COMMONWEALTH OF MASSACHUSETTS ~ STANDARD CONTRACT FORM

This form is jointly issued and published by the Office of the Comptroller (CTR), the Executive Office for Administration and Finance (ANF), and the Operational Services Division (OSD) as the default contract for all Commonwealth Departments when another form is not prescribed by regulation or policy. The Commonwealth deems void any changes made on or by attachment (in the form of addendum, engagement letters, contract forms or invoice terms) to the terms in this published form or to the **Standard Contract Form Instructions and Contractor Certifications,** the **Commonwealth Terms and Conditions for Human and Social Services** or the **Commonwealth IT Terms and Conditions** which are incorporated by reference herein. Additional non-conflicting terms may be added by Attachment. Contractors are required to access published forms at CTR Forms: https://www.macomptroller.org/forms. Forms are also posted at OSD Forms: https://www.mass.gov/lists/osd-forms.

CONTRACTOR LEGAL NAME: Massachusetts Behavioral Health Partnership **(and d/b/a):**	**COMMONWEALTH DEPARTMENT NAME:** Executive Office of Health and Human Services **MMARS Department Code:** EHS
Legal Address: (W-9, W-4): 1000 Washington St., Ste. 310, Boston, MA 02118-5002	**Business Mailing Address:** One Ashburton Place, 11th Fl., Boston, MA 02108
Contract Manager: Sharon Hanson **Phone:** 617-790-4000	**Billing Address (if different):** 600 Washington Street, Boston, MA 02111
E-Mail: sharon.hanson@carelon.com **Fax:**	**Contract Manager:** Emily Bailey **Phone:** 857-260-7574
Contractor Vendor Code: VC6000182737	**E-Mail:** emily.r.bailey@mass.gov **Fax:**
Vendor Code Address ID (e.g., "AD001"): AD001. **(Note: The Address ID must be set up for EFT payments.)**	**MMARS Doc ID(s):** N/A
	RFR/Procurement or Other ID Number: BD-22-1039-EHS01-EHS01-70615

☐ **NEW CONTRACT**

PROCUREMENT OR EXCEPTION TYPE: (Check one option only)

☐ **Statewide Contract** (OSD or an OSD-designated Department)
☐ **Collective Purchase** (Attach OSD approval, scope, budget)
☐ **Department Procurement** (includes all Grants - 815 CMR 2.00) (Solicitation Notice or RFR, and Response or other procurement supporting documentation)
☐ **Emergency Contract** (Attach justification for emergency, scope, budget)
☐ **Contract Employee** (Attach Employment Status Form, scope, budget)
☐ **Other Procurement Exception** (Attach authorizing language, legislation with specific exemption or earmark, and exception justification, scope and budget)

☒ **CONTRACT AMENDMENT**

Enter **Current Contract End Date *Prior*** to Amendment: **December 31, 2027**
Enter **Amendment Amount**: $ no change . (or "no change")

AMENDMENT TYPE: (Check one option only. Attach details of amendment changes.)

☒ **Amendment to Date, Scope or Budget** (Attach updated scope and budget)
☐ **Interim Contract** (Attach justification for Interim Contract and updated scope/budget)
☐ **Contract Employee** (Attach any updates to scope or budget)
☐ **Other Procurement Exception** (Attach authorizing language/justification and updated scope and budget)

The Standard Contract Form Instructions and Contractor Certifications and the following Commonwealth Terms and Conditions document are incorporated by reference into this Contract and are legally binding: (Check ONE option): ☒ Commonwealth Terms and Conditions ☐ Commonwealth Terms and Conditions For Human and Social Services ☐ Commonwealth IT Terms and Conditions

COMPENSATION: (Check ONE option): The Department certifies that payments for authorized performance accepted in accordance with the terms of this Contract will be supported in the state accounting system by sufficient appropriations or other non-appropriated funds, subject to intercept for Commonwealth owed debts under 815 CMR 9.00.
☒ **Rate Contract.** (No Maximum Obligation) Attach details of all rates, units, calculations, conditions or terms and any changes if rates or terms are being amended.)
☐ **Maximum Obligation Contract.** Enter total maximum obligation for total duration of this contract (or ***new*** total if Contract is being amended). $_____.

PROMPT PAYMENT DISCOUNTS (PPD): Commonwealth payments are issued through EFT 45 days from invoice receipt. Contractors requesting **accelerated** payments must identify a PPD as follows: Payment issued within 10 days _____% PPD; Payment issued within 15 days _____ % PPD; Payment issued within 20 days _____ % PPD; Payment issued within 30 days _____% PPD. If PPD percentages are left blank, identify reason: ☒ agree to standard 45 day cycle ☐ statutory/legal or Ready Payments (M.G.L. c. 29, § 23A); ☐ only initial payment (subsequent payments scheduled to support standard EFT 45 day payment cycle. See Prompt Pay Discounts Policy.)

BRIEF DESCRIPTION OF CONTRACT PERFORMANCE or REASON FOR AMENDMENT: (Enter the Contract title, purpose, fiscal year(s) and a detailed description of the scope of performance or what is being amended for a Contract Amendment. Attach all supporting documentation and justifications.)

Amendment 1 to MassHealth's Managed Behavioral Health Contract updates financial and other provisions and replaces/adds certain appendices in the Contract effective January 1, 2023.

ANTICIPATED START DATE: (Complete ONE option only) The Department and Contractor certify for this Contract, or Contract Amendment, that Contract obligations:

☐ 1. may be incurred as of the Effective Date (latest signature date below) and **no** obligations have been incurred **prior** to the Effective Date.
☒ 2. may be incurred as of **January 1, 2023**, a date **LATER** than the Effective Date below and **no** obligations have been incurred **prior** to the Effective Date.
☐ 3. were incurred as of _____, a date **PRIOR** to the Effective Date below, and the parties agree that payments for any obligations incurred prior to the Effective Date are authorized to be made either as settlement payments or as authorized reimbursement payments, and that the details and circumstances of all obligations under this Contract are attached and incorporated into this Contract. Acceptance of payments forever releases the Commonwealth from further claims related to these obligations.

CONTRACT END DATE: Contract performance shall terminate as of **December 31, 2027,** with no new obligations being incurred after this date unless the Contract is properly amended, provided that the terms of this Contract and performance expectations and obligations shall survive its termination for the purpose of resolving any claim or dispute, for completing any negotiated terms and warranties, to allow any close out or transition performance, reporting, invoicing or final payments, or during any lapse between amendments.

CERTIFICATIONS: Notwithstanding verbal or other representations by the parties, the **"Effective Date"** of this Contract or Amendment shall be the latest date that this Contract or Amendment has been executed by an authorized signatory of the Contractor, the Department, or a later Contract or Amendment Start Date specified above, subject to any required approvals. The Contractor certifies that they have accessed and reviewed all documents incorporated by reference as electronically published and the Contractor makes all certifications required under the Standard Contract Form Instructions and Contractor Certifications under the pains and penalties of perjury, and further agrees to provide any required documentation upon request to support compliance, and agrees that all terms governing performance of this Contract and doing business in Massachusetts are attached or incorporated by reference herein according to the following hierarchy of document precedence, the applicable Commonwealth Terms and Conditions, this Standard Contract Form, the Standard Contract Form Instructions and Contractor Certifications, the Request for Response (RFR) or other solicitation, the Contractor's Response (excluding any language stricken by a Department as unacceptable, and additional negotiated terms, provided that additional negotiated terms will take precedence over the relevant terms in the RFR and the Contractor's Response only if made using the process outlined in 801 CMR 21.07, incorporated herein, provided that any amended RFR or Response terms result in best value, lower costs, or a more cost effective Contract.

AUTHORIZING SIGNATURE FOR THE CONTRACTOR:

X: _____. **Date:** 6/29/2023.
(Signature and Date Must Be Captured At Time of Signature)

Print Name: Sharon Hanson.

Print Title: Vice President of Client Partnerships and CEO.

AUTHORIZING SIGNATURE FOR THE COMMONWEALTH:

X: Mike Levine. **Date:** 06/29/2023.
Mike Levine (Jun 29, 2023 17:59 EDT)
(Signature and Date Must Be Captured At Time of Signature)

Print Name: Mike Levine.

Print Title: Assistant Secretary for MassHealth.

AMENDMENT 1

to the

MANAGED BEHAVIORAL HEALTH VENDOR CONTRACT

Between

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

OFFICE OF MEDICAID

1 ASHBURTON PLACE

BOSTON, MA 02108

And

THE MASSACHUSETTS BEHAVIORAL HEALTH PARTNERSHIP

100 WASHINGTON STREET

BOSTON, MA 02118

WHEREAS, The Massachusetts Executive Office of Health and Human Services (referred throughout the Contract as either "EOHHS" or "MassHealth") and the Massachusetts Behavioral Health Partnership ("Contractor") entered into the Managed Behavioral Health Vendor Contract ("Contract"), effective January 1, 2023, to provide innovative, cost-effective, high quality care management services, network management services, quality management activities and comprehensive Behavioral Health services for certain MassHealth Covered Individuals, including but not limited to Care Management Program for individual Enrollees with complex medical and/or behavioral health conditions, through a program known as the MassHealth PCC Plan's Comprehensive Behavioral Health Program or Management Support Services, and Behavioral Health Specialty Programs; and

WHEREAS, in accordance with **Section 5.8** of the Contract, EOHHS and the Contractor desire to further amend their agreement effective January 1, 2023, except as otherwise noted below, in accordance with the rates, terms and conditions set forth herein; and

WHEREAS, EOHHS and the Contractor agree that the rates and terms stated herein are subject to the approval of the federal Centers for Medicare and Medicaid Services (CMS);

NOW, THEREFORE, in consideration of the mutual undertakings, EOHHS and the Contractor agree to amend the Contract as follows:

SECTION 1. DEFINITIONS AND ACRONYMS

Section 1.1 is hereby amended by inserting alphabetically the following definitions:

Abuse – actions or inactions by Providers (including the Contractor) and/or Members that are inconsistent with sound fiscal, business or medical practices, and that result in unnecessary cost to the MassHealth program, including, but not limited to practices that result in MassHealth reimbursement for services that are not Medically Necessary, or that fail to meet professionally recognized standards for health care.

Community Crisis Amount – the total amount paid for AMCI/YMCI, including follow-up, and Community Crisis Stabilization services provided under the Contract to Uninsured Individuals and persons covered by Medicare only.

Emergency Department Crisis Evaluation Payment – payment for initial crisis evaluation services in the emergency department provided under the Contract when not covered otherwise to Uninsured Individuals and persons covered by Medicare only.

Fraud – an intentional deception or misrepresentation made by a person or corporation with the knowledge that the deception could result in some unauthorized benefit under the MassHealth program to himself, the corporation, or some other person. It also includes any act that constitutes fraud under applicable federal or state health care fraud laws. Examples of provider fraud include: lack of referrals by PCPs to specialists, improper coding, billing for services never rendered, inflating bills for services and/or goods provided, and providers who engage in a pattern of providing and/or billing for medically unnecessary services. Examples of Covered Individual fraud include improperly obtaining prescriptions for controlled substances and card sharing.

Individuals without Mobile Crisis Coverage – those individuals who are not MassHealth eligible and are not Uninsured Individuals, and for whom mobile crisis intervention services are not covered otherwise.

Mobile Crisis Intervention Uncompensated Care Payment – payment for AMCI and YMCI services provided under the Contract when not covered otherwise to Individuals without Mobile Crisis Coverage.

Section 1.1 is further amended by striking the definitions below, and inserting in their places the following definitions:

Claim – a Provider's bill for services, a line item of service, or all services for one Covered Individual, Uninsured Individual, or Individual without Mobile Crisis Coverage.

Service Compensation Rate – a dollar amount to be paid monthly by EOHHS to the Contractor for the delivery of AMCI/YMCI, including follow-up, and Community Crisis Stabilization services to Uninsured Individuals and persons covered by Medicare only as set forth in this Contract.

SECTION 2. CONTRACTOR RESPONSIBILITIES

Section 2.3.B.2 is hereby amended by deleting it in its entirety and replacing it with the following:

"2. PCC Clinical Advisory Council

The Contractor shall establish and facilitate a PCC Clinical Advisory Council whose main objective is to support and promote improvement in the quality of clinical services provided to Enrollees. The meetings shall be held at least two times a year and may be held in-person or virtually.

a. The attendees of the PCC Clinical Advisory Council shall be subject to EOHHS's approval, and shall consist of:

1) all enrolled PCCs;

2) non-physician providers affiliated with PCC practices, by invitation only ,as determined by EOHHS; and

3) other MassHealth providers acting as specialists, by invitation only as determined by EOHHS.

b. The activities of the PCC Clinical Advisory Council shall include:

1) Meeting at a minimum two times in the Contract Year, with one of the meetings being a joint meeting with the BH Clinical Advisory Committee (see **Section 2.3.B.1**, above);

2) Developing agendas with the PCC Plan Director and Medical Director that promote and support the improvement in quality of clinical services provided to Enrollees including but not limited to topics pertinent to provider practice and care quality;

3) Engage speakers who present on salient topics in collaboration with the PCC Plan; and

4) Report on minutes to the meeting and provide follow-up on action items established."

Effective April 1, 2023, **Section 2.3.D.3** is hereby amended by deleting it in its entirety and replacing it with the following:

"3. Program Integrity Requirements

a. General Provisions

The Contractor shall:

1) Comply with all applicable federal and state program integrity laws and regulations regarding Fraud, waste and Abuse, including but not limited to, the Social Security Act and 42 CFR Parts 438, 455, and 456.

2) Implement and maintain written internal controls, policies and

procedures, and administrative and management arrangements or procedures designed to prevent, detect, reduce, investigate, correct and report known or suspected Fraud, waste and Abuse activities consistent with 42 CFR 438.608(a) and as further specified in this Contract.

3) In accordance with federal law, including but not limited to Section 6032 of the federal Deficit Reduction Act of 2005, make available written Fraud and Abuse policies to all employees. If the Contractor has an employee handbook, the Contractor shall include specific information about such Section 6032, the Contractor's policies, and the rights of employees to be protected as whistleblowers.

4) Meet with EOHHS regularly and upon request to discuss Fraud, waste and Abuse, audits, overpayment issues, reporting issues, and best practices for program integrity requirements.

5) At EOHHS' discretion, implement certain program integrity requirements for Providers, as specified by EOHHS, including but not limited to implementing National Correct Coding Initiative edits or other CMS claims processing/provider reimbursement manuals, and mutually agreed upon best practices for program integrity requirements.

b. Compliance Plan

1) The Contractor shall, in accordance with 42 CFR 438.608(a)(1), have a compliance plan designed to guard against Fraud, waste and Abuse.

2) At a minimum, the Contractor's compliance plan shall include the following:

a) Written policies, procedures, and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal and state laws regarding Fraud, waste and Abuse;

b) The designation of a compliance officer and a compliance committee, as described in 42 CFR 438.608, that is accountable to senior management;

c) Adequate Massachusetts-based staffing and resources to investigate incidents and develop and implement plans to assist the Contractor in preventing and detecting potential Fraud, waste, and Abuse activities. Staff conducting

program integrity activities for the Contractor shall be familiar with MassHealth and state and federal regulations on Fraud, waste and Abuse;

d) Effective training and education for the Contractor's employees, including but not limited to the Contractor's compliance officer and senior management;

e) Effective lines of communication between the compliance officer and the Contractor's employees, as well as between the compliance officer and EOHHS;

f) Enforcement of standards through well-publicized disciplinary guidelines;

g) Provision for internal monitoring and auditing as described in 42 CFR 438.608;

h) Provision for prompt response to detected offenses, and for development of corrective action initiatives, as well as the reporting of said offenses and corrective actions to EOHHS as stated in this Contract and as further directed by EOHHS; and

i) Communication of suspected violations of state and federal law to EOHHS, consistent with the requirements of this Section;

3) The Contractor's compliance plan shall be in place by the Contract Operational Start Date and in a form and format specified by EOHHS. The Contractor shall provide EOHHS with its compliance plan in accordance with **Appendix E-1**, annually, and when otherwise requested. The Contractor shall make any modifications requested by EOHHS within thirty (30) calendar days of a request.

c. Anti-Fraud, Waste, and Abuse Plan

1) The Contractor shall have an anti-Fraud, waste, and Abuse plan.

2) The Contractor's anti-Fraud, waste, and Abuse plan shall, at a minimum:

a) Require that the reporting of suspected and confirmed Fraud, waste, and Abuse be performed as required by this Contract;

b) Include a risk assessment of the Contractor's various Fraud, waste, and Abuse and program integrity processes, a listing

of the Contractor's top three vulnerable areas, and an outline of action plans in mitigating such risks.

(i) The Contractor shall submit to EOHHS this risk assessment quarterly at EOHHS' request and immediately after a program integrity related action, including financial-related actions (such as overpayment, repayment and fines).

(ii) With such submission, the Contractor shall provide details of such action and outline activities for employee education of federal and state laws and regulations related to Medicaid program integrity and the prevention of Fraud, Abuse, and waste, to ensure that all of its officers, directors, managers and employees know and understand the provisions of the Contractor's compliance plan and anti-Fraud, waste, and Abuse plan;

c) Outline activities for Provider education of federal and state laws and regulations related to Medicaid program integrity and the prevention of Fraud, waste, and Abuse, specifically related to identifying and educating targeted Providers with patterns of incorrect billing practices or overpayments;

d) Contain procedures designed to prevent and detect Fraud, waste, and Abuse in the administration and delivery of services under this Contract; and

e) Include a description of the specific controls in place for prevention and detection of potential or suspected Fraud, waste, and Abuse, such as:

(i) A list of automated pre-payment claims edits;

(ii) A list of automated post-payment claims edits;

(iii) A description of desk and onsite audits performed on post-processing review of claims;

(iv) A list of reports of Provider profiling and credentialing used to aid program and payment integrity reviews;

(v) A list of surveillance and/or utilization management protocols used to safeguard against unnecessary or inappropriate use of Medicaid services;

(vi) A list of provisions in the Subcontractor and Provider agreements that ensure the integrity of Provider credentials;

f) The Contractor shall have its anti-Fraud, waste, and Abuse plan in place by the Contract Operational Start Date and in a form and format specified by EOHHS. The Contractor shall provide EOHHS with its anti-Fraud, waste, and Abuse plan in accordance with **Appendix E-1**, annually, and when otherwise requested. The Contractor shall make any modifications requested by EOHHS within thirty (30) calendar days of a request.

d. Overpayments

1) Reporting Overpayments to EOHHS

a) The Contractor shall report overpayments to EOHHS using the following reports as specified in this section and **Appendix E-1**:

(i) Notification of Provider Overpayments Report;

(ii) Fraud and Abuse Notification Report;

(iii) Summary of Provider Overpayments Report; and

(iv) Self-Reported Disclosures Report.

b) In accordance with **Appendix E-1**, the Contractor shall submit to EOHHS the Notification of Provider Overpayments Report and Fraud and Abuse Notification Report no later than five business days after the identification of the overpayment.

c) In accordance with **Appendix E-1**, the Contractor shall submit to EOHHS the Summary of Provider Overpayments Report as follows:

(i) The Contractor shall report all overpayments identified, including but not limited to those resulting from potential Fraud, as further specified by EOHHS.

(ii) The Contractor shall, as further specified by EOHHS, report all overpayments identified during the Contract Year, regardless of dates of service, and all investigatory and recovery activity related to those overpayments. This report shall reflect all cumulative activity for the entire Contract Year plus six months

after the end of the Contract Year.

(iii) For any overpayments that remain unrecovered for more than six months after the end of the Contract Year, the Contractor shall continue to report all cumulative activity on such overpayments until all collection activity is completed.

2) Identifying and Recovering Overpayments

a) If the Contractor identifies an overpayment prior to EOHHS:

(i) The Contractor shall recover the overpayment and may retain any overpayments collected.

(ii) In the event the Contractor does not recover an overpayment first identified by the Contractor within one hundred and eighty (180) days after such identification, the Contractor shall provide justification in the Summary of Provider Overpayments report for any initial overpayment amounts identified but not recovered. EOHHS may, at its sole discretion, apply a Capitation Payment deduction equal to the amount of the overpayment identified but not collected in accordance with **Section 5.3.L.10.**

b) If EOHHS identifies an overpayment prior to the Contractor (such that the Contractor did not identify and report to EOHHS the overpayment in accordance with all applicable Contract requirements, including but not limited to the Summary of Provider Overpayments Report, within 180 days of the date(s) of service associated with any claim(s) included in the overpayment):

(i) Within 90 days of EOHHS' notification of the overpayment, the Contractor shall investigate the associated claims and notify EOHHS as to whether the Contractor agrees with or disputes EOHHS's findings, in the Response to Overpayments Identified by EOHHS Report as specified in **Appendix E-1**.

(ii) If the Contractor disputes EOHHS's finding, the Contractor's response shall provide a detailed description of the reasons for the dispute, listing the claim(s) and amount of each overpayment in dispute.

(iii) If the Contractor agrees with EOHHS's finding:

(a) The Contractor's response shall provide the amount of each overpayment agreed to.

(b) The Contractor shall complete collections of such agreed-upon overpayments. The Contractor shall submit a report to EOHHS of such collections within 90 days of the Contractor's response to EOHHS's notification, in the Agreed Upon Overpayments Collection Report as specified in **Appendix E-1**.

(iv) In the event the Contractor recovers an agreed-upon overpayment first identified by EOHHS within 90 days of the Contractor's response to EOHHS's notification, EOHHS may, at its sole discretion, apply a Capitation Payment deduction equal to 80% of the agreed-upon overpayment amount in accordance with **Section 5.3.L.10**. The Contractor shall retain the remaining 20% of the agreed-upon overpayment amount collected. In the event EOHHS determines that there is a valid justification for any agreed-upon overpayment amounts that cannot be collected (e.g., MFD hold), this Capitation Payment deduction shall be calculated based on the amount collected instead of the initial agreed-upon overpayment amount.

(v) In the event the Contractor does not recover an overpayment first identified by EOHHS within 90 days of the Contractor's response to EOHHS's notification, without providing sufficient justification for any initial overpayment amounts identified but not recovered as determined by EOHHS, EOHHS may, at its sole discretion, apply a Capitation Payment deduction equal to the amount of the overpayment identified but not collected in accordance with **Section 5.3.L.10.**

(vi) No Capitation Payment deductions shall apply to any amount of a recovery to be retained under the False Claims Act cases or through other investigations.

(vii) EOHHS shall calculate, following the end of the Contract Year, any and all Capitation Payment deductions for the prior Contract Year pursuant to this

section.

(viii) In the alternative to the above process, EOHHS may, in its discretion, recover the overpayment and may retain any overpayments collected.

3) Other Requirements Regarding Overpayments

a) The Contractor shall maintain and require its Providers to use a mechanism for the Provider to report when it has received an overpayment, to return the overpayment to the Contractor within 60 calendar days of the identification of the overpayment, and to notify the Contractor in writing of the reason for the overpayment. The Contractor shall report any such notifications by its Providers To EOHHS in the Self-Reported Disclosures report.

b) The Contractor may not act to recoup improperly paid funds or withhold funds potentially due to a Provider when the issues, services or claims upon which the recoupment or withhold is based on the following:

(i) The improperly paid funds were recovered from the Provider by EOHHS, the federal government, or their designees, as part of a criminal prosecution where the plan had no right of participation, or

(ii) The improperly paid funds currently being investigated by EOHHS are the subject of pending federal or state litigation or investigation, or are being audited by EOHHS, the Office of the State Auditor, CMS, Office of the Inspector General, or any of their agents.

e. Suspected Fraud

1) General Obligations

The Contractor shall:

a) Report, within five business days, in accordance with **Appendix E-1** and all other Contract requirements, any allegation of Fraud, waste, or Abuse regarding a Covered Individual or subcontractor, or EOHHS contractor, consistent with 42 CFR 455.2 or other applicable law to EOHHS;

b) Notify EOHHS, and receive EOHHS approval to make

such contact, prior to initiating contact with a Provider suspected of Fraud about the suspected activity;

c) Take no action on any claims which form the basis of a Fraud referral to EOHHS, including voiding or denying such claims and attempting to collect overpayments on such claims;

d) Provide to EOHHS an annual certification, in a form and format specified by EOHHS, attesting that the Contractor satisfies all Contract requirements regarding suspected Fraud including, but not limited to, the requirement to report any allegation of fraud to EOHHS;

e) Suspend payments to Providers for which EOHHS determines there is a credible allegation of Fraud pursuant to 42 CFR 455.23, and **Section 2.8.G** or as further directed by EOHHS, unless EOHHS identifies or approves the Contractor's request for a good cause exception as set forth in **Section 2.8.G.2.d**.

(i) As further directed by EOHHS, after the conclusion of a Fraud investigation that results in a verdict or settlement obtained by the Office of the Attorney General (AGO) Medicaid Fraud Division the Contractor shall disburse to EOHHS any money the Contractor held in a payment suspension account connected to the investigation to account for the verdict or settlement.

(ii) As further directed by EOHHS, if the amount of money the Contractor held in the payment suspension account exceeds the Provider's liability under the verdict or settlement, the Contractor shall release to the Provider the amount of money that exceeds the Provider's liability under the verdict or settlement.

(iii) As further directed by EOHHS, if EOHHS determines the Contractor may receive a finders' fee performance incentive as described in **Section 2.3.D.3.e.ii** below, the Contractor may retain any money in a payment suspension account necessary to satisfy all or part of the amount of such finders' fee performance incentive. If the Contractor is entitled to a finder's fee performance incentive in an amount greater than the amount held in a payment suspension account,

EOHHS will pay the Contractor the difference between the amount of the performance incentive and the amount in the payment suspension account.

f) The Contractor and subcontractors shall cooperate, as reasonably requested in writing, with the Office of the Attorney General's Medicaid Fraud Division, the Office of the State Auditor's Bureau of Special Investigations (BSI), or other applicable enforcement agency. Such cooperation shall include, but not be limited to, providing at no charge, prompt access and copies of any documents and other available information determined necessary by such agencies to carry out their responsibilities regarding fraud and abuse, maintaining the confidentiality of any such investigations, and making knowledgeable staff available at no charge to support any investigation, court, or administrative proceeding.

2) Monetary Recoveries by the Office of the Attorney General's Medicaid Fraud Division

a) Except as otherwise provided within this section, EOHHS shall retain all monetary recoveries made by MFD arising out of a verdict or settlement with Providers.

b) The Contractor shall receive a finders' fee performance incentive as follows:

(i) To receive the finders' fee performance incentive, the Contractor shall satisfy, in EOHHS' determination, the following requirements as they relate to MFD's case against a Provider:

(a) The Contractor made a Fraud referral to EOHHS pursuant to **Section 2.3.D.3.e**

(b) The Contractor's Fraud referral provided sufficient details regarding the Provider(s)', conduct, and time period of the allegation(s) of Fraud at issue;

(c) The Contractor attests, in a form and format specified by EOHHS, that the fraud referral arose out of the Contractor's own investigatory activity that led to the identification of the allegation(s) of Fraud at issue;

(d) The Contractor complies with all other obligations in **Section 2.3.D.3.e**;

(e) The Contractor made its Fraud referral to EOHHS prior to MFD's investigation becoming public knowledge; and

(f) The basis of the Contractor's Fraud referral – the specific Provider and allegedly fraudulent conduct – is the subject of a verdict or settlement achieved by MFD with a Provider that requires the Provider to pay EOHHS.

(ii) The amount of the finders' fee performance incentive, as determined by EOHHS, shall be as set forth in **Section 4.6.D**.

3) The Contractor shall abide by and adhere to any release of liability regarding a Provider in any verdict or settlement signed by MFD or EOHHS.

f. Other Program Integrity Requirements

The Contractor shall:

1) Prior to initiating an audit, investigation, review, recoupment, or withhold, or involuntarily termination of a Network Provider, the Contractor shall request from EOHHS deconfliction, cease all activity, and wait to receive permission from EOHHS to proceed. The Contractor shall wait until EOHHS either grants the deconfliction request or notifies the Contractor to continue to cease activity so as not to interfere in a law enforcement investigation or other law enforcement activities.

2) Notify EOHHS within two business days after contact by the Medicaid Fraud Division, the Bureau of Special Investigations or any other investigative authorities conducting Fraud and Abuse investigations, unless specifically directed by the investigative authorities not to notify EOHHS. The Contractor, and where applicable any Material Subcontractors or subcontractors, shall cooperate fully with the Medical Fraud Division, Bureau of Special Investigations, and other agencies that conduct investigations; full cooperation includes, but is not limited to, timely exchange of information and strategies for addressing Fraud and Abuse, as well as allowing prompt and direct access to information, free copies of documents, and other available information related to program violations, while maintaining the confidentiality of any

investigation. The Contractor shall make knowledgeable employees available at no charge to support any investigation, court, or administrative proceeding;

3) Report promptly to EOHHS, in accordance with **Appendix E-1** and all other Contract requirements, when it receives information about a Covered Individual's circumstances that may affect their MassHealth eligibility, including but not limited to a change in the Covered Individual's residence and the death of the Covered Individual;

4) Report no later than five business days to EOHHS, in accordance with **Appendix E-1** and all other Contract requirements, when it receives information about a Provider's circumstances that may affect its ability to participate in the Contractor's network or in MassHealth, including but not limited to the termination of the Provider's contract with the Contractor;

5) Verify, in accordance with other Contract requirements, through sampling, whether Covered Services that were represented to be delivered by Providers were received by Covered Individuals. The Contractor shall report the identification of any overpayments related to Covered Services that were represented to be delivered by Providers but not received by Covered Individuals in the following reports as set forth in **Appendix E-1**: Fraud and Abuse Notification, Notification of Provider Overpayments, and Summary of Provider Overpayments report;

6) Provide employees, as well as Material Subcontractors and agents, detailed information about the False Claims Act and other federal and state laws described in section 1902(a)(68) of the Social Security Act, including whistleblower protections.

   a) The Contractor shall comply with all federal requirements for employee education about false claims laws under 42 U.S.C. §1396a(a)(68) if the Contractor received or made Medicaid payments in the amount of at least $5 million during the prior federal fiscal year.

   b) If the Contractor is subject to such federal requirements, the Contractor shall:

      (i) On or before April 30th of each Contract Year, or such other date as specified by EOHHS, provide written certification, in accordance with **Appendix E-1** or in another form acceptable to EOHHS, and signed under

the pains and penalties of perjury, of compliance with such federal requirements;

(ii) Make available to EOHHS, upon request, a copy of all written policies implemented in accordance with 42 U.S.C. §1396a(a)(68), any employee handbook, and such other information as EOHHS may deem necessary to determine compliance; and

c) Failure to comply with this Section may result in intermediate sanctions in accordance with **Section 5.3.L.**

7) Designate a Fraud and Abuse prevention coordinator responsible for the following activities. Such coordinator may be the Contractor's compliance officer. The Fraud and Abuse prevention coordinator shall:

a) Assess and strengthen internal controls to ensure claims are submitted and payments properly made;

b) Develop and implement an automated reporting protocol within the claims processing system to identify billing patterns that may suggest Provider and Covered Individual Fraud and shall, at a minimum, monitor for under-utilization or over-utilization of services;

c) Conduct regular reviews and audits of operations to guard against Fraud and Abuse;

d) Receive all referrals from employees, Covered Individuals, or Providers involving cases of suspected Fraud and Abuse and developing protocols to triage all referrals involving suspected Fraud and Abuse;

e) Educate employees, Providers, and Covered Individuals about Fraud and how to report it, including informing employees of their protections when reporting fraudulent activities per Mass. Gen. Laws Ch. 12, section 5J; and

f) Establish mechanisms to receive, process, and effectively respond to complaints of suspected Fraud and Abuse from employees, Providers, and Covered Individuals, and report such information to EOHHS.

8) In accordance with Mass. Gen. Laws. Ch. 12, section 5J, not discriminate against an employee for reporting a fraudulent activity or for cooperating in any government or law enforcement authority's investigation or prosecution;

9) Upon a complaint of Fraud, waste, or Abuse from any source or upon identifying any questionable practices, report the matter in writing to EOHHS within five business days;

10) Make diligent efforts to recover improper payments or funds misspent due to fraudulent, wasteful or abusive actions by the Contractor, its parent organization, its Providers, or its Material Subcontractors;

11) Require Providers to implement timely corrective actions related to program integrity matters as approved by EOHHS or terminate Provider Contracts, as appropriate;

12) In accordance with **Appendix E-1**, submit a Summary of Provider Overpayments report in a form and format and at times specified by EOHHS, and submit ad hoc reports related to program integrity matters as needed or as requested by EOHHS;

13) In accordance with **Appendix E-1**, have the CEO or CFO certify in writing to EOHHS that after a diligent inquiry, to the best of their knowledge and belief, the Contractor is in compliance with this Contract as it relates to program integrity requirements and has not been made aware of any instances of Fraud and Abuse other than those that have been reported by the Contractor in writing to EOHHS.

g. Screening Employees and Subcontractors

In addition to the requirements set forth in **Section 2.8.G**, the Contractor shall screen employees and subcontractors by searching the Office of the Inspector General List of Excluded Individuals Entities and exclusion databases, including but not limited to those listed in **Appendix J** to determine if any such individuals or entities are excluded from participation in federal health care programs.

1) The Contractor shall conduct such screening upon initial hiring or contracting and on an ongoing monthly basis, or other frequency specified at **Appendix J**.

2) The Contractor shall notify EOHHS of any discovered exclusion of an employee or subcontractor within two business days of discovery.

3) The Contractor shall require its Providers to also comply with the requirements of this section with respect to its own employees and subcontractors.

h. Screening Providers

The Contractor shall screen Providers in accordance with the requirements set forth in **Section 2.8.G**."

Section 2.6.B is hereby amended by deleting it in in its entirety and replacing it with the following:

"B. Services to the Uninsured and Individuals without Mobile Crisis Coverage

1. The Contractor shall provide Individuals without Mobile Crisis Coverage with mobile crisis intervention initial evaluation and first day crisis intervention services without regard to enrollment with the Contractor.

2. The Contractor shall provide Uninsured Individuals and persons covered by Medicare only with Medically Necessary Behavioral Health crisis services without regard to enrollment with the Contractor.

3. The Contractor shall provide Uninsured Individuals and persons covered by Medicare only with Medically Necessary Behavioral Health initial crisis evaluation services in the emergency department without regard to enrollment with the Contractor."

Section 2.6.D.2.k is hereby amended by adding at the end therein the following:

"5) An ASD Assessor, at 0.5 FTE, to support PCPs to appropriately diagnose young children with less complex diagnoses, based on assessment reports and other documentation from MCPAP and other collateral partners, and their own medical rule outs. The ASD Assessor will partner with the EC MCPAP team to refine and implement protocols for working with the clinical team; receive referrals to the service through PCPs; conduct assessments using a screening tool to be determined by EOHHS; and work with the EC MCPAP team, family members, and PCP to share information to support diagnosis and referral to treatment. The ASD Assessor will provide assessment services and consultation in Central/Western Massachusetts. In the event of delays in hiring the ASD Assessor role, unspent funds may be used to support consultant time from Pediatric ASD diagnostic process experts to consult on development of protocols."

Section 2.6.D.2.o is hereby amended by adding at the end therein the following:

"3) The EC MCPAP team will base implementation plans on feedback from the project's Advisory Committee, including qualifications for the ASD Assessor and selection of assessment tool. The ASD Assessor and EC MCPAP team will develop workflows for outreach and referral, assessment, collaboration with collateral providers, consultation to pediatricians to support diagnosis by pediatricians, and coordinated support to families. The EC MCPAP team will develop and implement approaches to educate PCPs, families, and collaterals

about the ASD assessment project and process. The EC MCPAP team will evaluate the ASD assessment efforts, standardize protocols, and determine a plan to sustain and possibly scale the ASD assessment to other regions. The EC MCPAP team will track and report data on these activities to DPH and through DPH, to HRSA.

4) Enhance Autism Spectrum Disorder (ASD) assessment of children under age 6, by including an ASD Assessor at 0.5 FTE on the EC-MCPAP team in Central/Western Massachusetts. The ASD Assessor shall:

   a) Support PCPs to appropriately diagnose young children with less complex diagnoses, based on assessment reports and other documentation from MCPAP and other collateral partners, and their own medical rule outs;

   b) Conduct assessments using a screening tool to be determined by EOHHS in collaboration with the EC-MCPAP team;

   c) As part of the EC-MCPAP team, develop protocols for working with the member's clinical team, ASD consultant, family members, and PCP to share information to support diagnosis and referral to treatment;

   d) With the EC-MCPAP team, develop workflows for outreach and referrals; assessment; collaboration with collateral providers; and consultation to pediatricians, to support diagnosis by pediatricians and to coordinate support to families; and

   e) With the EC-MCPAP team, evaluate the ASD assessment efforts, standardize protocols, and develop plans to sustain and possibly scale the ASD assessment to other regions."

Section 2.7.F.3.f is hereby amended by deleting it in its entirety and replacing it with the following:

"f. For Residential Rehabilitation Services for Substance Use Disorders (ASAM Level 3.1)(RRS), including Adult RRS, Family RRS, Transitional Age Youth and Young Adult RRS, Youth RRS, Pregnancy Enhanced RRS, and Co-Occurring Enhanced RRS, the Contractor shall establish Provider rates at or above the rate floor as specified by EOHHS, unless otherwise directed by EOHHS, and shall use procedure codes as directed by EOHHS to provide payment for such services."

Section 2.7.F.3 is hereby amended by deleting **Section 2.7.F.3.g** it in its entirety and inserting in place thereof "[Reserved]".

Section 2.7.F.3.n.1 is hereby amended by deleting "**Section 2.7.F.3.J.2.**" and replacing it with "**Section 2.7.F.3.m**".

Section 2.7.F.3 is hereby amended by adding at the end therein the following:

"q. The Contractor shall increase payment rates temporarily to providers as set forth in **Appendix M** and as further specified by EOHHS."

Section 2.7.H.4.i is hereby amended by deleting it in its entirety and replacing it with the following language:

"i. In Contract Year 2023, at the direction of EOHHS, execute a public service campaign to increase public awareness of the AMCI, YMCI services and CBHCs. The Contractor shall submit reports as directed by EOHHS, including but not limited to reports on the public awareness materials developed, the plan for distributing such materials, and the costs of such development and distribution, as well as any reports as required by Project Expenditure Category 6.1 (Provision of Government Services)."

Section 2.7.H.5.a is hereby amended by deleting it in its entirety and replacing it with the following:

"a. Ensure that CBHCs provide Covered Individuals with unrestricted statewide access, and that Uninsured Individuals, persons covered by Medicare only, and Individuals without Mobile Crisis Coverage are provided with unrestricted state-wide access to AMCI and YMCI services immediately in response to a Behavioral Health crisis, on a 24-hour basis, seven days a week;"

Section 2.7.H.5 is hereby amended by inserting the following language as a new **Section 2.7.H.5.b** and renumbering subsequent sections accordingly:

"b. Share with MassHealth-contracted managed care entities and PCC Plan Providers any changes and/or updates to the CBHC provider network prior to disseminating that information to all Covered Individuals."

Section 2.7. is hereby amended by adding at the end therein the following:

"M. HCBS ARPA Payments for Community Behavioral Health Centers

1. As part of its investments of funding made available through the American Rescue Plan Act, EOHHS shall advance funding to the Contractor during CY2023 in the amount specified in **Appendix H-1** in support of CBHC infrastructure development. The Contractor shall disperse the funding in accordance with the following and as further directed by EOHHS:

a. The Contractor shall work with CBHC providers to ensure that the funding is applied towards supporting initial investment in CBHC infrastructure and development, including:

1) enabling CBHCs to develop appropriate spaces and programs to care for and stabilize members in comfortable,

therapeutic environments. All infrastructural investments will be made for the sole purpose of supporting members' comfort in treatment settings;

2) supporting the transformation of service delivery, physical space, and programming to create a welcoming community-based behavioral health access point; and

3) improving the CBHCs' ability to care for and further stabilize members on site, mitigating the need for transfer to a hospital-based setting.

b. The Contractor shall ensure that each CBHC provider utilizes the funding for allowable activities that specifically target improving level of comfort in the community-based setting for members awaiting emergency care from their clinical team or inpatient admissions.

1) Allowable uses are as follows:

a) Furnishings;

b) Bedding/blankets;

c) Items for activities of daily living (i.e. toiletries, sanitizer dispensers, shower facilities and linens, books, magazines, televisions, children's toys/games, etc.);

d) Telephony and internet technologies;

e) Security technologies;

f) Kitchen services (microwave/refrigerator, initial stock of easy meals, etc.);

g) First stock of easy to launder clothing; and

h) Other activities as appropriate.

2) Funding shall not be used for capital improvements.

c. During the CY2023 period, the Contractor shall provide payments to CBHCs in support of activities set forth in this **Section 2.7.M**. Such payments in aggregate shall not exceed the funding amount specified in **Appendix H-1**. The amount issued to each CBHC shall not exceed $419,231, and shall be equal for each CBHC, unless otherwise specified by EOHHS.

d. The Contractor shall ensure CBHCs are informed of permissible use of project funds listed above and provide attestation to that effect. The Contractor shall ensure that CBHC providers that receive funding return any funds not spent before January 1, 2024. The Contractor shall subsequently return any unspent funds to EOHHS. The Contractor shall further ensure that CBHC providers who receive funding submit a spending report on funding usage by March 31, 2024.

N. M-CAAP Training

The Contractor shall collaborate with the Brandon School and Residential Treatment Center in the development and delivery of training of clinicians about the Massachusetts Child and Adolescent Assessment Protocol (M-CAAP) for firesetting behaviors. The training shall include the delivery of an in person, two-day training (totaling 12 hours) for up to 25 individuals on the assessment and treatment of firesetting in children and adolescents. This training will use a structured decision-making approach and incorporate case study examples, as well as cover how to incorporate into an accepted reporting document risk mitigation strategies and recommendations that address co-morbid factors results."

Section 2.10 is hereby amended by adding at the end therein the following:

"F. Eligibility Redetermination Assistance

The Contractor is authorized and directed to communicate with Covered Individuals to help them renew their MassHealth coverage. The Contractor is authorized and directed to make appropriate use of prerecorded or artificial autodialed calls and automated texts in compliance with the Federal Communications Commission January 23, 2023, Declaratory Ruling. The Contractor shall consult its legal counsel about the appropriate use of autodialed calls and automated texts to Covered Individuals pursuant to the FCC Declaratory Ruling. The Contractor shall be responsible for complying with the ruling."

Section 2.15.B is hereby amended by adding at the end therein the following:

"3. Direct Service Reserve Account

The Contractor shall establish a Direct Service Reserve Account (DSRA) into which all payments received from EOHHS must be deposited.

a. The DSRA shall be:

1) An interest-bearing trust account in a banking institution located in Massachusetts and approved by EOHHS. The Commonwealth of

Massachusetts shall have the right and title to any and all interest earned in the DSRA.

2) Maintained, to the extend legally permissible, in a manner that prevents the creditors of the Contract from in any way encumbering or acquiring any funds in the DSRA.

b. In no event shall funds in the DSRA be used by the Contractor or any other agent or third party to satisfy, temporarily or otherwise, any Contractor liability, or for any other purpose except as provided under the Contract.

c. EOHHS may require at any time that the Contractor confer upon an authorized representative of EOHHS or a third party approved by EOHHS the obligation to approve all withdrawals and countersign all checks drawn on the DSRA.

d. The Contractor shall obtain approval of all aspects of the DSRA from EOHHS before establishing or making changes to the account, and shall make changes to the DSRA at the direction of EOHHS, as necessary.

e. The Contractor shall transfer all deposits other than deposits for the BH Covered Services Capitation Rate and the DMH Specialty Programs Services Compensation Rate out of the DSRA within seven business days of receiving them.

f. The Contractor shall transmit all interest income from the DSRA, net of bank charges, to EOHHS in the form of a check payable to the Commonwealth of Massachusetts, twice a year on dates to be specified by EOHHS.

1) In no case shall the Contractor use interest income as any Earnings or bonus payment.

2) The Contractor shall exclude interest income from reconciliations of administrative and service expenditures.

g. EOHHS may, at any time and at its discretion, audit the Contractor's administration of the DSRA funds consistent with the Contract requirements.

h. The Contractor shall comply with the following requirements relative to the management of the DSRA:

1) Separately tracking the following types of deposits from EOHHS into the DSRA:

a) BH Covered Services Capitation Rate payments, which includes the Administrative Component of the BH Covered Services Capitation Rate payments;

b) Care Management Engagement payment;

c) All Performance Incentive Arrangement payments;

d) PCC Plan Management Support Services payments;

e) DMH Specialty Services payments; and

f) DMH Administrative payments.

2) Establishing an audit trail that evidences that all payments and transfers from the DSRA are made from deposits received from EOHHS for that express purpose; specifically that:

a) All payments from the DSRA for BH Covered Services are made from deposits received from EOHHS for Covered Services for Covered Individuals and the administration and arrangement of BH Covered Services are made from deposits from EOHHS for that purpose (the Administrative Component of the BH Covered Services Capitation Rate);

b) All transfers from the DSRA for the Care Management Program- Engagement are made from deposits received from EOHHS for the Care Management Program;

c) All transfers from the DSRA for PCC Plan Management Support Services are made from deposits received from EOHHS for the PCC Plan Management Support Services; and

d) All payments from the DSRA for DMH Specialty Programs are made from deposits received from EOHHS for DMH Specialty Programs.

3) Tracking the interest earned on all deposits into the DSRA.

i. Except as specifically set forth in this **Section 2.15.B** the Contractor shall not withdraw funds from the DSRA except to pay Claims properly submitted by Providers for Covered Services authorized by the Contractor pursuant to the Contract.

j. The Contractor and EOHHS shall reconcile deposits into and transfers from the DSRA within 120 days of the end of each state fiscal year for the preceding fiscal year."

SECTION 4. PAYMENT AND FINANCIAL PROVISIONS

Section 4.2.A.2 is hereby amended by deleting it in its entirety and replacing it with the following:

"2. Exclusions from the Behavioral Health Covered Services Capitation Rates

EOHHS shall pay the Contractor for services provided by AMCI/YMCI and CCS providers to Uninsured Individuals and persons with Medicare only according to the methodology set forth in **Section 4.2.L**. EOHHS shall pay the Contractor for services provided by AMCI/YMCI providers to Individuals without Mobile Crisis Coverage according to the methodology set forth in **Section 4.2.R**. EOHHS shall pay the Contractor for crisis evaluation services provided by hospital providers to Uninsured Persons and Persons with Medicare Only according to the methodology set forth in **Section 4.2.S**."

Section 4.2.A.7 is hereby amended by inserting after "EOHHS shall pay the Contractor to provide the ASD-ID, EC MCPAP Programs", the following language: ", as described in **Section 2.6.D.2**".

Section 4.2.A is hereby amended by adding at the end therein the following:

"11. Payment Related to HCBS ARPA Payments for Community Behavioral Health Centers

EOHHS shall pay the Contractor for work pursuant to **Section 2.7.M**. Such payments shall be set forth in in **Appendix H-1**."

Section 4.2.L is hereby amended by deleting it in its entirety and replacing it with the following:

"L. Payment Provisions for AMCI/YMCI, including follow-up, and Community Crisis Stabilization services for Uninsured Individuals and Persons with Medicare Only

1. General Provisions

The Contractor shall:

a. For AMCI and YMCI, including follow-up, and CCS services for Uninsured Individuals and persons with Medicare only, require CBHCs to bill other insurances (TPL), where available and consistent with **Section 2.18**, and the Health Safety Net in accordance with applicable law.

b. Pay CBHCs the rate for AMCI and YMCI, including follow-up, and CCS services established by EOHHS and, as further directed by EOHHS, implement all policies and procedures with regard to payments and payment methodologies to CBHCs for AMCI,

YMCI, and CCS services for Uninsured Individuals and persons with Medicare only delivered under the Contract.

c. Not utilize the Community Crisis Amount except to pay for AMCI and YMCI, including follow-up, and CCS services delivered to Uninsured Individuals and persons with Medicare only.

d. For dates of service on January 1 and 2, 2023, or as otherwise directed by EOHHS, pay ESP providers for ESP and MCI services provided to Uninsured Individuals and persons with Medicare only, in accordance with **Appendix A-4**.

2. Payment Methodology

a. EOHHS shall annually provide the Contractor with an estimated amount it expects to pay each CBHC for AMCI and YMCI, including follow-up, and CCS services delivered on a Fee-for-Service basis by EOHHS.

b. The Contractor shall provide EOHHS with an annual report of the Contractor's estimate of the total amount it expects to pay for AMCI and YMCI, including follow-up, and CCS services, including both BH Covered Services and DMH Specialty Program delivered under the Contract.

c. Based on the Contractor's estimate of the amount it expects to pay for such AMCI and YMCI, including follow-up, and CCS services, EOHHS shall establish a Community Crisis Amount for Uninsured Individuals and persons with Medicare only.

d. The Community Crisis Amount shall be in accordance with **Appendix H-1**. The Contractor shall develop a plan to monitor and report on, throughout each Contract year, AMCI and YMCI, including follow-up, and CCS expenditures for Uninsured Individuals and persons with Medicare only compared to the amount in **Appendix H-1**. Such report shall also include monitoring of AMCI and YMCI, including follow-up, and CCS expenditures for Covered Individuals.

e. Notwithstanding any other provision of this Contract, EOHHS shall not be required to make any payments for AMCI and YMCI, including follow-up, and CCS services until it has received funding from DMH or the Behavioral Health Access and Crisis Intervention Trust Fund in the amounts necessary to make any such payments."

Section 4.2 is hereby amended by adding at the end therein the following:

"P. Payments Related to the Brandon School and Residential Treatment

EOHHS shall pay the Contractor for work pursuant to **Section 2.7.N**. Such payments shall be set forth in **Appendix H-1.**

Q. Payments Related to Behavioral Health Public Awareness Campaign

For work pursuant to **Section 2.7.H.4.i**, EOHHS shall issue payment to the Contractor in the amount specified in **Appendix H-1**. This payment shall be funded from the Coronavirus State Fiscal Recovery Fund established under section 9901 of the American Rescue Plan Act of 2021, Pub. L. 117-2 (March 11, 2021), and is therefore subject to all terms and conditions set forth in **Appendix N**.

R. Payment Provisions for AMCI and YMCI services Provided to Individuals without Mobile Crisis Coverage

1. General Provisions

The Contractor shall:

a. For AMCI and YMCI services for Individuals without Mobile Crisis Coverage, require CBHCs to bill other insurances (TPL), where available and consistent with **Section 2.18**.

b. Pay CBHCs the rate for the initial evaluation for AMCI and YMCI services, not including follow-up, established by the EOHHS and, as further directed by EOHHS, implement all policies and procedures with regard to payments and payment methodologies to CBHCs for AMCI and YMCI services for Individuals without Mobile Crisis Coverage.

c. Not utilize the Mobile Crisis Intervention Uncompensated Care Payment except to pay for the initial evaluation for AMCI and YMCI services delivered to Individuals without Mobile Crisis Coverage.

2. Payment Methodology

a. The Contractor shall provide EOHHS with an invoice on an expenditures at a frequency and format specified by EOHHS in **Appendix E-4**.

b. Based on the Contractor's invoice for expenditures, EOHHS shall make payments in accordance with **Appendix H-1**.

c. Notwithstanding any other provision of this Contract, EOHHS shall not be required to make any payments for AMCI and YMCI services until it has received funding from the Behavioral Health

Access and Crisis Intervention Trust Fund in the amounts necessary to make any such payments.

S. Payment Provisions for Crisis Evaluation Services in the Emergency Department Provided to Uninsured Individuals and Persons with Medicare Only

1. General Provisions

The Contractor shall:

a. For crisis evaluation services in the emergency department provided to Uninsured Individuals and Persons with Medicare Only, require hospitals to bill other insurances (TPL), where available and consistent with **Section 2.18**.

b. Pay hospitals the rate for crisis evaluation services in the emergency department established by the EOHHS and, as further directed by EOHHS, implement all policies and procedures with regard to payments and payment methodologies to hospitals for crisis evaluation services in the emergency department for Uninsured Individuals and Persons with Medicare Only.

c. Not utilize the Emergency Department Crisis Evaluation Payment except to pay for crisis evaluation services delivered to Uninsured Individuals and Persons with Medicare Only in an emergency department.

2. Payment Methodology

a. The Contractor shall provide EOHHS with an invoice on expenditures at a frequency and format specified by EOHHS in **Appendix E-4**.

b. Based on the Contractor's invoice for expenditures, EOHHS shall make payments in accordance with **Appendix H-1**.

c. Notwithstanding any other provision of this Contract, EOHHS shall not be required to make any payments for crisis evaluation services in the emergency department until it has received funding from the Behavioral Health Access and Crisis Intervention Trust Fund in the amounts necessary to make any such payments."

Section 4.3.B is hereby amended by deleting it in its entirety and replacing it with the following:

"B. Reconciliation Process for AMCI, YMCI, and Community Crisis Stabilization services Provided to Uninsured Individuals and Persons with Medicare Only

1. By 210 days after the end of each Contract Year, the Contractor shall provide EOHHS with a report (see **Appendix E-1**) of the Contractor's

actual expenditures for AMCI, YMCI, and CCS services provided to Uninsured Individuals and persons with Medicare only, based on Claims paid through no later than 180 days, including its best estimate of IBNR Claims and any applicable IBNR completion factor reported to EOHHS.

2. EOHHS shall conduct a year-end reconciliation of the Contractor's estimated expenditures on AMCI, YMCI, and CCS services provided to Uninsured Individuals and persons with Medicare only delivered under the Contract against actual expenditures, including IBNR.

3. If actual expenditures are less than the Contractor's estimates, EOHHS shall recoup the difference from the Contractor.

4. If actual expenditures are greater than the Contractor's estimate, EOHHS shall pay the difference to the Contractor.

5. The Contractor and EOHHS shall perform the reconciliation set forth in this section for ESP services provided to Uninsured Individuals and individuals with Medicare only on January 1 and 2, 2023 and as further specified by EOHHS."

Section 4.5 is hereby amended by deleting it in its entirety and replacing it with the following:

"Section 4.5 In-State Acute Hospital Add-on/Pursuant to Section 2.7.F.3.m

A. At a frequency to be specified by EOHHS, EOHHS shall pay the Contractor an amount equal to the sum of provider payments described in **Section 2.7.F.3.m** for the applicable time period.

B. For each Contract Year, EOHHS shall perform an annual reconciliation after the end of the Contract Year, of the directed payments described in **Section 2.7.F.3.m**. EOHHS shall remit to the Contractor the full amount of any underpayments it identifies. The Contractor shall remit to EOHHS the full amount of any overpayments identified by EOHHS. Such payments shall be made either through a check or, at the discretion of EOHHS, through recoupment from future capitation and/or reconciliation payments described in **Section 4.5**."

Section 4.6 is hereby amended by adding at the end therein the following:

"D. Finders' Fee Performance Incentive

If, as further described in **Section 2.3.D.3.e.ii**, EOHHS determines the Contractor meets the requirements to receive a finders' fee performance incentive, the amount of the incentive payment shall be equal to 50% of the Contractor's pro rata amount of the net state share of the total settlement or verdict amount, based on the Contractor's percentage of the single damages from covered conduct over the relevant time period as determined by EOHHS. The net state share is the gross

amount of the verdict or settlement minus any amounts owed as a repayment of federal financial participation to the federal government or other restitution called for in the verdict or settlement."

Section 4.7.C is hereby amended by striking the phrase "and 3.3".

SECTION 5. ADDITIONAL TERMS AND CONDITIONS

Section 5.3.L is hereby amended by adding the following **Section 5.3.L.10** at the end therein:

"10. Overpayment Capitation Deduction

a. In accordance with **Section 2.3.D.3.d**, if the Contractor identifies an overpayment prior to EOHHS and does not recover such overpayment within 180 days after identification, without providing sufficient justification, as determined by EOHHS, in the Summary of Provider Overpayments report to EOHHS, EOHHS may apply a Capitation Payment deduction in an amount equal to the overpayment identified but not collected;

b. In accordance with **Section 2.3.D.3.d** if EOHHS identifies an overpayment prior to the Contractor such that the Contractor did not identify and report such overpayment to EOHHS in accordance with all applicable Contract requirements, including but not limited to the Summary of Provider Overpayments Report, within 180 days of the date(s) of service associated with any Claim(s) included in the overpayment:

1) In the event the Contractor recovers such overpayment as agreed upon by EOHHS and the Contractor within 90 days of the Contractor's response to EOHHS's notification of the overpayment, EOHHS may apply a Capitation Payment deduction equal to 80% of the agreed-upon overpayment amount. No Capitation Payment deductions shall apply to any amount of a recovery to be retained under the False Claims Act cases or through other investigations.

2) In the event the Contractor does not recover such overpayment first identified by EOHHS within 90 days of the Contractor's response to EOHHS's notification of the overpayment, without providing sufficient justification to EOHHS for any initial overpayment amounts identified but not recovered as determined by the sole discretion of EOHHS, EOHHS may apply a Capitation Payment deduction equal to the amount of the overpayment identified but not collected. No Capitation Payment deductions shall apply to any amount of a recovery to be retained under the False Claims Act

cases or through other investigations.

c. EOHHS shall calculate, following the end of the Contract Year, any and all Capitation Payment deductions for the prior Contract Year pursuant to this **Section 5.3.L**.

d. Notwithstanding the Capitation Payment deductions described in this Section, EOHHS may take corrective action for a failure by the Contractor to take all steps necessary, as determined by EOHHS, to report overpayments as specified in this Contract, including those requirements set forth in **Section 2.3.D.3.d**."

APPENDICES

Appendix A-1 is hereby amended by deleting it in its entirety and replacing it with the attached **Appendix A-1**.

Appendix E-1 is hereby amended by deleting it in its entirety and replacing it with the attached **Appendix E-1**.

Appendix E-4 is hereby amended by deleting it in its entirety and replacing it with the attached **Appendix E-4**.

Appendix G is hereby amended by deleting it in its entirety and replacing it with the attached **Appendix G**.

Appendix H-1 is hereby amended by deleting it in its entirety and replacing it with the attached **Appendix H-1**.

Appendix L is hereby amended by deleting it in its entirety and replacing it with the attached **Appendix L**.

The Contract is hereby amended by adding at the end therein the attached **Appendix M**.

The Contract is hereby amended by adding at the end therein the attached **Appendix N**.

APPENDIX A-1
BEHAVIORAL HEALTH COVERED SERVICES

✓ Denotes a covered service

Service	Coverage Types				
	MassHealth Standard & CommonHealth Covered Individuals	MassHealth Family Assistance Covered Individuals	CarePlus Covered Individuals	Uninsured Individuals, and Persons Covered by Medicare Only	Individuals without Mobile Crisis Coverage
Inpatient Services - 24-hour services, delivered in a licensed or state-operated hospital setting, that provide clinical intervention for mental health or substance use diagnoses, or both. This service does not include continuing inpatient psychiatric care delivered at a facility that provides such services, as further specified by EOHHS. (See details below)					
1. Inpatient Mental Health Services - hospital services to evaluate and treat an acute psychiatric condition which 1) has a relatively sudden onset; 2) has a short, severe course; 3) poses a significant danger to self or others; or 4) has resulted in marked psychosocial dysfunction or grave mental disability.	✓	✓	✓		
2. Inpatient Substance Use Disorder Services (Level 4) – Intensive inpatient services provided in a hospital setting, able to treat Covered Individuals with acute medically complex withdrawal management needs, as well as co-occurring biomedical and/or psychiatric conditions. Services are delivered by an interdisciplinary staff of addiction credentialed physician and other appropriate credentialed treatment professionals with the full resources of a general acute care or psychiatric hospital available.	✓	✓	✓		
3. Observation/Holding Beds – hospital services, for a period of up to 24 hours, in order to assess, stabilize, and identify appropriate resources for Covered Individuals.	✓	✓	✓		
4. Administratively Necessary Day (AND) Services – a day(s) of inpatient hospitalization provided to Covered Individuals when said Covered Individuals are clinically ready for discharge, but an appropriate setting is not available. Services shall include appropriate continuing clinical services.	✓	✓	✓		

Service	Coverage Types				
	MassHealth Standard & CommonHealth Covered Individuals	MassHealth Family Assistance Covered Individuals	CarePlus Covered Individuals	Uninsured Individuals and Persons Covered by Medicare Only	Individuals without Mobile Crisis Coverage
Diversionary Services - those mental health and substance use disorder services that are provided as clinically appropriate alternatives to Behavioral Health Inpatient Services, or to support a Covered Individual returning to the community following a 24-hour acute placement; or to provide intensive support to maintain functioning in the community. There are two categories of Diversionary Services, those provided in a 24-hour facility, and those which are provided in a non-24-hour setting or facility. (See detailed services below)					
24-Hour Diversionary Services					
1. Youth and Adult Community Crisis Stabilization – services provided as an alternative to hospitalization, including short-term psychiatric treatment in structured, community-based therapeutic environments. Community Crisis Stabilization provides continuous 24-hour observation and supervision for Covered Individuals who do not require Inpatient Services.	✓	✓	✓		
2. Community-Based Acute Treatment for Children and Adolescents (CBAT) – mental health services provided in a staff-secure setting on a 24-hour basis, with sufficient clinical staffing to insure safety for the child or adolescent, while providing intensive therapeutic services including, but not limited to, daily medication monitoring; psychiatric assessment; nursing availability; Specialing (as needed); individual, group and family therapy; case management; family assessment and consultation; discharge planning; and psychological testing, as needed. This service may be used as an alternative to or transition from Inpatient services.	✓	✓			
3. Medically Monitored Intensive Services --Acute Treatment Services (ATS) for Substance Use Disorders (Level 3.7) – 24-hour, seven days week, medically monitored addiction treatment services that provide evaluation and withdrawal management. Withdrawal management services are delivered by nursing and counseling staff under a physician-approved protocol and physician-monitored procedures and include: bio-psychosocial	✓	✓	✓		

Service	Coverage Types				
	MassHealth Standard & CommonHealth Covered Individuals	MassHealth Family Assistance Covered Individuals	CarePlus Covered Individuals	Uninsured Individuals and Persons Covered by Medicare Only	Individuals without Mobile Crisis Coverage
assessment; induction to FDA approved medications for addictions when appropriate, individual and group counseling; psychoeducational groups; and discharge planning. Pregnant women receive specialized services to ensure substance use disorder treatment and obstetrical care. Covered Individuals with Co-Occurring Disorders receive specialized services to ensure treatment for their co-occurring psychiatric conditions. These services may be provided in licensed freestanding or hospital-based programs.					
4. Clinical Stabilization Services for Substance Use Disorders (Level 3.5) – 24-hour treatment services which can be used independently or following Acute Treatment Services for substance use disorders including comprehensive bio-psychosocial assessments and treatment planning, therapeutic milieu, intensive psycho education and counseling, outreach to families and significant others; linkage to medications for addiction therapy, connection to primary care and community supports and aftercare planning for individuals beginning to engage in recovery from addiction. Covered Individuals with Co-Occurring Disorders receive coordination of transportation and referrals to mental health providers to ensure treatment for their co-occurring psychiatric conditions. Pregnant women receive coordination of their obstetrical care.	✓	✓	✓		
5. Residential Rehabilitation Services for Substance Use Disorders (Level 3.1) - 24-hour structured and comprehensive rehabilitative environment that supports Covered Individual's independence and resilience and recovery from alcohol and/or other drug problems. Scheduled, goal-oriented clinical services are provided in conjunction with ongoing support and assistance for developing and maintaining interpersonal skills necessary to lead an alcohol and/or drug-free lifestyle. Specialized RRS services tailored for the needs of Youth, Transitional Age Youth, Young	✓	✓	✓		

Service	Coverage Types				
	MassHealth Standard & CommonHealth Covered Individuals	MassHealth Family Assistance Covered Individuals	CarePlus Covered Individuals	Uninsured Individuals and Persons Covered by Medicare Only	Individuals without Mobile Crisis Coverage
Adults, Families and Pregnant and Post-Partum Members are also available to eligible Covered Individuals.					
6. Co-Occurring Enhanced Residential Rehabilitation Services for Substance Use Disorders (Level 3.1) - 24-hour, safe, structured environment, located in the community, which supports Covered Individual's recovery from addiction and moderate to severe mental health conditions while reintegrating into the community and returning to social, vocation/employment, and/or educational roles. Scheduled, goal-oriented clinical services are provided in conjunction with psychiatry and medication management to support stabilization and development of skills necessary to achieve recovery. Clinical services are provided a minimum of five hours a week and additional outpatient levels of care may be accessed concurrently as appropriate. Programs will ensure that Members have access to prescribers of psychiatric and addiction medications.	✓	✓	✓		
7. Transitional Care Unit (TCU) – a community based therapeutic program offering high levels of supervision, structure and intensity of service within an unlocked setting. The program serves children and adolescents, under age 19, who are in the custody of the Department of Children and Families (DCF), who have been determined to need group care or foster care and no longer meet the clinical criteria for continued stay at an acute level of care. The TCU offers comprehensive services, including but not limited to, a therapeutic milieu, psychiatry, aggressive case management, and multidisciplinary, multi-modal therapies.	✓	✓			
Non-24-Hour Diversionary Services					
1. Community Support Program (CSP) - an array of services delivered by a community-based, mobile, multi-disciplinary team of professionals and paraprofessionals. These programs provide essential services to Covered Individuals with a long-standing history of a psychiatric or substance use disorder and to their	✓	✓	✓		

Service	Coverage Types				
	MassHealth Standard & CommonHealth Covered Individuals	MassHealth Family Assistance Covered Individuals	CarePlus Covered Individuals	Uninsured Individuals and Persons Covered by Medicare Only	Individuals without Mobile Crisis Coverage
families, or to Covered Individuals who are at varying degrees of increased medical risk, or to children/adolescents who have behavioral health issues challenging their optimal level of functioning in the home/community setting. Services include outreach and supportive services, delivered in a community setting, which will vary with respect to hours, type and intensity of services depending on the changing needs of the Covered Individual.					
2. Recovery Coaching – a non-clinical service provided by individuals currently in recovery from a substance use disorder who have been certified as Recovery Coaches and who have been trained to help people with addiction gain hope, explore recovery and achieve life goals. The focus of the Recovery Coach role is to create a relationship between equals that is non-clinical and focused on removing obstacles to recovery; facilitating initiation and engagement to treatment and serving as a guide and motivating factor for the Enrollee to maintain recovery and community tenure.	✓	✓	✓		
3. Recovery Support Navigators (RSN) – a specialized care coordination service intended to engage Enrollees with Substance Use Disorder in accessing and continuing Substance Use Disorder treatment. RSNs may be located in a variety of Substance Use Disorder treatment environments, doing outreach and building relationships with individuals in programs, including withdrawal management and step-down services. If an Enrollee accepts RSN services upon leaving a Substance Use Disorder treatment program, the RSN will work with the individual on accessing appropriate treatment and staying motivated for treatment and recovery.	✓	✓	✓		
4. Partial Hospitalization (PHP) – an alternative to Inpatient Mental Health Services, PHP services offer short-term day mental health programming available seven days per week. These services	✓	✓	✓		

Service	Coverage Types				
	MassHealth Standard & CommonHealth Covered Individuals	MassHealth Family Assistance Covered Individuals	CarePlus Covered Individuals	Uninsured Individuals and Persons Covered by Medicare Only	Individuals without Mobile Crisis Coverage
consist of therapeutically intensive acute treatment within a stable therapeutic milieu and include daily psychiatric management.					
5. Psychiatric Day Treatment – services which constitute a program of a planned combination of diagnostic, treatment and rehabilitative services provided to a person with mental illness who needs more active or inclusive treatment than is typically available through a weekly visit to a mental health center, individual Provider's office or hospital outpatient department, but who does not need 24-hour hospitalization.	✓	✓	✓		
6. Structured Outpatient Addiction Program (SOAP) – clinically intensive, structured day and/or evening substance use disorder services. These programs can be utilized as a transition service in the continuum of care for a Covered Individual being discharged from Acute Substance Abuse Treatment, or can be utilized by individuals, who need Outpatient Services, but who also need more structured treatment for a substance use disorder. These programs may incorporate the evidence-based practice of Motivational Interviewing into clinical programming to promote individualized treatment planning. These programs may include specialized services and staffing for targeted populations including pregnant women, adolescents and adults requiring 24 monitoring.	✓	✓	✓		
7. Program of Assertive Community Treatment (PACT) – a multi-disciplinary team approach to providing acute, active, ongoing, and long-term community-based psychiatric treatment, assertive outreach, rehabilitation and support. The program team provides assistance to Covered Individuals to maximize their recovery, ensure consumer-directed goal setting, assist individuals in gaining a sense of hope and empowerment, and provide assistance in helping the individuals served become better integrated into the community. Services are provided in the	✓	✓	✓		

Service	Coverage Types				
	MassHealth Standard & CommonHealth Covered Individuals	MassHealth Family Assistance Covered Individuals	CarePlus Covered Individuals	Uninsured Individuals and Persons Covered by Medicare Only	Individuals without Mobile Crisis Coverage
community and are available, as needed by the individual, 24 hours a day, seven days a week, 365 days a year.					
8. **Intensive Outpatient Program (IOP) -** a clinically intensive service designed to improve functional status, provide stabilization in the community, divert an admission to an Inpatient Service, or facilitate a rapid and stable reintegration into the community following a discharge from an inpatient service. The IOP provides time-limited, comprehensive, and coordinated multidisciplinary treatment.	✓	✓	✓		
Outpatient Services - mental health and substance use disorder services provided in person in an ambulatory care setting such as a Community Behavioral Health Center (CBHC), mental health center or substance use disorder clinic, hospital outpatient department, community health center, or practitioner's office. The services may be provided at a Covered Individual's home or school.					
Standard outpatient Services – those Outpatient Services most often provided in an ambulatory setting					
1. **Family Consultation -** a meeting of at least 15 minutes' duration, either in person or by telephone, with family members or others who are significant to the Covered Individual and clinically relevant to a Covered Individual's treatment to: identify and plan for additional services; coordinate a treatment plan; review the individual's progress; or revise the treatment plan, as required.	✓	✓	✓		
2. **Case Consultation -** an in-person or by telephone meeting of at least 15 minutes' duration, between the treating Provider and other behavioral health clinicians or the Covered Individual's primary care physician, concerning a Covered Individual who is a client of the Provider, to: identify and plan for additional services; coordinate a treatment plan; review the individual's progress; and revise the treatment plan, as required. Case Consultation	✓	✓	✓		

Service	Coverage Types				
	MassHealth Standard & CommonHealth Covered Individuals	MassHealth Family Assistance Covered Individuals	CarePlus Covered Individuals	Uninsured Individuals and Persons Covered by Medicare Only	Individuals without Mobile Crisis Coverage
shall not include clinical supervision or consultation with other clinicians within the same provider organization.					
3. Diagnostic Evaluation- an assessment of an Enrollee's level of functioning, including physical, psychological, social, educational and environmental strengths and challenges for the purpose of diagnosis and designing a treatment plan	✓	✓	✓		
4. Dialectical Behavioral Therapy (DBT) - a manual-directed outpatient treatment developed by Marsha Linehan, PhD, and her colleagues that combines strategies from behavioral, cognitive, and supportive psychotherapies for Covered Individuals with borderline personality disorder who also exhibit chronic, parasuicidal behaviors and adolescents who exhibit these symptoms. DBT may be used for other disorders if the Contractor determines that, based on available research, DBT is effective and meets the Contractor's criteria for determining medical necessity.	✓	✓	✓		
5. Psychiatric Consultation on an Inpatient Medical Unit - an in-person meeting of at least 15 minutes' duration between a psychiatrist or Advanced Practice Registered Nurse Clinical Specialist and a Covered Individual at the request of the medical unit to assess the Covered Individual's mental status and consult on a behavioral health or psychopharmacological plan with the medical staff on the unit.	✓	✓	✓		
6. Medication Visit - an individual visit specifically for psychopharmacological evaluation, prescription, review, and/or	✓	✓	✓		

Service	Coverage Types				
	MassHealth Standard & CommonHealth Covered Individuals	MassHealth Family Assistance Covered Individuals	CarePlus Covered Individuals	Uninsured Individuals and Persons Covered by Medicare Only	Individuals without Mobile Crisis Coverage
monitoring by a psychiatrist or R.N. Clinical Specialist for efficacy and side effects.					
7. Medication Administration – shall mean the injection of intramuscular psychotherapeutic medication by qualified personnel.	✓	✓	✓		
8. Couples/Family Treatment - the use of psychotherapeutic and counseling techniques in the treatment of a Covered Individual and his/her partner and/or family simultaneously in the same session.	✓	✓	✓		
9. Group Treatment – the use of psychotherapeutic or counseling techniques in the treatment of a group, most of whom are not related by blood, marriage, or legal guardianship.	✓	✓	✓		
10. Individual Treatment - the use of psychotherapeutic or counseling techniques in the treatment of an individual on a one-to-one basis.	✓	✓	✓		
11. Inpatient-Outpatient Bridge Visit - a single-session consultation conducted by an outpatient provider while a Covered Individual remains on an Inpatient psychiatric unit. The Inpatient-Outpatient Bridge Visit involves the outpatient Provider meeting with the Enrollee and the inpatient team or designated inpatient treatment team clinician.	✓	✓	✓		
12. Assessment for Safe and Appropriate Placement (ASAP) - an assessment, required by MGL 119 Sec. 33B, conducted by a	✓	✓			

Service	Coverage Types				
	MassHealth Standard & CommonHealth Covered Individuals	MassHealth Family Assistance Covered Individuals	CarePlus Covered Individuals	Uninsured Individuals and Persons Covered by Medicare Only	Individuals without Mobile Crisis Coverage
diagnostician with specialized training and experience in the evaluation and treatment of sexually abusive youth or arsonists, to evaluate individuals who are in the care and custody of DCF and who have been adjudicated delinquent for a sexual offense or the commission of arson, or have admitted to such behavior, or are the subject of a documented or substantiated report of such behavior, and who are being discharged from Inpatient Psychiatric Unit or Hospital or Community-Based Acute Treatment for Children/Adolescents or Intensive Community Based Acute Treatment for Children/Adolescents to a family home care setting. Services are provided through a DCF designated ASAP provider.					
13. **Collateral Contact –** a communication of at least 15 minutes' duration between a Provider and individuals who are involved in the care or treatment of a Covered Individual under 21 years of age, including, but not limited to, school and day care personnel, state agency staff, and human services agency staff.	✓	✓			
14. **Acupuncture Treatment -** the insertion of metal needles through the skin at certain points on the body, with or without the use of herbs, an electric current, heat to the needles or skin, or both, as an aid to persons who are withdrawing from dependence on substances or in recovery from addiction.	✓	✓	✓		
15. **Opioid Treatment Services —** supervised assessment and treatment of an individual, using FDA approved medications (including methadone, buprenorphine/naloxone, and naltrexone) along with a comprehensive range of medical and rehabilitative	✓	✓	✓		

Service	Coverage Types				
	MassHealth Standard & CommonHealth Covered Individuals	MassHealth Family Assistance Covered Individuals	CarePlus Covered Individuals	Uninsured Individuals and Persons Covered by Medicare Only	Individuals without Mobile Crisis Coverage
services, when clinically necessary, to alleviate the adverse medical, psychological or physical effects incident to opiate addiction. This term encompasses detoxification treatment and maintenance treatment.					
16. **Ambulatory Withdrawal Management (Level 2WM) -** outpatient services for Members who are experiencing a serious episode of excessive substance use or withdrawal complications. Ambulatory Withdrawal Management is provided under the direction of a physician and is designed to stabilize the Member's medical condition under circumstances where neither life nor significant bodily functions are threatened. The severity of the individual's symptoms will determine the setting, as well as the amount of nursing and physician supervision necessary during the course of treatment.	✓	✓	✓		
17. **Psychological Testing -** the use of standardized test instruments to assess a Covered Individual's cognitive, emotional, neuropsychological, verbal, and defensive functioning on the central assumption that individuals have identifiable and measurable differences that can be elicited by means of objective testing.	✓	✓	✓		
18. **Special Education Psychological Testing -** psychological, emotional or neuropsychological testing which is requested by school personnel responsible for initiating referrals for diagnosis and evaluation of children who qualify for special education programs pursuant to Mass Gen. Law 71B, and which shall be utilized toward the development of an Individualized Educational	✓	✓			

Service	Coverage Types				
	MassHealth Standard & CommonHealth Covered Individuals	MassHealth Family Assistance Covered Individuals	CarePlus Covered Individuals	Uninsured Individuals and Persons Covered by Medicare Only	Individuals without Mobile Crisis Coverage
Plan (IEP). Special Education Psychological Testing shall not be administered more than once a year unless new events have significantly affected the student's academic functioning.					
19. Applied Behavioral Analysis for members under 21 years of age (ABA Services) – a MassHealth service that focuses on the analysis, design, implementation, and evaluation of social and other environmental modifications to produce meaningful changes in human behavior. This service provides for the performance of behavioral assessments; interpretation of behavior analytic data; development of a highly specific treatment plan; supervision and coordination of interventions; and training other interveners to address specific objectives or performance goals in order to treat challenging behaviors that interfere with a youth's successful functioning. See 101 CMR 358.00.	✓	✓			
20. Early Intensive Behavioral Intervention (EIBI): a service provided to children under three years of age who have a diagnosis of autism spectrum disorder (ASD) and meet clinical eligibility criteria as defined by DPH. Such services shall be provided only by DPH-approved, Early Intensive Behavioral Intervention Service Providers.	✓	✓			
21. Preventive Behavioral Health Services - short-term interventions in supportive group, individual, or family settings, recommended by a physician or other licensed practitioner, practicing within their scope of licensure, that cultivate coping skills and strategies for symptoms of depression, anxiety, and other social/emotional	✓	✓			

Service	Coverage Types				
	MassHealth Standard & CommonHealth Covered Individuals	MassHealth Family Assistance Covered Individuals	CarePlus Covered Individuals	Uninsured Individuals and Persons Covered by Medicare Only	Individuals without Mobile Crisis Coverage
concerns, which may prevent the development of behavioral health conditions for members who are under 21 years old who have a positive behavioral health screen (or, in the case of an infant, a caregiver with a positive post-partum depression screening), even if the member does not meet criteria for behavioral health diagnosis. Preventive behavioral health services are available in group sessions when delivered in community-based outpatient settings, and in individual, family, and group sessions when provided by a behavioral health clinician practicing in an integrated pediatric primary care setting.					
Intensive Home or Community-Based Services for Youth – mental health and substance use disorder services provided to Enrollees in a community-based setting such as home, school, or community service agency. The services provided are more intensive than services that may be provided through a standard outpatient service. (See detailed services below)					
1. Family Support and Training: a service provided to the parent /caregiver of a youth (under the age of 21), in any setting where the youth resides, such as the home and other community settings. Family Support and Training is a service that provides a structured, one-to-one, strength-based relationship between a Family Support and Training staff and a parent/caregiver. The purpose of this service is for resolving or ameliorating the youth's emotional and behavioral needs by improving the capacity of the parent /caregiver to parent the youth so as to improve the youth's functioning. Services may include education, assistance in navigating the youth serving systems; fostering empowerment, including linkages to peer/parent support and self-help groups;	✓				

Service	Coverage Types				
	MassHealth Standard & CommonHealth Covered Individuals	MassHealth Family Assistance Covered Individuals	CarePlus Covered Individuals	Uninsured Individuals and Persons Covered by Medicare Only	Individuals without Mobile Crisis Coverage
assistance in identifying formal and community resources, support, coaching, and training for the parent/caregiver.					
2. Intensive Care Coordination: a service that provides targeted case management services to individuals under 21 with a Serious Emotional Disturbance including individuals with co-occurring conditions. This service includes assessment, development of an individualized care plan, referral and related activities to implement the care plan and monitoring of the care plan.	✓				
3. **In-Home Behavioral Services –** this service usually includes a combination of behavior management therapy and behavior management monitoring, as follows: a. Behavior Management Therapy: This service includes assessment, development of the behavior plan, and supervision and coordination of interventions to address specific behavioral objectives or performance. This service addresses challenging behaviors which interfere with the youth's successful functioning. The Behavior management therapist develops and monitors specific behavioral objectives and interventions, including a crisis-response strategy, that are incorporated into the youth's treatment plan. The therapist may also provide short-term counseling and assistance, depending on the youth's performance and level of intervention required. Phone contact and consultation may be provided as part of the intervention. b. Behavior Management Monitoring. This service includes implementation of the behavior plan, monitoring the youth's behavior, reinforcing	✓				

Service	Coverage Types				
	MassHealth Standard & CommonHealth Covered Individuals	MassHealth Family Assistance Covered Individuals	CarePlus Covered Individuals	Uninsured Individuals and Persons Covered by Medicare Only	Individuals without Mobile Crisis Coverage
implementation of the plan by parents or other caregivers and reporting to the behavior management therapist on implementation of the plan and progress toward behavioral objectives or performance goals. Phone contact and consultation may be provided as part of the intervention.					
4. **In-Home Therapy Services -** This service is a therapeutic clinical intervention and ongoing training and therapeutic support, as follows: a. The Therapeutic Clinical Intervention is a structured, consistent, therapeutic relationship between a licensed clinician and the youth and family for the purpose of treating the youth's mental health needs including improving the family's ability to provide effective support for the youth to promote healthy functioning of the youth within the family. The clinician develops a treatment plan and, using established psychotherapeutic techniques, works with the entire family or a subset of the family, to enhance problem-solving, limit-setting, communication, emotional support or other family or individual functions. The Therapeutic Clinical Intervention is provided by a qualified licensed clinician who will often work in a team that includes one or more qualified paraprofessionals. b. Ongoing Therapeutic Training and Support is a service provided by a paraprofessional to support implementation of the licensed clinician's treatment plan to achieve the goals of the treatment plan. The paraprofessional assists a licensed clinician in implementing the therapeutic objectives of the treatment plan designed to address the youth's mental	✓	✓			

Service	Coverage Types				
	MassHealth Standard & CommonHealth Covered Individuals	MassHealth Family Assistance Covered Individuals	CarePlus Covered Individuals	Uninsured Individuals and Persons Covered by Medicare Only	Individuals without Mobile Crisis Coverage
health and emotional challenges. This service includes teaching the youth to understand, direct, interpret, manage and control feelings and emotional responses to situations, and to assist the family in supporting the youth in addressing his or her emotional and mental health needs. Phone contact and consultation may be provided as part of the intervention.					
5. Therapeutic Mentoring Services - this service provides a structured, one-to-one mentoring relationship between a therapeutic mentor and a youth for the purpose of addressing daily living, social and communication needs. Each youth will have goals and objectives that are designed to support age-appropriate social functioning or ameliorate deficits in the youth's age-appropriate social functioning. These goals and objectives are developed by the youth, as appropriate, and his/her treatment team and are incorporated into the treatment plan. The service includes supporting, coaching and training the youth in age-appropriate behaviors, interpersonal communication, problem-solving and conflict resolution and relating appropriately to other youths, as well as adults, in recreational and social activities. The therapeutic mentor works with the youth in such settings as their home, school or social or recreational activities.	✓				
Crisis Services - Crisis Services are available seven days per week, 24 hours per day to provide treatment of any individual who is experiencing a mental health crisis. (See detailed services below)					
1. AMCI Encounter - each AMCI Encounter shall include at a minimum: crisis assessment, intervention and stabilization. **a.** Assessment - a face-to-face evaluation of an individual presenting with a behavioral health emergency, including assessment of the need for hospitalization, conducted by appropriate clinical personnel;	✓	✓	✓	✓	✓ **(initial crisis encounter only)**

Service	Coverage Types				
	MassHealth Standard & CommonHealth Covered Individuals	MassHealth Family Assistance Covered Individuals	CarePlus Covered Individuals	Uninsured Individuals and Persons Covered by Medicare Only	Individuals without Mobile Crisis Coverage
b. Intervention –the provision of psychotherapeutic and crisis counseling services to an individual for the purpose of stabilizing an emergency; and **c.** Stabilization – short-term behavioral health treatment in a structured environment with continuous observation and supervision of individuals who do not require hospital level of care. **d.** In addition, medication evaluation and specialing services shall be provided if Medically Necessary.					
2. YMCI - a short term mobile, on-site, and face-to-face therapeutic service provided for youth experiencing a behavioral health crisis and for the purpose of identifying, assessing, treating, and stabilizing the situation and reducing the immediate risk of danger to the youth or others consistent with the youth's risk management/safety plan, if any. Services are available 24 hours a day, 7 days a week.	✓	✓		✓	✓ **(initial crisis encounter only)**
3. Emergency Department-based Crisis intervention Mental Health Services - Crisis interventions include the crisis evaluation, stabilization interventions, and disposition coordination activities for members presenting to the ED in a behavioral health crisis. Elements of crisis evaluations include: a. Crisis Evaluation: Behavioral Health crisis assessment by a qualified behavioral health professional to individuals within 60 minutes of time of the member's readiness to receive such an assessment. Qualified behavioral health professionals include: qualified behavioral health professional, a psychiatrist, and other master's and bachelor's-level clinicians and staff sufficient to meet the needs of members served which may include certified peer specialists and recovery coaches.	✓	✓	✓	✓	

Service	Coverage Types				
	MassHealth Standard & CommonHealth Covered Individuals	MassHealth Family Assistance Covered Individuals	CarePlus Covered Individuals	Uninsured Individuals and Persons Covered by Medicare Only	Individuals without Mobile Crisis Coverage
b. Crisis Stabilization Interventions: Observation, treatment, and support to individuals experiencing a behavioral health crisis c. Discharge Planning and Care Coordination: A disposition plan that includes discharge planning to identify and secure an appropriate level of care and goals for that level of care.					
Other Behavioral Health Services - Behavioral Health Services that may be provided as part of treatment in more than one setting type					
1. Electro-Convulsive Therapy (ECT) - a therapeutic service which initiates seizure activity with an electric impulse while the individual is under anesthesia. It is administered in a facility that is licensed to provide this service by DMH.	✓	✓	✓		
2. Repetitive Transcranial Magnetic Stimulation (rTMS) - a noninvasive form of neurostimulation in which rapidly changing magnetic fields are applied to the surface of the scalp through a copper wire coil connected to a magnetic stimulator. The therapeutic service is used to treat depression that has not responded to standard treatment such as medications and psychotherapy.	✓	✓	✓		
3. Specialing - therapeutic services provided to an Enrollee in a variety of 24-hour settings, on a one-to-one basis, to maintain the individual's safety.	✓	✓	✓		

APPENDIX E-1

PROGRAM REPORTING REQUIREMENTS

This Appendix summarizes the programmatic reporting requirements described in the Contract. In accordance with **Section 2.14** of the Contract, the Contractor shall submit the report and corresponding Certification Checklist of all reports/submissions listed in **Appendix E** within the timelines specified herein.

For reports that have a performance target, the Contractor shall complete a narrative that includes the results, an explanation as to how the Contractor met the target or why it did not meet the target, and the steps the Contractor is taking to improve performance going forward.

The Contractor shall provide all reports in the form and format specified by EOHHS and shall participate with EOHHS in the development of detailed specifications for these reports. These specifications shall include benchmarks and targets for all reports, as appropriate. Targets shall be changed to reflect improvement in standards over time.

All exhibits referenced herein pertain to **Appendix E**, unless otherwise noted. Such exhibits set forth the form and format the Contractor shall use for each report. These exhibits shall be provided to the Contractor and may be updated by EOHHS from time to time, without a Contract amendment. EOHHS shall notify the Contractor of any updates to the exhibits.

The Contractor shall prepare and submit to EOHHS the reports described in this Appendix, as well as ad hoc reports that may be requested by EOHHS. General requirements for report submissions, including instructions on formatting and data handling, are set forth in **Section 2.14** of the Contract. In the event of any inconsistency between the descriptions in this Appendix and the provisions in the Contract, the Contract controls.

Reporting Timetables

The Contractor shall provide reports to EOHHS according to the following timetable, unless otherwise specified or approved by EOHHS. All references to "annual" or "year-to-date" reports or data refer to the Contract Year, unless otherwise specified.

Reportable Adverse Incidents – Use secure e-mail system to send Reportable Adverse Incident reports to EOHHS by 5:00 p.m. (Eastern Time) on the same day that the Contractor receives Reportable Adverse Incident notification by 3:00 p.m. on a business day, in accordance with the established protocol. Submit Reportable Adverse Incident reports to EOHHS by the next business day if the Contractor receives Reportable Adverse Incident notification after 3:00 p.m. or on a non-business day, in accordance with the established protocol, unless otherwise approved by EOHHS.

Daily Reports – no later than 5:00 p.m. on the next business day following the day reported.

Weekly Reports – no later than 5:00 p.m. the next business day following the week reported.

Monthly Reports – no later than 5:00 p.m. on the 20th day of the month immediately following the month reported for non-Claims-based reports; Claims-based reports will allow for a 90-day Claims lag. If the 20th of the month falls on a non-business day, the reports will be due on the next business day. Monthly reports due October 20, January 20, April 20, and July 20 may be submitted with quarterly reports.

Quarterly Reports – no later than 5:00 p.m. on the 30th day of the month following the end of the quarter reported, for non-Claims-based reports, i.e., October 30, January 30, April 30, and July 30; or, if the 30th of the month falls on a non-business day, the next business day. Quarterly reports due January 30th will be submitted on February 15th and July 30th will be submitted August 15th. Claims-based reports shall allow for a 90-day Claims lag and report time, so that, for example, reports due on October 30th will present data for service dates for the quarter from April-June.

Semiannual Reports – no later than 5:00 p.m. on the 30th day following the end of the semiannual period reported, for non-Claims-based reports, i.e., January 30 and July 30; or, if the 30th of the month falls on a non-business day, the next business day. Semiannual reports are due August 30th for January – June. Reports due February 15th are for July – December. Claims-based reports shall allow for a 90-day Claims lag, so that, for example, the report due on January 30th will present data through September 30th.

Annual Reports – no later than 5:00 p.m. on February 15th or, if February 15th falls on a non-business day, the next business day. Claims-based annual reports will allow for a 90-day Claims lag, so data due on February 15th will be for Claims no later than September.

One-time, Periodic, and Ad Hoc Reports – no later than the time stated, or as directed by EOHHS.

Reportable Adverse Incidents

1. BEHAVIORAL HEALTH REPORTABLE ADVERSE INCIDENTS AND ROSTER OF REPORTABLE ADVERSE INCIDENTS – DAILY INCIDENT DELIVERY REPORT – BH-01

Report of Reportable Adverse Incidents that comes to the attention of the Contractor.

One-time, Periodic and Ad Hoc Reports

2. AUTHORIZATION REPORTS FOR CBHI SERVICES – BH-N/A

Summary report of authorizations units of services requested, approved and denied for CBHI Services.

3. NETWORK PROVIDER PROTOCOLS

The Contractor shall notify EOHHS when it terminates a Provider within three (3) business days of such termination.

4. ADDITIONAL REPORTS AND REPORTING ACTIVITIES (FOR PCC PLAN)

The Contractor shall produce additional PMSS reports, including but not limited to analysis of trends identified from PMSS data, data and analytics on population health management,

and other supplemental and management reports that support quality and integration activities as negotiated by the parties.

5. **PROVIDER AND PCC QUALITY FORUMS**

   The Contractor shall provide a summary report on each series of quality forums described in **Section 2.13**. The report shall include, at a minimum, information on the number and type of attendees (profession and practice name), the location, the presentation topic and responses from attendees regarding the quality of the program presented. The report shall be submitted within 30 days after the last session of a forum series.

6. **PCC CLINICAL ADVISORY COMMITTEE**

   The PCC Clinical Advisory Committee shall report on minutes to the meeting and provide follow-up on action items established.

7. **BEHAVIORAL HEALTH URGENT CARE – AD HOC REPORTS**

   Provide any Behavioral Health Urgent Care ad hoc reports further specified by EOHHS.

8. **FRAUD AND ABUSE NOTIFICATION (WITHIN 5 BUSINESS DAYS) AND ACTIVITIES**

   Fraud and Abuse ad-hoc notification for overpayments related to suspected fraud.

9. **NOTIFICATION OF FOR-CAUSE PROVIDER SUSPENSIONS AND TERMINATIONS (WITHIN 3 BUSINESS DAYS)**

   Ad-hoc notification of for-cause provider suspensions and/or terminations of the Provider's contract with the Contractor.

10. **NOTIFICATION OF PROVIDER OVERPAYMENTS (WITHIN 5 BUSINESS DAYS)**

    Overpayment ad-hoc notification of provider overpayments unrelated to suspected fraud.

11. **SELF-REPORTED DISCLOSURES**

    Ad-hoc notification of provider self-reported disclosures of overpayments.

12. **RESPONSE TO OVERPAYMENTS IDENTIFIED BY EOHHS REPORT**

    Response to overpayments identified by EOHHS in response to EOHHS ad-hoc notifications of overpayments identified by EOHHS.

13. **AGREED UPON OVERPAYMENTS COLLECTION REPORT**

    Agreed upon overpayments collection report in response to EOHHS ad-hoc notification of overpayments identified by EOHHS.

Daily Reports

14. **DEPARTMENT OF MENTAL HEALTH (DMH) DAILY ADMISSIONS – BH-17**

    Report of DMH Clients who were admitted to Behavioral Health 24-hour Level-of-Care services. (Report provided to DMH.)

15. **COVERED INDIVIDUALS BOARDING IN EMERGENCY DEPARTMENTS OR ON ADMINISTRATIVELY NECESSARY DAYS (AND) STATUS – BH-26**

Report on any Covered Individuals awaiting placement in a 24-hour level of behavioral health care that remains in an emergency department for 24 hours or longer, as further specified by EOHHS. For AND Report, report on any Covered Individuals in AND status as described in **Appendix A-1,** in a format agreed to by EOHHS.

Weekly Reports

16. CBHI ACCESS REPORTING

Ensure that the Behavioral Health Service Access System is updated at least once a week for CBHI Services (ICC, IHBS, TM, and IHT) to show access and availability. CBHI Service reporting must be available to the public on the system.

Monthly Reports

17. CBHI SERVICES PROVIDER MONITORING REPORTS – BH-N/A

a. Provider access reports: Aggregated by Region and by service – including In-Home Therapy, Therapeutic Mentoring and In-Home Behavioral Services.

   "MABH Access (Availability and Waitlist Report)- IHT": Self-reported provider-level data

   "MABH Access (Availability and Waitlist Report)- TM": Self-reported provider-level data

   "MABH Access (Availability and Waitlist Report)- IHBS": Self-reported provider-level data

   "Provider Detail Report": Summary of IHT/IHBS/FST/TM providers by region

b. Provider access reports: Provider-specific data on capacity, access and wait times for In-Home Therapy, Therapeutic Mentoring and In-Home Behavioral Services.

   "IHT/TM/IHBS Monthly Provider Report and Addendum: Self-reported by providers. Provider-level data on availability of services inclusive of data on total capacity, slots, available and total youth waiting.

   "Waitlist F/U Report": Provider detail on the follow-up providers have with clients on the waiting list. Contractor gathers this detail through phone calls to providers and manually produces the report.

c. CSA Monthly Provider-level report and CSA waitlist follow-up report, Provider-specific. (due on the 30th of each month)

   "CSA Monthly Provider Report": Self-reported by CSAs. Includes data on members being served, total # members waiting, waiting by # days, average length of time from request to start of service

   "CSA Waitlist Follow-up Report": Self-reported by CSAs. Includes provider-level data on youth waiting for service for CSAs with waitlists inclusive of total # of youth waiting and youth who started the service at the time of the follow-up call from Contractor.

d. MCI Provider-level report on timeliness of encounter and location of Encounter.

"MCI Monthly Provider Report": Includes the # of encounters, average response time in minutes, and percentage of encounters with responses less than 30 minutes

18. CSA REPORTED AND AGGREGATED DATA – BH-N/A (MONTHLY)

CSA-reported data on referrals, discharges, enrollment and staffing, as described in CSA Operations Manual.

"MCI Referral to ED" : Provides source of referral to ED for MCI services as reported in the encounter data.

"IHT Response Time": Average time to first IHT appointment.

"CARD Report": A graph which represents the number of youth awaiting discharge from a BH acute hospital or diversionary level of care. Includes the number of youth awaiting discharge on the last day of each month of the fiscal year.

"Monthly Bed and Boarding Report": A chart which outlines the number of youth involved with Contractor awaiting inpatient hospital placement and the number of available inpatient beds.

"TCU Report": Count of the number of youth covered by Contractor who are in a Transitional Care Unit as of the last day of the month.

19. CBHC REPORTS – BH-N/A

CBHC Monitoring reports to be developed with the Contractor based on CBHC performance specifications, including on all services provided by CBHCs. Reports to be developed with the Contractor shall include services provided by CBHCs to Uninsured Individuals, persons covered by Medicare only, and Individuals without Mobile Crisis Coverage.

20. PROVIDER CONCERNS REPORT – BH-27

Report of all concerns reported by Network Providers stratified by PCC Network Providers and BH Network Providers.

"Provider Concern Report Month YYYY": Includes a summary about: whether the concern regards Contractor, the provider, or MassHealth; reason category and subcategory (quality of service, quality of care, access to care, billing/finance, or other issues); concern resolution type; an analysis of concerns; and management actions/next steps

21. PCC AND BH NETWORKS SITE VISIT REPORT – BH-29

Report of BH Network and PCC site visits, which includes but is not limited by the requirements of **Sections 2.8.H and 2.19.C**, respectively**.**

"Appendix E Report "PQM Site Visit Report

22. PCC PLAN MANAGEMENT SUPPORT SERVICES REPORT – BH-30

Report of PCC Plan Management Support deliverables.

"Month YYYY Plan Support Services Report": Comprehensive summary of the activities related to the PCC Plan Support Services Program including site visits, internal and external meetings, related data

23. CARE MANAGEMENT REPORT – BH-N/A

Report of all Care Management, Integrated Care Management and Practice-Based Care Management, which includes but is not limited to the requirements found **in Section 2.5.A-H** in a form and format to be determined by EOHHS and the Contractor.

"ICMP PBCM": Excel sheet detailing count and percentage

"ICMP PBCM Narrative": Details engagement, disenrollment, high-risk identification, noticeable changes, opportunities for improvement, interventions/next steps for ICMP and PBCM

24. CARE MANAGEMENT – PBCM REPORT

The Contractor shall calculate and report on the number of Participants in Practice Based Care Management on a monthly basis.

25. DATA GATHERING AND REPORTING CAPACITY IN THE MASSACHUSETTS BEHAVIORAL HEALTH ACCESS (MABHA) WEBSITE

Deliver to EOHHS and DMH: (1) a monthly progress report on the Contractor's progress toward implementing the efforts described in **Section 2.10.E.**

Quarterly Reports

26. TELEPHONE STATISTICS – BH-19

Report including a separate section for clinical calls and Provider and Covered Individual services calls that includes the number of calls, received, answered and abandoned, as well as the measures of Contract performance standards on calls answered within 30 seconds, and average speed of answer.

27. CANS COMPLIANCE: – BH-14

CANS Compliance. This report is required when CANS data is made available through the Virtual Gateway

"BH-14 CANSCompliance_by_LOC": Summary of members receiving outpatient/ICC/IHT in time frame, with CANS assessment marked with appropriate LOC, and compliance rate and summary of members receiving discharges for CBAT and inpatient, number of discharges with CANS assessment with appropriate LOC, and compliance

28. BEHAVIORAL HEALTH CLINICAL OPERATIONS/INPATIENT AND ACUTE SERVICE AUTHORIZATION, DIVERSIONS, MODIFICATION AND DENIAL REPORT – BH-13

Summary report on authorizations, diversions, modifications, and service denials of mental health inpatient services and substance use disorder acute services. In addition, summary report of number of:

- Covered Individuals enrolled in PACT;
- Covered Individuals enrolled in PACT who assessed psychiatric inpatient level of care;
- Covered Individuals enrolled in PACT who assessed Crisis Stabilization Services; and

- Covered Individual's enrolled in PACT who assessed Community Crisis Stabilization.

29. BEHAVIORAL HEALTH CLINICAL OPERATIONS AND ACUTE SERVICE AUTHORIZATION, DIVERSIONS, MODIFICATION AND DENIAL REPORT (ABA) – BH-08

Summary report on ABA authorizations, diversions, modifications, and service denials.

"ABA Clinical Ops Data and Graphs"

"ABA Clinical Ops"

30. SUBSTANCE USE DISORDER CLINICAL OPS/INPATIENT AUTHORIZATION REPORT – BH-23

Substance Use Disorder Clinical Operations/Inpatient & Acute Service Authorization Modification and Denial Report

"BH SUD Clinical Ops Quarterly Q#_CYYYYY": Includes the number of notifications and continued stayed requests as well as the number of continued stay requests approved, modified, or denied. Timeliness is also reported

31. PHARMACY RELATED ACTIVITIES REPORT – BH-N/A

A report on pharmacy-related activities the Contractor has performed in support of the Contract, which includes but is not limited to the requirements found in **Section 2.6.D.**

"Pharmacy Related Activities Report CYYYYYQ#": Includes information by age groups on any BH med, on any AP med, on AP without a BH diagnosis, and polypharmacy

32. BEHAVIORAL HEALTH UTILIZATION AND COST REPORT – BH-15

A summary of Behavioral Health costs and utilization.

33. CLAIMS PROCESSING REPORT – BH-N/A

Behavioral Health Claims processed, paid, denied, and pending per month.

"Denied Claims": Summarizes all claim lines and claim dollars by denial reasons

"Pended Claims": Summarizes all claim lines and claim dollars by pend reasons

"Claims Activity": Summarizes claims received and paid/denied/pended, an analysis, and action items/next steps

"253A": Pie chart describing percentage of claims denied, paid, and pended every month

"253B": Pie chart describing percentage of claims denied, paid, and pended for the year

"253C": Pie chart describing percentage of claims denied, paid, and pended from 2023

34. BH PROVIDER NETWORK ACCESS AND AVAILABILITY REPORTS: – BH-18

a. Summary of significant changes in the Provider Network (including, but not limited to: changes in MassHealth Covered Services; enrollment of a new population in the Contractor's plan; changes in benefits; changes in Network Provider payment methodology).

b. BH Network geographic access.

c. Use of Out-of-Network Providers.

d. Appointment time availability standards.

e. Secret shopper report

Through these five reports, the Contractor must demonstrate that it 1) maintains a Provider Network that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of Covered Individuals in each of the State's regions; and 2) offers an appropriate range of specialty services that is adequate for the anticipated number of Covered Individuals in each of the State's regions.

"7175 BH Practitioners": Includes 7 provider maps, access summaries by city, and access details by city. Psychiatrists, psychologists, LCSW, LMFT, licensed mental health counselors, and registered nurse clinical nurse specialists.

"Geo Access Report": Summarizes geo-access standards for inpatient and outpatient services and whether or not they are incompliance with those standards

"7174 BH Facilities": Includes 3 provider maps, access summaries by city, and access details by city. Inpatient, outpatient, and group

"3556_BH_ORA": Provider and service changes for the PCC plan, ACO, and Managed Behavioral Health Plan

"Provider Changes": Additions, deletions, and changes to the Provider Network within the previous quarters with a focus on practitioners and facilities

"Use of Out of Network Providers Report": OON providers who provided services to Covered Individuals for BH Services and are located out-of-state and those who provided services to Covered Individuals due to linguistic/cultural needs, geographic issues, and specialty needs

35. QUARTERLY FRAUD AND ABUSE REPORT – CM-19

36. QUARTERLY SUMMARY OF PROVIDER OVERPAYMENT – CM-35

37. QUARTERLY PROGRAM INTEGRITY COMPLIANCE PLAN, AND ANTI-FRAUD, WASTE AND ABUSE PLAN – CM-51

38. EC - MASSACHUSETTS CHILD PSYCHIATRY ACCESS PROJECT REPORT – BH-N/A

Report of early childhood BH Encounters by MCPAP Providers statewide stratified by months and year to date **(Section 2.6.D.2.f-j).**

39. QUARTERLY MCPAP PROGRAM UTILIZATION, STRATIFIED BY MONTH

Other program utilization data elements that may be identified by EOHHS and DPH.

"MCPAP Activity 3Yr Trending": Includes aggregate counts, activity by team (BH advocacy, face-to-face, phone, practice education, and resource-referral), and activity for ASDID for MCPAP team.

"MCPAP Utilization Report with ASD": Includes utilization summaries by region, by region and practice, and by practice and provider type for ASD.

40. MCPAP AVERAGE ENCOUNTER

Average number of encounters per unduplicated Covered Individuals by month, by ASD-ID for MCPAP Behavioral Team and Statewide Physician Consult Team.

41. MCPAP QUARTERLY ENCOUNTER

For each ASD-ID for MCPAP Behavioral Team and Statewide Physician Consult Team: number of encounters by type of encounter by month, diagnosis, reason for contact, and insurance status of the child. For ASD-ID for MCPAP Behavioral Team and Statewide Physician Consult Team, must include location of individual (e.g., home, school, emergency department, community-based behavioral health provider), the email address of the individual/ family, name of the AMCI/YMCI Team or ED seeking consult, and patient demographic data including race, ethnicity, and primary language. Quarterly and annual reports should show quarterly trends in number of encounters by type of encounter for three years.

42. MCPAP QUARTERLY UNDUPLICATED COUNT

For each ASD-ID for MCPAP Team (i.e., Boston North, Boston South, and Central/West), Site/Institution, and statewide ASD-ID for MCPAP Behavioral Team and Statewide Physician Consult Team: unduplicated monthly count of Covered Individuals served, by type of encounter and insurance status of the Covered Individual. Quarterly and annual reports should show quarterly trends in number of Covered Individuals served for three years.

43. MCPAP QUARTERLY RESPONSE TIME

For each ASD-ID Behavioral Team and ASD-ID Statewide Physician Consult Team, percentage of providers that receive advice within 30 minutes of their contact (for those providers that do not request call back later than 30 minutes) stratified by month.

44. MCPAP AND ASD-ID APPOINTMENT AVAILABILITY

For each ASD-ID team, the wait time for the first and next available appointments for face-to-face assessment with a MCPAP psychiatrist or with a MCPAP Behavioral Health clinician, stratified by month. If an ASD-ID team fails to meet one or both of the wait time standards described in **Section 2.6.D.2.e.** for three consecutive months, the Contractor shall submit a report detailing the reasons why they are unable to meet the standards. The report must describe the number of face to face visits completed by each institution, reason for assessments, and the age, gender, diagnoses, and insurance coverage of children receiving the assessments.

45. EC-MCPAP AND ASD-ID OUTREACH AND TRAINING

The number of outreach and training activities for MCPAP providers including:

1. Number and type of outreach and training activities conducted by ASD-ID for AMCI/YMCI teams and EDs as in **Section 2.6.D.2.f.6**. Number, if known, of individuals reached. Number of public awareness activities conducted by ASD-ID for families of individuals with ASD/IDD, pediatric providers, staff at Autism Support Centers, and parent resource groups, or other stakeholders on topics described in **Section 2.6.D.2.f.7.** Number, if known, of individuals reached.
2. Number and type of outreach and training activities conducted for EC-MCPAP

46. PHARMACY QUARTERLY ACTIVITIES REPORT

The pharmacy director's quarterly activities report to EOHHS on pharmacy-related activities as described in **Section 2.6.D.1.a.6.**

47. CSA REPORTED AND AGGREGATED DATA (QUARTERLY)

"**IHT Key Indicator**": Includes the percentage of enrollees who use TT&S, percentage of enrollees who receive services from a MA clinician, percentage of enrollees using other LOC, and average units billed per month

"**IHBS Key Indicator**": Includes the total youths enrolled by age group, enrollment by Hub type, number of enrollees receiving services by either a MA or BA-level clinician. Point-in-time data.

"**TM Key Indicator**": Includes the total youth enrolled by age group and enrollment by Hub type. There are three different versions of the report based on provider enrollment size.

"**MCI Key Indicator**"**- Statewide**: Displays data on the number of distinct MCI encounters, the number of encounters occurring in the community, average response times, and the percent of MCI encounters resulting in an inpatient admission.

"**MCI Key Indicator**"**- Provider Level**: Displays data by provider-level on the number of distinct MCI encounters, the number of encounters occurring in the community, average response times, and the percent of MCI encounters resulting in an inpatient admission.

48. PAYMENT SUSPENSION

Notification of payment suspensions for a provider.

Semi-Annual Reports

49. BOH APPEALS REPORT – BH-N/A

A report that includes but is not limited to, for each category of Adverse Action, the number, nature, resolution and time frame for resolution of BOH Appeals, stratified by level of Appeal, Region, and Level of Care.

50. GRIEVANCE AND INTERNAL APPEALS REPORT – BH-22

A report on the number of Grievances and Internal Appeals, including the type of Grievance or Internal Appeal, type of resolution, and the timeframe for resolution. Includes analysis and next steps.

51. COORDINATION OF BENEFITS/THIRD-PARTY LIABILITY REPORT – BH-N/A

a. Third-party health insurance cost avoidance Claims amount, by carrier

b. Third-party health insurance total recovery savings, by carrier.

"Coordination of Benefits": Contractor's actual savings via Third Party Insurance Benefit Coordination and the actual cost of avoidance via the denial of claims

"TPLSAV": Savings amounts per month

"353_ORA": Historical list of savings

"4669_ORA": Quarterly report of total claim lines and total claimed

"5630_ORA": Monthly payment timeliness report including total claims, average days for payment, SD days for payment, and #/% claims paid within 30 days

52. CSA REPORTED AND AGGREGATED DATA

"Wraparound Fidelity Index": Set of four interviews that measure the nature of the wraparound process that an individual family receives to measure fidelity to principles.

"Team Observation Measure": Observation of care planning team meetings by supervisors to assess adherence to standards of high-quality wraparound.

53. SUMMARY OF PROVIDER OVERPAYMENTS

Detailed summary of provider overpayments (cover letter with instructions and template to be provided by EOHHS).

Annual Reports

54. NETWORK MANAGEMENT STRATEGIES REPORT – BH-N/A

A summary description of the Contractor's network management strategies and activities related to access, appropriateness of care, continuity of care, cost efficiency, and treatment outcomes; including an analysis of the effectiveness of the Contractor's strategies and activities; and the Contractor's plans for implementing new strategies or activities.

55. BEHAVIORAL HEALTH ADVERSE INCIDENT SUMMARY REPORT – BH-02

Summary report of Reportable Adverse Incidents. Incidents are categorized by sentinel, major, moderate, and minimal. Report includes graphs and an analysis of the incidents along with action items/next steps.

56. BEHAVIORAL HEALTH AMBULATORY CONTINUING CARE RATE – BH-04

Report of Outpatient Services or non-24-hour Diversionary Services a Covered Individual receives after being discharged from a 24-hour Level of Care service.

57. BEHAVIORAL HEALTH READMISSION RATES REPORT – BH-03

Report of the number and rate of readmissions to 24-hour Level of Care within 7, 30, 60 and 90 days of discharge from a 24-hour Level of Care setting, stratified by type of service, DMH involvement, PCC Plan enrollment, and age.

58. BEHAVIORAL HEALTH URGENT CARE PROGRAM – ANNUAL REPORT

Annual analysis and summary of the Behavioral Health Urgent Care Member Experience Survey.

59. PAY FOR PERFORMANCE INCENTIVE REPORTING – BH-N/A

Report on selected Pay-for-Performance measures, as defined in **Appendix G**.

60. SATISFACTION SURVEY SUMMARY – BH-32

Periodic reports as described in **Section 2.13.F.5.d-f** due within 60 calendar days following the end of the survey period, the results and analysis of the findings report of satisfaction survey conducted with Network Providers, PCCs, and Covered Individuals.

61. MEDICAL RECORDS REVIEW REPORT – BH-11

Report that includes requirements found in **Section 2.14.K** as will be developed by EOHHS and Contractor.

62. PCC PLAN MANAGEMENT SUPPORT SERVICES REPORT – BH-33

Summary report of PMSS activities and integration efforts for the previous Contract Year that includes efforts to enhance integration and PCC health delivery, goals, and results as required by but not limited to **Section 2.19A.**

63. PCC COMPLIANCE WITH PCC PROVIDER AGREEMENT – BH-34

Report of PCCs' compliance with the PCC Provider Agreement as required by but not limited to **Section 2.19.B.**

64. PROVIDER PREVENTABLE CONDITIONS – BH-N/A

Report on Provider Preventable Conditions as required in **Section 2.15.E.**

65. QUALITY MANAGEMENT PLAN FOR BH MANAGEMENT

The Contractor must submit a single plan, on an annual basis, that defines the quality management program, details the Contractor's quality activities, and provides for self-assessment of the Contractor's responsibilities under the Contract, as required by **Section 2.13.F**.

66. QUALITY MANAGEMENT PLAN FOR PCC PLAN MANAGEMENT SUPPORT SERVICES

The Contractor must submit a single plan, on an annual basis, that reflects the Contractor's organizational QM philosophy and structure and includes PCC Plan Management Support Services-related activities, as required in **Section 2.13.G.1**.

67. NETWORK PROVIDER SATISFACTION SURVEY

Assessment and analysis of Network Provider satisfaction with the Contractor's administration and management of the BHP and Care Management Program stratified by Provider type and specialty, at least biennially as required in **Section 2.13.F.5**.

68. PCC PROVIDER SATISFACTION SURVEY

Assessment and analysis of PCC satisfaction with the Contractor's administration and management of the BHP, PCC Plan Management Support Services, and the Care Management Program stratified by Provider type and specialty, at least biennially as required in **Section 2.13.F.5**.

69. COVERED INDIVIDUAL SATISFACTION SURVEY

Assessment and analysis of Covered Individual's satisfaction with the Contractor, at least biennially as required in **Section 2.13.F.5**.

70. MOBILE CRISIS INTERVENTION/RUNAWAY ASSISTANCE PROGRAM (MCI/RAP) OUTCOME AND OUTPUT MEASURES REPORT- BH-N/A

An annual summary report on outcomes and outputs related to the MCI/RAP which includes but is not limited to the requirements found in **Section 2.7.I.5.**

71. PCC PLAN MANAGEMENT SUPPORT SERVICES TRAINING – BH-35

Summary of activities related to the approved plan for training and enhancing staff performance on all functions associated with the PCC Plan Management Support Services; and the results of training on staff performance.

72. MCPAP TEAMS

Composition of MCPAP Teams for ASD-ID for MCPAP including staffing and their FTEs (Full Time Equivalents).

"FTE YYYY"

73. MCPAP ANNUAL ENCOUNTERS

For ASD-ID for MCPAP Behavioral Team and Statewide Team: number of encounters by type of encounter, diagnosis, reason for contact, and insurance status of the child. For ASD-ID for MCPAP Behavioral Team and Statewide Physician Consult Team, must include location of individual (e.g., home, school, emergency department, community-based behavioral health provider), the email address of the individual/ family, name of the AMCI/YMCI Team or ED seeking consult, and patient demographic data including race, ethnicity, and primary language. Quarterly and annual reports should show quarterly trends in number of encounters by type of encounter for three years.

"MCPAP Encounter Report"

74. MCPAP ANNUAL UNDUPLICATED COUNT

For ASD-ID for MCPAP Behavioral Team and Statewide Team: unduplicated count of Covered Individuals served, by type of encounter and insurance status of the Covered Individual. Quarterly and annual reports should show quarterly trends in number of Covered Individuals served for three years.

"MCPAP FYXXQX Insurance Report"

"MCPAP Unduplicated Mbrs 3Yr Trending": Chart showing unduplicated members served overall and by team

75. ASD-ID FOR MCPAP CHILDREN CONSULTATION

For each ASD-ID for MCPAP Behavioral Team and Statewide Physician Consult Team, the number of children and young adults whom AMCI/YMCI teams or EDs request consultation for at least two or more times during the contract year (i.e., episodes of care). This episode report must describe the demographics of the patient (e.g., age, gender, diagnoses, insurance, race, ethnicity, primary language, etc.), type and average number of encounters provided to AMCI/YMCI or ED and family (if relevant), reasons for consultation, type of intervention advised/ provided, and outcome of consultation.

76. MCPAP ANNUAL PROVIDER EXPERIENCE SURVEY

Results of annual Provider Experience Surveys for ASD-ID for MCPAP.

77. COMMUNITY SUPPORT PROGRAM – CHRONICALLY HOMELESS INDIVIDUALS (CSP-CHI)

Provide annually the Community Support Program – Chronically Homeless Individuals (CSP-CHI) report as specified by EOHHS.

78. COMMUNITY SUPPORT PROGRAM – CHRONICALLY HOMELESS INDIVIDUALS (CSP-TPP)

Provide annually the Community Support Program – Tenancy Preservation Program (CSP-TPP) report as specified by EOHHS.

79. MATERIAL SUBCONTRACTORS

Submit annually to EOHHS a list of all Material Subcontractors. Such annual report shall include notification if any of its Material Subcontractors are certified Minority Business Enterprises. The Contractor shall submit an updated list at least 30 days in advance of any changes to the list or as otherwise directed by EOHHS

80. CBHC ADMINISTRATIVE OVERSIGHT

The Contractor shall develop an annual report that tracks utilization of Massachusetts Behavioral Health Access System and other data as agreed to by other parties.

81. CSA REPORTED AND AGGREGATED DATA

"Wraparound Fidelity Index": Set of four interviews that measure the nature of the wraparound process that an individual family receives to measure fidelity to principles**.**

"Team Observation Measure": Observation of care planning team meetings by supervisors to assess adherence to standards of high-quality wraparound**.**

82. QUALITY MANAGEMENT FOR PCC PLAN MANAGEMENT SUPPORT SERVICES

The Contractor shall create and implement a single, comprehensive Quality Management plan, and this plan should include an annual retrospective QM activities report based on the previous year's QM plan, which the Contractor shall prepare and submit to EOHHS for approval within the first month of each Calendar Year.

83. SUMMARY REPORT OF FOR-CAUSE PROVIDER SUSPENSIONS AND TERMINATIONS

Annual summary report of for-cause provider suspensions and/or terminations of the Provider's contract with the Contractor

84. PROGRAM INTEGRITY COMPLIANCE PLAN AND ANTI-FRAUD, WASTE, AND ABUSE PLAN

Compliance plan and anti-fraud, waste, and abuse plan

ATTACHMENT A
APPENDIX E-4

FINANCIAL REPORTS

1. FINANCIAL STABILITY AND INSOLVENCY PROTECTION REPORT

a. **Annual** report, due 60 calendar days after the start of each Contract Year. The report includes:

   1. Documentation of the Contractor's current liability protection policies, including professional liability, worker's compensation, comprehensive liability and property damage; and

   2. Documentation from the Contractor on how it intends to meet the financial stability requirements as described in Contract.

b. **Annual** Insolvency Reserve report, due within one month after the start of each Contract Year. The report includes documentation of the Contractor's financial insolvency insurance, reserves, or a combination of both, in an amount reasonably determined by EOHHS to be adequate to both:

   1. Provide to Covered Individuals for a period of 60 days following the date of insolvency all Covered Services and all other services required under this Contract; and

   2. Continue to provide all such services to Covered Individuals confined in an acute hospital on the date of insolvency, until the date of the Covered Individual's discharge.

2. CAPITATION REVENUE/EXPENSE REPORTS FOR ALL COVERED SERVICES

Monthly report of expense data for all Covered Services, submitted in accordance with the format specified by EOHHS. The report shall include but not be limited to:

a. a summary of the Contractor's monthly and fiscal year-to-date service expenditures for each Rating Category (RC) as well as for the Contractor's total membership;

b. the per-Covered Individual per-month (PMPM) cost, as determined by EOHHS, and total dollars spent for every classification of service, in accordance with the format specified by EOHHS;

c. an indication whether expenses apply to capitated or FFS arrangements with Network Providers, if applicable;

d. incurred but not reported (IBNR) claims adjustments to the service expenditure data, applying the most recent available IBNR adjustments to the following categories:

   1. Inpatient;

   2. Outpatient, including Outpatient day;

3. Diversionary, including 24-hour Diversionary, and all other services. Expenses for these categories shall be reported with and without the application of IBNR adjustments;
4. Substance Use Disorder (SUD)services; and
5. Applied Behavior Analysis (ABA) services

e. detailed description of and possible explanations for large variations in IBNR adjustments between reporting months;

f. a statement of the gains or losses that the Contractor expects the Contractor and EOHHS to experience for the fiscal year, based on the Contractor's monthly expenditure experience, and IBNR estimates and risk-sharing arrangements.

3. QUARTERLY FINANCIAL REPORT IN A FORMAT SPECIFIED BY EOHHS

4. ADMINISTRATIVE REPORT

Annual report of the administrative expenses, by line item, incurred by the Contractor for the Contract Year, including but not limited to:

a. detailed information, by line item, on the Contractor's administrative Direct Costs, Indirect Costs, and Earnings;

b. supporting documents to justify the Contractor's calculations; and

c. a detailed cost summary for components of the Administrative Budget including Care Management.

d. Monthly administrative costs report as specified by EOHHS.

5. IBNR METHODOLOGY REPORT

Annual report, due within 60 calendar days after the start of each Contract Year, providing a detailed description of the Contractor's IBNR methodology for each RC, if available, or if not available, for all Rating Categories for Covered Individuals in the aggregate and for each of the following categories:

a. Inpatient Services;

b. Outpatient Services, including Outpatient Day;

c. Diversionary and all other services;

d. Substance use Disorder Services; and

e. Applied Behavior Analysis services

6. RECONCILIATION REPORT FOR RISK SHARING

Annual report, due within 210 calendar days after the end of each Contract Year, detailing actual expenditures for each applicable RC for the Contract Year, in accordance with the Contract and the format specified by EOHHS for the Capitation Revenue/Expense Report.

7. RECONCILIATION PROCESS FOR CRISIS SERVICES PROVIDED TO UNINSURED INDIVIDUALS AND PERSONS WITH MEDICARE ONLY

Annual report, due within 210 calendar days after the end of the Contract Year, the Contractor shall provide EOHHS with a report of the Contractor's actual expenditures for AMCI/YMCI and CCS services provided to Uninsured Individuals and persons with Medicare only. Any ESP, MCI, and CCS services covered prior to the transition to AMCI/YMCI, shall be included in the report.

8. CONTINUING SERVICES DURING APPEAL RECONCILIATION REPORT

Annual report, due within 210 days after the end of each Contract Year, detailing actual expenditures for each applicable RC for the Contract Year in accordance with the Contract and in the format specified by EOHHS.

9. DSRA/CASH MANAGEMENT REPORTS

a. **Quarterly** Cash Management Report that includes but is not limited to:
    1. statement of deposits from EOHHS and payments by the Contractor, by month, for the quarter reported, stratified by:
        a. type of deposit; and
        b. type of payment.
    2. cash requirements for Covered Services paid from the DSRA that display estimated payroll totals against projected cash balances.

b. **Semiannual** submission of copies of reconciled monthly bank statements that show interest credited to the DSRA for the period reported.

c. **Annual** Cash Reconciliation Report, due within 60 calendar days after the end of each state fiscal year, that indicates the total deposits into and total payments and transfers from the DSRA. The report and format shall be based on the methodology for separately tracking the various types of deposits into the DSRA from EOHHS, as described in **Section 2.18.B**.

10. INDEPENDENT AUDIT REPORT

Copy of the **Annual** report for the Contractor and its parent corporation, if applicable, due within 30 calendar days after its publication.

a. Provides EOHHS with the Contractor's most recent audited financial statement in accordance with Generally Accepted Accounting Principles (GAAP)

11. ATTESTATION REPORT

The Contractor shall provide to EOHHS an attestation report from its independent auditor on the effectiveness of the internal controls over operations of the Contractor related to this Contract in accordance with statements and standards for attestation engagements as

promulgated by the American Institute of Certified Public Accountants. The Contractor shall provide such report annually and within 30 days of when the independent auditor issues such report; provided, however, if the Contractor is Service Organization Control (SOC) compliant, the Contractor shall annually submit a copy of the SOC report in lieu of the attestation report described above within 30 days of the Contractor's independent auditors issuing its SOC report.

12. MEDICAL LOSS RATIO REPORT (MLR)

Provide **annually** the Medical Loss Ratio report as specified in Section 2.15.C of the Contract.

13. RATIO ANALYSIS REPORT

The Contractor shall submit **annually** by June 30th, a Financial Ratio Analysis, that describes the Contractor's performance for financial ratios required by EOHHS in accordance with the definitions in **Exhibit 1** and the format in **Exhibit 2** below. The report shall be generated from the Contractor's audited financial statements.

14. ENCOUNTER VALIDATION REPORT

Provide **quarterly** financial encounter Validation Report as specified in Section 5.3.L and in a format specified by EOHHS.

15. QUARTERLY REPORT FOR AMCI/YMCI SERVICES PROVIDED TO INDIVIDUALS WITHOUT MOBILE CRISIS COVERAGE

Quarterly the Contractor shall provide EOHHS with a report of the Contractor's actual expenditures for AMCI/YMCI services provided to Individuals without Mobile Crisis Coverage.

16. QUARTERLY REPORT FOR EMERGENCY DEPARTMENT CRISIS EVALUATION SERVICES PROVIDED TO UNINSURED PERSONS AND PERSONS WITH MEDICARE ONLY

Quarterly the Contractor shall provide EOHHS with a report of the Contractor's actual expenditures for crisis intervention services provided to Uninsured Persons and Persons with Medicare Only in an emergency department.

EXHIBIT 1: FINANCIAL RATIO DEFINITIONS

FINANCIAL INDICATOR	FORMULA
RATE OF RETURN	
ASSETS	Net Income/Total Assets (%)
REVENUES	Net Income/Total Revenue (%)

FINANCIAL INDICATOR	FORMULA
EQUITY	Net Income/Equity (%)
LIQUIDITY	
CURRENT RATIO	Current Assets / Current Liabilities
ACID TEST	(Current Assets - Accounts Receivable) / Current Liabilities
WORKING CAPITAL	Current Assets - Current Liabilities ($)
CASH TO CLAIMS AND PAYABLES	(Cash and Cash Equivalents) / Claims and Payables
DAYS OF TOTAL IBNR	Total IBNR Claims (Estimated) / (Total Medical Claims / 365) (# Days)
CLAIMS AS A % OF REVENUE	Claims Payable / Total Revenue (%)
CAPITAL STRUCTURE	
DEBT RATIO	Total Debt / Total Assets (%)
DEBT SERVICE COVERAGE	(Net Income + Depreciation + Interest) / (Interest Expense + Current Loans + Notes Payable)
RECEIVABLES TO CURRENT ASSETS	Premium Receivables / Current Assets (%)
CASH TO CURRENT ASSETS	Cash / Current Assets (%)
EQUITY PER ENROLLEE	Total Equity / Total Enrollees ($)
PROFITABILITY	
OPERATING MARGIN	Operating income/Premium revenue (exclude investment income and non-Healthcare related revenue)
NET PROFIT MARGIN	Net Income / Total Revenue (include income from all sources including investments)
GROSS PROFIT MARGIN	(Premiums Revenue - Total Medical Costs) / Premiums Revenue (%)
NET WORTH	Total Assets - Total Liabilities ($)
BEHAVIORAL HEALTH EXPENSE RATIO / BEHAVIORAL HEALTH LOSS RATIO	Total Behavioral Health Costs / Total Revenue (%)
BEHAVIORAL HEALTH EXPENSE PMPM	Total Behavioral Health Costs / Member Months ($)
BEHAVIORAL HEALTH EXPENSE PMPD	Total Behavioral Health Costs / Member Days ($)
ADMINISTRATIVE EXPENSE RATIO	Total Administrative Costs / Total Revenue (%)

EXHIBIT 2
FINANCIAL RATIO ANALYSIS

Plan:
Fiscal Year **Contract Year Ending December 31, 2023**

	Fiscal Year Ending		
Financial Indicator	**20XX**	**20XX**	**20XX**
1 RATE OF RETURN			
ASSETS			
REVENUE			
EQUITY			
2 EQUITY			
CURRENT RATIO			
ACID TEST			
CASH TO CLAIMS AND OTHER PAYABLES			
DAYS OF TOTAL IBNR			
CLAIMS PAYABLE AS A % OF REVENUE			
3 CAPITAL STRUCTURE			
DEBT RATIO			
DEBT SERVICE COVERAGE			
RECEIVABLES TO CURRENT ASSETS			
CASH TO CURRENT ASSETS			
EQUITY PER ENROLLEE			
4 PROFITABILITY			
NET PROFIT MARGIN			
GROSS PROFIT MARGIN			
NET WORTH ($000)			
BEHAVIORAL HEALTH EXPENSE RATIO			
BEHAVIORAL EXPENSE PMPM			
ADMINISTRATIVE EXPENSE RATIO (1)			

APPENDIX G
BEHAVIORAL HEALTH PERFORMANCE INCENTIVES

Effective Calendar Year 2023

Introduction

The performance-based incentives for Calendar Year 2023 (henceforth referred to as CY23) are summarized below. The summary includes baseline criteria, population descriptions, strategic goals, specific performance targets, and associated available earnings.

The earnings associated with each performance-based incentive correspond with the degree of the Contractor's success in meeting the established incremental goals. The measure of the Contractor's success for each performance-based incentive is described in detail below. For each performance-based incentive, levels of success are associated with levels of payment, referred throughout this document as "Performance and Payment Levels." The Contractor shall only be paid the single amount listed within each level which corresponds to the actual results achieved based on the measurement methodologies, and not to exceed the maximum annual incentive for each performance incentive.

Methodology

The Contractor shall design a project methodology, for review and approval by EOHHS, for each of the performance-based incentives in **Appendix G**. Each methodology shall further define and clarify the purposes, goals and deliverables associated with each incentive, and shall provide the technical specification for each measurement. Methodology to be defined include, at minimum: baseline period and analytics, denominator, numerator, continuous eligibility requirements, measurement period, population exclusions, timeline and associated deliverables, and final reporting schedules. EOHHS will use **Appendix G**, the Contractor's performance to identified benchmarks and milestones, and the project methodology when reviewing the results of each project to determine the amount of incentive payments, if any, the Contractor has earned. For all measures, unless otherwise specified, the measurement period for the calculation of results shall conform with the Contract Year period.

Measures, Developing the Benchmarks and Goals

The Contractor shall produce all required baseline measurements, and shall use the same methodology when assessing performance for the measurement period. For HEDIS measures, HEDIS Technical Specifications will be used for the performance-based incentives corresponding to each measurement year. For CY23, the Contractor shall refer to the technical measure specifications for HEDIS 2023. For all non-HEDIS measures, the Contractor shall follow the 2023 technical specifications for each measure steward identified by EOHHS. For CY23, EOHHS shall set the benchmark (threshold, goal, and improvement targets) for each measure in performance incentive 1 based on national, regional, and state benchmarks, historical

performance of Contractor, baseline Contractor performance, and spread, distribution, or variation in historical performance. Benchmarks (threshold, goal and improvement targets) will be established for a five-year period. EOHHS does not anticipate changing benchmark values from year to year (or based on Contractor performance or ranking from year-to-year). However, benchmarks will be monitored and reviewed annually, with flexibility to address extenuating circumstances, including, but not limited to: benchmarks that are excessively high or low relative to overall Contractor performance, significant changes to practice standards, significant changes to measure specifications impacting results, and other unforeseen events impacting performance, e.g., the COVID-19 public health emergency.

Performance Assessment Methodology

In CY23, incentive payments for performance-based incentive 1 will be calculated using the Performance Assessment Methodology (PAM). According to the PAM, the Contractor will have the opportunity to achieve its full eligible quality incentive amount for excellent quality performance. This may be achieved by establishing a clear threshold and goal benchmark for measures, in effect over the duration of the performance year periods set (e.g., five years); providing opportunity to earn incentive for year-over-year self-improvement (e.g., using gap to goal targets); and providing opportunity to earn incentive payments for each measure based on attainment (e.g., meeting threshold, in-between threshold and goal, and goal performance), and for meeting targets for improvement.

As part of the PAM, the Contractor earns points for performance on each measure. The Contractor earns 10 points for meeting the goal for the assigned time period and can earn 1-9 points proportional for performance between the threshold performance and the goal performance. The Contractor earns zero points for performance below the assigned threshold performance for each measure. The Contractor can earn 5 bonus points for meeting the improvement target over the base year, whether or not the Contractor has met threshold or goal performance targets. Bonus points are designed to reward improvements in performance regardless of their starting rate of performance. No partial credit is awarded for bonus points for improvement that does not meet improvement target.

The Contractor can earn a maximum of 15 points per eligible measure through goal attainment and improvement (bonus points). The maximum allowable total points is 10 multiplied by the number of measures. Strong performance on one measure can offset weaker performance of other measures. The proportional score for the Contractor is equal to the sum of the Contractor's earned points divided by the maximum allowable points. Proportional scores are between 0-1. The highest proportional performance score for the Contractor is 1. The payment amount is equal to the proportional score multiplied by the eligible payment amount.

The Contractor shall develop the following strategic priorities for network performance improvement in CY23: (1) Promotion of High Quality Care; (2) Promotion of Equitable Care;

(3) Value-Based Payment Development and (4) Development of Community Behavioral Health Center (CBHC) Quality and Outcomes Measures.

I. Incentive 1, Promotion of High Quality Care

The Contractor shall assess their performance for calendar year 2023 on the measures outlined below. Goals for each measure will be set for a five-year period and a modified gap-to-goal analysis will determine the improvement targets for each of the next five years. For all HEDIS measures, EOHHS has used 2021 data for the benchmarks outlined below. For the CMS IPFQR Measure, EOHHS has used the most recently available data (2019) to set the benchmarks, though prior to final performance calculation, EOHHS will compare 2019 CMS IPFQR data with 2020 CMS IPFQR data, to determine if the impact of the COVID pandemic necessitates flexibility, as described above, in revising the benchmarks. For the HEDIS and IPFQR measure, the Contractor shall calculate its performance for CY2022, which shall serve as the base year performance for the purpose of improvement goal calculation. For RY2023, the Contractor shall report on its performance for calendar year 2023 for the OUD measure (M5), and performance on this measure will not be subject to incentive payment for 2023. The Contractor shall receive two thirds of the maximum eligible incentive ($666,666) at the end of CY2023, with the last one third ($333,334) reserved for reconciliation of the final CY2023 performance calculation, to be conducted by the end of Q2 2024 when all claims from calendar year 2023 can be reviewed. Data should be stratified by PCC members, Primary Care ACO, and other.

Measure	Goal	Threshold Benchmark	Goal Benchmark	Improvement Goal per Year	Maximum Eligible Incentive
M1-a	FUM-7 day: Youth (<18 years old)[1]	69%	88%	1.5%	$1,000,000
M1-b	FUM-7 day: Adult (18+ years old)[1]	61%	75%	1.5%	
M2-a	FUH- 7 day: Youth (<18 years old)[1]	60%	71%	2%	
M2-b	FUH- 7 day: Adult (18+ years old)[1]	41%	55%	2%	
M3	30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility [2]	23%	19%	0.5%	
M4	Pharmacotherapy for Opioid Use Disorder (POD)[1]	28%	33%	0.5%	
M5	Use of Pharmacotherapy for Opioid Use Disorder (OUD)[3]	Reporting Only for CY2023[3]			

[1]= HEDIS Measure (or subset); Contractor to use HEDIS Technical Specifications

[2]= CMS IPFQR Measure; Contractor to use CMS IPFQR Technical Specifications

[3]= CMS Measure; Contractor to use CMS Technical Specifications. For 2023, this measure will be Reporting-Only to help establish benchmarks for future years; for 2023, performance on this measure will not be subject to incentive payment.

The maximum incentive payment for CY23 for Incentive 1 is $1,000,000.

II. Incentive 2, Promotion of Equitable Care

In line with EOHHS's commitment to improve quality of care and advance health equity, with a focus on initiatives addressing health-related social needs and health disparities demonstrated by variation in quality performance, Incentive 2 will focus on supporting the Contractor in collecting and reporting Race, Ethnicity, Language, and Disability (RELD) and Sexual Orientation and Gender Identify (SOGI) data and screening for, and reporting, Health-related Social Needs (HRSN). Measures for 2023 will include an initial assessment of currently collected beneficiary-reported RELD SOGI data and currently screened for HRSN, reporting of currently collected RELD SOGI and HRSN data, stratification of clinical quality measure performance by available RELD SOGI data, and the development of the infrastructure, practices, and procedures for robust collection of beneficiary-reported RELD SOGI data and HRSN screening in 2024. The Contractor will be incentivized through annual milestones to achieve at least 80% of data completeness for beneficiary-reported RELD SOGI data by the end of CY2027, and meaningful improvement on HRSN screening by the end of CY2027. The specific incentive measures for CY23 will be set forth in an amendment to this Appendix G by the end of Q1 2023.

The maximum incentive payment for CY23 for Incentive 2 is $1,000,000.

III. Incentive 3, Value-Based Payment Development

In partnership with EOHHS and building upon the Contractor's existing value-based payment (VBP) strategy, the Contractor shall develop a VBP strategy which includes the expansion of existing, successful VBP arrangements to additional membership and with additional provider partnerships for high-risk populations, including those identified below. The Contractor's VBP strategy shall include meaningful targets to continually increase the amount of the Contractor's membership in an HCP-LAN Level 3 or 4 VBP arrangement by 2027.

The Contractor's VBP strategy shall include the below populations (P1-P4) with a focus on quality and outcomes measures. The Contractor will earn full incentive payments for each measure outlined below (M1-M4) if the specified requirements are met. If one of the following requirements is not met, or if any of the following requirements are not met by the outlined deadline, the Contractor may be ineligible to earn full incentive payment for that specific measure, as determined by EOHHS.

	Goal	Incentive
M1	By May 5, 2023, the Contractor shall submit a review that includes: 1. A baseline analysis of each of the below populations to understand current population cost, care utilization patterns, and outcomes. 2. A market scan to identify the current landscape and evidence for value-based arrangements for each of the below populations.	$50,000
M2	By the end of 2023 Q2, the Contractor shall submit a proposal that identifies: 1. Detailed recommendations for opportunities to expand membership in current VBP arrangements for each of the below populations, including high-priority outcome measures, reimbursement structure, provider partnerships and multi-year implementation strategy. 2. Detailed recommendations for novel VBP arrangements for each of the below populations, including high-priority outcome measures, reimbursement structure, provider partnerships and multi-year implementation strategy 3. Collaborate with EOHHS to determine which of the below populations to prioritize for M3 and M4	$50,000
M3	By the end of 2023 Q4, the Contractor will have concrete plans to implement a contract for a new VBP arrangement between the Contractor and a provider organization for one of the below populations for 2024.	$250,000
M4	By the end of 2023 Q4, the Contractor will have concrete plans to advance at least one existing HCP-LAN level 1 or 2 VBP arrangement to an HCP-LAN level 3 or 4 for 2024	$150,000

	Population	High Priority Outcomes
P1	Youth (<21 years old) with ASD	Pivotal skill development/mastery, caregiver engagement and satisfaction, improved access to care, co-morbidity management, and school retention
P2	Teens and young adults (15 to 35 years old) with a new-onset psychotic disorder (within first 3 years of onset)	Quality of life, family functioning, symptom severity (including duration of untreated psychosis), participation and progress in work or school, and community tenure/reduction in acute bed days
P3	Adults with SMI (3 years beyond first onset)	Quality of life, symptoms severity, vocational functioning, social connectedness, medication side-effect management, and community tenure/reduction in acute bed days
P4	Care for Opioid Use Disorder-Diversionary Levels of Care and Outpatient MAT induction and maintenance	For Diversionary Levels of Care include increased community tenure/reduction of acute care utilization. For Outpatient MAT induction and maintenance include retention in MAT treatment, and increased community tenure/reduction of acute care utilization.

The maximum incentive payment for CY23 for Incentive 3 is $500,000.

IV. Incentive 4, CBHC Quality and Outcomes Measures

In partnership with EOHHS during Q1 of 2023, the Contractor shall develop and oversee CBHC quality and outcomes measure reporting (inclusive of outpatient, A/YMCI, A/YCCS services delivered by CBHCs). This development shall include methodology and collection processes, a pay-for-reporting (P4R) approach to support CBHC provider reporting of identified measures, and a proposed timeline with proposed goals for execution. The Contractor shall also provide technical assistance to the CBHC network in executing P4R for identified measures and build report templates for sharing data with MassHealth, CBHCs, and other key stakeholders.

In Q2 of 2023, after review and approval from EOHHS, the Contractor shall execute the reporting process identified in Q1 of 2023 at the agreed upon cadence, and with the agreed upon goals for execution for the remainder of CY23. The incentive payment amount will be based upon performance towards the agreed upon goals for execution set forth by the Contractor at the end of Q1 2023, and agreed upon by EOHHS.

The maximum incentive payment for Incentive 4 for CY23 is $500,000.

APPENDIX H-1

PAYMENT AND RISK SHARING PROVISIONS

Section 1. MassHealth Capitation Payment and Related Payment Provisions

A. Per-Member Per-Month (PMPM) Capitation Rates for Contract Year 2023 (CY23)

1. PCC and TPL: PMPM ($) Rates January 1, 2023 - December 31, 2023

Rating Category	Medical Services PMPM	ABA PMPM	SUD PMPM	Admin PMPM	Total PMPM
Rating Category I Child	$157.35	$16.47	$0.61	$5.53	$179.96
Rating Category I Adult	$65.80	$-	$6.74	$5.11	$77.65
Rating Category I TPL	$23.65	$6.11	$0.29	$4.76	$34.81
Rating Category II Child	$428.78	$232.81	$0.31	$13.58	$675.48
Rating Category II Adult	$225.34	$-	$12.76	$11.51	$249.61
Rating Category II TPL	$60.15	$59.94	$1.19	$9.62	$130.90
Rating Category IX	$85.85	$-	$11.13	$5.94	$102.92
Rating Category X	$369.56	$-	$77.00	$13.91	$460.47

2. Primary Care ACO: PMPM ($) Rates January 1, 2023 - December 31, 2023

Rating Category	Medical Services PMPM	ABA PMPM	SUD PMPM	Admin PMPM	Total PMPM
Rating Category I Child	$66.42	$7.70	$0.23	$4.00	$78.35
Rating Category I Adult	$58.80	$-	$8.07	$4.08	$70.95
Rating Category II Child	$351.55	$218.48	$1.07	$11.56	$582.66
Rating Category II Adult	$272.84	$-	$24.62	$11.41	$308.87
Rating Category IX	$100.06	$-	$20.06	$4.91	$125.03
Rating Category X	$497.54	$-	$236.39	$13.40	$747.33

B. Risk Sharing Corridors for Contract Period CY23, for the Medical Services rates Component of Rating Categories Child I, Adult I, Child II, Adult II, I-TPL, II-TPL, IX, and X (pursuant to Section 4 of the Contract) for PCC and TPL programs

1. Gain on the Medical Services Capitation Rates excluding ABA and SUD services

The amount of the Gain on the aggregate Medical Services Capitation Rates for the Contract shall be defined as the difference between the Total Medical Services Capitation Payment and the Contractor's Total Expenditures for Covered Services, if such actual expenditures are less than the Total Medical Services Capitation Payment for Contract Year 2023. EOHHS and the Contractor shall share such gain in accordance with the table below.

Gain	MassHealth Share	Contractor Share
Less than or equal to 1.5%	0%	100%
Above 1.5% and less than or equal to 3%	50%	50%
Above 3%	100%	0%

2. Loss on the Medical Services Capitation Rates excluding ABA and SUD services

The amount of the Loss on the aggregate Medical Services Capitation Rates for the Contract shall be defined as the difference between the Total Medical Services Capitation Payment and the Contractor's Total Expenditures for Covered Services, if such actual expenditures are greater than the Total Medical Services Capitation Payment for Contract Year 2023. EOHHS and the Contractor shall share such loss in accordance with the table below.

Loss	MassHealth Share	Contractor Share
Less than or equal to 1.5%	0%	100%
Above 1.5% and less than or equal to 3%	50%	50%
Above 3%	100%	0%

C. Risk Sharing Corridors for CY23 for the Medical Services rates Component of Rating Categories Child I, Adult I, Child II, Adult II, IX, and X (pursuant to Section 4 of the Contract) for the Primary Care ACO program

1. Gain on the Medical Services Capitation Rates excluding ABA and SUD services

The amount of the Gain on the aggregate Medical Services Capitation Rates for the Contract shall be defined as the difference between the Total Medical Services Capitation Payment and the Contractor's Total Expenditures for Covered Services, if such actual expenditures are less than the Total Medical Services Capitation Payment

for the CY23. EOHHS and the Contractor shall share such gain in accordance with the table below.

Gain	MassHealth Share	Contractor Share
Between 0 and $100,000	99%	1%
>$100,000	100%	0%

2. **Loss on Medical Services Capitation Rates excluding ABA and SUD services**

The amount of the Loss on the Capitation Rates for the Contract shall be defined as the difference between the Total Medical Services Capitation Payment and the Contractor's Total Expenditures for Covered Services, if such actual expenditures are greater than the Total Medical Services Capitation Payment for the CY23. EOHHS and the Contractor shall share such loss in accordance with the table below.

Loss	MassHealth Share	Contractor Share
Between 0 and $100,000	99%	1%
>$100,000	100%	0%

D. Risk Sharing Corridors for Contract Year 2023 effective January 1, 2023, through December 31, 2023, for ABA and SUD Services for PCC, TPL and Primary Care ACO programs

The Contractor and EOHHS shall share risk for ABA and SUD Services in accordance with the following provisions:

1. For Contract Year 2023, EOHHS shall conduct separate reconciliations with respect to ABA and SUD Services, as follows:

    a. EOHHS will first determine the amount paid to the Contractor by EOHHS for ABA and SUD Services for Contract Year 2023, by multiplying the following:

        i. The ABA and SUD Add-On rates determined by EOHHS and provided to the Contactor in **Section 1.A** above; by

        ii. The number of applicable member months for the period.

    b. EOHHS will then determine the Contractor's expenditures for ABA and SUD Services for Contract Year 2023, using claims data submitted in the report described in **Section D.2** below and Encounter Data submitted by the Contractor.

    If the amount paid to the Contractor, as determined by the calculation described in Section D.1.a above, is greater than the Contractor's expenditures, as determined by the calculation described in Section D.1.b above, then the Contractor shall be considered to have experienced a gain with

respect to ABA and SUD Services for Contract Year 2023. EOHHS and the Contractor shall share such gain in accordance with the table below for ABA and SUD services:

Gain	MassHealth Share	Contractor Share
Between $0 and $100,000	99%	1%
> $100,000	100%	0%

If the amount paid to the Contractor, as determined by the calculation described in **Section D.1.a** above, is less than the Contractor's expenditures, as determined by the calculation described in **Section D.1.b.** above, then the Contractor shall be considered to have experienced a loss with respect to ABA and SUD Services for Contract Year 2023. EOHHS and the Contractor shall share such loss in accordance with the table below:

Loss	MassHealth Share	Contractor Share
Between $0 and $100,000	99%	1%
> $100,000	100%	0%

2. To assist with the reconciliation process for ABA and SUD Services described above, the Contractor shall, within 180 days after the end of Contract Year 2023, submit claims data with respect to ABA and SUD services in the form and formats specified in **Appendix E**.

Section 2. MassHealth Other Payments

A. Care Management Program

The Contractor shall calculate the number of engaged enrollees in the Practice Based Care Management program (PBCM) by month and report to EOHHS on a quarterly basis. EOHHS shall issue the Engagement PPPM amount, upon review and approval.

Base Per-Participant Per-Month (PPPM) engagement rate for Practice Based Care Management:

Per Participant Per Month.....$150.00

B. Performance Incentives Arrangements

Total Performance Incentive Payments may not exceed 105 percent of approved Capitation Payments attributable to the Covered Individuals or services covered by the Contract.

The CY2023 Payments for performance incentives detailed in Appendix G to the Contract shall be $3,000,000.00.

C. PCC Plan Management Support

For CY23, EOHHS shall pay the Contractor a fixed amount of $850,000 for PCC Plan Management Support for PCC Plan enrollment up to 85,000 members, to be paid out in monthly installments.

EOHHS reserves the right to reduce the fixed annual amount for PCC Plan Management Support if the PCC Plan enrollment goes below 70,000 Enrollees and is projected to stay at or below that level, as determined by EOHHS.

If PCC Plan enrollment exceeds 85,000 Enrollees and is projected to stay above 85,000 members, as determined by EOHHS, EOHHS shall pay the Contractor an additional Per Enrollee Per Month rate of $1 for each additional member in excess of 85,000. The payments shall be based on the monthly PCC member estimates used for prospective monthly capitation payment calculations and shall not be reconciled to actual PCC Plan enrollment.

Section 3. Other Non-MassHealth Payments

A. DCF -Mobile Crisis Intervention/Runaway Assistance Program (MCI/RAP) Payment Provisions

Contingent upon receipt of funding from DCF, EOHHS shall pay the Contractor $52,000.00 in support of the Mobile Crisis Intervention/Runaway Assistance Program. The Contractor shall allocate these funds to each of the Contractor's Community Behavioral Health Centers that contract with the Contractor to operate the MCI/RAP in accordance with **Section 4.2.I**.

B. Autism Spectrum Disorder-Intellectual Disability (ASD-ID) for MCPAP (pursuant to Section 4.2.A.7 of the Contract)

EOHHS shall pay the Contractor $650,000 in Calendar Year 2023 in support of the ASD-ID for MCPAP activities.

1. The Contractor's ASD-ID for MCPAP spending shall not exceed the funding amount set forth in this sub-section.
2. Any unspent funds at the end of the Contract period shall carry-over and be applied towards the ASD-ID for MCPAP activities in subsequent contract periods, if any.
3. EOHHS reserves the right to require reporting on expenditures related to this program.

C. Early Childhood MCPAP (pursuant to Section 4.2.A.7 of the Contract)

Subject to availability of funding from DPH, EOHHS shall pay the Contractor $376,123in Calendar Year 2023 in support of the Early Childhood (EC) MCPAP activities.

1. The Contractor's EC MCPAP program spending in CY2023 shall not exceed the funding amount set forth in this sub-section.
2. Any unspent funds at the end of the Contract period shall carry-over and be applied towards the EC MCPAP activities in subsequent contract periods, if any.
3. EOHHS reserves the right to require reporting on expenditures related to this program.

D. Crisis Service Safety Initiative – "Living Room Model" (pursuant to Section 4.2.A.8 of the Contract)

The Crisis Services Safety Initiative payment shall be $1,403,388 in Contract Year 2023. This amount will be paid out in monthly installments determined by EOHHS.

E. Medication for Opioid Use Disorder (MOUD) Access and Pain Management Support (pursuant to Section 4.2.A.9 of the Contract) (also known as MCSTAP)

The MOUD Access and Pain Management Support payment shall be $325,000 in Contract Year 2023. As further specified by EOHHS, EOHHS and the Contractor shall enter into a separate payment agreement related to this payment.

F. Community Crisis Program for Uninsured Individuals Service Compensation Rate Payment (pursuant to Section 4.2.K of the Contract)

The Community Crisis Program for Uninsured Individuals Service Compensation Rate Payment shall be $6,880,000.00 in Contract Year 2023 and paid out in monthly installments to be determined by EOHHS.

G. Community Crisis Administration Payment

The CY23 funding for the administration of Community Crisis Program for Uninsured Individuals shall be $185,000. The payments will be issued in monthly installments to be determined by EOHHS.

H. DPH Emergency Department (ED) Boarding Grant Initiatives Payment (pursuant to Section 4.2.M of the Contract)

Contingent upon receipt of funding from DPH, EOHHS shall pay the Contractor $2,500,000 in support of ED boarding initiatives. EOHHS shall determine the disbursement frequency of the funds. The ED boarding initiatives spending shall not exceed the funding amount set forth in this sub-section. Any unspent funds at the end of the contract period shall be returned to EOHHS unless otherwise directed. EOHHS reserves the right to require reporting on expenditures related to the ED boarding initiatives in a form and frequency determined by EOHHS.

I. CBHC Activities Payment (pursuant to Section 4.2.A.11 of the Contract)

In Contract Year 2023, EOHHS shall issue payments to the Contractor in the amount of $10,900,000, in support of CBHC activities. The Contractor's spending on CBHC activities described in Section 2.7.M shall not exceed the funding provided in Contract Year 2023. Any unspent funds shall be returned to EOHHS, unless otherwise directed by EOHHS.

J. Behavioral Health Public Awareness Campaign (pursuant to Section 4.2.P of the Contract)

In Contract Year 2023, EOHHS shall issue payments to the Contractor in the amount of $5,000,000, in support of the Behavioral Health Public Awareness Campaign described in Section 2.7.H.4.i of the Contract. The payment shall be paid out in one or more monthly installments to be determined by EOHHS. The Contractor's spending on the Behavioral Health Public Awareness campaign shall not exceed the funding provided in Contract Year 2023.

K. DCF payment for the Massachusetts Child and Adolescent Assessment Protocol (M-CAAP) Training (pursuant to Section 4.2.P of the Contract)

Contingent upon receipt of funds from DCF, EOHHS shall issue payment to the Contractor in the amount of $2,500 in support of M-CAAP training in Contract Year 2023. The Contractor's expenditures on M-CAAP training shall not exceed the funding amount in this sub-section.

L. Mobile Crisis Intervention Uncompensated Care Payment (pursuant to Section 2.6.B.1 of the Contract)

1. For each individual for which the Contractor pays for the mobile crisis intervention initial evaluation and first day crisis interventions pursuant to **Section 2.6.B.1** of the Contract, EOHHS shall pay the Contractor a rate of $1,024.64 for a mobile non-emergency department encounter or $695.29 for a community-based encounter for such individual.
2. To facilitate payment of the aforementioned claims, the Contractor shall submit invoices to EOHHS at a frequency and format specified by EOHHS in **Appendix E-4**.

M. Emergency Department Crisis Evaluation Payment (pursuant to Section 2.6.B.3 of the Contract)

1. For each individual for which the Contractor pays for the initial crisis evaluation service in the emergency department pursuant to **Section 2.6.B.3** of the Contract, EOHHS shall pay the Contractor a rate of $695.29 for such individual.
2. To facilitate payment of the aforementioned claims, the Contractor shall submit invoices to EOHHS at a frequency and format specified by EOHHS in **Appendix E-4**.

Appendix L: Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule

APPENDIX L - Commonwealth of Massachusetts Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule

Effective 1/1/2023 - 3/31/2023

Unique Code/Modifier Combinations

Category of Service	Procedure Code	Modifier Group	Procedure Description	Unit Cost
MH and SA OP Services	90791	UG - Doctoral Level (Child Psychiatrist)	Psychiatric Diagnostic Evaluation	$ 208.27
MH and SA OP Services	90791	U6 - Doctoral Level (MD / DO)	Psychiatric Diagnostic Evaluation	$ 167.15
MH and SA OP Services	90791	AH - Doctoral Level (PhD, PsyD, EdD)	Psychiatric Diagnostic Evaluation	$ 143.48
MH and SA OP Services	90791	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Psychiatric Diagnostic Evaluation	$ 144.66
MH and SA OP Services	90791	HO-Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Psychiatric Diagnostic Evaluation	$ 130.48
MH and SA OP Services	90791	U3 - Intern (PhD, PsyD, EdD) / or MAT	Psychiatric Diagnostic Evaluation	$ 81.83
MH and SA OP Services	90791	U4 - Intern (Master's)	Psychiatric Diagnostic Evaluation	$ 72.20
MH and SA OP Services	90791	HA-CANS; UG-Doctoral Level (Child Psychiatrist)	CANS - Psychiatric Diagnostic Evaluation, Members under 21	$ 223.27
MH and SA OP Services	90791	HA-CANS; U6-Doctoral Level (MD / DO)	CANS - Psychiatric Diagnostic Evaluation, Members under 21	$ 182.15
MH and SA OP Services	90791	HA-CANS; AH-Doctoral Level (PhD, PsyD, EdD)	CANS - Psychiatric Diagnostic Evaluation, Members under 21	$ 158.48
MH and SA OP Services	90791	HA-CANS; SA, UF -Nurse Practitioner/Board Certified RNCS and APRN-BC	CANS - Psychiatric Diagnostic Evaluation, Members under 21	$ 159.66
MH and SA OP Services	90791	HA-CANS; HO-Master's Level	CANS - Psychiatric Diagnostic Evaluation, Members under 21	$ 145.48
MH and SA OP Services	90791	HA-CANS; U3-Intern (PhD, PsyD, EdD)	CANS - Psychiatric Diagnostic Evaluation, Members under 21	$ 96.83
MH and SA OP Services	90791	HA-CANS; U4-Intern (Master's)	CANS - Psychiatric Diagnostic Evaluation, Members under 21	$ 87.20
MH and SA OP Services	90792	UG - Doctoral Level (Child Psychiatrist)	Psychiatric Diagnostic Evaluation with Medical Services	$ 131.80
MH and SA OP Services	90792	U6-Doctoral Level (MD / DO)	Psychiatric Diagnostic Evaluation with Medical Services	$ 114.31
MH and SA OP Services	90792	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Psychiatric Diagnostic Evaluation with Medical Services	$ 104.57
MH and SA OP Services	90832	UG-Doctoral Level (Child Psychiatrist)	Individual Psychotherapy, approximately 20-30 minutes	$ 69.60

* See Section 2.7.C.2.e.1 for adjustment to unit cost if using CANS Tool.

Appendix L: Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule

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Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	90832	U6-Doctoral Level (MD / DO)	Individual Psychotherapy, approximately 20-30 minutes	$ 69.60
MH and SA OP Services	90832	AH-Doctoral Level (PhD, PsyD, EdD)	Individual Psychotherapy, approximately 20-30 minutes	$ 59.16
MH and SA OP Services	90832	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Individual Psychotherapy, approximately 20-30 minutes	$ 59.16
MH and SA OP Services	90832	HO-Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Individual Psychotherapy, approximately 20-30 minutes	$ 52.20
MH and SA OP Services	90832	U7-Certified Addiction Counselor / Certified Alcohol & Drug Abuse Counselor	Individual Psychotherapy, approximately 20-30 minutes	$ 52.20
MH and SA OP Services	90832	U3-Intern (PhD, PsyD, EdD) / or MAT	Individual Psychotherapy, approximately 20-30 minutes	$ 35.49
MH and SA OP Services	90832	U4-Intern (Master's)	Individual Psychotherapy, approximately 20-30 minutes	$ 31.32
MH and SA OP Services	90833	U6-Doctoral Level (MD / DO)	Add-On Code; Psychotherapy, 30 minutes, when Performed with an Evaluation and Management Service	$ 63.83
MH and SA OP Services	90833	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Add-On Code; Psychotherapy, 30 minutes, when Performed with an Evaluation and Management Service	$ 54.25
MH and SA OP Services	90834	UG-Doctoral Level (Child Psychiatrist)	Individual Psychotherapy, approximately 45 minutes	$ 115.70
MH and SA OP Services	90834	U6-Doctoral Level (MD / DO)	Individual Psychotherapy, approximately 45 minutes	$ 101.66
MH and SA OP Services	90834	AH-Doctoral Level (PhD, PsyD, EdD)	Individual Psychotherapy, approximately 45 minutes	$ 95.89
MH and SA OP Services	90834	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Individual Psychotherapy, approximately 45 minutes	$ 95.46
MH and SA OP Services	90834	HO-Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Individual Psychotherapy, approximately 45 minutes	$ 95.46
MH and SA OP Services	90834	U3-Intern (PhD, PsyD, EdD) / or MAT	Individual Psychotherapy, approximately 45 minutes	$ 47.98
MH and SA OP Services	90834	U4-Intern (Master's)	Individual Psychotherapy, approximately 45 minutes	$ 47.26
MH and SA OP Services	90836	U6-Doctoral Level (MD / DO)	Add-On Code; Psychotherapy, 45 minutes, when Performed with an Evaluation and Management Service	$ 82.90

* See Section 2.7.C.2.e.1 for adjustment to unit cost if using CANS Tool.

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Effective 1/1/2023 - 3/31/2023

Unique Code/Modifier Combinations

Category of Service	Procedure Code	Modifier Group	Procedure Description	Unit Cost
MH and SA OP Services	90836	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Add-On Code; Psychotherapy, 45 minutes, when Performed with an Evaluation and Management Service	$ 82.90
MH and SA OP Services	90837	UG-Doctoral Level (Child Psychiatrist)	Psychotherapy, 60 minutes	$ 135.04
MH and SA OP Services	90837	U6-Doctoral Level (MD / DO)	Psychotherapy, 60 minutes	$ 135.04
MH and SA OP Services	90837	AH-Doctoral Level (PhD, PsyD, EdD)	Psychotherapy, 60 minutes	$ 127.53
MH and SA OP Services	90837	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Psychotherapy, 60 minutes	$ 125.69
MH and SA OP Services	90837	HO-Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Psychotherapy, 60 minutes	$ 125.69
MH and SA OP Services	90837	U3-Intern (PhD, PsyD, EdD) / or MAT	Psychotherapy, 60 minutes	$ 68.87
MH and SA OP Services	90837	U4-Intern (Master's)	Psychotherapy, 60 minutes	$ 60.77
MH and SA OP Services	90838	U6-Doctoral Level (MD / DO)	Add-On Code; Psychotherapy, 60 minutes, when Performed with an Evaluation and Management Service	$ 106.08
MH and SA OP Services	90838	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Add-On Code; Psychotherapy, 60 minutes, when Performed with an Evaluation and Management Service	$ 91.42
MH and SA OP Services	90846	UG-Doctor Level (Child Psychiatrist)	Family Psychotherapy (without patient present)	$ 141.42
MH and SA OP Services	90846	U6-Doctor Level (MD/DO)	Family Psychotherapy (without patient present)	$ 107.62
MH and SA OP Services	90846	AH-Doctoral Level (PhD, PsyD, EdD)	Family Psychotherapy (without patient present)	$ 100.47
MH and SA OP Services	90846	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Family Psychotherapy (without patient present)	$ 97.55
MH and SA OP Services	90846	HO-Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Family Psychotherapy (without patient present)	$ 101.43
MH and SA OP Services	90846	U3-Intern (PhD, PsyD, EdD) / or MAT	Family Psychotherapy (without patient present)	$ 50.23
MH and SA OP Services	90846	U4-Intern (Master's)	Family Psychotherapy (without patient present)	$ 48.77
MH and SA OP Services	90847	UG-Doctoral Level (Child Psychiatrist)	Family Psychotherapy (conjoint psychotherapy) (with patient present)	$ 141.42

Appendix L: Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule

APPENDIX L - Commonwealth of Massachusetts Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule **Effective 1/1/2023 - 3/31/2023**				
Unique Code/Modifier Combinations				
Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	90847	U6-Doctoral Level (MD / DO)	Family Psychotherapy (conjoint psychotherapy) (with patient present)	$ 107.62
MH and SA OP Services	90847	AH-Doctoral Level (PhD, PsyD, EdD)	Family Psychotherapy (conjoint psychotherapy) (with patient present)	$ 101.43
MH and SA OP Services	90847	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Family Psychotherapy (conjoint psychotherapy) (with patient present)	$ 101.43
MH and SA OP Services	90847	HO-Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Family Psychotherapy (conjoint psychotherapy) (with patient present)	$ 101.43
MH and SA OP Services	90847	U3-Intern (PhD, PsyD, EdD) / or MAT	Family Psychotherapy (conjoint psychotherapy) (with patient present)	$ 50.23
MH and SA OP Services	90847	U4-Intern (Master's)	Family Psychotherapy (conjoint psychotherapy) (with patient present)	$ 48.77
MH and SA OP Services	90849	UG-Doctor Level (Child Psychiatrist)	Multi-family group psychotherapy	$ 46.29
MH and SA OP Services	90849	U6-Doctor Level (MD/DO)	Multi-family group psychotherapy	$ 38.84
MH and SA OP Services	90849	AH-Doctoral Level (PhD, PsyD, EdD)	Multi-family group psychotherapy	$ 35.86
MH and SA OP Services	90849	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Multi-family group psychotherapy	$ 33.00
MH and SA OP Services	90849	HO-Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Multi-family group psychotherapy	$ 27.69
MH and SA OP Services	90849	U3-Intern (PhD, PsyD, EdD) / or MAT	Multi-family group psychotherapy	$ 17.96
MH and SA OP Services	90849	U4-Intern (Master's)	Multi-family group psychotherapy	$ 16.50
MH and SA OP Services	90853	UG-Doctoral Level (Child Psychiatrist)	Group psychotherapy (other than of a multiple-family group)	$ 46.29
MH and SA OP Services	90853	U6-Doctoral Level (MD / DO)	Group psychotherapy (other than of a multiple-family group)	$ 38.84
MH and SA OP Services	90853	AH-Doctoral Level (PhD, PsyD, EdD)	Group psychotherapy (other than of a multiple-family group)	$ 35.86
MH and SA OP Services	90853	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Group psychotherapy (other than of a multiple-family group)	$ 33.12

* See Section 2.7.C.2.e.1 for adjustment to unit cost if using CANS Tool.

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Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	90853	HO-Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Group psychotherapy (other than of a multiple-family group)	$ 33.12
MH and SA OP Services	90853	U3-Intern (PhD, PsyD, EdD) / or MAT	Group psychotherapy (other than of a multiple-family group)	$ 17.96
MH and SA OP Services	90853	U4-Intern (Master's)	Group psychotherapy (other than of a multiple-family group)	$ 16.50
MH and SA OP Services	90882	UG-Doctoral Level (Child Psychiatrist)	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers or institutions.	$ 51.11
MH and SA OP Services	90882	U6-Doctoral Level (MD / DO)	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers or institutions.	$ 44.33
MH and SA OP Services	90882	AH-Doctoral Level (PhD, PsyD, EdD)	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers or institutions.	$ 23.97
MH and SA OP Services	90882	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers or institutions.	$ 38.36
MH and SA OP Services	90882	HO-Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers or institutions.	$ 23.63
MH and SA OP Services	90882	U3-Intern (PhD, PsyD, EdD) / or MAT	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers or institutions.	$ 12.00
MH and SA OP Services	90882	U4-Intern (Master's)	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers or institutions.	$ 11.81
MH and SA OP Services	90887	UG-Doctoral Level (Child Psychiatrist)	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	$ 79.19
MH and SA OP Services	90887	U6-Doctoral Level (MD / DO)	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	$ 79.19
MH and SA OP Services	90887	AH-Doctoral Level (PhD, PsyD, EdD)	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	$ 67.32

* See Section 2.7.C.2.e.1 for adjustment to unit cost if using CANS Tool.

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Effective 1/1/2023 - 3/31/2023

Unique Code/Modifier Combinations

Category of Service	Procedure Code	Modifier Group	Procedure Description	Unit Cost
MH and SA OP Services	90887	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	$ 67.32
MH and SA OP Services	90887	HO-Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	$ 59.40
MH and SA OP Services	90887	U3-Intern (PhD, PsyD, EdD) / or MAT	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	$ 40.39
MH and SA OP Services	90887	U4-Intern (Master's)	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	$ 35.64
MH and SA OP Services	96372	U6 - Doctoral Level (MD / DO)	Therapeutic, Prophylactic or Diagnostic Injection; subcutaneous or intramuscular	$ 31.25
MH and SA OP Services	96372	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Therapeutic, Prophylactic or Diagnostic Injection; subcutaneous or intramuscular	$ 23.22
MH and SA OP Services	97810	*N/A*	Acupuncture, 1 or more needles; without electrical stimulation, initial 15 minutes of personal one-to-one contact	$ 19.84
MH and SA OP Services	97811	*N/A*	Add-On Code; Acupuncture, 1 or more needles; without electrical stimulation, each additional 15 minutes of personal one-to-one contact with re-insertion of needle(s).	$ 19.84
MH and SA OP Services	99202	UG-Doctoral Level (Child Psychiatrist)	Evaluation and Management for New Patient, 15-29 minutes	$ 75.25
MH and SA OP Services	99202	U6-Doctoral Level (MD / DO)	Evaluation and Management for New Patient, 15-29 minutes	$ 67.91
MH and SA OP Services	99202	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for New Patient, 15-29 minutes	$ 60.78
MH and SA OP Services	99203	UG- Doctoral Level (Child Psychiatrist)	Evaluation and Management for New Patient, 30-44 minutes	$ 108.55
MH and SA OP Services	99203	U6-Doctoral Level (MD / DO)	Evaluation and Management for New Patient, 30-44 minutes	$ 103.65
MH and SA OP Services	99203	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for New Patient, 30-44 minutes	$ 88.11
MH and SA OP Services	99204	UG-Doctoral Level (Child Psychiatrist)	Evaluation and Management for New Patient, 45-59 minutes	$ 164.00

* See Section 2.7.C.2.e.1 for adjustment to unit cost if using CANS Tool.

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Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	99204	U6-Doctoral Level (MD / DO)	Evaluation and Management for New Patient, 45-59 minutes	$ 153.89
MH and SA OP Services	99204	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for New Patient, 45-59 minutes	$ 133.25
MH and SA OP Services	99205	UG-Doctoral Level (Child Psychiatrist)	Evaluation and Management for New Patient, 60-74 minutes	$ 203.69
MH and SA OP Services	99205	U6-Doctoral Level (MD / DO)	Evaluation and Management for New Patient, 60-74 minutes	$ 203.31
MH and SA OP Services	99205	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for New Patient, 60-74 minutes	$ 172.81
MH and SA OP Services	99211	UG-Doctoral Level (Child Psychiatrist)	Evaluation and Management for an Established Patient, 5 minutes	$22.06
MH and SA OP Services	99211	U6-Doctoral Level (MD / DO)	Evaluation and Management for an Established Patient, 5 minutes	$22.06
MH and SA OP Services	99211	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for an Established Patient, 5 minutes	$18.75
MH and SA OP Services	99212	UG-Doctoral Level (Child Psychiatrist)	Evaluation and Management for an Established Patient, 10-19 minutes	$52.73
MH and SA OP Services	99212	U6-Doctoral Level (MD / DO)	Evaluation and Management for an Established Patient, 10-19 minutes	$52.73
MH and SA OP Services	99212	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for an Established Patient, 10-19 minutes	$44.82
MH and SA OP Services	99213	UG-Doctoral Level (Child Psychiatrist)	Evaluation and Management for an Established Patient, 20-29 minutes	$84.11
MH and SA OP Services	99213	U6-Doctoral Level (MD / DO)	Evaluation and Management for an Established Patient, 20-29 minutes	$84.11
MH and SA OP Services	99213	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for an Established Patient, 20-29 minutes	$71.49
MH and SA OP Services	99214	UG-Doctoral Level (Child Psychiatrist)	Evaluation and Management for an Established Patient, 30-39 minutes	$143.98
MH and SA OP Services	99214	U6-Doctoral Level (MD / DO)	Evaluation and Management for an Established Patient, 30-39 minutes	$118.51
MH and SA OP Services	99214	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for an Established Patient, 30-39 minutes	$100.73
MH and SA OP Services	99215	UG-Doctoral Level (Child Psychiatrist)	Evaluation and Management for an Established Patient, 40-54 minutes	$166.57
MH and SA OP Services	99215	U6-Doctoral Level (MD / DO)	Evaluation and Management for an Established Patient, 40-54 minutes	$166.57
MH and SA OP Services	99215	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for an Established Patient, 40-54 minutes	$141.58
MH and SA OP Services	99231	UG-Doctoral Level (Child Psychiatrist)	Subsequent Hospital Care for Eval and Management, 15 minutes	$ 78.07

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Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	99231	U6-Doctoral Level (MD / DO)	Subsequent Hospital Care for Eval and Management, 15 minutes	$ 59.27
MH and SA OP Services	99231	AH-Doctoral Level (PhD, PsyD, EdD)	Subsequent Hospital Care for Eval and Management, 15 minutes	$ 56.89
MH and SA OP Services	99231	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Subsequent Hospital Care for Eval and Management, 15 minutes	$ 47.47
MH and SA OP Services	99232	UG-Doctoral Level (Child Psychiatrist)	Subsequent Hospital Care for Eval and Management, 25 minutes	$ 117.11
MH and SA OP Services	99232	U6-Doctoral Level (MD / DO)	Subsequent Hospital Care for Eval and Management, 25 minutes	$ 88.19
MH and SA OP Services	99232	AH-Doctoral Level (PhD, PsyD, EdD)	Subsequent Hospital Care for Eval and Management, 25 minutes	$ 84.66
MH and SA OP Services	99232	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Subsequent Hospital Care for Eval and Management, 25 minutes	$ 70.63
MH and SA OP Services	99233	UG-Doctoral Level (Child Psychiatrist)	Subsequent Hospital Care for Eval and Management, 35 minutes	$ 156.16
MH and SA OP Services	99233	U6-Doctoral Level (MD / DO)	Subsequent Hospital Care for Eval and Management, 35 minutes	$ 117.59
MH and SA OP Services	99233	AH-Doctoral Level (PhD, PsyD, EdD)	Subsequent Hospital Care for Eval and Management, 35 minutes	$ 112.88
MH and SA OP Services	99233	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Subsequent Hospital Care for Eval and Management, 35 minutes	$ 94.18
MH and SA OP Services	99251	UG-Doctoral Level (Child Psychiatrist)	Initial Inpatient Consultation, 20 minutes	$ 104.74
MH and SA OP Services	99251	U6-Doctoral Level (MD / DO)	Initial Inpatient Consultation, 20 minutes	$ 79.50
MH and SA OP Services	99251	AH-Doctoral Level (PhD, PsyD, EdD)	Initial Inpatient Consultation, 20 minutes	$ 76.32
MH and SA OP Services	99251	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Initial Inpatient Consultation, 40 minutes	$ 63.67
MH and SA OP Services	99252	UG-Doctoral Level (Child Psychiatrist)	Initial Inpatient Consultation, 40 minutes	$ 157.11
MH and SA OP Services	99252	U6-Doctoral Level (MD / DO)	Initial Inpatient Consultation, 40 minutes	$ 118.32
MH and SA OP Services	99252	AH-Doctoral Level (PhD, PsyD, EdD)	Initial Inpatient Consultation, 40 minutes	$ 113.58
MH and SA OP Services	99252	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Initial Inpatient Consultation, 40 minutes	$ 94.77
UG-MH and SA OP Services	99253	UG-Doctoral Level (Child Psychiatrist)	Initial Inpatient Consultation, 55 minutes	$ 209.47
MH and SA OP Services	99253	U6-Doctoral Level (MD / DO)	Initial Inpatient Consultation, 55 minutes	$ 157.74
MH and SA OP Services	99253	AH-Doctoral Level (PhD, PsyD, EdD)	Initial Inpatient Consultation, 55 minutes	$ 151.44
MH and SA OP Services	99253	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Initial Inpatient Consultation, 55 minutes	$ 126.35

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Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	99254	UG-Doctoral Level (Child Psychiatrist)	Initial Inpatient Consultation, 80 minutes	$ 280.95
MH and SA OP Services	99254	U6-Doctoral Level (MD / DO)	Initial Inpatient Consultation, 80 minutes	$ 210.98
MH and SA OP Services	99254	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Initial Inpatient Consultation, 80 minutes	$ 169.00
MH and SA OP Services	99255	UG-Doctoral Level (Child Psychiatrist)	Initial Inpatient Consultation - Comprehensive, 110 minutes	$ 370.12
MH and SA OP Services	99255	U6-Doctoral Level (MD / DO)	Initial Inpatient Consultation - Comprehensive, 110 minutes	$ 277.57
MH and SA OP Services	99255	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Initial Inpatient Consultation - Comprehensive, 110 minutes	$ 222.33
MH and SA OP Services	99281	U6-Doctoral Level (MD/DO)	Emergency Department visit for the evaluation and management of a patient, which requires 3 key components: A problem-focused history; A problem-focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor.	$ 20.14
MH and SA OP Services	99282	UG-Doctoral Level (Child Psychiatrist)	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem-focused history; An expanded problem-focused examination; and Medical decision-making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity.	$ 35.37
MH and SA OP Services	99282	U6-Doctoral Level (MD/DO)	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity.	$ 33.68

* See Section 2.7.C.2.e.1 for adjustment to unit cost if using CANS Tool.

Appendix L: Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule

APPENDIX L - Commonwealth of Massachusetts Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule **Effective 1/1/2023 - 3/31/2023**				
Unique Code/Modifier Combinations				
Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	99282	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity.	$ 32.70
MH and SA OP Services	99283	UG-Doctoral Level (Child Psychiatrist)	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity.	$ 53.52
MH and SA OP Services	99283	U6-Doctoral Level (MD/DO)	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity.	$ 50.97
MH and SA OP Services	99283	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity.	$ 49.49

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Unique Code/Modifier Combinations				
Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	99284	UG-Doctoral Level (Child Psychiatrist)	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.	$ 100.58
MH and SA OP Services	99284	U6-Doctoral Level (MD/DO)	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.	$ 95.80
MH and SA OP Services	99284	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.	$ 93.01

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Unique Code/Modifier Combinations				
Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	99285	UG-Doctoral Level (Child Psychiatrist)	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.	$ 148.78
MH and SA OP Services	99285	U6-Doctoral Level (MD/DO)	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.	$ 141.69
MH and SA OP Services	99285	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.	$ 136.30
MH and SA OP Services	99402	AH-Doctoral Level (PhD, PsyD, EdD)	Preventative Medicine Counseling , 30 minutes (Psychological Testing)	$ 40.98
MH and SA OP Services	99402	U3-Intern (PhD, PsyD, EdD) / or MAT	Preventative Medicine Counseling, 30 minutes (Psychological Testing)	$ 20.50
MH and SA OP Services	99404	U6-Doctoral Level (MD / DO)	Preventative Medicine Counseling, 60 minutes (Counseling and/or Risk Factor Reduction Intervention)	$ 194.82
MH and SA OP Services	99404	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Preventative Medicine Counseling, 60 minutes (Counseling and/or Risk Factor Reduction Intervention)	$ 168.60

* See Section 2.7.C.2.e.1 for adjustment to unit cost if using CANS Tool.

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Unique Code/Modifier Combinations				
Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	99417	U6-Doctoral Level (MD / DO)	Add-On Code; Prolonged office or other outpatient evaluation and management service, requiring total time with or without direct patient contact beyond usual service, on the date of the primary service (e.g., 99205 or 99215), each 15 minutes	$ 26.08
MH and SA OP Services	99417	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Add-On Code; Prolonged office or other outpatient evaluation and management service, requiring total time with or without direct patient contact beyond usual service, on the date of the primary service (e.g., 99205 or 99215), each 15 minutes	$ 26.08
Diversionary Services	H0037	*N/A*	Community Psychiatric Supportive Treatment Program, per diem (Community Based Acute Treatment - CBAT)	$ 654.13
Diversionary Services	H0037	U2-Autism Diagnosis	Community Psychiatric Supportive Treatment Program, per diem (CBAT Autism Speciality)	$ 1,093.70
Diversionary Services	H2012	*N/A*	Behavioral Health Day Treatment, per hour (Psychiatric Day Treatment)	101 CMR 307.00
Diversionary Services	H2012	*N/A*	Behavioral Health Day Treatment, per hour (Enhanced Psychiatric Day Treatment)	101 CMR 307.00
Diversionary Services	H2015	*N/A*	Comprehensive community support services, per 15 minutes (Community Support Program)	$ 13.97
Diversionary Services	H2015	HF-Substance Abuse Program	Recovery Support Navigator – Self-help/peer service by a recovery advocate trained in Recovery Coaching. Rate is in 15-minutes increments.	101 CMR 444.00
Diversionary Services	H2016	HH-Integrated Mental Health/Substance Abuse Program	Effective on the later of October 1, 2021 or the date on which CMS approves these services, comprehensive community support program, per diem (Enrolled Client Day) (behavioral health service by a navigator trained to support members with justice involvement) (CSP-JI)	$17.23
Diversionary Services	H2016	HM-Less than bachelor degree level	Comprehensive community support program, per diem (Enrolled Client Day) (recovery support service by a recovery advocate trained in Recovery Coaching)	101 CMR 346.00
Diversionary Services	H2020	*N/A*	Therapeutic behavioral services, per diem (Dialectical Behavior Therapy)	$ 26.50
Diversionary Services	H2022	HE-Mental Health Program	Intensive Hospital Diversion Services for Children, per diem	$ 175.19
Diversionary Services	S9484	*N/A*	Crisis intervention mental health services, per hour (Urgent Outpatient Services)	$ 147.57

* See Section 2.7.C.2.e.1 for adjustment to unit cost if using CANS Tool.

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Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	H0014	*N/A*	Alcohol and/or drug services; ambulatory detoxification (Adult or Adolescent)	$ 227.65
Crisis Intervention Services	S9485	*ET-Emergency Services*	Crisis intervention mental health services, per diem. (Adult Community Crisis Stabilization per day rate)	101 CMR 305
Crisis Intervention Services	S9485	*ET-Emergency Services; HA-Child/Adolescent Program*	Crisis intervention mental health services, per diem. (Youth Community Crisis Stabilization Per day rate)	101 CMR 305
Crisis Intervention Services	S9485	*HB-Adult Program, non-geriatric*	Crisis intervention mental health services, per diem. (Adult Mobile Crisis Intervention provided at hospital emergency department. Inclusive of initial evaluation and all follow-up intervention. Use Place of Service code 23.)	$ 695.29
Crisis Intervention Services	S9485	*HE-Mental Health Program*	Crisis intervention mental health services, per diem. (Adult Mobile Crisis Intervention provided at CBHC site. Inclusive of initial evaluation and first day crisis interventions.)	101 CMR 305
Crisis Intervention Services	S9485	*HA-Child/Adolescent Program; HE-Mental Health Program*	Crisis intervention mental health services, per diem. (Youth Mobile Crisis Intervention provided at CBHC site. Inclusive of initial evaluation and first day crisis interventions.)	101 CMR 305
Crisis Intervention Services	S9485	*U1-MCI - Mobile Non-Emergency Department / or MAT*	Crisis intervention mental health services, per diem. (Adult Mobile Crisis Intervention provided at community-based sites of service outside of the CBHC site. Inclusive of initial evaluation and first day crisis interventions. Use Place of Service 15.)	101 CMR 305
Crisis Intervention Services	S9485	*HA-Child/Adolescent Program; U1-MCI - Mobile Non-Emergency Department / or MAT*	Crisis intervention mental health services, per diem. (Youth Mobile Crisis Intervention provided at community-based sites of service outside of the CBHC site. Inclusive of initial evaluation and first day crisis interventions Use Place of Service code 15.)	101 CMR 305
Crisis Intervention Services	S9485		Crisis intervention mental health services, per diem. (BH Crisis evaluation provided at hospital emergency department by hospital. Inclusive of initial evaluation and all follow-up interventions over 24-hour period.)	$ 695.29
Crisis Intervention Services	S9485	U1-ESP - Mobile Non-Emergency Department / or MAT	Crisis intervention mental health service, per diem (Emergency Service Program Mobile Non-Emergency Department - Uninsured)	$ 1,024.64
Crisis Intervention Services	S9485	HE-Mental Health Program	Crisis intervention mental health services, per diem (Emergency Service Program Community Based - Uninsured)	$ 695.29
Other Outpatient	90870	*N/A*	Electroconvulsive therapy (includes necessary monitoring)	$ 630.95

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APPENDIX L - Commonwealth of Massachusetts Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule **Effective 1/1/2023 - 3/31/2023**				
Unique Code/Modifier Combinations				
Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
Other Outpatient	96112	AH-Doctoral Level (PhD, PsyD, EdD)	Developmental Testing administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; first hour (Learning Disorders)	$ 180.72
Other Outpatient	96113	AH-Doctoral Level (PhD, PsyD, EdD)	Add-On Code; Each additional 30 minutes (List separately in addition to code for primary procedure) (Developmental/Behavioral Screening and Testing)	$ 90.36
Other Outpatient	96116	AH-Doctoral Level (PhD, PsyD, EdD)	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), by physician o rother qualified health professional, both face-to-face time with the patient and time interpreting test results and preparing the report; first hour	$ 120.46
Other Outpatient	96121	AH-Doctoral Level (PhD, PsyD, EdD)	Add-On Code; Each additional hour (List separately in addition to code for primary procedure)	$ 120.46
Other Outpatient	96130	AH-Doctoral Level (PhD, PsyD, EdD)	Psychological testing evaluation services by physician or other qualified health care professional, including integrating of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour	$ 91.39
Other Outpatient	96131	AH-Doctoral Level (PhD, PsyD, EdD)	Add-On Code; Each additional hour (List separately in addition to code for primary procedure)	$ 91.39
Other Outpatient	96132	AH-Doctoral Level (PhD, PsyD, EdD)	Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour	$ 91.39
Other Outpatient	96133	AH-Doctoral Level (PhD, PsyD, EdD)	Add-On Code; Each additional hour (List separately in addition to code for primary procedure)	$ 91.39

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Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
Other Outpatient	96136	AH-Doctoral Level (PhD, PsyD, EdD)	Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes (Test administration and scoring by professional)	$ 45.70
Other Outpatient	96137	Doctoral Level (PhD, PsyD, EdD)	Add-On Code; Each additional 30 minutes (List separately in addition to code for primary procedure) (Test administration and scoring by professional)	$ 45.70
Other Outpatient	96138	*N/A*	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes	$ 22.85
Other Outpatient	96139	*N/A*	Add-On Code; Each additional 30 minutes (List separately in addition to code for primary procedure) (Test administration and scoring by technician)	$ 22.85
Other Outpatient	H0032	HO-HO-Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Mental health service plan development by a nonphysician (Bridge consultation inpatient/outpatient)	$ 166.67
Other Outpatient	H0046	UG-Doctoral Level (Child Psychiatrist)	Mental health services, not otherwise specified (Collateral Contact)	$ 46.46
Other Outpatient	H0046	U6-Doctoral Level (MD/DO)	Mental health services, not otherwise specified (Collateral Contact)	$ 40.30
Other Outpatient	H0046	AH-Doctoral Level (PhD, PsyD, EdD)	Mental health services, not otherwise specified (Collateral Contact)	$ 21.79
Other Outpatient	H0046	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Mental health services, not otherwise specified (Collateral Contact)	$ 34.87
Other Outpatient	H0046	HO-Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Mental health services, not otherwise specified (Collateral Contact)	$ 21.48
Other Outpatient	H0046	U7-Certified Addiction Counselor / Certified Alcohol & Drug Abuse Counselor	Mental health services, not otherwise specified (Collateral Contact)	$ 21.48
Other Outpatient	H0046	U3-Intern (PhD, PsyD, EdD) / or MAT	Mental health services, not otherwise specified (Collateral Contact)	$ 10.91
Other Outpatient	H0046	U4-Intern (Master's)	Mental health services, not otherwise specified (Collateral Contact)	$ 10.74

* See Section 2.7.C.2.e.1 for adjustment to unit cost if using CANS Tool.

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APPENDIX L - Commonwealth of Massachusetts Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule **Effective 1/1/2023 - 3/31/2023**				
Unique Code/Modifier Combinations				
Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
Other Outpatient	H0046	HE-Mental Health Program	Mental health services, not otherwise specified, per diem (Enrolled Client Day) (Certified Peer Specialist)	101 CMR 305
Other Outpatient	H2028	*N/A*	Sexual offender treatment service, per 15 minutes (ASAP - Assessment for Safe and Appropriate Placement)	$ 22.79
MH and SA OP Services	H0001	U1-ESP - Mobile Non-Emergency Department / or MAT	MAT - Alcohol and/or drug assessment (buprenorphine and naltrexone medication evaluation by physician and/or midlevel practitioner)	$ 146.93
MH and SA OP Services	H0004		Behavioral health counseling and therapy, per 15 minutes (individual counseling)	101 CMR 346
MH and SA OP Services	H0005		Alcohol and/or drug services; group counseling by a clinician (per 45 minutes, group counseling, one unit maximum per day)	101 CMR 346
MH and SA OP Services	H0005	HG	Alcohol and/or drug services group counseling by a clinician (per 90-minute unit) (one unit maximum per day)	101 CMR 346
MH and SA OP Services	T1006		Alcohol and/or substance abuse services; family/couple counseling (per 30 minutes, one unit maximum per day)	101 CMR 346
MH and SA OP Services	T1006	HF	Alcohol and/or substance abuse services; family/couple counseling (per 60 minutes, one unit maximum per day)	101 CMR 346

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APPENDIX L - Commonwealth of Massachusetts Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule **Effective 4/1/2023** Unique Code/Modifier Combinations				
Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	90791	UG - Doctoral Level (Child Psychiatrist)	Psychiatric Diagnostic Evaluation	$ 208.27
MH and SA OP Services	90791	U6 - Doctoral Level (MD / DO)	Psychiatric Diagnostic Evaluation	$ 167.15
MH and SA OP Services	90791	AH - Doctoral Level (PhD, PsyD, EdD)	Psychiatric Diagnostic Evaluation	$ 143.48
MH and SA OP Services	90791	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Psychiatric Diagnostic Evaluation	$ 144.66
MH and SA OP Services	90791	HO-Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Psychiatric Diagnostic Evaluation	$ 130.48
MH and SA OP Services	90791	U3 - Intern (PhD, PsyD, EdD) / or MAT	Psychiatric Diagnostic Evaluation	$ 81.83
MH and SA OP Services	90791	U4 - Intern (Master's)	Psychiatric Diagnostic Evaluation	$ 72.20
MH and SA OP Services	90791	HA-CANS; UG-Doctoral Level (Child Psychiatrist)	CANS - Psychiatric Diagnostic Evaluation, Members under 21	$ 223.27
MH and SA OP Services	90791	HA-CANS; U6-Doctoral Level (MD / DO)	CANS - Psychiatric Diagnostic Evaluation, Members under 21	$ 182.15
MH and SA OP Services	90791	HA-CANS; AH-Doctoral Level (PhD, PsyD, EdD)	CANS - Psychiatric Diagnostic Evaluation, Members under 21	$ 158.48
MH and SA OP Services	90791	HA-CANS; SA, UF -Nurse Practitioner/Board Certified RNCS and APRN-BC	CANS - Psychiatric Diagnostic Evaluation, Members under 21	$ 159.66
MH and SA OP Services	90791	HA-CANS; HO-Master's Level	CANS - Psychiatric Diagnostic Evaluation, Members under 21	$ 145.48
MH and SA OP Services	90791	HA-CANS; U3-Intern (PhD, PsyD, EdD)	CANS - Psychiatric Diagnostic Evaluation, Members under 21	$ 96.83
MH and SA OP Services	90791	HA-CANS; U4-Intern (Master's)	CANS - Psychiatric Diagnostic Evaluation, Members under 21	$ 87.20
MH and SA OP Services	90792	UG - Doctoral Level (Child Psychiatrist)	Psychiatric Diagnostic Evaluation with Medical Services	$ 131.80
MH and SA OP Services	90792	U6-Doctoral Level (MD / DO)	Psychiatric Diagnostic Evaluation with Medical Services	$ 114.31
MH and SA OP Services	90792	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Psychiatric Diagnostic Evaluation with Medical Services	$ 104.57

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Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	90832	UG-Doctoral Level (Child Psychiatrist)	Individual Psychotherapy, approximately 20-30 minutes	$ 69.60
MH and SA OP Services	90832	U6-Doctoral Level (MD / DO)	Individual Psychotherapy, approximately 20-30 minutes	$ 69.60
MH and SA OP Services	90832	AH-Doctoral Level (PhD, PsyD, EdD)	Individual Psychotherapy, approximately 20-30 minutes	$ 59.16
MH and SA OP Services	90832	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Individual Psychotherapy, approximately 20-30 minutes	$ 59.16
MH and SA OP Services	90832	HO-Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Individual Psychotherapy, approximately 20-30 minutes	$ 52.20
MH and SA OP Services	90832	U7-Certified Addiction Counselor / Certified Alcohol & Drug Abuse Counselor	Individual Psychotherapy, approximately 20-30 minutes	$ 52.20
MH and SA OP Services	90832	U3-Intern (PhD, PsyD, EdD) / or MAT	Individual Psychotherapy, approximately 20-30 minutes	$ 35.49
MH and SA OP Services	90832	U4-Intern (Master's)	Individual Psychotherapy, approximately 20-30 minutes	$ 31.32
MH and SA OP Services	90833	U6-Doctoral Level (MD / DO)	Add-On Code; Psychotherapy, 30 minutes, when Performed with an Evaluation and Management Service	$ 63.83
MH and SA OP Services	90833	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Add-On Code; Psychotherapy, 30 minutes, when Performed with an Evaluation and Management Service	$ 54.25
MH and SA OP Services	90834	UG-Doctoral Level (Child Psychiatrist)	Individual Psychotherapy, approximately 45 minutes	$ 115.70
MH and SA OP Services	90834	U6-Doctoral Level (MD / DO)	Individual Psychotherapy, approximately 45 minutes	$ 101.66
MH and SA OP Services	90834	AH-Doctoral Level (PhD, PsyD, EdD)	Individual Psychotherapy, approximately 45 minutes	$ 95.89
MH and SA OP Services	90834	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Individual Psychotherapy, approximately 45 minutes	$ 95.46
MH and SA OP Services	90834	HO-Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Individual Psychotherapy, approximately 45 minutes	$ 95.46
MH and SA OP Services	90834	U3-Intern (PhD, PsyD, EdD) / or MAT	Individual Psychotherapy, approximately 45 minutes	$ 47.98

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Unique Code/Modifier Combinations

Category of Service	Procedure Code	Modifier Group	Procedure Description	Unit Cost
MH and SA OP Services	90834	U4-Intern (Master's)	Individual Psychotherapy, approximately 45 minutes	$ 47.26
MH and SA OP Services	90836	U6-Doctoral Level (MD / DO)	Add-On Code; Psychotherapy, 45 minutes, when Performed with an Evaluation and Management Service	$ 82.90
MH and SA OP Services	90836	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Add-On Code; Psychotherapy, 45 minutes, when Performed with an Evaluation and Management Service	$ 82.90
MH and SA OP Services	90837	UG-Doctoral Level (Child Psychiatrist)	Psychotherapy, 60 minutes	$ 135.04
MH and SA OP Services	90837	U6-Doctoral Level (MD / DO)	Psychotherapy, 60 minutes	$ 135.04
MH and SA OP Services	90837	AH-Doctoral Level (PhD, PsyD, EdD)	Psychotherapy, 60 minutes	$ 127.53
MH and SA OP Services	90837	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Psychotherapy, 60 minutes	$ 125.69
MH and SA OP Services	90837	HO-Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Psychotherapy, 60 minutes	$ 125.69
MH and SA OP Services	90837	U3-Intern (PhD, PsyD, EdD) / or MAT	Psychotherapy, 60 minutes	$ 68.87
MH and SA OP Services	90837	U4-Intern (Master's)	Psychotherapy, 60 minutes	$ 60.77
MH and SA OP Services	90838	U6-Doctoral Level (MD / DO)	Add-On Code; Psychotherapy, 60 minutes, when Performed with an Evaluation and Management Service	$ 106.08
MH and SA OP Services	90838	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Add-On Code; Psychotherapy, 60 minutes, when Performed with an Evaluation and Management Service	$ 91.42
MH and SA OP Services	90846	UG-Doctor Level (Child Psychiatrist)	Family Psychotherapy (without patient present)	$ 141.42
MH and SA OP Services	90846	U6-Doctor Level (MD/DO)	Family Psychotherapy (without patient present)	$ 107.62
MH and SA OP Services	90846	AH-Doctoral Level (PhD, PsyD, EdD)	Family Psychotherapy (without patient present)	$ 100.47
MH and SA OP Services	90846	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Family Psychotherapy (without patient present)	$ 97.55
MH and SA OP Services	90846	HO-Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Family Psychotherapy (without patient present)	$ 101.43

* See Section 2.7.C.2.e.1 for adjustment to unit cost if using CANS Tool.

Appendix L: Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule

APPENDIX L - Commonwealth of Massachusetts Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule **Effective 4/1/2023** Unique Code/Modifier Combinations				
Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	90846	U3-Intern (PhD, PsyD, EdD) / or MAT	Family Psychotherapy (without patient present)	$ 50.23
MH and SA OP Services	90846	U4-Intern (Master's)	Family Psychotherapy (without patient present)	$ 48.77
MH and SA OP Services	90847	UG-Doctoral Level (Child Psychiatrist)	Family Psychotherapy (conjoint psychotherapy) (with patient present)	$ 141.42
MH and SA OP Services	90847	U6-Doctoral Level (MD / DO)	Family Psychotherapy (conjoint psychotherapy) (with patient present)	$ 107.62
MH and SA OP Services	90847	AH-Doctoral Level (PhD, PsyD, EdD)	Family Psychotherapy (conjoint psychotherapy) (with patient present)	$ 101.43
MH and SA OP Services	90847	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Family Psychotherapy (conjoint psychotherapy) (with patient present)	$ 101.43
MH and SA OP Services	90847	HO-Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Family Psychotherapy (conjoint psychotherapy) (with patient present)	$ 101.43
MH and SA OP Services	90847	U3-Intern (PhD, PsyD, EdD) / or MAT	Family Psychotherapy (conjoint psychotherapy) (with patient present)	$ 50.23
MH and SA OP Services	90847	U4-Intern (Master's)	Family Psychotherapy (conjoint psychotherapy) (with patient present)	$ 48.77
MH and SA OP Services	90849	UG-Doctor Level (Child Psychiatrist)	Multi-family group psychotherapy	$ 46.29
MH and SA OP Services	90849	U6-Doctor Level (MD/DO)	Multi-family group psychotherapy	$ 38.84
MH and SA OP Services	90849	AH-Doctoral Level (PhD, PsyD, EdD)	Multi-family group psychotherapy	$ 35.86
MH and SA OP Services	90849	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Multi-family group psychotherapy	$ 33.00
MH and SA OP Services	90849	HO-Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Multi-family group psychotherapy	$ 27.69
MH and SA OP Services	90849	U3-Intern (PhD, PsyD, EdD) / or MAT	Multi-family group psychotherapy	$ 17.96
MH and SA OP Services	90849	U4-Intern (Master's)	Multi-family group psychotherapy	$ 16.50
MH and SA OP Services	90853	UG-Doctoral Level (Child Psychiatrist)	Group psychotherapy (other than of a multiple-family group)	$ 46.29
MH and SA OP Services	90853	U6-Doctoral Level (MD / DO)	Group psychotherapy (other than of a multiple-family group)	$ 38.84
MH and SA OP Services	90853	AH-Doctoral Level (PhD, PsyD, EdD)	Group psychotherapy (other than of a multiple-family group)	$ 35.86

* See Section 2.7.C.2.e.1 for adjustment to unit cost if using CANS Tool.

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Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	90853	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Group psychotherapy (other than of a multiple-family group)	$ 33.12
MH and SA OP Services	90853	HO-Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Group psychotherapy (other than of a multiple-family group)	$ 33.12
MH and SA OP Services	90853	U3-Intern (PhD, PsyD, EdD) / or MAT	Group psychotherapy (other than of a multiple-family group)	$ 17.96
MH and SA OP Services	90853	U4-Intern (Master's)	Group psychotherapy (other than of a multiple-family group)	$ 16.50
MH and SA OP Services	90882	UG-Doctoral Level (Child Psychiatrist)	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers or institutions.	$ 51.11
MH and SA OP Services	90882	U6-Doctoral Level (MD / DO)	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers or institutions.	$ 44.33
MH and SA OP Services	90882	AH-Doctoral Level (PhD, PsyD, EdD)	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers or institutions.	$ 23.97
MH and SA OP Services	90882	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers or institutions.	$ 38.36
MH and SA OP Services	90882	HO-Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers or institutions.	$ 23.63
MH and SA OP Services	90882	U3-Intern (PhD, PsyD, EdD) / or MAT	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers or institutions.	$ 12.00
MH and SA OP Services	90882	U4-Intern (Master's)	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers or institutions.	$ 11.81
MH and SA OP Services	90887	UG-Doctoral Level (Child Psychiatrist)	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	$ 79.19
MH and SA OP Services	90887	U6-Doctoral Level (MD / DO)	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	$ 79.19

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Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	90887	AH-Doctoral Level (PhD, PsyD, EdD)	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	$ 67.32
MH and SA OP Services	90887	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	$ 67.32
MH and SA OP Services	90887	HO-Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	$ 59.40
MH and SA OP Services	90887	U3-Intern (PhD, PsyD, EdD) / or MAT	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	$ 40.39
MH and SA OP Services	90887	U4-Intern (Master's)	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	$ 35.64
MH and SA OP Services	96372	U6 - Doctoral Level (MD / DO)	Therapeutic, Prophylactic or Diagnostic Injection; subcutaneous or intramuscular	$ 31.25
MH and SA OP Services	96372	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Therapeutic, Prophylactic or Diagnostic Injection; subcutaneous or intramuscular	$ 23.22
MH and SA OP Services	97810	*N/A*	Acupuncture, 1 or more needles; without electrical stimulation, initial 15 minutes of personal one-to-one contact	$ 19.84
MH and SA OP Services	97811	*N/A*	Add-On Code; Acupuncture, 1 or more needles; without electrical stimulation, each additional 15 minutes of personal one-to-one contact with re-insertion of needle(s).	$ 19.84
MH and SA OP Services	99202	UG-Doctoral Level (Child Psychiatrist)	Evaluation and Management for New Patient, 15-29 minutes	$ 75.25
MH and SA OP Services	99202	U6-Doctoral Level (MD / DO)	Evaluation and Management for New Patient, 15-29 minutes	$ 67.91
MH and SA OP Services	99202	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for New Patient, 15-29 minutes	$ 60.78
MH and SA OP Services	99203	UG- Doctoral Level (Child Psychiatrist)	Evaluation and Management for New Patient, 30-44 minutes	$ 108.55
MH and SA OP Services	99203	U6-Doctoral Level (MD / DO)	Evaluation and Management for New Patient, 30-44 minutes	$ 103.65

* See Section 2.7.C.2.e.1 for adjustment to unit cost if using CANS Tool.

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Category of Service	Procedure Code	Modifier Group	Procedure Description	Unit Cost
MH and SA OP Services	99203	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for New Patient, 30-44 minutes	$ 88.11
MH and SA OP Services	99204	UG-Doctoral Level (Child Psychiatrist)	Evaluation and Management for New Patient, 45-59 minutes	$ 164.00
MH and SA OP Services	99204	U6-Doctoral Level (MD / DO)	Evaluation and Management for New Patient, 45-59 minutes	$ 153.89
MH and SA OP Services	99204	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for New Patient, 45-59 minutes	$ 133.25
MH and SA OP Services	99205	UG-Doctoral Level (Child Psychiatrist)	Evaluation and Management for New Patient, 60-74 minutes	$ 203.69
MH and SA OP Services	99205	U6-Doctoral Level (MD / DO)	Evaluation and Management for New Patient, 60-74 minutes	$ 203.31
MH and SA OP Services	99205	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for New Patient, 60-74 minutes	$ 172.81
MH and SA OP Services	99211	UG-Doctoral Level (Child Psychiatrist)	Evaluation and Management for an Established Patient, 5 minutes	$ 22.06
MH and SA OP Services	99211	U6-Doctoral Level (MD / DO)	Evaluation and Management for an Established Patient, 5 minutes	$ 22.06
MH and SA OP Services	99211	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for an Established Patient, 5 minutes	$ 18.75
MH and SA OP Services	99212	UG-Doctoral Level (Child Psychiatrist)	Evaluation and Management for an Established Patient, 10-19 minutes	$ 52.73
MH and SA OP Services	99212	U6-Doctoral Level (MD / DO)	Evaluation and Management for an Established Patient, 10-19 minutes	$ 52.73
MH and SA OP Services	99212	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for an Established Patient, 10-19 minutes	$ 44.82
MH and SA OP Services	99213	UG-Doctoral Level (Child Psychiatrist)	Evaluation and Management for an Established Patient, 20-29 minutes	$ 84.11
MH and SA OP Services	99213	U6-Doctoral Level (MD / DO)	Evaluation and Management for an Established Patient, 20-29 minutes	$ 84.11
MH and SA OP Services	99213	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for an Established Patient, 20-29 minutes	$ 71.49
MH and SA OP Services	99214	UG-Doctoral Level (Child Psychiatrist)	Evaluation and Management for an Established Patient, 30-39 minutes	$ 143.98
MH and SA OP Services	99214	U6-Doctoral Level (MD / DO)	Evaluation and Management for an Established Patient, 30-39 minutes	$ 118.51
MH and SA OP Services	99214	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for an Established Patient, 30-39 minutes	$ 100.73
MH and SA OP Services	99215	UG-Doctoral Level (Child Psychiatrist)	Evaluation and Management for an Established Patient, 40-54 minutes	$ 166.57

* See Section 2.7.C.2.e.1 for adjustment to unit cost if using CANS Tool.

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Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	99215	U6-Doctoral Level (MD / DO)	Evaluation and Management for an Established Patient, 40-54 minutes	$ 166.57
MH and SA OP Services	99215	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for an Established Patient, 40-54 minutes	$ 141.58
MH and SA OP Services	99231	UG-Doctoral Level (Child Psychiatrist)	Subsequent Hospital Care for Eval and Management, 15 minutes	$ 78.07
MH and SA OP Services	99231	U6-Doctoral Level (MD / DO)	Subsequent Hospital Care for Eval and Management, 15 minutes	$ 59.27
MH and SA OP Services	99231	AH-Doctoral Level (PhD, PsyD, EdD)	Subsequent Hospital Care for Eval and Management, 15 minutes	$ 56.89
MH and SA OP Services	99231	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Subsequent Hospital Care for Eval and Management, 15 minutes	$ 47.47
MH and SA OP Services	99232	UG-Doctoral Level (Child Psychiatrist)	Subsequent Hospital Care for Eval and Management, 25 minutes	$ 117.11
MH and SA OP Services	99232	U6-Doctoral Level (MD / DO)	Subsequent Hospital Care for Eval and Management, 25 minutes	$ 88.19
MH and SA OP Services	99232	AH-Doctoral Level (PhD, PsyD, EdD)	Subsequent Hospital Care for Eval and Management, 25 minutes	$ 84.66
MH and SA OP Services	99232	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Subsequent Hospital Care for Eval and Management, 25 minutes	$ 70.63
MH and SA OP Services	99233	UG-Doctoral Level (Child Psychiatrist)	Subsequent Hospital Care for Eval and Management, 35 minutes	$ 156.16
MH and SA OP Services	99233	U6-Doctoral Level (MD / DO)	Subsequent Hospital Care for Eval and Management, 35 minutes	$ 117.59
MH and SA OP Services	99233	AH-Doctoral Level (PhD, PsyD, EdD)	Subsequent Hospital Care for Eval and Management, 35 minutes	$ 112.88
MH and SA OP Services	99233	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Subsequent Hospital Care for Eval and Management, 35 minutes	$ 94.18
MH and SA OP Services	99251	UG-Doctoral Level (Child Psychiatrist)	Initial Inpatient Consultation, 20 minutes	$ 104.74
MH and SA OP Services	99251	U6-Doctoral Level (MD / DO)	Initial Inpatient Consultation, 20 minutes	$ 79.50
MH and SA OP Services	99251	AH-Doctoral Level (PhD, PsyD, EdD)	Initial Inpatient Consultation, 20 minutes	$ 76.32
MH and SA OP Services	99251	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Initial Inpatient Consultation, 40 minutes	$ 63.67
MH and SA OP Services	99252	UG-Doctoral Level (Child Psychiatrist)	Initial Inpatient Consultation, 40 minutes	$ 157.11
MH and SA OP Services	99252	U6-Doctoral Level (MD / DO)	Initial Inpatient Consultation, 40 minutes	$ 118.32
MH and SA OP Services	99252	AH-Doctoral Level (PhD, PsyD, EdD)	Initial Inpatient Consultation, 40 minutes	$ 113.58
MH and SA OP Services	99252	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Initial Inpatient Consultation, 40 minutes	$ 94.77

* See Section 2.7.C.2.e.1 for adjustment to unit cost if using CANS Tool.

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Category of Service	Procedure Code	Modifier Group	Procedure Description	Unit Cost
UG-MH and SA OP Services	99253	UG-Doctoral Level (Child Psychiatrist)	Initial Inpatient Consultation, 55 minutes	$ 209.47
MH and SA OP Services	99253	U6-Doctoral Level (MD / DO)	Initial Inpatient Consultation, 55 minutes	$ 157.74
MH and SA OP Services	99253	AH-Doctoral Level (PhD, PsyD, EdD)	Initial Inpatient Consultation, 55 minutes	$ 151.44
MH and SA OP Services	99253	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Initial Inpatient Consultation, 55 minutes	$ 126.35
MH and SA OP Services	99254	UG-Doctoral Level (Child Psychiatrist)	Initial Inpatient Consultation, 80 minutes	$ 280.95
MH and SA OP Services	99254	U6-Doctoral Level (MD / DO)	Initial Inpatient Consultation, 80 minutes	$ 210.98
MH and SA OP Services	99254	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Initial Inpatient Consultation, 80 minutes	$ 169.00
MH and SA OP Services	99255	UG-Doctoral Level (Child Psychiatrist)	Initial Inpatient Consultation - Comprehensive, 110 minutes	$ 370.12
MH and SA OP Services	99255	U6-Doctoral Level (MD / DO)	Initial Inpatient Consultation - Comprehensive, 110 minutes	$ 277.57
MH and SA OP Services	99255	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Initial Inpatient Consultation - Comprehensive, 110 minutes	$ 222.33
MH and SA OP Services	99281	U6-Doctoral Level (MD/DO)	Emergency Department visit for the evaluation and management of a patient, which requires 3 key components: A problem-focused history; A problem-focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor.	$ 20.14
MH and SA OP Services	99282	UG-Doctoral Level (Child Psychiatrist)	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem-focused history; An expanded problem-focused examination; and Medical decision-making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity.	$ 35.37

* See Section 2.7.C.2.e.1 for adjustment to unit cost if using CANS Tool.

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Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	99282	U6-Doctoral Level (MD/DO)	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity.	$ 33.68
MH and SA OP Services	99282	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity.	$ 32.70
MH and SA OP Services	99283	UG-Doctoral Level (Child Psychiatrist)	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity.	$ 53.52
MH and SA OP Services	99283	U6-Doctoral Level (MD/DO)	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity.	$ 50.97

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Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	99283	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity.	$ 49.49
MH and SA OP Services	99284	UG-Doctoral Level (Child Psychiatrist)	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.	$ 100.58
MH and SA OP Services	99284	U6-Doctoral Level (MD/DO)	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.	$ 95.80

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Unique Code/Modifier Combinations				
Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	99284	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.	$ 93.01
MH and SA OP Services	99285	UG-Doctoral Level (Child Psychiatrist)	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.	$ 148.78
MH and SA OP Services	99285	U6-Doctoral Level (MD/DO)	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.	$ 141.69

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Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	99285	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.	$ 136.30
MH and SA OP Services	99402	AH-Doctoral Level (PhD, PsyD, EdD)	Preventative Medicine Counseling , 30 minutes (Psychological Testing)	$ 40.98
MH and SA OP Services	99402	U3-Intern (PhD, PsyD, EdD) / or MAT	Preventative Medicine Counseling, 30 minutes (Psychological Testing)	$ 20.50
MH and SA OP Services	99404	U6-Doctoral Level (MD / DO)	Preventative Medicine Counseling, 60 minutes (Counseling and/or Risk Factor Reduction Intervention)	$ 194.82
MH and SA OP Services	99404	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Preventative Medicine Counseling, 60 minutes (Counseling and/or Risk Factor Reduction Intervention)	$ 168.60
MH and SA OP Services	99417	U6-Doctoral Level (MD / DO)	Add-On Code; Prolonged office or other outpatient evaluation and management service, requiring total time with or without direct patient contact beyond usual service, on the date of the primary service (e.g., 99205 or 99215), each 15 minutes	$ 26.08
MH and SA OP Services	99417	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Add-On Code; Prolonged office or other outpatient evaluation and management service, requiring total time with or without direct patient contact beyond usual service, on the date of the primary service (e.g., 99205 or 99215), each 15 minutes	$ 26.08
Diversionary Services	H0037	*N/A*	Community Psychiatric Supportive Treatment Program, per diem (Community Based Acute Treatment - CBAT)	$ 654.13
Diversionary Services	H0037	U2-Autism Diagnosis	Community Psychiatric Supportive Treatment Program, per diem (CBAT Autism Speciality)	$ 1,093.70
Diversionary Services	H2012	*N/A*	Behavioral Health Day Treatment, per hour (Psychiatric Day Treatment)	101 CMR 307.00
Diversionary Services	H2012	*N/A*	Behavioral Health Day Treatment, per hour (Enhanced Psychiatric Day Treatment)	101 CMR 307.00

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Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
Diversionary Services	H2015	*HF-Substance Abuse Program*	Recovery Support Navigator – Self-help/peer service by a recovery advocate trained in Recovery Coaching. Rate is in 15-minutes increments.	101 CMR 444.00
Diversionary Services	H2015	*N/A*	Comprehensive community support services, per 15 minutes (Community Support Program)	101 CMR 362.00
Diversionary Services	H2016	HH-Integrated Mental Health/Substance Abuse Program	Effective on the later of October 1, 2021 or the date on which CMS approves these services, comprehensive community support program, per diem (Enrolled Client Day) (behavioral health service by a navigator trained to support members with justice involvement) (CSP-JI)	101 CMR 362.00
Diversionary Services	H2016	HK - Specialized mental health programs for high-risk populations	Comprehensive community support program, per diem, for members who are 1) experiencing Homelessness and are frequent users of acute health MassHealth services, or 2) are experiencing chronic homelessness	101 CMR 362
Diversionary Services	H2016	HE - Mental Health Program	Comprehensive community support program, per diem, for members who are At Risk of Homelessness and facing Eviction as a result of behavior related to a disability	101 CMR 362
Diversionary Services	H2016	HM-Less than bachelor degree level	Comprehensive community support program, per diem (Enrolled Client Day) (recovery support service by a recovery advocate trained in Recovery Coaching)	101 CMR 346.00
Diversionary Services	H2020	*N/A*	Therapeutic behavioral services, per diem (Dialectical Behavior Therapy)	$ 26.50
Diversionary Services	H2022	HE-Mental Health Program	Intensive Hospital Diversion Services for Children, per diem	$ 175.19
Diversionary Services	S9484	*N/A*	Crisis intervention mental health services, per hour (Urgent Outpatient Services)	$ 147.57
MH and SA OP Services	H0014	*N/A*	Alcohol and/or drug services; ambulatory detoxification (Adult or Adolescent)	$ 227.65
Crisis Intervention Services	S9485	*ET-Emergency Services*	Crisis intervention mental health services, per diem. (Adult Community Crisis Stabilization per day rate)	101 CMR 305
Crisis Intervention Services	S9485	*ET-Emergency Services; HA-Child/Adolescent Program*	Crisis intervention mental health services, per diem. (Youth Community Crisis Stabilization Per day rate)	101 CMR 305
Crisis Intervention Services	S9485	*HB-Adult Program, non-geriatric*	Crisis intervention mental health services, per diem. (Adult Mobile Crisis Intervention provided at hospital emergency department. Inclusive of initial evaluation and all follow-up intervention. Use Place of Service code 23.)	$ 695.29
Crisis Intervention Services	S9485	*HE-Mental Health Program*	Crisis intervention mental health services, per diem. (Adult Mobile Crisis Intervention provided at CBHC site. Inclusive of initial evaluation and first day crisis interventions.)	101 CMR 305

Appendix L: Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule

APPENDIX L - Commonwealth of Massachusetts Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule **Effective 4/1/2023**				
Unique Code/Modifier Combinations				
Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
Crisis Intervention Services	S9485	*HA-Child/Adolescent Program; HE-Mental Health Program*	Crisis intervention mental health services, per diem. (Youth Mobile Crisis Intervention provided at CBHC site. Inclusive of initial evaluation and first day crisis interventions.)	101 CMR 305
Crisis Intervention Services	S9485	*U1-MCI - Mobile Non-Emergency Department / or MAT*	Crisis intervention mental health services, per diem. (Adult Mobile Crisis Intervention provided at community-based sites of service outside of the CBHC site. Inclusive of initial evaluation and first day crisis interventions. Use Place of Service 15.)	101 CMR 305
Crisis Intervention Services	S9485	*HA-Child/Adolescent Program; U1-MCI - Mobile Non-Emergency Department / or MAT*	Crisis intervention mental health services, per diem. (Youth Mobile Crisis Intervention provided at community-based sites of service outside of the CBHC site. Inclusive of initial evaluation and first day crisis interventions Use Place of Service code 15.)	101 CMR 305
Crisis Intervention Services	S9485		Crisis intervention mental health services, per diem. (BH Crisis evaluation provided at hospital emergency department by hospital. Inclusive of initial evaluation and all follow-up interventions over 24-hour period.)	$ 695.29
Crisis Intervention Services	S9485	U1-ESP - Mobile Non-Emergency Department / or MAT	Crisis intervention mental health service, per diem (Emergency Service Program Mobile Non-Emergency Department - Uninsured)	$ 1,024.64
Crisis Intervention Services	S9485	HE-Mental Health Program	Crisis intervention mental health services, per diem (Emergency Service Program Community Based - Uninsured)	$ 695.29
Other Outpatient	90870	*N/A*	Electroconvulsive therapy (includes necessary monitoring)	$ 630.95
Other Outpatient	96112	AH-Doctoral Level (PhD, PsyD, EdD)	Developmental Testing administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; first hour (Learning Disorders)	$ 180.72
Other Outpatient	96113	AH-Doctoral Level (PhD, PsyD, EdD)	Add-On Code; Each additional 30 minutes (List separately in addition to code for primary procedure) (Developmental/Behavioral Screening and Testing)	$ 90.36
Other Outpatient	96116	AH-Doctoral Level (PhD, PsyD, EdD)	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), by physician o rother qualified health professional, both face-to-face time with the patient and time interpreting test results and preparing the report; first hour	$ 120.46

* See Section 2.7.C.2.e.1 for adjustment to unit cost if using CANS Tool.

Appendix L: Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule

APPENDIX L - Commonwealth of Massachusetts Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule **Effective 4/1/2023** Unique Code/Modifier Combinations				
Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
Other Outpatient	96121	AH-Doctoral Level (PhD, PsyD, EdD)	Add-On Code; Each additional hour (List separately in addition to code for primary procedure)	$ 120.46
Other Outpatient	96130	AH-Doctoral Level (PhD, PsyD, EdD)	Psychological testing evaluation services by physician or other qualified health care professional, including integrating of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour	$ 91.39
Other Outpatient	96131	AH-Doctoral Level (PhD, PsyD, EdD)	Add-On Code; Each additional hour (List separately in addition to code for primary procedure)	$ 91.39
Other Outpatient	96132	AH-Doctoral Level (PhD, PsyD, EdD)	Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour	$ 91.39
Other Outpatient	96133	AH-Doctoral Level (PhD, PsyD, EdD)	Add-On Code; Each additional hour (List separately in addition to code for primary procedure)	$ 91.39
Other Outpatient	96136	AH-Doctoral Level (PhD, PsyD, EdD)	Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes (Test administration and scoring by professional)	$ 45.70
Other Outpatient	96137	Doctoral Level (PhD, PsyD, EdD)	Add-On Code; Each additional 30 minutes (List separately in addition to code for primary procedure) (Test administration and scoring by professional)	$ 45.70
Other Outpatient	96138	*N/A*	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes	$ 22.85
Other Outpatient	96139	*N/A*	Add-On Code; Each additional 30 minutes (List separately in addition to code for primary procedure) (Test administration and scoring by technician)	$ 22.85

Appendix L: Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule

APPENDIX L - Commonwealth of Massachusetts Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule **Effective 4/1/2023** Unique Code/Modifier Combinations				
Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
Other Outpatient	H0032	HO-HO-Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Mental health service plan development by a nonphysician (Bridge consultation inpatient/outpatient)	$ 166.67
Other Outpatient	H0046	UG-Doctoral Level (Child Psychiatrist)	Mental health services, not otherwise specified (Collateral Contact)	$ 46.46
Other Outpatient	H0046	U6-Doctoral Level (MD/DO)	Mental health services, not otherwise specified (Collateral Contact)	$ 40.30
Other Outpatient	H0046	AH-Doctoral Level (PhD, PsyD, EdD)	Mental health services, not otherwise specified (Collateral Contact)	$ 21.79
Other Outpatient	H0046	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Mental health services, not otherwise specified (Collateral Contact)	$ 34.87
Other Outpatient	H0046	HO-Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Mental health services, not otherwise specified (Collateral Contact)	$ 21.48
Other Outpatient	H0046	U7-Certified Addiction Counselor / Certified Alcohol & Drug Abuse Counselor	Mental health services, not otherwise specified (Collateral Contact)	$ 21.48
Other Outpatient	H0046	U3-Intern (PhD, PsyD, EdD) / or MAT	Mental health services, not otherwise specified (Collateral Contact)	$ 10.91
Other Outpatient	H0046	U4-Intern (Master's)	Mental health services, not otherwise specified (Collateral Contact)	$ 10.74
Other Outpatient	H0046	HE-Mental Health Program	Mental health services, not otherwise specified, per diem (Enrolled Client Day) (Certified Peer Specialist)	101 CMR 305
Other Outpatient	H2028	*N/A*	Sexual offender treatment service, per 15 minutes (ASAP - Assessment for Safe and Appropriate Placement)	$ 22.79
MH and SA OP Services	H0001	U1-ESP - Mobile Non-Emergency Department / or MAT	MAT - Alcohol and/or drug assessment (buprenorphine and naltrexone medication evaluation by physician and/or midlevel practitioner)	$ 146.93
MH and SA OP Services	H0004		Behavioral health counseling and therapy, per 15 minutes (individual counseling)	101 CMR 346
MH and SA OP Services	H0005		Alcohol and/or drug services; group counseling by a clinician (per 45 minutes, group counseling, one unit maximum per day)	101 CMR 346
MH and SA OP Services	H0005	HG	Alcohol and/or drug services group counseling by a clinician (per 90-minute unit) (one unit maximum per day)	101 CMR 346

* See Section 2.7.C.2.e.1 for adjustment to unit cost if using CANS Tool.

Appendix L: Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule

APPENDIX L - Commonwealth of Massachusetts Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule **Effective 4/1/2023**				
Unique Code/Modifier Combinations				
Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	T1006		Alcohol and/or substance abuse services; family/couple counseling (per 30 minutes, one unit maximum per day)	101 CMR 346
MH and SA OP Services	T1006	HF	Alcohol and/or substance abuse services; family/couple counseling (per 60 minutes, one unit maximum per day)	101 CMR 346

Appendix M

Directed Payments Related to Certain Behavioral Health Services

Exhibit 1: Summary of Behavioral Health Services Rate Increases by Service

Covered Service	Codes	Increase	Rate Increase Effective Date	Rate Increase End Date
Acute Treatment Services (ATS) for Substance Use Disorders and Clinical Support Services for Substance Use Disorders (including Individualized Treatment Services)	H0011, H0010, H2036-HK, H2036-HF	10%	1/1/2023	6/30/2023
Community-Based Acute Treatment for Children and Adolescents (CBAT), including Autism CBAT	H0037, H0037-U2	10%	1/1/2023	6/30/2023
Community Support Program (CSP) - including CSP for Chronically Homeless Individuals (CSP-CHI) and CSP - Social Impact Funding (SIF)	H2015, H2016-HK, H2016-HH, H2016-HE	10%	1/1/2023	3/31/2023
Intensive Outpatient Program (IOP)	Rev Code 0905, 0906	10%	1/1/2023	12/31/2023
Partial Hospitalization (PHP)	Rev Codes 9012, 9013	10%	1/1/2023	12/31/2023
Program of Assertive Community Treatment (PACT)	H0040	10%	1/1/2023	6/30/2023
Psychiatric Day Treatment (Behavioral Health Day Treatment)	H2012, H2012-U1	10%	1/1/2023	1/31/2024
Psychological Testing (including Psychological Neuropsychological Testing) and Special Education Psychological Testing	96130-AH, 96131-AH, 96132-AH, 96133-AH, 96136-AH, 96137-AH, 96138, 96139	10%	1/1/2023	6/30/2023
Residential Rehabilitation Services for Substance Use Disorders, including Adult Residential, Transitional Age Youth and Young Adult Residential, Youth Residential, and Pregnancy Enhanced Residential (excluding Co-Occurring Enhanced RRS)	H0019, H0019-TH, H0019-HD, H0019-HD, H0019-HV, H0019-H9, H0019-HR [EXCLUDE H0019-HH]	10%	1/1/2023	6/30/2023
Structured Outpatient Addiction Program (SOAP), including Enhanced SOAP	H0015, H0015-TF	10%	1/1/2023	6/30/2023
Transitional Care Unit (TCU)	Rev codes 0100, 0114, 0124, 0134, 0144, 0154	10%	1/1/2023	12/31/2023

For Residential Rehabilitation Services (RRS), Acute Treatment Services (ATS), Clinical Stabilization Services (CSS), Program of Assertive Community Treatment (PACT), 60-minute Psychotherapy codes, and Psychiatric Day Treatment (Behavioral Health Day Treatment), the Contractor shall apply the percentage increases to contracted rates effective as of July 1, 2021.

For dates of service on or after February 1, 2022, for Behavioral Health Urgent Care (BHUC), the Contractor shall apply the percentage increases to contracted rates effective as of February 1, 2022. The percentage increase will be in addition to the BHUC directed payment set forth in managed care plan contracts.

For all other services, the Contractor shall apply the percentage increases indicated in the table to the plan's contracted rates with providers as of June 30, 2021.

Appendix N

Executive Office of Health and Human Services
Coronavirus State Fiscal Recovery Fund (FRF) Contract Addendum
(Assistance Listing Number 21.027)

Notice: The contract, agreement, statement of work, or purchase order ("Contract") between the Massachusetts Behavioral Health Partnership ("Contractor") and the Executive Office of Health and Human Services ("EOHHS") to which this addendum is attached or otherwise incorporated is funded, in whole or in part, using federal assistance provided to the Commonwealth of Massachusetts by the U.S. Department of the Treasury under Section 9901 of the American Rescue Plan Act of 2021 ("ARPA"), which established the Coronavirus State Fiscal Recovery Fund ("FRF").

In accordance with ARPA, the U.S. Department of the Treasury's regulations implementing the FRF (31 CFR Part 35), the Award Terms and Conditions, and the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards, 2 C.F.R. Part 200, the following terms and conditions apply to the Contractor in connection with its performance of the Contract.
These terms and conditions are in addition to, and in no way limit or alter, the other terms, conditions, rights, and remedies set forth in or applicable to the Contract, including those set forth in the Commonwealth of Massachusetts Standard Contract Form and Commonwealth Terms and Conditions. In the event of any conflict among the requirements applicable to the Contract, the most stringent requirements will apply.

1. **Contracting with Small and Minority Businesses, Women's Business Enterprises, And Labor Surplus Area Firms (2 CFR § 200.321).** To the extent the Contractor is permitted and intends to utilize subcontractors under the Contract, the Contractor agrees to take affirmative steps to assure that minority businesses, women's business enterprises, and labor surplus area firms are used whenever possible. Affirmative steps must include:
    a. Placing qualified small and minority businesses and women's business enterprises on solicitation lists;
    b. Assuring that small and minority businesses, and women's business enterprises are solicited whenever they are potential sources;
    c. Dividing total requirements, when economically feasible, into smaller tasks or quantities to permit maximum participation by small and minority businesses, and women's business enterprises;
    d. Establishing delivery schedules, where the requirement permits, which encourage participation by small and minority businesses, and women's business enterprises;
    e. Using the services and assistance, as appropriate, of such organizations as the Small Business Administration and the Minority Business Development Agency of the Department of Commerce; and
    f. Requiring the subcontractor take the affirmative steps listed in paragraph (a) through (e) above.

2. **Domestic Preferences for Procurements (2 CFR § 200.322).** As appropriate and to the extent consistent with law, the Contractor should, to the greatest extent practicable, provide a preference for the purchase, acquisition, or use of products, or materials produced in the United States (including but not limited to iron, aluminum, steel, cement, and other manufactured products). This requirement must be included in all subawards

including all contracts and purchase orders for work or products under this Contract. For purposes of this section:

a. "produced in the United States" means, for iron and steel products, that all manufacturing processes from the initial melting stage through the application of coatings, occurred in the United States; and

b. "manufactured products" means items and construction materials composed in whole or in part of non-ferrous metals such as aluminum; plastics and polymer-based products such as polyvinyl chloride pipe; aggregates such as concrete; glass, including optical fiber; and lumber.

3. **Procurement of Recovered Materials (2 CFR § 200.323).**

a. To the extent applicable, the Contractor shall comply with the requirements of Section 6002 of the Solid Waste Disposal Act, as amended by the Resource Conservation and Recovery Act.

b. The requirements of Section 6002 include procuring only items designated in guidelines of the Environmental Protection Agency (EPA) at 40 CFR Part 247 that contain the highest percentage of recovered materials practicable, consistent with maintaining a satisfactory level of competition, where the purchase price of the item exceeds $10,000 or the value of the quantity acquired during the preceding fiscal year exceeded $10,000; procuring solid waste management services in a manner that maximizes energy and resource recovery; and establishing an affirmative procurement program for procurement of recovered materials identified in the EPA guidelines.

4. **Suspension and Debarment (Executive Orders 12549 and 12689).**

a. This Contract is funded through payments received by the Commonwealth of Massachusetts from the FRF. FRF funds are subject to 2 CFR Part 180 and U.S. Department of the Treasury's implementing regulations at 31 CFR Part 19. The Contract is a covered transaction for purposes of such regulations.

b. As such, the Contractor is required to verify, and by executing this Contract the Contractor hereby certifies, that neither it nor any of the Contractor's principals are excluded, disqualified, or otherwise ineligible (as such terms are defined at 31 CFR Part 19, Subpart I) for participation in a covered transaction. Such parties are ineligible if listed on the government-wide Excluded Parties List System in the System for Award Management (SAM) in accordance with 2 CFR Part 180 and U.S. Department of the Treasury's implementing regulations at 31 CFR Part 19 that implement Executive Orders 12549 and 12689, "Debarment and Suspension."

c. The Contractor must comply with 31 CFR Part 19, subpart C, and shall include a requirement to comply with these requirements in any lower tier covered transaction under it enters into.

d. The Contractor shall have an ongoing duty during the term of this Contract to disclose to EOHHS on an ongoing basis any occurrence that would prevent the Contractor from making the certifications contained in this Section 4. Such disclosure shall be made in writing to EOHHS within five (5) business days of when the Contractor discovers or reasonably believes there is a likelihood of such occurrence. This certification is a material representation of fact relied upon by EOHHS. If it is later determined that the Contractor did not comply with 31 CFR Part 19, subpart C, in addition to remedies available to EOHHS, the Federal government

may pursue available remedies, including but not limited to suspension and/or debarment.

5. **Never Contract with the Enemy.** The Contractor must comply with 2 C.F.R. § 200.183, which implements Title VIII, Subtitle E of the FY 2015 NDAA (Pub. L. 113-291), as amended by Sec. 822 of the FY 2020 NDAA (Pub. L. 116-92), and prohibits recipients from providing funds to persons or entities actively opposing United States or coalition forces involved in contingency operations.

6. **Prohibition on Certain Telecommunications and Video Surveillance Services or Equipment (2 CFR § 200.216).**

a. Pursuant to 2 CFR §200.216, EOHHS is prohibited from using FRF funds to procure or obtain, or enter into a contract (or extend or renew a contract) to procure or obtain equipment, services, or systems that use covered telecommunications equipment or services as a substantial or essential component of any system, or as critical technology as part of any system.

b. As described in Public Law 115-232, section 889, "Covered telecommunications equipment or services" is:

i. Telecommunications equipment produced by Huawei Technologies Company or ZTE Corporation (or any subsidiary or affiliate of such entities);

ii. For the purpose of public safety, security of government facilities, physical security surveillance of critical infrastructure, and other national security purposes, video surveillance and telecommunications equipment produced by Hytera Communications Corporation, Hangzhou Hikvision Digital Technology Company, or Dahua Technology Company (or any subsidiary or affiliate of such entities);

iii. Telecommunications or video surveillance services provided by such entities or using such equipment; and

iv. Telecommunications or video surveillance equipment or services produced or provided by an entity that the Secretary of Defense, in consultation with the Director of National Intelligence or the Director of the Federal Bureau of Investigation, reasonably believes to be an entity owned or controlled by, or otherwise connected to, the government of a covered foreign country.

c. The Contractor agrees that it shall not provide covered telecommunications equipment or services in the performance of this Contract.

d. A compilation of prohibited telecommunications and video surveillance equipment and services entities may be found in the System for Award Management (SAM) excluded parties list.

7. **Remedies for Contract Violation.** *[Required for contracts exceeding $250,000]* Should the Contractor violate of any of the terms of the Contract, EOHHS may pursue all available administrative, contractual, or legal remedies, as well as any applicable sanctions and penalties.

8. **Contract Work Hours and Safety Standards Act (40 U.S.C. 3701-3708).** *[Required for contracts exceeding $100,000 that involve the employment of mechanics or laborers]* To the

extent the Contract involves the employment of mechanics or laborers (as defined in 29 CFR Part 5 and including watchmen and guards) for any part of the contract work, the Contractor agrees to the following terms:

a. *Overtime requirements*. The Contractor shall not require or permit any such laborer or mechanic in any workweek in which he or she is employed on such work to work in excess of forty hours in such workweek unless such laborer or mechanic receives compensation at a rate not less than one and one-half times the basic rate of pay for all hours worked in excess of forty hours in such workweek.

b. *Violation; liability for unpaid wages; liquidated damages*. In the event of any violation of the clause set forth in paragraph (a) of this section, the Contractor and any subcontractor responsible therefor shall be liable for the unpaid wages. In addition, the Contractor and any such subcontractor shall be liable to the United States (in the case of work done under contract for the District of Columbia or a territory, to such District or to such territory), for liquidated damages. Such liquidated damages shall be computed with respect to each individual laborer or mechanic, including watchmen and guards, employed in violation of the clause set forth in paragraph (a) of this section, in the sum of $29 for each calendar day on which such individual was required or permitted to work in excess of the standard workweek of forty hours without payment of the overtime wages required by the clause set forth in paragraph (a) of this section.

c. *Withholding for unpaid wages and liquidated damages*. EOHHS shall upon its own action or upon written request of an authorized representative of the Department of Labor withhold or cause to be withheld, from any moneys payable on account of work performed by the contractor or subcontractor under any such contract or any other Federal contract with the same prime contractor, or any other federally-assisted contract subject to the Contract Work Hours and Safety Standards Act, which is held by the same prime contractor, such sums as may be determined to be necessary to satisfy any liabilities of such contractor or subcontractor for unpaid wages and liquidated damages as provided in the clause set forth in paragraph (b) of this section.

d. *Records*. The Contractor shall maintain payrolls and basic payroll records during the course of the work and shall preserve them for a period of three years from the completion of the contract for all laborers and mechanics, including guards and watchmen, working on the Contract. Such records shall contain the name and address of each such employee, social security number, correct classifications, hourly rates of wages paid, daily and weekly number of hours worked, deductions made, and actual wages paid. The records to be maintained under this paragraph shall be made available by the Contractor for inspection, copying, or transcription by authorized representatives of EOHHS and the Department of Labor, and the Contractor will permit such representatives to interview employees during working hours on the job.

e. *Subcontracts*. The Contractor shall insert in any subcontracts the clauses set forth in paragraph (a) through (d) of this section and also a clause requiring the subcontractors to include these clauses in any lower tier subcontracts. The prime contractor shall be responsible for compliance by any subcontractor or lower tier subcontractor with the clauses set forth in paragraphs (a) through (d) of this section.

9. **The Clean Air Act (42 U.S.C. 7401-7671q.) and the Federal Water Pollution Control Act (33 U.S.C. 1251-1387), as amended.** *[Required for contracts exceeding $150,000]*

a. The Contractor agrees to comply with all applicable standards, orders or regulations issued pursuant to the Clean Air Act (42 U.S.C. 7401-7671q) and the Federal Water Pollution Control Act as amended (33 U.S.C. 1251-1387).

b. The Contractor agrees to report each violation to EOHHS and understands and agrees that EOHHS will, in turn, report each violation as required to assure notification to the U.S. Department of the Treasury and the appropriate Environmental Protection Agency Regional Office.

c. The Contractor agrees to include the above requirements in each subcontract exceeding $150,000 financed in whole or in part with FRF funds.

10. **Other Federal Environmental Laws and Regulations**. The Contractor shall comply with all other applicable federal environmental laws and regulations.

11. **Byrd Anti-Lobbying Amendment (31 U.S.C. 1352).** [*Required for contracts exceeding $100,000*] The Contractor certifies that:

a. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

b. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the Contractor shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

c. To the extent the Contractor is permitted and intends to utilize subcontractors under the Contract , the Contractor shall require that the language of this certification be included in all subcontracts and that all subcontractors shall certify and disclose accordingly.

d. This certification is a material representation of fact upon which reliance was placed when this Contract was entered into or amended. The making of this certification is a prerequisite for entering into or amending this Contract imposed by 31 U.S.C. 1352. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

12. **Non-Discrimination.** The Contractor shall comply with all applicable federal laws and regulations prohibiting discrimination including, without limitation, the following:

a. Title VI of the Civil Rights Act of 1964 (42 U.S.C. §§ 2000d et seq.) and U.S. Department of the Treasury's implementing regulations at 31 C.F.R. Part 22, which prohibit discrimination on the basis of race, color, or national origin under programs or activities receiving federal financial assistance;

b. The Fair Housing Act, Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§ 3601 et seq.), which prohibits discrimination in housing on the basis of race, color, religion, national origin, sex, familial status, or disability;

c. Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. § 794), which prohibits discrimination on the basis of disability under any program or activity receiving federal financial assistance;

d. The Age Discrimination Act of 1975, as amended (42 U.S.C. §§ 6101 et seq.), and U.S. Department of the Treasury's implementing regulations at 31 C.F.R. Part 23, which prohibit discrimination on the basis of age in programs or activities receiving federal financial assistance; and

e. Title II of the Americans with Disabilities Act of 1990, as amended (42 U.S.C. §§ 12101 et seq.), which prohibits discrimination on the basis of disability under programs, activities, and services provided or made available by state and local governments or instrumentalities or agencies thereto.

13. **Publications**. To the extent the Contractor is authorized or directed to produce publications pursuant to this Contract, any such publications produced with FRF funds must display the following language: "This project [is being] [was] supported, in whole or in part, by federal award number [enter project FAIN] awarded to the Commonwealth of Massachusetts by the U.S. Department of the Treasury."

14. **Maintenance of and Access to Records.**

a. The Contractor shall maintain records pertinent to the Contract in a manner consistent with 2 C.F.R. § 200.334.

b. The Contractor shall make available to EOHHS, the U. S. Department of the Treasury, the Treasury Office of Inspector General, the Government Accountability Office, or any of their authorized representatives any documents, papers, or other records, including electronic records, of the Contractor that are pertinent to the Contract, in order to make audits, investigations, examinations, excerpts, transcripts, and copies of such documents. This right also includes timely and reasonable access to the Contractor's personnel for the purpose of interview and discussion related to such documents. This right of access shall continue as long as records are retained.

15. **Increasing Seat Belt Use in the United States.** Pursuant to Executive Order 13043, 62 FR 19217 (Apr. 18, 1997), the Contractor is encouraged to adopt and enforce on-the job seat belt policies and programs for their employees when operating company-owned, rented or personally owned vehicles.

16. **Reducing Text Messaging While Driving.** Pursuant to Executive Order 13513, 74 FR 51225 (Oct. 6, 2009), the Contractor is encouraged to adopt and enforce policies that ban text messaging while driving and should establish workplace safety policies to decrease accidents caused by distracted drivers.

17. **Subcontractors.** To the extent the Contractor is permitted and intends to utilize subcontractors under the Contract, the Contractor agrees to incorporate all relevant provisions of this addendum into its written agreement with the subcontractor.