



State of Rhode Island
Executive Office of Health and Human Services
Certification Standards
Providers of Home Based Therapeutic Services
(inclusive of ABA)

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HOME AND COMMUNITY BASED TREATMENT INFORMATION AND BACKGROUND

This is the third revision of the Rhode Island Executive Office of Health and Human Services (EOHHS) Certification Standards for Providers of Home Based Therapeutic Services (HBTS). Certification Standards were first issued in February of 2003 and then revised in June of 2006. This edition of the HBTS Certification Standards (inclusive of ABA) replaces all previous HBTS Certification Standards and guidelines, verbal and written, as issued by the EOHHS.

The development of Certification Standards and the provision of certified Home Based Therapeutic Services are intended to:

1. Improve the functioning of children with special health care needs as set forth in approved HBTS Treatment Plans. This includes maximizing their ability to live at home and actively participate as valued members of their families and communities to the best of their capabilities, and to support the transition to adulthood.
2. Ensure HBTS provider-agencies shall demonstrate reliability, consistency, and quality of service in full compliance with these Certification Standards.
3. Confirm that monitoring, oversight, adherence to quality assurance shall be the responsibility of EOHHS to demonstrate that HBTS provider-agencies are rendering efficient, cost effective treatment aimed at addressing clearly defined treatment goals/objectives subject to onsite reviews and/or requested performance reports.
4. Ensure HBTS provider-agencies shall maintain and adhere to family center principles.
5. Ensure HBTS provider-agencies shall maintain ongoing collaborative and communicative relations with all referral sources.

EOHHS accepts applications to become a certified HBTS provider-agency on an ongoing basis. These Standards serve to provide families, potential HBTS applicants, and providers with a full description of HBTS. EOHHS is responsible for the development, implementation, monitoring and enforcement of these HBTS Standards.

Changes to HBTS Certification Standards since the last revision in 2006 include:

1. HBTS Treatment Plans are approved for 12 months with required 6 month progress reports.
2. Travel reimbursement was eliminated and rate adjustments were provided.
3. There are five distinct phases for HBTS. HBTS is based upon the rationale of providing skilled and ongoing structured clinical interventions and learning opportunities at maximum intensity to less intensive and more practice based experiences to promote the acquisition of new skills, development of stabilization of functioning, and prevention of regression over time. The five HBTS phases are reflective of different levels of clinical intensity and support to allow for transition to less intensive services, whenever possible. The phases are as follows (*See – Appendix 9: HBTS Phases*):
 - a. HBTS Phase 1: Pre-Treatment Consultation
 - b. HBTS Phase 2: Specialized Treatment and Treatment Support
 - c. HBTS Phase 3: Treatment Support
 - d. HBTS Phase 4: Post-Treatment Consultation
 - e. HBTS Phase 5: Ongoing HBTS
4. Effective January 1, 2012 RI law mandates third party health insurance coverage for Applied Behavior Analysis Therapy (ABA) for qualifying children and adolescents with Autism Spectrum Disorders until the covered individual reaches the age of fifteen. The law applies only to group health insurance and does not extend to the Small Employer

- Health Insurance Availability Act, or the Individual Health Insurance Coverage Act. Benefits also include coverage for physical therapy, speech therapy and occupational therapy services¹. Any health insurance company doing business in RI must comply with this mandate. Providers have the discretion to opt out of such arrangements without change in certification status with notice to EOHHS.
5. Licensure for Board Certified Behavioral Analysts (BCBA) and Board Certified Assistant Behavior Analyst (BCaBA) was mandated in January 2012 and is to be overseen by the Rhode Island Department of Health.
 6. Current and future HBTS ABA provider-agencies are encouraged to establish and maintain credentials with third party health insurance plans doing business in RI.
 7. Only licensed healthcare clinicians² can provide Clinical Supervision or Treatment Consultation for HBTS. Exception from professional licensure was removed for counselor and principal counselor certifications issued by Rhode Island Department of Mental Health, Retardation, and Hospitals (now Department of Behavioral Health, Developmental Disabilities and Hospitals), and certifications from the RI Department of Education for school social worker, school psychologist, and special educator with a Master's degree.
 8. Language interpreter services may be billed to Medicaid for HBTS and ABA therapy when no other method of interpretation is available (*See – Appendix 13: Language Interpretation Services*).
 9. HBTS provider-agencies are required to accept all referrals unless the child's clinical needs or HBTS is not a suitable program whether due to lack of staff availability, lack of clinical experience with a particular condition, or geographic limitations. Provider-agencies shall not decline a referral based on cultural or language barriers.
 10. Provider-agencies specializing in ABA therapy are able to provide services as Direct Service Providers for HBTS subject to approval by EOHHS (*See – Appendix 6: Requirements of ABA Programs*).
 11. ABA therapy is allowed to be delivered in center based practices subject to approval by EOHHS (*See - Appendix 7: Center Based ABA Practice Requirements*).
 12. To enable greater flexibility in HBTS, the use of Clinical Supervision has been changed from 2 hours per week to 8 hours total per month.
 13. If a child or adolescent is receiving HBTS and PASS, the total number of treatment hours (treatment intensity) per week must be substantiated through the establishment and documentation of medical necessity, measurable goals with frequency and duration of each service to be delivered, and evidence of collaboration between provider-agencies, up to 25 hours. It is preferred that a child/adolescent receive both PASS and HBTS from the same provider-agency to ensure consistency and efficient treatment.
 14. HBTS treatment hours (treatment intensity) per week must be substantiated through the establishment and documentation of medical necessity, measurable goals with frequency and duration of each service to be delivered, up to 20 hours.
 15. HBTS service plans will no longer be required to be reviewed by CEDARR clinicians.
 16. HBTS service plans will no longer be required to be aligned with CEDARR Family Care Plans.
 17. Prior authorization from each HBTS provider using a batch form shall be sent once a week, prior to the start date of service, to EOHHS for fee for service enrolled families.

¹ Rhode Island General Laws §20.11

² Licensed health care professionals eligible for HBTS Clinical Supervision or Treatment Consultation include: licensed independent social worker, marriage and family therapist, mental health counselor, psychologist and BCBA.

Providers shall follow the procedures established by third party payers for managed care enrolled families.

I. HBTS SCOPE OF SERVICES

HBTS is intended for children and adolescents with moderate to severe special health care needs that experience chronic developmental, cognitive, physical, medical, neurological, behavioral and/or emotional conditions. Their health and well-being requires a type and amount of services that exceeds their typically developing peers. HBTS are more intensive than outpatient treatment but less restrictive than inpatient hospitalization or residential care. HBTS are provided for children living at home or in foster care (not specialized foster care through DCYF) with services delivered in a child's home, community, or outpatient setting.³ HBTS are based upon medical necessity, as documented by a physician's prescription (*See – Appendix 1: Definition of Medical Necessity*), have defined treatment goals and measured objectives, and is authorized by a third party payer for Medicaid eligible clients. Prescriptions for service shall be obtained by the provider-agency.

HBTS is not intended to replace clinically necessary therapies such as behavioral health treatment including emergency treatment, psychiatric care, speech and language therapy, occupational therapy, or physical therapy. HBTS represent an integrated set of service components involving the provision of Specialized Treatment, Treatment Support, or ABA therapy with measurable goals and objectives written and approved by a licensed healthcare professional.

Prior Authorization (PA) Services

Reimbursement for HBTS requires prior authorization (PA).

Service Components

An integrated HBTS Treatment Plan can include the following reimbursable services:

1. HBTS Pre-Treatment Consultation

Pre-Treatment Consultation involves consultation to the family regarding interventions to assist them in managing their child's behaviors before working directly with the child. This time is also used to conduct observations and gather information necessary for the development of a comprehensive HBTS Treatment Plan.

2. HBTS Post-Treatment Consultation

Post-Treatment Consultation provides short-term support to the family upon the conclusion of a period of HBTS Specialized Treatment. This is designed to allow families to practice skills, maintain their child's gains, and when necessary seek out other less intense forms of treatment.

3. 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

³ Center based HBTS is reserved for EOHHS approved providers to offer ABA interventions.

(Treatment Consultation and Specialty Consultation), and at the conclusion of HBTS (Post-Treatment).

4. HBTS Treatment Consultation and Specialty Treatment Consultation

This type of consultation addresses specific HBTS goals and objectives within one's professional discipline. HBTS Specialty Consultations and related goals are not a substitution for necessary therapeutic services defined in an IEP or IFSP. Treatment recommendations are solely to foster a child's practice of targeted skills.

5. 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.

6. 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 the child and family's Treatment Plan, and under the supervision of a licensed healthcare professional.

7. 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.

8. 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 (*See – Appendix 2: Treatment Support Domains*), namely:

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.

9. Applied Behavior Analysis (ABA) Services (Subset of HBTS)

EOHHS recognizes that ABA discrete trial interventions are highly specialized and a distinct form of basic behavior therapy principles. 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 with authorization from EOHHS or the family's insurance provider.

Lead Therapy in ABA Treatment

Lead therapy is regarded as an administrative support by EOHHS. The Lead Therapist must report to the Behavior Analyst and/or Clinical Supervisor.

The following are responsibilities of the Lead Therapist:

1. Must maintain a professional working relationship with families including how to apply instructional strategies.
2. May attend all clinical treatment meetings for an assigned child and assist in the development of an HBTS plan, as deemed clinically necessary by the provider agency.
3. Must maintain formal supervision sessions with the Behavior Analyst and/or Clinical Supervisor.
4. Must develop instructional materials, prepare drills, update materials, gather and manage treatment data, and provide information for Treatment Plan updates/modifications.
5. May directly observe the assigned child and treatment worker once per month; provide guidance and summarize observations, as deemed clinically necessary by the provider agency.
6. Must provide emergency coverage as an HBTS treatment worker when necessary.

Third Party Healthcare Coverage and Coordination of Care for ABA Treatment

EOHHS has no authority to develop treatment plans when commercial health insurance is being used to pay for ABA treatment of autism spectrum disorders. In many instances, third party payers may be using the same group of certified HBTS provider-agencies as EOHHS. The treatment provider and child's parents/guardians are responsible to verify if third party coverage is available for the treatment of autism from their health insurance plan. EOHHS requires proof of commercial insurance coverage. The scope of services and possible out of pocket costs will vary depending on the client's health insurance plan. Supplemental costs such as deductibles and copayments may be covered by Medicaid⁴.

⁴ Medicaid reimbursement is subject to Medicaid allowable amounts and deductible requirements.

For individuals covered by Medicaid and commercial insurance, Medicaid will assume responsibility for payment of the ABA treatment once the commercial health care coverage benefit has been exhausted. Payment will revert back to the commercial insurance at the start of every benefit year.

10. Occupational Therapy Consultation

This service includes goals, objectives, and activities to address the functional needs of a child related to adaptive development, adaptive behavior and play as well as sensory, motor and postural development. These services are designed to improve the child's functional ability to perform tasks in home and community settings, (e.g., feeding and eating, toileting, assisting with dressing/undressing, assisting with grooming, oral hygiene, bathing, functional communication, play skills, and community mobility).

11. Physical Therapy Consultation

This service includes goals, objectives, and activities to promote sensory-motor function through enhancement of musculoskeletal status, neurobehavioral organization, perceptual and motor development, cardiopulmonary status, and effective environmental adaptation. These services are for the purposes of increasing functioning during the child's natural activities and routines.

12. Speech and Language Therapy Consultation

This service includes goals, objectives, and activities for the habilitation or rehabilitation of communicative or oral motor disorders and delays in development of communication skills. These services are intended to increase the functional and meaningful communication of the child by engaging in learning opportunities occurring in the home and community settings.

13. Language Interpretation Support

Provider-agencies can bill for interpretation services to enable families that do not speak English to receive HBTS when no other method of interpretation is available. Reimbursement for interpretation services makes it possible for provider-agencies to accept all referrals without regard for language or cultural issues (*See – Appendix 13: Language Interpretation Support*).

14. 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.

15. Assessment and Treatment Planning

Provider-agencies shall Utilize all referral and collateral information (i.e., IEP, IFSP, contact with providers/teachers, review relevant medical or behavioral health evaluations/records), and maintain ongoing parent/caregiver/guardian communication. The identification and prioritization of treatment goals and objectives shall be clearly written, specific and measurable. Interventions shall be defined. The level of parent participation shall be clear and consistent. Parents/Caregivers/Guardians must sign all proposed Treatment Plans.

- **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. HBTS treatment hours per week must be substantiated through the establishment and documentation of medical necessity, measurable goals with frequency and duration of each service to be delivered, up to 20 hours (excluding ABA programs). Treatment is to be individualized and based on collaboration with the child's family and all relevant parties involved in developing a plan of care for the child and family. Ultimately, it is the provider-agency's responsibility to justify that the number of treatment hours are medically necessary.

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.

Coordination of Care and HBTS

Coordination of care involves maintaining ongoing relations with referral sources, the child's medical home and other providers of care for children/adolescents receiving HBTS. This involves consistent communication with involved parties about treatment and recommendations, as well as receiving input from others and ongoing coordination during transitions of care.

Transportation of HBTS Clients

In the course of provision of services the provider-agency may want to provide transportation if clinically relevant. The State is approving only the service provision and accepts no liability or responsibility for transportation. The inclusion of transportation as part of a Treatment Plan must relate to facilitating the accomplishment of defined and previously approved treatment objectives. Transportation can only relate to the child receiving HBTS and is not to be included in a treatment plan for solely convenience.

The provider-agency must demonstrate that it has procedures in place to protect the safety of child being transported by staff and vehicles engaged in transportation:

1. Current and adequate vehicle insurance that allows for transporting children.
2. Current vehicle registration and valid State inspection.
3. The driver's history must be free of accidents for the past year, with no history of DWI. Parents have signed a waiver for each driver releasing EOHHS of any liability and responsibility for anything that occurs as a result of transportation activities.
4. EOHHS will not approve 2:1 coverage during transportation.
5. Seat belts and/or child restraints must be utilized as required by State law.

II. TARGET POPULATION

Referrals

Certified HBTS provider-agencies are expected to accept all referrals of Medicaid enrolled children and adolescents determined to be eligible for HBTS. Provider-agencies are allowed to decline a referral or decline to submit a treatment plan if the child/adolescent does not meet the criteria for HBTS.

Mainstreaming

HBTS provider-agencies shall not intentionally exhibit preferential enrollment of children and families in any way based on their referral source or third party payer. A violation of these terms may be considered a material breach and any such material breach may be grounds for suspension or termination of certification.

Eligibility

The population eligible to be served by HBTS must meet all of the following criteria:

- a. Children birth to their 21st birthday who are Medicaid eligible.
- b. Children who are eligible for Medical Assistance through Supplemental Security Income (SSI), Katie Beckett (through age 18), Adoption Subsidy, Rite Care, or Rite Share.
- c. Children who have potentially chronic (twelve months or longer in experienced or expected duration) and moderate to severe cognitive, developmental, medical/neurological, and/or psychiatric conditions whose level of functioning is significantly compromised.

Verification of Eligibility

Provider-agencies have the responsibility to verify continuous Medicaid coverage.

III. LEVEL OF CARE

HBTS is an intensive outpatient service within the continuum of care for children and adolescents with special health care needs. It requires more frequent contact with the child/adolescent and parents/caregivers/guardians engaged in treatment. Treatment is often several hours per day throughout the course of a week. It may take place in the child's home or community setting. HBTS may be combined with other outpatient therapies, supports, or educational services and is not to be used as a replacement for recommended or required therapies. HBTS is medically necessary treatment and not to provide companionship for the child/adolescent or Respite for the family.

Level of Adaptive Functioning

Children and adolescents in need of HBTS shall demonstrate impairments in one or more of the following areas:

1. Cognitive Functioning: Intellectual disability or intellectual developmental disorder.
2. Problem Solving Functioning: Judgment, insight, reasoning, impulse control, and/or learning.
3. Adaptive Skills: Communication/speech, dressing, eating, sleeping, or social relatedness.
4. Regulation of Mood: Marked instability of mood (e.g., irritability, depression, anxiety, or mania).
5. Medical/Neurological Condition(s): Underlying or co-occurring conditions contribute to behavioral, emotional, cognitive, or functional impairments.

Clinical Criteria

The following criteria pertain to the initial determination of eligibility. Treatment Plan approval requires all of the following criteria to be met and documented:

1. A formal diagnosis by a licensed health care professional with competence in child psychology, child psychiatry, or child development, made within the last two years, is required. Provider agencies shall work with families and/or third party payers to obtain, as applicable.
2. The child demonstrates symptoms and behavior consistent with a diagnosis from the current version of the DSM and/or ICD and on the basis of best available clinical and evidence based practice standards can be expected to respond to HBTS intervention.
3. The child presents with medical and/or physical condition(s) that require intensive therapeutic intervention.
4. Outpatient services provided at an intensified level have not been sufficient due to the child's special healthcare needs. However, this does not necessarily preclude from consideration the role of family therapy or other supports for a family that may be seeking HBTS.
5. There is evidence that the child requires a comprehensive and integrated program of medical and psychosocial services to support improved functioning at the least restrictive level of care.
6. The child and family require support in order to remain stable outside of an inpatient environment, or to transition to independent living from a more restrictive setting.
7. The child, parent(s), caregiver(s) or legal guardian, are willing to accept and cooperate with HBTS, including the degree of caregiver participation outlined in the HBTS Treatment Plan.

In some instances, the following criteria may also apply:

1. The child may be at risk for hospitalization(s) or out-of-home placement without eventual use of HBTS. HBTS is not intended to serve as emergency care and referrals do not provide immediate access. HBTS may not be provided when Child and Adolescent Intensive Treatment Services (CAITS), Child and Family Intensive Treatment (CFIT), or Enhanced Outpatient Services (EOS) are being used.

Clinical Criteria for Continuing Care

Reasons for a Treatment Plan at this level of care to be continued and/or reauthorized involve all of the following criteria:

1. Severity of condition(s) and resulting impairment continue to require this level of treatment.
2. Treatment Planning is individualized to the child/youth and their family's changing condition with realistic and specific goals and objectives stated. The mode, intensity and frequency of treatment are consistent with best known clinical and/or evidence based practice.
3. Active treatment is occurring and continued progress toward goals is expected. Progress in relation to goals is clearly evident, measurable and described in observable terms.
4. If treatment objectives have not yet been achieved; documentation supports continued interventions

IV. COMMITMENT TO FAMILY CENTERED CARE

Family-centered care represents a set of values, attitudes, and approaches to services for children with special needs and their families. HBTS provider-agencies are required to have established and maintained principles of family centered care (*See – Appendix 5: Core Principles of Family Centered Care*).

HBTS provider-agencies shall adhere to family centered practices and share with families policies involving program philosophy, services, and operations. Each of the following must be met:

1. Ongoing communication with parent(s)/caregiver(s)/guardian(s) in all aspects of treatment and responsibilities.
2. Client rights including consent to receive HBTS, confidentiality, solicitation of parent(s)/caregiver(s)/guardian(s) input, requirements for parent/caregiver/guardian participation, documentation and response to complaints and prompt complaint resolution and handling of after hour's emergencies.
3. Written description of services available.
4. Policies regarding the delivery, suspension or termination of HBTS with parents/caregivers/guardians prior to initiating services.

V. LIMITATIONS OF SERVICE

EOHHS and/or the third party payer reserves the right to determine that HBTS are being used effectively to reach target populations. The degree of effectiveness will depend on the target population served and the individual needs of the child. The following guidelines shall be followed:

1. HBTS will not be used for respite or childcare.
2. A previous evaluation by a licensed mental health professional must have taken place within two years prior as part of the determination of Level of Care and HBTS approval. During the course of HBTS care, additional evaluation(s), as deemed clinically necessary, must take place within two years following the beginning of home-based treatment, or as needed.
3. HBTS is not a substitute for mental health services provided by licensed professional clinicians.
4. HBTS will not take the place of services provided by Private Duty Nursing, or the roles and responsibilities assigned to Certified Nursing Assistants). However, it is recognized that some children may require both HBTS and nursing care, including CNA services. The administration of medication, as prescribed by physician (or other comparable licensed health professional), cannot be given by HBTS staff to a child during a course of care. While a parent/caregiver/guardian has discretion to give medication, the HBTS worker cannot assume this responsibility. Under the RI Nurse Practice Act (5-34-1.1) medication administration cannot be assigned to unlicensed personnel which includes Home Based Workers. Should a child require medication during the Home Based Therapy, the family must make arrangements for another adult to administer the medication if the family is unavailable.
5. Medicaid does not reimburse experimental treatments.

VI. TEMPORARY SUSPENSION OF SERVICES

Suspension or Termination of HBTS

Certified HBTS provider-agencies shall adhere to the following protocols regarding suspension or discontinuation of HBTS. The HBTS Provider Agency must:

- a. Have established written policies and procedures regarding termination of services.
- b. Inform the referral source and the child's medical home when care is suspended or discontinued.
- c. Provide written notification to the child's parents/caregivers/guardians as well as to the referral source and medical home 30 days prior to discontinuation of HBTS.
- d. Document specific reasons for discontinuation.
- e. Ensure the family is aware of the provider agency's dispute resolution procedure process.
- f. Provide transitional support.
- g. Conform to all aspects of mandated reporting of suspected child abuse. Child abuse/maltreatment is defined as any abuse committed by an adult towards a child. This abuse may be emotional, physical, sexual, or neglectful in nature, and may be committed by a parent, guardian or other relative, a coach, a clergy member, or other adult. All persons in Rhode Island are required by law to report known or suspected cases of child abuse and/or neglect to the Department of Children, Youth, and Families within 24 hours of becoming aware of such abuse/neglect. See Rhode Island's mandated reporting laws (RIGL 40-11-3) for more information.
- a. Seek emergency evaluation of a child/adolescent when indicated for immediate risks of safety.
- b. Seek intervention from local police when indicated.
- c. Have continuous written documentation describing safety concerns and directives to staff, and family that have led to a suspension or termination.
- d. Inform referral sources, the child's medical home, payer or managed care organization care manager when parents request termination of HBTS, within 30 days of request, as needed.

Reasons for a Treatment Plan to be temporarily suspended or terminated can involve any of the following criteria:

1. Loss of Medicaid eligibility.
2. The child/adolescent is at risk of harm to self or others, or sufficient impairment exists requiring a more intensive level of service beyond community-based intervention.
3. The child/adolescent's home environment presents safety risks to the staff making home visits. These include, but are not limited to: sexual harassment, threats of violence or assault, alcohol or illegal drug use, fire arms and health risks. The provider-agency has the legal responsibility to report suspected child abuse or neglect. All persons in Rhode Island are required by law to report known or suspected cases of child abuse and/or neglect to the Department of Children, Youth, and Families within 24 hours of becoming aware of such abuse/neglect.
4. The child/adolescent, family, or guardian is not successfully following HBTS requirements and/or the provider-agency's program rules and regulations, despite multiple, documented attempts to address non-compliance issues.
5. The child/adolescent has an illness or medical hospitalization.

All instances and circumstances that effect temporary suspension of services or termination are serious. Provider-agencies have the obligation to effect a smooth transition to other services when applicable.

Discharge Criteria

Reasons to end HBTS can include any of the following criteria:

1. The child's documented Treatment Plan goals and objectives have been successfully met.
2. The child no longer meets service initiation or continuing care criteria, or meets criteria for a less/more intensive level of care.
3. Consent for treatment has been withdrawn by a youth 18 or older, or his/her parent(s) or legal guardian(s).
4. Loss of Medicaid eligibility.

EOHHS Fair Hearing Process

An Administrative Fair Hearing can be requested by a parent when service authorization is denied or lost, or when an HBTS Treatment Plan is denied. A Fair Hearing allows for testimony to be presented from all parties subject to questioning from a Hearing Officer and subsequent written decision. Rules and procedures for requesting a Fair Hearing are as follows:

1. The recipient's parent/caregiver/guardian will receive written notification of the approved treatment plan following a second clinical review.
2. The parent/caregiver/guardian must file notice of objection within ten (10) days from the date of authorization for a Hearing.
3. If the request for a Fair Hearing is received by EOHHS within ten days, there will be no modification to the requested intensity of service and services shall continue until the Hearing decision is rendered. During this time, the provider-agency may submit claims as the proposed Treatment Plan remains in effect.
4. If a request is received after ten days, the approved intensity of service will stand until a Hearing decision is rendered. Claims will be paid in accordance with prior authorization.

MCO Fair Hearing Process

Managed Care Organizations are required to follow the RI Department of Health regulations regarding utilization review inclusive of appeals.

<http://sos.ri.gov/documents/archives/regdocs/released/pdf/DOH/4534.pdf>

Appendices

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APPENDIX 1: DEFINITION OF MEDICAL NECESSITY

As defined and applied to all State Medicaid programs (See: RI EOHHS Medical Assistance Program, 300-40-3, September 1997), *Medical Necessity* refers to *medical, surgical, or other services required for the prevention, diagnosis, cure or treatment of a health related condition*. It includes services necessary to prevent a regression in either medical or mental health status. Services must be provided in the most cost effective and efficient manner. Services are not to be provided solely for the convenience of the beneficiary or service provider.

The prescription or recommendation of a physician or other service provider of medical services is required for a determination of medical necessity to be made, but such prescription or recommendation does not mean that the Medical Assistance Program will determine the provider's recommendation to be medically necessary. Prescriptions for service shall be obtained by the provider-agency. The Medical Assistance Program is the final arbiter of determination of medical necessity (See RI EOHHS Medical Assistance Program, 300-40-4, September, 1997).

APPENDIX 2: TREATMENT SUPPORT DOMAINS

The following gives guidance to help understand the purpose of Treatment Support as a service that provides structure, guidance, redirection and supervision to a child. The following components help to distinguish this service from Respite. As part of an overall Treatment Plan, Treatment Support is a complement to Specialized Treatment.

1. **Acquiring and Using Information:** Acquiring and Using Information is the application or use of information a child has learned. It involves being able to perceive relationships, reason, and make logical choices. Individuals think in different ways. Some children think in pictures, that is, they may solve a problem by watching and imitating what another person does. For others, thinking involves using language to understand others as well as to express oneself. Related tasks could involve:
 - a. Learning to read, write, do arithmetic and understand new information
 - b. Follow directions and instructions
 - c. Ask for information
 - d. Explain something
 - e. Communicate basic information – name, address, telephone number, yes/no, take/give messages, make requests, and express functional needs (e.g., toileting, drink, food, etc.)
 - f. Learning to take a bus
 - g. Shopping
2. **Attending and Completing Tasks:** Involves directing and sustaining attention while engaged in an activity or task. This involves focusing long enough to begin and complete an activity and being able to return to it if distracted. Related tasks could involve:
 - a. Attends to directions and instructions
 - b. Listens and attends to what others are saying
 - c. Remains at a designated task or activity for a specified time
3. **Interacting and Relating to Others:** Involves participating with one's family and others for practical and social purposes. Interactions and relating require a child to respond to a variety of emotional and behavioral cues. Speaking intelligently and fluently, turn taking, responding to authority, and understanding another person's feelings form the foundation of social interactions. Related tasks could involve:
 - a. Playing games and turn taking
 - b. Developing and using manners while in the community or at home
 - c. Using proper language
 - d. Joining community activities
 - e. Helping others
4. **Caring for Your Self:** Caring for Your Self is important to a child's sense of mastery and development of competence. It involves engaging in self-care activities as independently as possible for physical, developmental and emotional needs. Related tasks could involve:
 - a. Hygiene activities
 - b. Grooming
 - c. Arranging, preparing meals, and eating meals
 - d. Doing laundry

- e. Selecting clothes and dressing
5. **Maintaining Health and Physical Well-being:** Involves developing an understanding of daily habits that are necessary to good health. For a child, this means learning to recognize healthy practices as well as having time to engage in meaningful recreation. Related tasks could involve:
- a. Outdoor activities
 - b. A schedule of physical exercise
 - c. Participating in after school sports
 - d. Movement exercises
 - e. Media activities – computer, television, and video games

Treatment Support can be provided by the same individual doing Specialized Treatment or by an individual who meets the qualifications for a home-based Treatment Support worker. The home-based Treatment Support worker is trained on interventions and behavioral approaches used during Specialized Treatment. The occurrence of target behaviors will be monitored and recorded during shift hours.

APPENDIX 3: CORE PRINCIPLES OF FAMILY CENTERED CARE

Family-centered care reflects a shift from the traditional focus on the biomedical aspects of a child's condition to a concern with seeing the child in context of their family and recognizing the primacy of family in the child's life. The principles argue in favor of an approach that respects families as integral and coequal parts of the health care team.

Incorporating into policy and practice the recognition that the family is the constant in a child's life, while the service system and support personnel within those systems fluctuate.

1. Providing individualized services in accordance with the unique needs and potential of each child and guided by the child and family specific care plan that recognizes health, emotional, social, and educational strengths, as well as needs.
2. Facilitating family/professional collaboration at all levels of hospital, home and community care.
3. Exchanging complete and unbiased information between families and professionals in a supportive manner at all times.
4. Incorporating into policy and practice the recognition and honoring of cultural diversity, strengths and individuality within and across all families, including ethnic, racial, spiritual, social, economic, educational and geographic diversity.
5. Encouraging and facilitating family-to-family support and networking.
6. Appreciating families as families and children as children, recognizing that they possess a wide range of strengths, concerns, emotions, and aspirations beyond their need for specialized health and developmental services and support.
7. Ensuring services that enable smooth transitions among service systems and natural supports, relevant to developmental stages of the child and family.
8. Full disclosure to families of any anticipated delays in start of services, changes in personnel, and provider-agency policies and procedures in the provision of home-based services.

APPENDIX 4: PROVIDER QUALIFICATIONS

An approved provider must be able to demonstrate that it complies with core State requirements as to organizational structure and process. These requirements pertain to areas such as incorporation, management of administrative and financial systems, human resource management, information management, quality assurance/performance improvement and others. State requirements in these areas are consistent with the types of expectations or standards, which would be set forth and surveyed by health care accrediting bodies, and which are generally held to be critical to effective, consistent, high quality organizational performance and care provision.

Applicants are not required to systematically address in detail each of these areas in their applications, rather these are set forth as fundamental requirements for approved entities. In many areas applicants will be asked to provide assurances that their agency systematically addresses each of the standards identified. In certain areas, more specific descriptions regarding the manner in which the agency meets the standard is required. The Application Guide provides guidance as to how the application should be structured and the areas, which need to be addressed.

Incorporation and Accountable Entity

The applicant for approval as a Home Based Therapeutic Services provider-agency must be legally incorporated. The approved entity shall serve as the accountable entity responsible for meeting all of the terms and conditions for providing HBTS. Applicants must clearly present the overall structure by which services, requirements and programmatic goals will be met. The corporate structure of the entity must be clearly delineated.

Partnership or Collaboration

Satisfactory performance as a certified HBTS provider-agency calls for significant organizational capability. In some cases this capability may be present within a single organization and application for approval will be made based on the strengths of that single organization. In other cases the application may represent the joint effort of several parties, which have the combined capabilities to meet approval requirements. This could come, for example, through a joint venture, a formal partnership or an integrated series of executed contractual arrangements. Regardless of form, a single legal entity will be approved with overall responsibility for performance. The certified HBTS provider-agency is to be the single billing agent for all HBTS.

Governance and Mission

The governance of the entity must be clearly delineated. Composition of the Board of Directors and any conditions for membership must be clear. Specific standards regarding governance and mission are as follows:

1. The agency has a clearly stated mission and publicly stated values and goals.
2. The agency is operated/overseen by some type of legally or officially established governing body, with a set of governing documents or by laws. This governing body has full authority and responsibility for the operation of the organization.
3. The governing body is self-perpetuating and has a recruitment and periodic replacement process for members to assure continuity and accountability.
4. The governing body hires, supervises, and collaborates with a chief executive officer or director. Together the executive and governing bodies provide organizational leadership.
5. The governing body has final accountability for all programs. Through a collaborative relationship with the executive and the management team, the governing body is

responsible for developing the program goals and mission and ensuring compliance with legal and regulatory requirements.

Well Integrated and Organized Management and Operation Structure

The applicant shall provide clear identification of who is accountable for the performance of HBTS. This includes administration, clinical program quality, and management of service delivery and overall financial management.

Administration

Specific standards regarding administration are as follows:

1. The Executive, under supervision of the governing body, is responsible for financial management, achieving program outcomes, meeting client needs, and implementing the governing body's strategic goals.
2. A current chart of organization, which clearly defines lines of authority within the organization, must be maintained and provided as part of the approval application.
3. The management of the organization is involved in the planning process for performance improvement and is involved in planning for priorities and setting goals and objectives for the written Quality Assurance/Performance Improvement plan.
4. There is a written corporate compliance plan in place that is adopted by the governing body.

Financial Systems

The organization must have strong fiscal management that makes it possible to provide the highest level of service to clients. Fiscal management is conducted in accordance with responsible business practices and regulatory requirements. The organization must be able to obtain relevant data, process and report on it in meaningful ways, and analyze and draw meaningful conclusions from it. Managers must use financial data to design budgets that match the constraints of the organization's resources, and provide ongoing information to aid the governing body in managing and improving services.

Specific standards regarding financial systems are as follows:

1. Financial Management is provided by a Chief Financial Officer, Fiscal Director, or Manager with demonstrated experience and expertise in managing the finances of a human services organization with third party reimbursement. In larger organizations (e.g. with revenues in excess of \$1 million) this might be an MBA with demonstrated finance experience or a CPA; in smaller organizations a comptroller with a degree in accounting might be sufficient. This individual must possess expertise in financial and client/patient accounting, financial planning and management
2. The organization's financial practices are consistent with the most up to date accounting methods and comply with all regulatory requirements.
3. The organization's financial planning process includes annual budgeting, revenue projections, regular utilization and revenue/expense reports, billing audits, annual financial audits by an independent CPA, and planning to ensure financial solvency.
4. The organization has written policies and procedures that guide the financial management activities (including written policies for and procedures for expenditures, billing, cash control; general ledger, billing system; registration/intake system; payroll system; accounts payable; charge and encounter reporting system and accounting administration).
5. The organization has evidence of internal fiscal control activities, including, but not limited to cash-flow analysis, review of billing and coding activities.

6. The system must track utilization of service units separately for each individual client and aggregate this information by payer, performing provider, and diagnosis/problem.
7. The organization has a billing office/function that bills for services rendered and collects fees for service and reimbursement.
8. The organization assesses potential and actual risks, identifies exposures, and responds to these with preventive measures.
9. The organization carries adequate general liability insurance, and ensures that professional liability policies are maintained for program personnel.
10. Where the organization contracts with outside entities and/or providers, policies and procedures mandate contract language to detail the entity's or provider's accountability to the Governing Body and its' By-laws.
11. The organization has systems that facilitate timely and accurate billing of fee-for-service, capitated, and case-rated insurance plans, clients and other funding sources. Once bills are forwarded to payers, the system properly manages payments, follow-up billing, collection efforts and write-offs.
12. The organization has a written credit and collections manual with policies and procedures that describes the rules governing client and third-party billing. Specifically, the organization has in place and adheres to policies and procedures ensuring compliance with Medicaid regulations pertaining to coordination of benefits and third party liability. Medicaid by statute and regulation is secondary payer to all other insurance coverage.
13. Clinical, billing and reception/intake staff receives ongoing training and updates regarding new and changed billing and collection rules and regulations.

Human Resources and Staffing

Human Resource activities within the organization are conducted to ensure that proper staffing through hiring, training, and oversight of staff activities. The organization provides clear information to employees about job requirements and performance expectations, and supports continuing education, both internal and external, that is relevant to the job requirements of the individual.

Specific standards regarding Human Resources and Staffing are as follows:

1. The organization's personnel practices contribute to the effective performance of staff by hiring sufficient and qualified individuals who are culturally and linguistically competent to perform clearly defined jobs.
2. Employee personnel records are kept that contain a checklist tickler system to track training, credentialing and other activities. A copy of each employee's active license will be kept on file.
3. The provider-agency must perform annual written performance appraisals of staff based on input from families and supervisors. These must be available in the personnel files for review by EOHHS upon request.
4. Policies and procedures contain staff requirements for cultural competency that are reflected in the job descriptions.
5. Staff is hired that match the requirements set forth in both the relevant job description and in the policies and procedures.
6. Each employee's record contains a job title and description reflecting approved education, experience and other requirements, caseload expectations, supervisory and reporting relationships, and annual continuing education and training requirements. Supervisory job descriptions establish expectations for both contributing to the organization's goal attainment and for communicating the goals and values of the organization. All job descriptions include standards of expected performance.

7. The organization provides a clear supervisory structure that includes plainly delineated areas of control and caseloads. The roles of team members are defined with a clear scope of practice for each. Supervisors receive specialized training and coaching to develop their capacities to function as managers and experts in their clinical and/or technical fields. The organization holds supervisors accountable for communicating organizational goals, as well as for clinical and technical supervision. This includes:
 - a. Protocols for communication and coordination with all interested parties (e.g., special education, primary care physician, or other specialists).
 - b. Clear procedures for addressing unmet licensure requirements will be stated. Credentialing records will be maintained annually to document compliance.
8. Credentials of staff established by the management team and approved by the Governing Body are contained in the job descriptions. An individual hired into a position has his or her credentials verified through primary source verification, and records are maintained in the employee's record.
9. A record of primary source verification is maintained in the individual employee record. This includes, at a minimum, verification of licensure, review of insurance coverage, liability claims history, verification of board certification for physicians, verification of education and training required by law, and professional references and performance evaluations about applicant's ability to perform requested duties. The individual employee record for behavioral health practitioners should also contain a signed statement from the practitioner that addresses if any Medicare or Medicaid sanctions have been imposed in the most recent three-year period.
10. Staff have relevant credentials and meets qualifying standards of the organization. These are updated and checked regularly but at least annually
11. The organization provides training and training opportunities for all levels of staff.
12. Staff are required to participate in training activities on an ongoing basis, as specified by the organization position, job descriptions and continuing education requirements

Quality Assurance and Performance Improvement

The organization is required to have policies and procedures and demonstrable activities for quality review and improvement (e.g. formal Quality Assurance or Performance Improvement plan). The organization ensures that information is collected and used to improve the overall quality of service and performance of the program. Standards regarding Quality Assurance/Performance Improvement are as follows:

1. The organization has a Quality Assurance/Performance Improvement program that includes a written performance improvement plan with annual review of goals and objectives, data analysis, outcomes management, records review and operational/systems improvement. Written records are maintained for PI program activities.
2. The PI program contains specific timetables for activities and measurable goals and objectives, which consider client concerns and input.
3. Effective data analysis is conducted that includes an assessment of client or organizational needs, identification of service gaps, and integration of that data into organizational decision-making processes.

Information Management and Record Keeping

Standards regarding information management and record keeping are as follows:

1. The organization obtains, manages, and uses information to enhance and improve its performance. Information it maintains is timely, accurate, and easily accessible, whether maintained in electronic or other format. Evidence exists that information gathered and maintained is used in decision-making for the organization.

2. The organization maintains a written plan for information management which includes: client record-keeping policies and procedures; confidentiality policies and procedures; and record security policies and procedures. The plan provides for the timely and accurate collection of data and sets forth a reporting schedule.
3. The organization shall ensure that its information management systems are protected from unauthorized outside access and shall meet all applicable HIPAA regulatory requirements when such standards are promulgated and effective.
4. The information management plan specifies standard forms and types of data collected for client intake, admission, assessment, referral, services, and discharge.
5. The information management plan has an incident reporting and client grievance-reporting component.
6. Information management processes are planned and designed to meet the organization's internal and external reporting and tracking needs, and are relevant to its size and complexity. Mechanisms exist to share and disseminate information both internally and externally.
 - a. The organization maintains signed releases for sharing of clinical information.
 - b. Where necessary, signed affiliation agreements exist.
 - c. Reports are available on an established schedule (weekly, bi-weekly, monthly, quarterly, etc.) for use by service providers, case managers, supervisors, managers, CEO, and the Governing Body for assessing client and organizational progress.
 - d. Reports to authorities (state, federal, and other funding and regulatory entities) for review are submitted accurately, in the required formats and on a timely basis.
7. The organization has written policies and procedures regarding confidentiality, security, and integrity of information, and has mechanisms to safeguard records and information against loss, destruction and unauthorized access or disclosure.
 - a. The organization has policies and procedures in place to safeguard administrative records, clinical records, and electronic records.
 - b. Electronic records are backed up, transmitted data is encrypted and secure, and access is password protected.
8. Client information is accessible and is maintained in a consistent and timely manner, with enough information to support the consumer's needs or diagnosis, to justify services delivered, and to document a course of treatment and service outcomes.
 - a. Every client will have a record that contains: an initial assessment, the detailed assessment of client assets and needs, client goals care/Treatment Plan, documentation of care/services provided, documentation of change in client's status, and where necessary, discharge summary.
 - b. All records must include evidence of informed consent, where required.
9. The client record documents treatments/interventions provided and results from the treatments/interventions. All entries into the client records are dated and authenticated, and follow established policies and procedures.
 - a. Changes in client's condition or lack of change following service provision are recorded in the client record at the time of service provision and signed by the service provider.

- b. Achievement of a client objective or milestone toward an objective is noted in the client record. Achievement of an objective or milestone results in a revised assessment.
 - c. Lack of progress in achieving a client objective or milestone toward objective results in a reassessment of the client.
10. The client record will be the basis for billing all service hours. All service billings must be substantiated in the client record. Additional clarification regarding Medicaid and EOHHS requirements is included in Appendix 12 (*See – Documentation Guidelines for HBTS*).

Health Safety, Risk Management

The organization supports an environment that promotes optimal safety and reduces un-necessary risk for clients, family members and staff. The home-based nature of HBTS calls for specific policies and procedures to assure that services are provided in a safe and effective manner for both the child and the staff.

Standards regarding Health, Safety, and Risk Management are as follows:

1. The organization's policies and procedures designate managers who monitor implementation of Health and Safety policies and report to the Quality Assurance Performance Improvement program committee and the Governing Body.
2. The organization will have protocols for identification and monitoring of safety risks, family crises, medical emergencies and difficult situations.
3. Health and safety policies and procedures are clearly communicated to agency staff, visitors, and clients.
4. Programs will have an effective incident review process.

APPENDIX 5: REQUIREMENTS FOR ORGANIZATIONS FOR DELIVERY OF SERVICE

Ethical Practice

Certified HBTS provider-agencies shall require HBTS staff to be knowledgeable and aware of Principles of Ethical Care and Professional Conduct. They must be posted on site and presented to parent(s)/guardians with reference to:

1. Crisis intervention and management of emergency situations.
2. Client and professional boundaries.
3. Grievance policies and procedures.
4. Use of aversive behavior techniques and/or use of physical/mechanical restraints.
5. Conflicts of interest.

Crisis Intervention and Restraint

EOHHS regards the use of physical restraint by a provider-agency to be the “last resort” when an emergency situation takes place that presents an immediate and serious safety risk (i.e., danger) to the child and/or staff person. Clearly established policy and procedures must include the following:

1. Staff shall be certified in a crisis intervention model which includes physical or mechanical restraint techniques (e.g., basket hold, floor and prone restraints, or application of mechanical devices). Documentation of training must be placed in the staff record.
2. Staff shall be thoroughly knowledgeable about physical and mechanical restraint guidelines and emergency situations that may dictate the use of these interventions.
3. Staff shall be thoroughly trained in conflict de-escalation and problem solving interventions.
4. Staff shall receive certification in First Aid and cardio-pulmonary resuscitation in the event of an emergency related to restraint.
5. Restraint techniques should never be performed as a means of punishment or to force compliance.
6. Each restraint episode must be documented by staff with the Clinical Supervisor having responsibility to review the incident for necessity and use of alternative interventions.
7. The occurrence of multiple restraints on a daily or weekly basis may be cause for an emergency psychiatric and/or medical consultation and re-evaluation of the continuation of HBTS.
8. Provider-agencies may elect to decline a referral when there is a current history of prior restraints and/or the likelihood of such an occurrence. Safety of staff and HBTS client is a priority. Provider agencies shall obtain previous treatment histories with families and/or referral sources and as necessary, obtain releases of information from families for previous treatment providers.

Administrative Management

The provider-agency must:

1. Provide an organizational chart with reporting relationships and functional tasks. Administrative and clinical positions must have job descriptions including required skills and experience.
2. Demonstrate that it can meet staffing requirements for the home-based worker, Clinical Supervisor, Treatment Consultant, and Treatment Coordinator.
3. Have policies and procedures that delineate personnel management with respect to Department of Health licensure requirements, orientation, training, continuing

- education/professional development, management of clinical services via Clinical Supervision and Treatment Consultation, and address management of professional misconduct.
- 4. Demonstrate that it has an organized approach to recruitment and retention of staff as well as providing background screening for new staff.
 - a. A *Background Criminal Investigation* (BCI) by local or state police and the *Child Abuse Neglect Tracking System* (CANTS) by DCYF are required of all potential employees.
- 5. Demonstrate an organized and reliable process for accepting and managing referrals from referral sources.
- 6. Have written policies and procedures that address communication with referral sources, the child's medical home and payer.
- 7. Demonstrate that it can responsibly deliver services, namely:
 - a. Families must be involved in the scheduling of services for their Treatment Plan and be made aware of a provider-agency's hours of operation including day, evening and weekend coverage.
 - b. Disruption in treatment (e.g., staff vacations, sick time, holidays, etc.) will at all times be minimized such that continuity of care is maintained throughout a period of authorization.
 - c. With respect to multiple home-based workers providing services, whether Specialized Treatment or Treatment Support, the provider-agency shall limit the number of workers assigned to a given case to ensure continuity and consistency in treatment.
- 8. Have staffing capacity to meet the needs of the clientele to be served.
- 9. Conduct annual family satisfaction surveys. When multiple children with a family are receiving services, one survey is needed for each child receiving services. The format and content should include but is not limited to:
 - a. Sensitivity to family centeredness and cultural competencies.
 - b. Availability of Clinical Supervisor, Treatment Consultant, and/or Treatment Coordinator.
 - c. Progress made during treatment (e.g., accomplishment of goals/objectives, community participation, and quality of life).
 - d. Satisfaction with communication (i.e., family, school personnel, CEDARR, referral source, medical professionals, and others).
 - e. Staffing reliability (i.e., coverage of authorized hours and promptness).
 - f. Professionalism of staff and services (e.g., handling gifts, personal requests, and boundaries).
 - g. Processing of complaints and grievances.

Clinical Model

The provider-agency must demonstrate that it employs evidence-based practice guidelines and provide a complete description of its clinical model. Policies and procedures must be systematically organized and define how treatment is to be planned, delivered, monitored, and evaluated. List any agency accreditation such as:

- Council on Accreditation (COA)
- Commission on Accreditation of Rehabilitation Facilities (CARF)
- Joint Commission on Accreditation of Hospital Care Organizations (JCAHO)

Staffing and Staff Qualifications

The provider-agency must demonstrate that it can meet staffing requirements for the home-based worker, Clinical Supervisor, Treatment Consultant, and Treatment Coordinator, namely:

Home-Based Specialized Treatment Worker Requirements

1. Must be at least 19 years of age; have a high-school degree or equivalent, and two years of supervised experience working with children with special health care needs, or
2. Must have an Associate's degree in human services (i.e., psychology, counseling, child development, education, nursing, etc.), or
3. Must be currently enrolled in not less than six (6) semester hours of relevant undergraduate coursework at an accredited college or university, or
4. EOHHS will allow provider-agencies to employ as home-based workers for Specialized Treatment and Treatment Support individuals with at least 3 years of experience with adults with developmental disabilities to work as home-based workers. The provider-agency must provide this individual with training in child specific orientation, and
5. Have successfully passed BCI and CANTs screenings.

Home-Based Treatment Support Worker Requirements

1. Must be at least 19 years of age; have a high-school degree or equivalent, and one year of supervised experience working with children; or
2. EOHHS will allow provider-agencies to employ as home-based workers for Specialized Treatment and Treatment Support individuals with at least 3 years of experience with adults with developmental disabilities to work as home-based workers. The provider-agency must provide this individual with training in child specific orientation; or
3. Must have an Associate's degree in human services (i.e., psychology, counseling, child development, education, nursing, etc); or
4. Must demonstrate competency to work with children with special health care needs as evidenced by provider-agency's skills validation requirement, and
5. Must have successfully passed BCI and CANTs screenings.

Clinical Supervisor Requirements

1. Must be a Rhode Island licensed health care professional in one of the following: licensed independent clinical social worker, licensed clinical social worker, marriage and family therapist, mental health counselor, psychologist, or BCBA.
2. Have successfully passed BCI and CANTs screenings.

Treatment Consultant Requirements

1. Must be 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, Occupational Therapist, Physical Therapist or Speech and Language Pathologist.
2. The hiring of OT, PT and SLP therapists employed by a Local Education Authority (LEA) may be subject to DOE and/or LEA regulations that could limit or prohibit their participation as Treatment Consultants for HBTS. Independently licensed professionals may not be prohibited from providing treatment consultation. It is the responsibility of the provider-agency to confirm if a conflict of interest exists, and
3. Must have successfully passed BCI and CANTs screenings.

Treatment Coordinator Requirements

1. Must possess a minimum of a Bachelor's degree, and

2. Must have successfully passed BCI and CANTS screenings.

Lead Therapist

1. Must be at least 19 years of age; have a high-school degree or equivalent, and two years of supervised experience working with children with special health care needs, or
2. Must have an Associate's degree in human services (i.e., psychology, counseling, child development, education or nursing, etc.), or
3. Must be currently enrolled in not less than six (6) semester hours of relevant undergraduate coursework at an accredited college or university, or
4. Must demonstrate competency to work with children with special health care needs as evidenced by active participation in agency – specific formal training with completion of objective testing within 12 months of hire,
5. Must have been employed as a Home Based Specialized Treatment Worker for 6 consecutive months in an ABA program,
6. Has received 6 to 12 months of clinical supervision, and
7. Have successfully passed BCI and CANTS screenings.

BCBA and BCaBA

EOHHS recognizes that individuals in possession of valid BCBA or BCaBA certifications from the Board of Behavior Analysts are license eligible in RI. EOHHS will only allow the provision of Clinical Supervision and Treatment Consultation by individuals in possession of a BCBA.

Competency Requirements for Licensed Health Care Professionals

Licensure relates to broad areas of clinical practice and by itself does not ensure that providers have the specific and current competencies to work effectively with the special needs being addressed in HBTS. In addition to licensure, EOHHS requires that individuals engaged in providing Clinical Supervision or Treatment Consultation for HBTS demonstrate competency to work with specific target populations. Specifically, evidence of the following is required unless otherwise noted:

Training:	2 years of supervision post degree while working with related target population(s); and
Education:	Ongoing continued professional education including certification as a BCBA.
Continuing Education:	Licensed clinicians must conform to the requirements of their respective Boards for maintaining continuing education credits.

Reciprocity for Individuals with Professional Licenses from Other States

The provider-agency must submit all of the following information to EOHHS:

- 1) The individual must have an active license from an issuing state.
- 2) The individual has applied for reciprocity including the expected date of licensure from the Department of Health in Rhode Island.

The provider-agency must confirm that licensure has been provided by the Department of Health in Rhode Island.

Licensure

These Certification Standards require that individuals engaged in providing Clinical Supervision or Treatment Consultation for HBTS hold a currently valid license from the Rhode Island

Department of Health (DOH) or certification as a BCBA. All BCBA clinicians must obtain licensure from DOH when procedures are issued.

Relevant DOH policies are:

- 1) Clinical Social Worker: R5-39.1 CSW/ICSW
- 2) Mental Health Counselor and Marriage and Family Therapist: R5-63.2 MHC/MFT
- 3) Psychologist: RS-44-PSY
- 4) Occupational Therapist: R5-40.1-OCC
- 5) Physical Therapist: R5-40-PT/PTA
- 6) Speech Pathologists and Audiologists: R5-48-SPA
- 7) Physician: R5-37-MD/DO
- 8) Board Certified Behavior Analyst: BCBA

Clinical Supervision

Clinical Supervision is a required component of HBTS for both Specialized Treatment and Treatment Support. 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 abuse and risk to child welfare, harassment of home-based staff or any other serious circumstances that may compromise or interfere with treatment.

All clinical staff rendering Clinical Supervision and/or Treatment Consultation must possess a valid license from the Rhode Island Department of Health and meet competency requirements set forth in these Certification Standards. New applicants must demonstrate that its clinical staff meets this standard when applying to become an HBTS provider-agency.

Board Certified Behavioral Analysts and Board Certified Assistant Analysts are eligible for professional licensure. RI Department of Health is responsible for developing and issuing licensure requirements and for establishing and maintaining a process for licensure and licensure renewal. Eligible professionals should consult with the Division of Professional Regulations within the RI Department of Health for current information. BCBA certified individuals may provide Clinical Supervision and Treatment Consultation.

Policies and procedures must be in place to establish and maintain clinical supervision, namely:

1. Clinical supervision can only be provided by licensed health care professionals with competence and experience working with the population being served.
2. The services of the Clinical Supervisor must be documented in writing with respect to date, duration of supervision, which home-based worker received supervision, and reflect sufficient content to substantiate the delivery of this service.
3. Define the ratio of the Clinical Supervisor's time for managing a caseload and participation in team meetings. It is not the intention of EOHHS to propose a ratio of cases that a Clinical Supervisor may carry. EOHHS does require that the provider-agency and the Clinical Supervisor show discretion and engage responsible ethical practice. This means that the Clinical Supervisor will have adequate time to provide Clinical Supervision while remaining available and responsive to home-based staff and families. This also applies to any individual who may serve in the capacity of as Treatment Consultant. Any pattern of conduct by a Clinical Supervisor or Treatment

Consultant providing more than 30 hours of service per week, unless approved by EOHHS, shall be subject to review by EOHHS.

4. Reporting structure must delineate Clinical Supervisor's accountability to provider-agency directors and/or program director.

Documentation of Clinical Supervision

While HBTS provider-agencies may vary in terms of formatting, documentation of clinical supervision must include the following specifics:

1. Child's name
2. Recipient(s) of clinical supervision
3. Date of clinical supervision
4. Place of clinical supervision
5. Duration of clinical supervision
6. Purpose and content of clinical supervision
7. Recommendations and follow up provided by clinical supervisor
8. Signature of clinical supervisor

Clinical Supervision of Home-Based Specialized Treatment and Treatment Support Workers

The functions associated with Clinical Supervision are as follows:

Clinical Supervisor's Activities	Non-Reimbursable Activities
<ul style="list-style-type: none"> • 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 • Telephone consultation for purposes of clinical supervision 	<ul style="list-style-type: none"> • Agency administrative meetings • In person or telephone discussions relating to administrative issues

Management of Clinical Staff

The provider-agency must make sure that all clinical staff and home-based workers are fully qualified and prepared to render HBTS. Recommended training for all home-based workers shall include, but not be limited to the following:

Clinical Training

Child Development
Behavior Modification
Family Dynamics
Crisis Intervention
Substance Abuse
Psychiatric/Medical Disorders
Child Abuse
Domestic Violence
Developmental Disorders
Approved Restraint Techniques

Medical Training

CPR – First Aid
Universal Precautions
Responding to emergency situations\

HBTS Specifics

Client rights and family centered care
Ethics (especially boundary issues) and confidentiality
Child abuse reporting
Collaboration with other providers
Collecting data and documentation requirements
Overview of the clinical record and HBTS Treatment Plan

- a. Clinical Training
- b. Medical Training
- c. HBTS Specifics

APPENDIX 6: REQUIREMENTS OF ABA PROGRAMS

Provider-agencies must answer the following:

1. ABA programs for children with autism have a defined “curriculum scope and sequence”, that lists skills in all domains (learning to learn, communication, social, academic, self-care, motor, play and leisure, etc.), broken into smaller component skills and sequenced developmentally, or from simple to complex. Please describe the curriculum scope and sequence that you will use.
2. ABA programs for children with autism use a skills assessment, to determine skills that the individual does and does not have. Selection of treatment goals for each individual is then guided by data from that initial skills assessment. Please describe the skills assessment that you will use to identify treatment goals and objectives.
3. ABA programs for children with autism use a variety of systematic procedures to teach new skills, maintain previously mastered skills, and generalize skills to new environments. Please describe which teaching techniques you will use (e.g., discrete trial training, task analysis and chaining, incidental teaching, etc. What type of prompting procedures will be used in these teaching programs?
4. ABA programs for children with autism require the effective use of reinforcement. Please describe what techniques you will use to systematically identify preferences in the individuals with who you work? How will you validate that the items used contingently in skill acquisition programs truly function as reinforcers?
5. ABA programs for children with autism require that skills to be increased and challenging behaviors to be decreased are operationally defined, in observable terms; data must be collected by direct observation on an ongoing basis. Please describe how you will measure the effectiveness of your teaching programs and the programs used to reduce challenging behavior?
6. Treating challenging behavior in children with autism must be function-based. Please describe the methods of functional assessment/analysis that you will use? How will this data be analyzed?
7. Once you have identified the function of challenging behavior in an individual, what behavioral interventions will you use for behaviors maintained by a) positive reinforcement; b) negative reinforcement; and c), and automatic reinforcement?
8. Occasionally, when dealing with severe challenging behavior, restrictive procedures may be required. What type of restrictive procedures will you use? How will you train staff on these procedures? How will the use of these procedures be monitored? Who will be responsible for the oversight and monitoring of these procedures?
9. How are you going to train your staff? Provide details regarding your training procedures, curricula, and ongoing in-services you plan to provide your staff.
10. What is your plan for the use of clinical staff for this program? Please send credentials of any clinical staff you plan to use for this program?
11. How do you plan to use lead therapy, clinical supervision and treatment consultation?

APPENDIX 7: OFFICE/CENTER BASED ABA PRACTICE REQUIREMENTS

Provider-agencies must answer the following:

1. Provide a description of your program that informs parents/guardians about the advantages of using an office or center based approach to ABA treatment. Describe when it is clinically indicated to combine office/center based ABA with at home ABA services.
2. How are the goals and objectives determined for each component of care should both home and center based treatment be used?
3. How are hours of intervention determined?
4. Describe how will collaborate with professionals when a child is receiving ABA school based interventions.
5. Describe program supervision, use of live video observation, skype, length of therapy sessions, and the roles/responsibilities of parents/guardians.

APPENDIX 8: PROVIDER APPROVAL PROCESS

Submission of Application for New Provider Providers

There is no limit to the number of entities that may become certified as provider-agencies for HBTS. There is no prohibition against a provider-agency also offering other Direct Services (i.e., PASS, Respite, or Kids Connect) subject to satisfactory approval in those areas by EOHHS.

All applicants will be evaluated on the basis of written materials submitted to EOHHS. Applicants should anticipate a minimum of two months for the review process, which may include on-site inspections as well as additional written clarification before issuing its findings. A favorable determination will result in the issuance of a Letter of Approval.

During the period of review, staff from EOHHS may inform a provider-agency that an unfavorable decision is anticipated. The provider-agency may withdraw its application without prejudice and resubmit at a later time. There is no limit to the number of times that potential applicant can seek to become a Certified Direct Service Provider for HBTS.

Instructions for Interested Parties

Applicants should contact EOHHS with a letter of intent. Inquiries and completed applications should be directed to:

Brenda Duhamel
Chief, Family Health Systems
Executive Office of Health and Human Services
Center for Child and Family Health
74 West Road – Hazard Building – Lower Level
Cranston, RI 02920

Possible Outcomes of the Application Review Process

Applications for HBTS approval will be reviewed and scored based on the degree to which an applicant demonstrates a program that complies with the requirements set forth in these HBTS Certification Standards. Three basic outcomes are possible as a result of the application review process, namely:

1. *Approval with No Conditions* – The applicant is deemed in compliance with all requirements.
2. *Approval with Conditions* – The applicant may describe a program that meets most of the Certification Standards, but for one reason or another does not fully comply with approval requirements at the time of application submission. Should this occur, the applicant will be deemed certified upon submission of additional, edited documents in order to demonstrate compliance with all requirements.
3. *Not Approved* - The application does not meet the requirements for approval and therefore will not be offered to that agency. Should this occur, the applicant will be provided with specific written feedback and can choose to reapply at a later date.

Period of Approval

The initial period of approval shall last three years from receipt of signed letters of agreement stipulating conditions and requirements necessary for approval as a HBTS provider. Thereafter, EOHHS has the sole responsibility and discretion to extend approval and/or require re-approval based upon its ongoing oversight and monitoring of HBTS provider-agencies. In each instance, EOHHS will inform the provider-agency in writing with new letters of agreement.

Compliance

1. Approved HBTS provider-agencies must comply with these HBTS Certification Standards throughout the awarded period of approval. Failure of EOHHS to insist on strict compliance with all practice and performance standards shall not constitute a waiver of any of these provisions, and shall not limit the right of EOHHS to demand full compliance. EOHHS reserves the right to amend program requirements with reasonable notice to participating provider-agencies.
2. EOHHS in its capacity to monitor and evaluate HBTS provider-agencies may take any of the following actions and/or issue other sanctions that it deems necessary pursuant to Medicaid or other Federal and Rhode Island laws, namely:
 - a. EOHHS can inspect written records of HBTS provider-agencies including documentation of clinical services and billing for Medicaid services within three days of written notification.
 - b. EOHHS can inspect sites and/or interview staff pursuant to complaints and/or compliance deficiencies with these practice standards.
 - c. EOHHS can require a plan of corrective action with clearly defined measures stipulating objectives, personnel responsible for managing and remedying identified deficiencies, and listing of dates for achieving success for all deficiencies. EOHHS reserves the right to specify the time for achieving part and full remediation of all identified deficiencies.
 - d. EOHHS can require further modification of any plan of corrective action.
 - e. EOHHS can suspend new referrals for up to 6-months as part of any plan of corrective action.
 - f. EOHHS can require recoupment of funds for violations of these Certification Standards and/or violations of Medicaid and/or State laws.
3. EOHHS shall institute Provisional Approval status following formal notice to the provider-agency on the one hundred twenty first day (121) for continued non-compliance to have cured identified deficiencies. The provider-agency may seek to suspend such an action by filing notice of appeal to EOHHS no later than thirty days (30) following notification of non-compliance and issuance of Provisional Approval. In the event that a provider-agency's appeal is not successful, the provider-agency may seek resolution through the Administrative Procedures Act (APA Appeal) to Superior Court. In the event a provider-agency takes this action, imposition of Provisional Approval will be stayed pending the outcome of the appeal.

The consequences of Provisional Approval status involve rate reductions and specified requirements regarding the administration and management of HBTS with EOHHS ongoing oversight for the next ninety (90) days. Such action may involve on site visits including record documentation reviews, interview of staff, submission of required reports, financial/billing information, and/or other requirements that it deems necessary. EOHHS will set forth a period of time whereby the provider-agency must come into full compliance or risk the revocation of approval.

4. EOHHS has the responsibility to inform agencies when aware of instances of fraud, suspected fraud, misuse of Medicaid funds, or professional misconduct. This may include referral to legal or licensing authorities and/or to the Surveillance Utilization Review (SURS) department of EOHHS.
5. Revocation of approval is the most serious penalty and one that EOHHS reserves for provider-agencies inability to rectify deficiencies and/or violations of these practice standards.

EOHHS Oversight and Authorization

EOHHS in accordance with Medicaid regulations may place limits on services (i.e., establish amount, duration and scope of services) and exclude any item or service that it determines is not medically necessary, is unsafe, experimental, or is not generally recognized as an accepted method of medical practice or treatment. EOHHS has the authority to conduct site visits.

Monitoring and Quality Assurance

Site visits will be conducted by EOHHS staff to monitor appropriate use of Medicaid services and compliance with the procedures outlined in this manual. Providers will be notified of EOHHS site visits in advance. During these visits, staff will review the following:

- Client records and Treatment Plans
- Staff orientation programs and attendance logs
- Agency policy and procedures related to HBTS service provision
- Claims information/documentation
- Staff time sheets
- Complaint log
- Clinical Supervision notes

Unannounced site visits may also be conducted at the discretion of the Department. EOHHS staff may contact or visit families as part of the oversight and monitoring activities.

In the event of adverse findings of a minor nature, repayment to EOHHS will be required. In situations where, in the opinion of the Department, significant irregularities in billing or utilization are revealed, providers may be required to do a complete self-audit in addition to making repayments. In either case, technical assistance in developing and implementing a plan of corrective action, where appropriate and applicable, will be offered to the provider.

In addition to monitoring conducted by EOHHS, providers are subject to periodic fiscal and program audits by the Health Care Financing Administration.

Client Record Guidelines

All Home Based Therapeutic Services must be provided in accordance with a comprehensive Treatment Plan that documents the medical necessity of the services. Medicaid is, by definition, a medical program, which pays for medical services. A Treatment Plan is regarded as a prescription for services and must be signed by a licensed an appropriate professional, in this case, a Licensed Practitioner of the Healing Arts.

Treatment Plans for clients for whom providers are billing Medicaid must conform to the following guidelines:

1. Each client shall have a current written, comprehensive, individualized Treatment Plan that is based on assessments of the client's medical/behavioral needs. The diagnosis must clearly be evident in the Treatment Plan and the diagnosis must be considered as the

- overall plan is developed. There must be a clear connection between the diagnosis and the symptoms of the condition for which the client is being referred.
2. Responsibility for the overall development and implementation of the Treatment Plan must be assigned to an appropriate member of the professional staff.
 3. The Treatment Plan must be reviewed at major decision points in each client's course of treatment including:
 4. The time of admission and discharge
 5. A major change in the client's condition
 6. The point of the estimated length of treatment and thereafter based on the estimated length of treatment, e.g., re-reviews of the Treatment Plan
 7. At least every six months of treatment
 8. The Treatment Plan must contain specific goals that the client must achieve and/or maintain as well as maximum growth and adaptive capabilities. These goals must be based on periodic assessments of the client and as indicated appropriate, the client's family.
 9. Progress notes should reflect a judgment being made by the provider regarding the results of the treatment rendered, i.e., an assessment of why the interventions prescribed are/are not working. The notes should also show that the writer is aware of why things were done rather than merely what was done.

APPENDIX 9: HBTS PHASES

Phase 1: Pre-Treatment – up to 6 months

Description: All HBTS referrals will begin with Pre-treatment service. As a result of this support, families are expected to gain meaningful information about their child's disorder, learn strategies for managing behavior, and - in some instances – may not require the implementation of direct intensive home-based treatment. For other families, it is expected that Pre-Treatment Consultation will also help in the development of a more comprehensive and informed HBTS Treatment Plan based upon having had Pre-Treatment Consultation. OT, PT, and SLP clinicians can also provide pre-Treatment Consultation.

If a family is receiving mental health services focusing on the above mentioned issues or has in the past 6 months received outpatient services, then they can be exempt from beginning HBTS with Pre-treatment.

If a family is currently receiving HBTS services and the clinicians from the HBTS provider agency determined with the parents that Pre-treatment services would be helpful, then they can receive this service in addition to direct service hours.

For a family who will not proceed to Phase 2 Pre-treatment can continue for another 6 months. An out-patient referral should be made if the family will require longer-term ongoing treatment.

Intensity: 2 hours per week provided by a licensed clinician.

Phase 2: HBTS Specialized Treatment/Treatment Support – up to 2 years

Description: HBTS represents one-on-one intense therapeutic services provided to a child by a home-based worker (paraprofessional) in accordance with the approved Treatment Plan under the supervision of the licensed Clinical Supervisor. Specialized Treatment may address the development of behavioral, communication, social, and functional skills, as well as reinforce skills included in a child's Individual Educational Plan (IEP) or Individualized Family Service Plan (IFSP). This is accomplished by incorporating HBTS Specialty Consultations.

HBTS services in Phase 2 can include a combination of Specialized Treatment and Treatment Support (described below). During the first year up to 100% of services can be Specialized Treatment. During the second year of HBTS Treatment Support should be introduced into the treatment plan unless there is sound clinical justification for not using it. Up to 60% of hours can be Treatment Support in the second year of Phase 2.

Intensity: Maximum 20 hours per week

Phase 3: Treatment Support – up to 6 months

Description: Treatment Support is a less therapeutically intensive component of home-based direct treatment services. Treatment Support allows for approved HBTS hours to be used for the purposes of providing structure, supervision, guidance, and redirection when the child is not directly engaged in active goal-directed treatment. The Clinical Supervisor must direct the activities of the home-based worker providing Treatment Support.

The goal of Treatment Support is to assist children with moderate to severe developmental and neuro-medical conditions whose level of functioning limits their participation and ability to engage in sustained Specialized Treatment. Treatment Support is intended to facilitate some children's transition into adulthood by supporting a child's ability to remain at home and to participate in the community. It encourages and facilitates activities of daily living by providing structure, supervision, guidance, and redirection while engaging in cognitive, physical and social activities that would be typical for a child their age.

Phase 3 of the program will provide a child with continued support at a slightly decreased intensity in order to maintain the progress made during Phases 1 and 2.

Intensity: For families not receiving PASS, a maximum of 20 hours per week of Treatment Support.

Phase 4: Post-treatment – up to 6 months

Description: This is a time-limited service to allow for support as a child and family ends HBTS and/or is preparing to transition to other services. The treatment consultant reviews with parents specific therapeutic interventions to maintain gains and progress made during HBTS. Mental health and specialty consultants can provide post-treatment consultation. It is expected that post-treatment consultation be provided over a period of 6 months. If additional time is required, a request and justification should be made to EOHHS or the third party payer.

After a child and family have progressed through the first three phases of HBTS, the parents have the option of receiving Post-treatment from their HBTS agency. The family has the right to decline these services if they are not interested in receiving them.

Intensity: Maximum 1 hour per week

Phase 5: HBTS Post 2 years

Some children may require continued HBTS services for a variety of reasons. These are children who have long-term profound impairments or severe disabilities requiring the child to receive a high level of monitoring or supervision. The intended outcome of Phase 5 of HBTS is continued progress or maintaining functional levels for each treatment goal demonstrated by data collected, to demonstrate a decrease or maintained functional level in behavioral problems, outburst or aggression, improvement or maintenance of functional level in adaptive living skills and parents feeling more confident and competent in managing their child's behavior and treatment.

Children must have a current Vineland Adaptive Behavior Scale assessment, or equivalent, and meet 3 of the following criteria to be eligible for HBTS beyond 2 years.

- a. Have had multiple psychiatric hospitalizations over the past year (over 2)
- b. Have been in residential treatment within the past 3 years and continue to display significant behavioral difficulties
- c. Receive 1:1 aid in school and are placed in a self-contained special education class or school
- d. Have an IQ of 60 or below evaluated within the past 2 years
- e. Are non-verbal and/or present with significant risk to self-preservation and independent functioning

Duration: Ongoing and assessed annually by use of a standardize measure (i.e. Adaptive Behavior Assessment System, Vineland, etc.)

Intensity: Maximum 20 hours per week of Treatment Support with up to 50% of Specialized Treatment if clinically indicated.

HBTS PHASES

Phase	Billable Components	Max allowable
Phase 1 - up to 6 months Pre-Treatment Consultation	Treatment Consultation Pre-Treatment	2 hours per week
	Treatment Coordination	15 minutes per week
Phase 2a - Year 1 Specialized Treatment	Plan Development	1 every 12 months
	Supervision	Max 8 hours per month
	Specialized Treatment	Max 20 hours per week
	Treatment Consultation	1 hour per month
	Treatment Coordination	Up to 2 hours per week
	Orientation	10 hours
Phase 2b - Year 2 Specialized Treatment / Treatment Support Phase 2b must include some Treatment Support hours.	Plan Development	1 every 12 months
	Supervision	Max 8 hours per month
	Specialized Treatment	Max 20 hours per week
	Treatment Support	(Max 60%)
	Treatment Consultation	1 hour per month
	Treatment Coordination	Up to 2 hours per week
Phase 3 - up to 6 months Treatment Support	Plan Development	1 every 12 months
	Supervision	1 hours per week
	Treatment Support	(100%) Max 20 hours per week
	Treatment Consultation	1 hour per month
	Treatment Coordination	Up to 1 hour per week
	Orientation	5 hours
Phase 4 - up to 6 months Post-Treatment Consultation	Treatment Consultation Post-Treatment	1 hour per week
	Treatment Coordination	15 min per week
Phase 5 - Ongoing HBTS Requires EOHHS review after Phase 2 Phase 5 is considered to be Treatment Support and can include up to 50% Specialized Treatment if clinically indicated.	Plan Development	1 every 12 months
	Supervision	Max 4 hours per month
	Treatment Support	Max 20 hours per week
	Specialized Treatment	(can be up to 50%)
	Treatment Consultation	1 hour per month
	Treatment Coordination	Up to 2 hours per week
	Orientation	5 hours

APPENDIX 10: HBTS REIMBURSABLE SERVICES

Pre-Treatment & Post-Treatment Consultation

Service	Personnel	Qualifications	Approved Units (1 unit=30 minutes)	Comments
Pre-Treatment Consultation	Treatment Consultant or Clinical Supervisor	Licensed health care professional with competency working with children with special health care needs Masters or Doctoral degree	Maximum = 4 units per week for up to 6 months	<ul style="list-style-type: none"> • Provides direct support and information to families of children on the HBTS referral list • Teach parents specific therapeutic interventions to reduce a child’s challenging behaviors and improve child’s functional skills • Conducts functional assessments • Not crisis intervention • Documents consultation • Takes place in child’s home or provider-agency • Prior Authorization Required for Each Service 6 – month authorization period
Treatment Coordination	Treatment Coordinator	Bachelor’s degree	Maximum = 2 units per week (15 minute unit) for up to 6 months	<ul style="list-style-type: none"> • Activities conducted on behalf of a specific child and family to ensure coordination with all relevant caregivers and others involved in child’s plan of care and documents consultation • Takes place in child’s home or provider-agency • Collects and manages data for summary reports • Prior Authorization Required for Each Service 6 – month authorization period
Post Treatment Consultation	Treatment Consultant or Clinical Supervisor		Maximum 2 units per week for up to 6 months	<ul style="list-style-type: none"> • Continues to provides direct support and information to families • Not crisis intervention • Continues to review and refine therapeutic interventions to maintain gains and progress made during HBTS. • Prior Authorization Required for Each Service 6 – month authorization period

Service	Personnel	Qualifications	Approved Units (1 unit=30 minutes)	Comments
Treatment Consultation	Treatment Consultant	Licensed health-care professional Competency working with children having special health care needs Masters or Doctoral degree	Minimum = None Maximum = 2 units per month	<ul style="list-style-type: none"> • Not the same person as Clinical Supervisor • Provides specific expertise and direction to therapeutic regimen • Conducts functional behavior assessments • Can be episodic or ongoing • Provides direction for emergency situations • Documents consultation • Must be child-specific sustained activity greater than 15 minutes in duration
Specialty Treatment Consultation Occupational, Physical, & Speech and Language Therapies	Occupational, Physical or Speech Therapist	Licensed OT, PT or SLP therapist Competency working with children having special health care needs	Minimum = 2 units per month Maximum = 4 units per month	<ul style="list-style-type: none"> • Writes OT, PT, SLP goals and objectives for treatment plan, in coordination with child's IEP or IFSP • Instruct home-based workers on proper implementation of treatment interventions • Observe home-based workers treating the child on a monthly basis • Documents using specialty consultation forms • Must be child-specific sustained activity greater than 15 minutes in duration
Clinical Supervision for Home-Based Worker (HBTS)	Clinical Supervisor	Licensed health-care professional with established competency working with children with special health care needs Masters or Doctoral degree	8 to 16 units per month (4 – 8 hours)	<ul style="list-style-type: none"> • Individual or group supervision if more than 2 home-based workers working with child. • Responsible for the development of Treatment Plan and writing of goals and objectives. • Instruct home-based workers on proper implementation of treatment interventions. • Observe home-based workers treating the child on a monthly basis. • Provides direction for emergency situations. • Documents supervision. • Must be child-specific sustained activity greater than 15 minutes
Lead Therapy (ABA)	Lead Therapist	Be at least 19 years of age, have a high school degree or equivalent, and two years of supervised experience working with children with special health care needs, or Have an Associate's degree in human services (i.e., psychological, counseling, child development, education or nursing, etc.)	Determined on a case by case basis	<ul style="list-style-type: none"> • Participate in the development of an HBTS Plan. • Participate in the development of instructional strategies. • Prepare instructional materials. • Observe the treatment worker and provide guidance. • Work with families to apply instructional strategies. • Maintain the integrity of a Treatment Plan, that is, look to observe how a child is succeeding. This involves data collection and data management.

Service	Personnel	Qualifications	(1 unit=30 minutes)	Comments
Child Specific Orientation	Treatment Consultant or Clinical Supervisor	Licensed health care professional with established competencies in working with children with special health care needs.	Maximum = 20 units per staff per child	<ul style="list-style-type: none"> • May orient and train new worker to the child's Treatment Plan • Can include 1:1 supervision and observing experienced HBTS worker treatment with a child
Home-Based Specialized Treatment	Home-Based Treatment Worker	Workers must be at least 19 years of age; high school degree or equivalent, minimum 2 years of supervised experience working with children with special health care needs, or Associate's degree in human services, or Currently enrolled in not less than six (6) semester hours of relevant under – graduate course work at an accredited college or university, or Previous work related experience with adults with developmental disabilities, EOHHS approval required, and active participation in an agency specific formal training program approved by EOHHS, and successful completion of objective testing within twelve (12) months of hire	Minimum = 20 units per week Maximum = 24 units per week	<ul style="list-style-type: none"> • Intensive treatment provided in the home and/or community setting • Implement child's individualized Treatment Plan • Home-Based worker collects data on responses to interventions for each treatment goal and objective
Treatment Support Worker	Home-Based Treatment Worker	Workers must be at least 19 years of age; high school graduate or equivalent, minimum plus 1 year of supervised experience with working with children, or Associate's degree in human services	Determined on a case by case basis Maximum = 24 units	<ul style="list-style-type: none"> • Staff trained on interventions and behavior program(s) used with child • Data kept during shift for targeted behavior(s)
Clinical Supervision of Treatment Support Worker	Clinical Supervisor	Masters or Doctoral degree	8 to 16 units per month (4 – 8 hours)	<ul style="list-style-type: none"> • Documents supervision • Must be child-specific sustained activity greater than 15 minutes in duration
Treatment Coordination	Treatment Coordinator	Bachelor's degree	Depending upon the phase between 4 to 8 units per week Unit = 15 minutes	<ul style="list-style-type: none"> • Activities conducted on behalf of a specific child to ensure coordination with all relevant caregivers and others involved in child's plan of care • Collects and manages data for summary reports

APPENDIX 12: LANGUAGE INTERPRETATION SUPPORT

1. A maximum of 8 hours per month can be used for the following purposes:
 - a. Up to 4 hours a month for Clinical Supervision of direct service staff where the parents participate (Team Meetings).
 - b. Up to 4 hours a month for parent training – including intake and initial assessments, and for meeting with the family when writing a full Treatment Plan renewal.
2. Up to 8 hours a month during HBTS Phase 1: Pre-Treatment.

Procedure Code	Description	Units of Service	Max Units/Month	Rate/Unit
T1013	Interpretation	15 minutes	32 (8 Hours)	\$13.58

3. A bilingual Treatment Coordinator may be used if preferred at the Treatment Coordinator rate.

APPENDIX 13: PRIOR AUTHORIZATION PROCEDURE CODES

Prior Authorization Required Services

Service	Procedure Code
Home Based – Specialized Treatment	T1024 TG
Home Based – Treatment Support	T1024 TF

Non-PA Services

Service	Procedure Code
Child Specific Orientation	S9445
Clinical Supervision – Master Level Clinician	H0046HO
Clinical Supervision – Doctoral Level Clinician	H0046HP
Lead Therapy	H0046
Specialized Treatment Consultation – Occupational Therapist	H2014
Specialized Treatment Consultation – Physical Therapist	H2014
Specialized Treatment Consultation – Speech and Language Therapist	H2014
Treatment Consultation – Master Level Clinician	H2014HO
Treatment Consultation – Doctoral Level Clinician	H2014HP
Treatment Coordination	T1016
Interpretation	T1013

APPENDIX 15: PERFORMANCE AND QUALITY MEASURES

1. % of delivered authorized direct service hours provided.
 - a. % of services not delivered based on a provider reason.
 - b. % of services not delivered based on a family reason.
2. % of provider-agency telephone contact with the family within 7 days of referral.
3. % face to face intake within 21 calendar days of telephone contact.
4. % of Initial treatment plans developed within 30 days of intake.
5. % treatment starting within 30 days of receiving authorization.
6. # of complaints received and logs of timeliness of complaint resolution
7. Summary of family satisfaction survey methods and results

The State reserves the right to request additional performance and quality measures on an ongoing basis with 30 days' notice.