members will monitor and document medication side effects and provide supportive services. This clinical team will also assist the client with medication adherence strategies for all psychiatric and medical prescriptions.

## **10. Contractor Responsibilities**

The Contractor is responsible for offering contracts to all EOHHS specified OTP HH providers. The Contractor will pay a specified rate to each provider for OTP HH services as directed by the EOHHS. The Contractor is responsible for following all guidance material distributed by EOHHS relating to this program, including the *OTP HH Billing Manual*. The Contractor will not pay less than currently established rates but may bundle or provide global rates, with the approval of EOHHS.”

## **11. Supportive Employment-Related Services**

Work-related services to help clients value, find, and maintain meaningful employment in community-based job sites and services to develop jobs and coordinate with community-based employers. The principles of the evidence-based practice Individual Placement and Support (IPS) will be used to find employment. Services Include but are not limited to:

1. Assessment of job-related interests and abilities through a complete education and work history assessment as well as on-the-job assessments in community-based jobs.
2. Assessment of the effect of the client’s mental illness on employment with identification of specific behaviors that interfere with the client’s work performance and development of interventions to reduce or eliminate those behaviors and find effective job accommodations.
3. Development of an ongoing employment rehabilitation plan to help each client establish the skills necessary to find and maintain a job.
4. Individual supportive counseling to assist clients to identify and cope with mental illness symptoms that may interfere with their work performance.
5. On-the-job or work-related crisis intervention.
6. Work-related supportive services, such as assistance with grooming and personal hygiene, securing of appropriate clothing, wake-up calls, and transportation, if needed.
7. Job Development
8. On-site supports as needed
9. Coordination of supports through in collaboration with the Office of Rehabilitation Services (ORS)
10. Job coaching

## **12. Ensuring Safe and Stable Housing**

1. Find housing which is safe, of good quality, and affordable (e.g., apartment hunting; finding a roommate; landlord negotiations; cleaning, furnishing, decorating; and procuring necessities such as telephones, furnishings, linens)
2. Perform household activities, including house cleaning, cooking, grocery shopping, and laundry

3. Carry out personal hygiene and grooming tasks, as needed
4. Develop or improve money-management skills
5. Use available transportation
6. Have and effectively use a personal physician and dentist

### **13. Natural Supports and Social/Interpersonal Relationship Identification**

Provide opportunities to practice social skills and receive feedback and support required to:

1. Improve communication skills, develop assertiveness, and increase self-esteem
2. Develop social skills, increase social experiences, and develop meaningful personal relationships
3. Plan appropriate and productive use of leisure time
4. Relate to landlords, neighbors, and others effectively
5. Familiarize themselves with available social and recreational opportunities and increase their use of such opportunities

### **14. Recovery Support Services**

Services to validate clients' experiences and to guide and encourage clients to take responsibility for and actively participate in their own recovery.

1. Recovery counseling and support
2. Introduction and referral to consumer self-help programs and advocacy organizations that promote recovery

### **15. Education, Support, and Consultation to Clients' Families and Other Major Supports**

Services provided regularly under this category to clients' families and other major supports with client agreement or consent, include:

1. Individualized psychoeducation about the client's opiate addiction and chronic illness and the role of the family and other significant people in the therapeutic process
2. Intervention to restore contact, resolve conflict, and maintain relationships with family and or other significant people
3. Ongoing communication and collaboration, face-to-face and by telephone, between the OTP HH team and the family
4. Introduction and referral to family self-help programs and advocacy organizations that promote recovery

5. Assistance to clients with children (including individual supportive counseling, parenting training, and service coordination) including but not limited to:
  - a. Services to help clients throughout pregnancy and the birth of a child
  - b. Services to help clients fulfill parenting responsibilities and coordinate services for the child/children
  - c. Services to help clients restore relationships with children who are not in the client's care and custody

**16. Care Transitions**

The OTP HH team will ensure consumers are engaged by assuming an active role in discharge planning. The team will communicate and ensure collaboration between consumers, professionals across sites of care, potentially reducing medical errors, missed appointments, and dissatisfaction with care. Specific functions include:

1. Engage with the client upon admission to the hospital and ensure that the discharge plan addresses physical and behavioral health needs.
2. Upon hospital discharge (phone calls or home visit):
  - Ensure that reconciliation of pre- and post-hospitalization medication lists is completed.
  - Assist consumer to identify key questions or concerns.
  - Ensure the client understands medications, their potential side-effects, is knowledgeable about indications if their condition is worsening and how to respond and is educated on how to prevent worsening of health conditions.
  - Review transition care goals with the team, provide relevant follow up and transfer information, function as resource to the client on all matters related to transition.
3. Identify and educate on linkages between primary and specialty medical care, behavioral healthcare, long-term care and home and community-based services.

**Team Composition and Staffing Levels**

*The OTP Health Home staff is made up of the following multi-disciplinary complement of staff:*

- The OTP Health Home team staff composition required to provide services, based on a population of one hundred twenty-five patients (125) per team, is outlined below. *Any deviation from that staffing pattern will require a written proposal to the Department for approval that includes clinical and financial justification.*

**Qualifications:**

**Health Home FTE\***

Master's Level Team Coordinator	1.0
Physician	0.25

Registered Nurse	1.0
Case Manager – Hospital/Healthcare Liaison	1.0
Case Manager	1.0
Pharmacist	0.10
<b>Total Personnel</b>	<b>4.35</b>

#### Reimbursement Arrangement

The provider is reimbursed based on a bundled rate for their OTP HH participants.

Billing for OTP Health Home will be a bundled rate. Providers will be required to submit encounter data/shadow claims to the Contractor for MCO clients and for the State for Medicaid FFS clients.

Billing for OTP HH will consist of the specified OTP HH code as well as other clinical services provided apart from the bundle. The OTP HH bundled rate is for care coordination activities only and does not include any clinical services or Medication Assistance Treatment (MAT) services. OTP HH can be billed while an individual is in an institutionalized setting. Refer to the *OTP HH Program Description* for detailed information on billing.

#### **Contractor Responsibility:**

The Contractors will support the following:

- Provide OTP Health with reporting to facilitate the coordination of medical and behavioral health care.
- The Contractor will use utilization data (inpatient admissions, readmissions, ER visits, and Pharmacy reports) along with predictive models to identify members with new health risks to share with OTP Health Homes.
- The Contractor will be responsible for oversight to ensure contract requirements are being met.
- The Contractor will assist the OTP Health Homes with identifying necessary components of metric reporting.
- The Contractor will adhere to the reporting date requirements based on a reporting calendar.
- The Contractor will adhere to the withhold payout requirements based on a reporting calendar.
- Continuity of care requirements, including maintenance of relationships between members and treating providers. This includes beneficiaries transitioning into the managed care organization.
- The Contractor will hold the member harmless.

The Contractor will ensure that the OTP Health Homes are submitting HIPAA compliant claims data for services delivered under the OTP HH and ACT bundles.

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