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 Sections 2.06, 2.08, and 2.09 and 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 restrictive 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 that 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:

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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:

Improve Care and Access	• Improve overall health and quality of life of children and families • Improve family ability to manage symptoms/behaviors in the home • Improve ability for children to thrive in their communities
Reduce Cost	• Decrease utilization of the ER • Decrease utilization of higher costs settings such as hospitals or residential placements • Encourage alternative payment methodologies for these services
Improve Quality	• Promote evidence-based practices • Encourage provider incentives to improve quality of care

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 Providerwith established competency working with children with special health care needs. Master's or Doctoral degree.
4. Treatment Consultant:
   a. Rhode Island licensed Health Care Providerin 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. <u>Personal Assistance Services & Supports (PASS)</u>:

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 Providerwith 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.

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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.