Medicaid Section 1115 Substance Use Disorder & Serious Mental Illness and Serious Emotional Disturbance Demonstration Components Monitoring Protocol Template

Note: PRA Disclosure Statement to be added here

1. Title page for the state's substance use disorder (SUD) and serious mental illness and serious emotional disturbance (SMI/SED) demonstration components

The state should complete this title page as part of its integrated SUD and SMI/SED monitoring protocol. This form should be submitted as the title page for all monitoring reports. The content of this table should stay consistent over time. Definitions for certain rows are provided below the table.

Overall section 1115 demonstration	
State	*Massachusetts*
Demonstration name	*MassHealth*
Approval period for section 1115 demonstration	*10/01/2022-12/31/2027*
SUD demonstration	
SUD demonstration start date[a]	*10/01/2022*
Implementation date of SUD demonstration, if different from SUD demonstration start date[b]	*10/01/2022*

SUD demonstration goals and objectives	**Access to Critical Levels of Care for OUD and other SUDs.** Coverage of OUD/SUD treatment services across a comprehensive continuum of care including: outpatient; intensive outpatient; medication assisted treatment (medication as well as counseling and other services with sufficient provider capacity to meet needs of Medicaid beneficiaries in the state); intensive levels of care in residential and inpatient settings; and medically supervised withdrawal management. **Use of Evidence-based SUD-specific Patient Placement Criteria.** Providers will assess treatment needs based on SUD-specific, multidimensional assessment tools, such as the ASAM Criteria or other assessment and placement tools that reflect evidence-based clinical treatment guidelines **Patient Placement.** The state will continue to employ a utilization management approach, in accordance with state law, such that beneficiaries have access to SUD services at the appropriate level of care and that the interventions are appropriate for the diagnosis and level of care, including an independent process for reviewing placement in residential treatment settings. **Use of Nationally Recognized SUD-specific Program Standards to set Provider Qualifications for Residential Treatment Facilities.** Residential treatment providers must align with the program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding in particular the types of services, hours of clinical care, and credentials of staff for residential treatment settings. Residential treatment providers must also be in compliance with state licensure requirements for substance use disorder treatment programs. **Standards of Care for Residential Treatment Settings.** The state will review residential treatment providers to ensure that providers deliver care consistent with the specifications in the ASAM Criteria or other comparable, nationally recognized SUD program standards based on evidence-based clinical treatment guidelines for types of services, hours of clinical care, and credentials of staff for residential treatment settings.

	Standards of Care for Medication Assisted Treatment. Residential treatment providers must offer Medication Assisted Treatment (MAT) on-site or facilitate access to MAT off-site. **Sufficient Provider Capacity at each Level of Care including Medication Assisted Treatment for SUD/OUD.** The state must ensure sufficient provider capacity in the critical levels of care throughout the state, including those that offer MAT. **Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and SUD/OUD.** The state has implemented opioid prescribing guidelines along with other interventions to prevent prescription drug abuse and expand coverage of and access to naloxone for overdose reversal as well as implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs. **Improved Care Coordination and Transitions between levels of care.** The state will continue to ensure residential and inpatient facilities link beneficiaries with community-based services and supports following stays in these facilities. **SUD Health IT Plan.** Implementation of the milestones and metrics for the SUD Health IT Plan.
SMI/SED demonstration	
SMI/SED demonstration start date[a]	*10/01/2022*
Implementation date of SMI/SED demonstration, if different from SMI/SED demonstration start date[b]	10/01/2022

SMI/SED demonstration goals and objectives	**Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings**. Hospitals that meet the definition of an IMD in which beneficiaries receiving demonstration services under the SMI and SED program are residing must be licensed or approved as meeting standards for licensing established by the agency of the state or locality responsible for licensing hospitals prior to the state claiming FFP for services provided to beneficiaries residing in a hospital that meets the definition of an IMD. In addition, hospitals must be in compliance with the conditions of participation set forth in 42 CFR Part 482 and either: a) be certified by the state agency as being in compliance with those conditions through a state agency survey, or b) have deemed status to participate in Medicare as a hospital through accreditation by a national accrediting organization whose psychiatric hospital accreditation program or acute hospital accreditation program has been approved by CMS. Residential treatment providers that meet the definition of an IMD in which beneficiaries receiving demonstration services under the SMI program are residing must be licensed, or otherwise authorized, by the state to primarily provide treatment for mental illnesses. They must also be accredited by a nationally recognized accreditation entity prior to the state claiming FFP for services provided to beneficiaries residing in a residential facility that meets the definition of an IMD. Facilities providing Youth Community Crisis Stabilization and Community Based Acute Treatment for Children and Adolescents (CBAT) services must meet these requirements.[1] A transition period to comply with rules is permitted and described in STC 7.9. Establishment of an oversight and auditing process that includes unannounced visits for ensuring participating psychiatric hospitals and residential treatment settings meet state licensure or certification requirements as well as a national accrediting entity's accreditation requirements. Use of a utilization review entity (for example, a MCO or administrative service organization) to ensure beneficiaries have access to the appropriate levels and types of care and, in accordance with state law, to provide oversight to ensure lengths of stay are limited to what is medically necessary and only those who have a clinical need to receive

	treatment in psychiatric hospitals and residential treatment settings are receiving treatment in those facilities. Establishment of a process for ensuring that participating psychiatric hospitals and residential treatment settings meet applicable federal program integrity requirements and establishment of a state process to conduct risk-based screening of all newly enrolling providers, as well as revalidation of existing providers (specifically, under existing regulations, the state must screen all newly enrolling providers and reevaluate existing providers pursuant to the rules in 42 CFR Part 455 Subparts B and E, ensure treatment providers have entered into Medicaid provider agreements pursuant to 42 CFR 431.107, and establish rigorous program integrity protocols to safeguard against fraudulent billing and other compliance issues). Implementation of a state requirement that participating psychiatric hospitals and residential treatment settings screen beneficiaries for co-morbid physical health conditions and substance use disorders (SUDs) and demonstrate the capacity to address co-morbid physical health conditions during short-term stays in residential or inpatient treatment settings (e.g., with on-site staff, telemedicine, and/or partnerships with local physical health providers). **Improving Care Coordination and Transitioning to Community-Based Care.** Implementation of a process to ensure that psychiatric hospitals and residential treatment settings provide intensive pre-discharge, care coordination services to help beneficiaries transition out of those settings into appropriate community-based outpatient services, including requirements that facilitate participation of community-based providers in transition efforts (e.g., by allowing beneficiaries to receive initial services from a community-based provider while the beneficiary is still residing in these settings and/or by engaging peer support specialists to help beneficiaries make connections with available community-based providers and, where applicable, make plans for employment). Implementation of a process to assess the housing situation of a beneficiary transitioning to the community from psychiatric hospitals and residential treatment settings and to connect beneficiaries who may experience homelessness upon discharge or who would be discharged

	to unsuitable or unstable housing with community providers that coordinate housing services, where available. Implementation of a requirement that psychiatric hospitals and residential treatment settings have protocols in place to ensure contact is made by the treatment setting with each discharged beneficiary within 72 hours of discharge and to help ensure follow-up care is accessed by individuals after leaving those facilities by contacting the individuals directly and, as appropriate, by contacting the community-based provider they were referred to. Implementation of strategies to prevent or decrease the length of stay in emergency departments among beneficiaries with SMI or SED (e.g., through the use of peer support specialists and psychiatric consultants in EDs to help with discharge and referral to treatment providers). Implementation of strategies to develop and/or enhance interoperability and data sharing between physical, SUD, and mental health providers, with the goal of enhancing coordination so that disparate providers may better share clinical information to improve health outcomes for beneficiaries with SMI or SED. **Increasing Access to Continuum of Care Including Crisis Stabilization Services.** Establishment of a process to annually assess the availability of mental health services throughout the Commonwealth, particularly crisis stabilization services, and updates on steps taken to increase availability. Commitment to implementation of the financing plan described in STC 7.2(d). Implementation of strategies to improve the state's capacity to track the availability of inpatient and crisis stabilization beds to help connect individuals in need with that level of care as soon as possible. Implementation of a requirement that providers, plans, and utilization review entities use an evidence-based, publicly available patient assessment tool, preferably endorsed by a mental health provider association (e.g., LOCUS or CASII) to determine appropriate level of care and length of stay. **Earlier Identification and Engagement in Treatment, Including Through Increased Integration.** Implementation of strategies for

	identifying and engaging individuals, particularly adolescents and young adults, with SMI/SED in treatment sooner, including through supported employment and supported education programs. Increasing integration of behavioral health care in non-specialty care settings, including schools and primary care practices, to improve identification of SMI/SED conditions sooner and improve awareness of and linkages to specialty treatment providers. Establishment of specialized settings and services, including crisis stabilization services, focused on the needs of young people experiencing SMI or SED. **Health IT Plan.** Implementation of the milestones and metrics for the SMI/SED Health IT Plan.

[a] **SUD and SMI/SED demonstration components start date:** For monitoring purposes, CMS defines the start date of the demonstration components as the *effective date* listed in the state's STCs at time of the SUD and SMI/SED component approval. For example, if the state's STCs at the time of approval note that the SUD and SMI/SED demonstration components are effective January 1, 2020 – December 31, 2025, the state should consider January 1, 2020 to be the start date of these components. Note that the effective date is considered to be the first day the state may begin the demonstration component. In many cases, the effective date is distinct from the approval date of a demonstration component; that is, in certain cases, CMS may approve a section 1115 demonstration component with an effective date that is in the future. For example, CMS may approve an extension request on December 15, 2020, with an effective date of January 1, 2021 for the new demonstration component period. In many cases, the effective date also differs from the date a state begins implementing its demonstration component. The SMI/SED demonstration component start date will be auto-populated with the information entered in the "SUD demonstration start date" row. The state should review for accuracy.

[b] **Implementation date of SUD and SMI/SED demonstration components:** The date the state began claiming or will begin claiming federal financial participation for services provided to individuals in institutions for mental diseases.

2. Acknowledgement of narrative reporting requirements

☒ The state has reviewed the narrative questions in the Monitoring Report Template provided by CMS and understands the expectations for quarterly and annual monitoring reports. The state will provide the requested narrative information (with no modifications).

3. Acknowledgement of budget neutrality reporting requirements

☒ The state has reviewed the Budget Neutrality Workbook and understands the expectations for quarterly and annual monitoring reports. The state will provide the requested budget neutrality information (with no modifications).

4. Retrospective reporting

The state is not expected to submit metrics data until after monitoring protocol approval, to ensure that data reflects the monitoring plans agreed upon by CMS and the state. Prior to monitoring protocol approval, the state should submit quarterly and annual monitoring reports with narrative updates on implementation progress and other information that may be applicable, according to the requirements in its STCs.

For a state that has a monitoring protocol approved after one or more initial quarterly monitoring report submissions, it should report metrics data to CMS retrospectively for any prior quarters (Qs) of the section 1115 SUD and SMI/SED demonstration components that precede the monitoring protocol approval date. A state is expected to submit retrospective metrics data—provided there is adequate time for preparation of these data— in its second monitoring report submission that contains metrics. The retrospective monitoring report for a state with a first demonstration year (DY) of less than 12 months should include data for any baseline period Qs preceding the SUD and SMI/SED demonstration components, as described in Part A of the state's monitoring protocols. (See Appendix B of the Monitoring Protocol Instructions for further instructions on determining baseline periods for first DYs that are less than 12 months.) If a state needs additional time for preparation of these data, it should propose an alternative plan (i.e., specify the monitoring report that would capture the data) for reporting retrospectively on its section 1115 SUD and SMI/SED demonstration components.

In the monitoring report submission containing retrospective metrics data, the state should also provide a general assessment of metrics trends from the start of the demonstration components through the end of the current reporting period. The state should report this information in Part B of its monitoring report submission (Section 3: Narrative information on implementation, by milestone and reporting topic). This general assessment is not intended to be a comprehensive description of every trend observed in the metrics data. Unlike other monitoring report submissions, for instance, the state is not required to describe all metric changes (+ or - greater than 2 percent). Rather, the assessment is an opportunity for a state to provide context on its

retrospective metrics data and to support CMS's review and interpretation of these data. For example, consider a state that submits data showing an increase in the number of medication-assisted treatment (MAT) providers (SUD Metric #14) over the course of the retrospective reporting period. This state may decide to highlight this trend for CMS in Part B of its monitoring report (under SUD Milestone 4) by briefly summarizing the trend and explaining that during this period, a grant supporting training for new MAT providers throughout its state was implemented.

For further information on how to compile and submit a retrospective monitoring report, the state should review Section B of the Monitoring Report Instructions document.

☒ The state will report retrospectively for any Qs prior to monitoring protocol approval as described above, in the state's second monitoring report submission that contains metrics after monitoring protocol approval.

☐ The state proposes an alternative plan to report retrospectively for any Qs prior to monitoring protocol approval: *Insert narrative description of proposed alternative plan for retrospective reporting. Regardless of the proposed plan, retrospective reporting should include retrospective metrics data and a general assessment of metric trends for the period. The state should provide justification for its proposed alternative plan.*

5. SMI/SED Annual Assessment of the Availability of Mental Health Services reporting

☒ The state will use data as of the following month and day of each calendar year to conduct its Annual Assessment of the Availability of Mental Health Services: **January 31**