

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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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 psychosocial 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 Provider 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 Provider 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 Provider 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.

DRAFT - Final Documents to be provided to awarded Contractor