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:** Alejandro Garcia Davalos	**Phone:** 781-227-1913
Contractor Vendor Code: VC6000182737		**E-Mail:** Alejandro.E.GarciaDavalos@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 6 makes these changes/additions to the MBHP contract: 1) replaces language on requirements concerning the Patient and Family Advisory Committee (PFAC); 2) changes the meeting requirement of the PCC CAC Meeting to be held at the discretion of EOHHS; 3) clarifies direction on how MBHP determines member eligibility for Care management or Intensive Care Coordination (by utilizing Community Partner Enrollment roster and CARES Enrollment Report); 4) expands MBHP coverage of Mobile Crisis (AMCI/YMCI/CCS) and up to three units of the outpatient CBHC bundle without regard to enrollment with MBHP; 5) clarifies requirements around ASD-ID (Autism Spectrum Disorder) for MCPAP; 6) clarifies use of medical necessity determination for CSP services; 7) adds requirement that MBHP shall work with EOHHS to implement payment and program innovation for BHUC providers, as well as developing Performance Specifications for the delivery of BHUC services; 8) clarifies requirements of HRSN program; 9) adds requirement for MBHP to continue collaborative work on CBHI, including procurement and management of Community Service Agencies; 10) adds requirement for MBHP to establish and maintain a publicly accessible, standards-based Provider Directory application programming interface (API) in accordance with federal law; 11) adds requirements for MBHP to collaborate with MASOC in the development and delivery of clinician training about the MA Child and Adolescent Assessment Protocol (M-CAAP) for sexual behaviors; 12) replaces and updates language on DSRA requirements; 13) adds requirement for MBHP to ensure all material subcontractors meet MLR requirements; 14) replaces and updates language and requirements around Health Equity.15) updates the financial and payment provisions including RY25 capitation rates effective 01/01/25 and other RY25 non-capitation funding.**

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 _____, 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: Sharon Hanson. **Date:** 12/20/24.

(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:** 12/24/2024.

(Signature and Date Must Be Captured At Time of Signature)

Print Name: Mike Levine.

Print Title: Assistant Secretary for MassHealth.

AMENDMENT 6

to the

MANAGED BEHAVIORAL HEALTH VENDOR CONTRACT

Between the

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

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, EOHHS and the Contractor amended the Managed Behavioral Health Vendor Contract on 06/29/2023 (Amendment #1); 10/04/2023 (Amendment #2); 12/28/2023 (Amendment #3); 05/15/2024 (Amendment #4); 08/28/2024 (Amendment #5) and

WHEREAS, in accordance with **Section 5.8** of the Contract, EOHHS and the Contractor desire to further amend their agreement effective January 1, 2025, 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. Definition and Acronyms

Section 1.1 is hereby amended by inserting the following definitions in the correct alphabetical order:

"HRSN Service Manual – The MassHealth manual detailing requirements for the provision of HRSN Services, which may be accessed here [https://www.mass.gov/info-details/information-for-masshealth-acos-and-hrsn-providers].

Medication for Addiction Treatment (MAT) – use of a medication approved by the federal Food and Drug Administration (FDA) for the treatment of a substance use disorder.

Outpatient Crisis Payment – payment for up to 3 units of outpatient CBHC bundle services provided to Uninsured Individuals and persons covered by Medicare who are experiencing a behavioral health crisis."

Section 1.1 is further amended by striking the phrase "Applied Behavioral Analysis" in its definition and replacing it with "Applied Behavior Analysis".

Section 1.1 is further amended by amending Section (1) of the definition of **"Adverse Action"** to include the following language at the end therein: "provided, however, that the suspension of HRSN Supplemental Services in accordance with **Section 2.6.D.12** shall not be considered an Adverse Action."

Section 1.1 is further amended by modifying the definition of **"Behavioral Health Urgent Care (BHUC) Program"** by striking the phrase "Medication Assisted Treatment" and replacing it with "Medication for Addiction Treatment".

Section 1.1 is further amended by striking the definition of **"Medication for Opioid Use Disorder (MOUD)"** and replacing it with the following definition: "use of a medication approved by the federal Food and Drug Administration (FDA) for the treatment of an opioid use disorder."

Section 1.1 is further amended by striking the definition of "**Mobile Crisis Intervention Uncompensated Care Payment**" and replacing it with the following definition: "payment for AMCI/YMCI including follow-up, Community Crisis Stabilization, and up to three units of outpatient CBHC bundle services provided under the Contract when not covered otherwise to Individuals without Crisis Coverage who are experiencing a behavioral health crisis.

Section 1.1 is further amended by modifying the definition of "**Opioid Treatment Programs (OTP)**" by striking the phrase "are addicted to opioids" and replacing it with the "have opioid use disorders".

Section 1.1 is further amended by changing the definition name of "**Recovery Coach**" to "**Peer Recovery Coach"** and alphabetically relocating the definition.

Section 1.1 is further amended by modifying the definition of **"Urgent Care"** by striking the phrase "Medication Assisted Treatment" and replacing it with "Medication for Addiction Treatment".

Section 1.2 is hereby amended by inserting alphabetically the following acronym:

PCACO – Primary Care ACO

Section 1.2 is further amended by striking "Applied Behavioral Analysis" and replacing it with "Applied Behavior Analysis".

Section 1.2 is further amended by striking "HEC Health Equity Committee" and replacing it with "HQEC Health Quality and Equity Committee".

Section 2. Contractor Responsibilities

Section 2.3.B is hereby amended by adding at the end therein the following:

"5. A Health Quality and Equity Committee as described in **Section 2.20.A.**

Section 2.3.B.2.b.1 is hereby amended by striking it in its entirety and replacing it with the following language:

"Meeting at the discretion of EOHHS. The meetings may be a joint meeting with the BH Clinical Advisory Committee (see **Section 2.3.B.1**, above);".

Section 2.3.B.3 is hereby amended by deleting it in its entirety and replacing it with the following language:

"3. Patient and Family Advisory Committee (PFAC)

a) Duties of the PFAC include but are not limited to:

1) Providing regular feedback to the Governing Board on issues of Covered Individuals' care and services;

2) Identifying and advocating for preventive care practices to be utilized by the Contractor;

3) Being involved with the development and updating of cultural and linguistic policies and procedures, including those related to Quality Improvement, education, and operational and cultural competency issues affecting groups who speak a primary language other than English;

4) Advising on the cultural appropriateness and member-centeredness of necessary member or provider targeted services, programs, and trainings; Contractor Marketing Materials and campaigns; and Contractor partnerships; and

5) Providing input and advice on member experience survey results and other appropriate data and assessments.

b) The PFAC shall be exclusively made up of Covered Individuals and family members of Covered Individuals.

c) The composition of the PFAC shall, to the extent possible, reflect the diversity of the MassHealth member population, and shall:

1) Consider cultural, linguistic, racial, disability, sexual orientation, and gender identities, among others; and

2) Include representatives from parents or guardians of pediatric Covered Individuals.

d) The Contactor shall ensure:

1) Reasonable accommodations include interpreter services, as well as other resources that may be needed to support participation by Covered Individuals and their family members in the PFAC; and

2) That the process and opportunity for joining the PFAC is publicized such that any Covered Individual (or their family members as applicable) may have the opportunity to apply to join or otherwise participate.

e) The Contractor shall report on the PFAC as part of its Health Quality and Equity Strategic Plan report as set forth in **Appendix E-1.**

Section 2.3.D.3.d.2.b.vii is hereby amended by striking it in its entirety and replacing it with the following:

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

Section 2.5.C.2.g is hereby amended by inserting after "Peer Specialists," the word "Peer".

Section 2.5.D is hereby amended by adding at the end therein the following:

"12. At the direction of EOHHS, the Contractor shall utilize other reports provided by EOHHS (e.g. Community Partner Enrollment roster for PCC Plan members and/or the CARES Enrollment Report) to determine member eligibility for Care Management."

Section 2.6.B.1 and **Section 2.6.B.2** are hereby amended by striking them in their entirety and replacing them with the following:

1. The Contractor shall provide Individuals without Mobile Crisis Coverage who are experiencing a behavioral health crisis with AMCI/YMCI including follow-up, Community Crisis Stabilization, and up to three units of outpatient CBHC bundle without regard to enrollment with the Contractor.

2. The Contractor shall provide Uninsured Individuals and persons covered by Medicare only who are experiencing a behavioral health crisis with Medically Necessary Behavioral Health crisis services, including AMCI/YMCI including follow-up, Community Crisis Stabilization and up to three units of outpatient CBHC bundle without regard to enrollment with the Contractor."

Section 2.6.C.2.c.8 is hereby amended by inserting at the end therein the following:

m) "Enhanced Structured Outpatient Addiction Program (ESOAP)".

Section 2.6.C.2.c.8.e is hereby amended by striking the word "Support" and replacing it with the word "Stabilization".

Section 2.6.C.2.c.9 is hereby amended by striking the word "Support" and replacing it with the word "Stabilization".

Section 2.6.C.5.a.2.g is hereby amended by inserting after the word "current" the phrase "or previous".

Section 2.6.D.2 is hereby amended by striking the last sentence in the first paragraph and replacing it with the following sentence:

"Through consultation and education, ASD-ID for MCPAP improves AMCI, YMCI, and ED providers and pediatric primary care providers' competencies in behavioral assessment and intervention, parent coaching, and in making effective referrals for patients who need community-based services and provides access to pharmacological consultation on an emergency basis."

Section 2.6.D.2.a is hereby amended by deleting it in its entirety and replacing it with the following language:

> "a. Maintain a network of ASD-ID for MCPAP providers to provide crisis consultation to AMCI/YMCI providers, emergency department providers and pediatric primary care providers treating children and young adults with ASD-ID."

Section 2.6.D.2.e is hereby amended by striking the first sentence in the first paragraph and replacing it with the following:

"Contract with a sufficient number of ASD-ID for MCPAP Behavioral Team and ASD-ID for MCPAP Statewide Physician Consult Team providers to ensure continuous access for AMCI, YMCI, ED and pediatric primary care providers between 11:00 a.m. to 7:00 p.m., Monday through Saturday, (excluding holidays) including the following:".

Section 2.6.D.2.e.3 is hereby amended by striking the term "applied behavioral analysis" and replacing it with "Applied Behavior Analysis".

Section 2.6.D.4.a is hereby amended by inserting after the phrase "primary care" the phrase "and other".

Section 2.6.D.5 is hereby amended by adding at the end therein the following language:

"d. The Contractor shall:

1) require providers serving members enrolled in a PCACO to refer to the PCACO's guidelines for medical necessity determination for CSP-HI services.

2) require providers serving members enrolled in a PCC Plan to refer to the Commonwealth's Fee For Service guidelines for medical necessity determination for CSP-HI services."

Section 2.6.D.6 is hereby amended by adding at the end therein the following language:

"c. The Contractor shall:

1) require providers serving members enrolled in a PCACO to refer to the PCACO's guidelines for medical necessity determination for CSP-TPP services.

2) require providers serving members enrolled in a PCC Plan to refer to the Commonwealth's Fee For Service guidelines for medical necessity determination for CSP-TPP services.

Sections 2.6.D.10 is hereby amended by adding at the end therein the following language:

"d. The Contractor shall work with EOHHS to strategize and implement payment and program innovation for BHUC providers.

e. The Contractor shall develop Performance Specifications for the delivery of Behavioral Health Urgent Care services as specified by EOHHS and submit such Performance Specifications to EOHHS when directed by EOHHS. The contractor shall update EOHHS within 30 days if there are any updates to the Performance Specifications."

Section 2.6.D.12 is hereby amended by deleting it in its entirety and inserting in lieu thereof the following:

"Health Related Social Needs (HRSN) Supplemental Services for Covered Individuals Enrolled in a PCACO

The Contractor shall work with each PCACO to provide HRSN Supplemental Services as follows and as further specified by EOHHS, including but not limited to the HRSN Service Manual:

a. The Contractor shall provide the HRSN Supplemental Services selected by each PCACO in accordance with the requirements in this section. Each PCACO's selection shall be reflected in **Appendix O, Exhibit 2** and described in **Appendix O, Exhibit 1**.

b. Providing HRSN Supplemental Services

The Contractor shall:

1) Arrange, coordinate, and provide to Covered Individuals enrolled in a PCACO the HRSN Supplemental Services selected by each PCACO, specified in **Appendix O, Exhibit 2** and described in **Appendix O, Exhibit 1**, in accordance with the requirements of this Contract, the HRSN Service Manual, and as otherwise specified by EOHHS.

2) Coordinate with each PCACO to:
    a) Ensure that a Covered Individual enrolled in a PCACO receives only one HRSN Category 1 Supplemental Nutrition Service at any given time.
    b) Provide HRSN Category 2 Supplemental Nutrition Services only to a Covered Individual enrolled in a PCACO who is also receiving a HRSN Category 1 Supplemental Nutrition Service.

3) Coordinate with the PCACO to require Providers of HRSN Supplemental Services to request and receive service registration from the Contractor, or the PCACO, prior to providing HRSN Supplemental Services. This service registration is not an authorization and therefore is not subject to the authorization and utilization management requirements set forth in **Section 2.6.C.** The Contractor shall work with each PCACO to:

    a) Respond to Provider service registration requests no later than seven (7) business days after receipt of the request; and

b) Require Providers of HRSN Supplemental Services to include, at minimum, the following information when submitting a service registration request:
   (i) The MassHealth identification number of the Covered Individual enrolled in a PCACO;
   (ii) National Provider Identifier;
   (iii) HRSN Supplemental Service for which the service registration request is being submitted; and
   (iv) Anticipated service duration.

c. Contracting with Providers of HRSN Supplemental Services

1) The Contractor shall coordinate with each PCACO to execute and maintain written contracts with a sufficient number of Providers, as determined by each PCACO, of the HRSN Supplemental Services for each PCACO as set forth in **Appendix O, Exhibit 2**, to ensure Covered Individuals enrolled in a PCACO have timely access to such services. The Contractor shall work with each PCACO to establish contracting protocols to allow information sharing and coordination between the three entities. The Contractor shall execute and maintain contracts with those Providers of HRSN Supplemental Services identified by each PCACO.

   a) If there are an insufficient number of qualified providers located in Massachusetts who are able to provide Covered Individuals enrolled in a PCACO with appropriate access to HRSN Supplemental Services, the Contractor shall contract with out-of-state providers meeting all requirements in the Contract and the HRSN Service Manual, as determined by the PCACO.
   b) The Contractor shall work with each PCACO to screen, credential, and enroll Providers of HRSN Supplemental Services in accordance with **Section 2.8.G** provided, however, that the Contractor shall establish processes accounting for the fact that these providers are not subject to NCQA standards and certain traditional licensing requirements.
   c) The Contractor shall work with each PCACO to ensure Providers of HRSN Supplemental Services meet the Provider qualifications set forth in the HRSN Service Manual and as further specified by EOHHS.

2) The Contractor shall coordinate with each PCACO to ensure that all Providers of HRSN Supplemental Services establish, maintain, and implement written policies and procedures for working with the Contractor and the PCACO, including but not limited to addressing:

a) Referrals and their disposition;
b) Information exchange;
c) Start and end dates of HRSN Supplemental Services;
d) Timing and outcomes of determinations for whether a Covered Individual enrolled in a PCACO meets the criteria to receive HRSN Supplemental Services; and
e) Coordination with the Contractor and the PCACO.

3) The Contractor shall ensure that staff of Providers of HRSN Supplemental Services receive documented training to enhance the quality and cultural competence of services delivered and to broaden their skills related to the provision of HRSN Supplemental Services.
4) [Reserved]
5) [Reserved]

d. Administrative, Customer Service for Covered Individuals enrolled in a PCACO Services, and Reporting Requirements

1) The Contractor shall update key personnel to appoint an HRSN Point of Contact consistent with **Section 2.3.A.3**.
2) As further specified by EOHHS, the Contractor shall include information about HRSN Supplemental Services in the Contractor's Covered Individuals handbook. Such information shall be consistent with the HRSN Service Manual when applicable, and shall include, in addition to all other Covered Individuals handbook requirements, the following information:
    a) A list of HRSN Supplemental Services the Contractor provides consistent with **Appendix O, Exhibit 2** and a description of such services;
    b) Description of who may receive HRSN Supplemental Services;
    c) How Covered Individuals enrolled in a PCACO may access such services.
3) In accordance with **Section 2.7.G,** the Contractor shall include Providers of HRSN Supplemental Services in its Provider Directory.
4) The Contractor shall collaborate with each PCACO to develop, implement, and maintain processes for collecting, sharing, and reporting data related to HRSN Supplemental Services as further specified by EOHHS.
5) The Contractor shall ensure that information about consent, screening, and referrals is documented in the Covered Individual enrolled in a PCACO's medical records.

e. Determining Whether a Covered Individual enrolled in a PCACO Meets the Criteria for Receiving HRSN Supplemental Services

The Contractor shall coordinate with the PCACO to ensure Covered Individuals enrolled in a PCACO meet the criteria for receiving HRSN Supplemental Services in accordance with the requirements set forth in the HRSN Service Manual as follows:

1) The Contractor shall work with each PCACO to ensure the Covered Individual enrolled in a PCACO meets the criteria for receiving HRSN Supplemental Services at all of the following times:

    a) Prior to the start date of a Covered Individual enrolled in a PCACO receiving HRSN Supplemental Services;
    b) No less than:
        (i) For HRSN Supplemental Housing Services, every 12 months.
        (ii) For HRSN Category 1 Supplemental Nutrition Services, every 6 months. If the Covered Individual enrolled in a PCACO is pregnant or postpartum, they may alternately be assessed at 2 months postpartum if they were first assessed during the pregnancy, resulting in a timing interval between assessments that is longer than 6 months.
        (iii) For HRSN Category 2 Supplemental Nutrition Services, every 12 months.
    c) Whenever a Covered Individual enrolled in a PCACO experiences a major change that may impact whether the Covered Individual enrolled in a PCACO meets the criteria to receive HRSN Supplemental Services.

2) Determinations for whether a Covered Individual enrolled in a PCACO meets the criteria to receive HRSN Supplemental Services may be determined by the Contractor, the PCACO, a BH or LTSS CP, or a Provider, including a Provider of HRSN Supplemental Services.

3) The Contractor shall ensure that information about whether and how the Covered Individual enrolled in a PCACO meets the criteria for receiving a HRSN Supplemental Service is:

    a) Made available to the Provider providing the HRSN Supplemental Service(s) and the PCACO; and
    b) Documented in the Covered Individual enrolled in a PCACO's medical record.

4) [Reserved]
5) For any determination that a Covered Individual enrolled in a PCACO does not meet the criteria to receive HRSN Supplemental Services, the Contractor shall work with each PCACO to:

a) Make best efforts to work with the Covered Individual enrolled in a PCACO and their care team, as appropriate, to ensure the Covered Individual enrolled in a PCACO's needs are met (e.g. coordinating care in accordance with **Section 2.5.I**)
b) Ensure the Covered Individual enrolled in a PCACO is made aware of their rights to file a grievance, in accordance with **Section 2.12**.

f. HRSN Supplemental Services Service Plan

The Contractor shall coordinate with the PCACO to ensure that Providers of HRSN Supplemental Services develop and maintain a service plan for all Covered Individuals enrolled in a PCACO receiving HRSN Supplemental Services as follows:

1) Service plans shall:
    a) Be person-centered;
    b) Identify the service(s) provided and responsible parties;
    c) Identify ways to support the Covered Individuals enrolled in a PCACO in mitigating barriers to accessing and utilizing services;
    d) Identify the Covered Individual enrolled in a PCACO's needs and individualized strategies and interventions for meeting those needs;
    e) As appropriate, be developed in consultation with the Covered Individual enrolled in a PCACO and Covered Individual enrolled in a PCACO's chosen support network including family and other natural or community supports; and
    f) Subject to consent by the Covered Individual enrolled in a PCACO and as appropriate, incorporate available records from referring and existing providers and agencies, including any bio-psychosocial assessment, reasons for referral, goal, and discharge recommendations.
2) The Contractor shall work with the PCACO to ensure Providers of HRSN Supplemental Services:
    a) Collect or have access to all the information necessary to create, review, and update a service plan.
    b) Review and update service plans:
        (i) No less than every 12 months;
        (ii) Whenever a Covered Individual enrolled in a PCACO experiences a major change that may impact their HRSNs; and
        (iii) Upon the request of the Covered Individual enrolled in a PCACO.

g. Provider Payments for HRSN Supplemental Services

The Contractor shall pay Providers the rates equal to those established by each PCACO in accordance with the MassHealth HRSN Supplemental Services Fee Schedule and shall use procedure codes as directed by EOHHS to provide payment for such services.

h. Suspension of HRSN Supplemental Services

The Contractor shall suspend the provision of an HRSN Supplemental Service upon EOHHS' notification that overall funding levels for that HRSN Supplemental Service (or for all HRSN Supplemental Services) has been reached for the Contract Year and, as further directed by EOHHS, shall provide Covered Individuals enrolled in a PCACO notice of such suspension.

i. Additional Terms and Conditions
   1) The Contractor shall ensure that receiving HRSN Supplemental Services remains the choice of the Covered Individual enrolled in a PCACO, and that the Covered Individual enrolled in a PCACO may opt out at any time.
   2) The Contractor shall not apply requirements related to continuity of care in **Section 2.2.C** or related to out-of-network access in **Section 2.8.B.19** to HRSN Supplemental Services.
   3) The Contractor shall ensure all Providers of HRSN Supplemental Services have appropriate policies and procedures in place to address potential conflicts of interest between service planning and service delivery."

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

"Q. For Applied Behavior Analysis (ABA), the Contractor shall
   a. As further directed by EOHHS, collaborate on EOHHS' efforts to improve network performance and provider capacity;
   b. Ensure that ABA is provided in accordance with EOHHS approved ABA performance specifications and ABA Medical Necessity Criteria, as further specified by EOHHS;
   c. In accordance with **Section 2.6**.**C** submit authorization and utilization management policies and procedures for ABA to EOHHS upon request. The Contractor shall make changes to such policies and procedures if directed by the EOHHS; and
   d. Require all ABA Providers to maintain an accredited status with a nationally recognized accreditation body specialized in ABA and track status as further directed by EOHHS. Additionally, the Contractor shall:
      1) No later than December 31, 2026, require that all ABA Providers who offer center-based ABA Services obtain accreditation with a nationally recognized accreditation body specialized in ABA;

2) No later than December 31, 2027, require that all ABA Providers obtain and maintain accreditation status with a nationally recognized accreditation body specialized in ABA;
3) Maintain records of any ABA Providers who sought and were denied accreditation and provide a summary of the most recent accreditation review to EOHHS upon the ABA Provider accreditation denial notification, including but not limited to:
    a) Accreditation results;
    b) Recommended actions;
    c) Recommended improvements;
    d) Corrective action plans; and
    e) Expiration date of accreditation."

Section 2.7.F.3.e is hereby amended by striking "Applied Behavioral Analysis" and replacing it with "Applied Behavior Analysis".

Section 2.7.F.4.b is hereby amended by deleting "EOHH" and replacing it with "EOHHS".

Section 2.7.F.4.c is hereby amended by striking the phrase "In return for such Providers providing the Contractor with accurate and complete information specified above,"

Section 2.7.F.5.c is hereby amended by striking the phrase "In return for such Providers providing the Contractor with accurate and complete information specified above,"

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

"9. The Contractor shall establish and sustain a publicly accessible, standards-based Provider directory application programming interface (API) in accordance with federal law, including but not limited to the Consolidated Appropriations Act, 2023 and the CMS Interoperability and Patient Access final rule."

Section 2.7.G.1 is hereby amended by adding at the end therein the following language:

"h. Whether the Provider is accepting new patients.
i. Whether the Provider offers services via telehealth."

Section 2.7.G.1.f is hereby amended by striking it in its entirety and replacing it with the following:

f. Which accommodations the Provider's office or facility has for people with physical disabilities, including offices, exam rooms, and equipment;

Section 2.7.G.3.c is hereby amended by inserting between "a" and "machine-readable" the following: "searchable,".

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

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 who are experiencing a behavioral health crisis are provided with unrestricted state-wide access to AMCI and YMCI services, Community Crisis Stabilization, and up to three units of outpatient CBHC bundle services immediately in response to a Behavioral Health crisis, on a 24-hour basis, seven days a week".

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

"7. The Contractor shall continue collaborative work focused on the Children's Behavioral Health Initiative. This collaborative work with EOHHS shall enhance the integration of care and the delivery of services for covered individuals according to the following:

a. As directed by EOHHS issue a Request For Proposal (RFP) to procure CSA providers as defined by EOHHS.
b. As directed by EOHHS, and in collaboration with EOHHS, select providers to be CSAs.
c. In consultation with EOHHS, and as further directed by EOHHS, execute provider agreements with each selected provider for each service area designated by EOHHS. Such provider agreements shall require CSAs to conform to the Performance Specifications for Intensive Care Coordination (ICC), Family Support and Training (FS&T), and Family-based Intensive Treatment (FIT). The Contractor will use the performance specifications and medical necessity criteria documents approved by EOHHS in contracting.
d. Work with EOHHS to produce a workplan to encompass the following deliverables to be executed by July 31, 2025, unless otherwise modified by EOHHS:

    1) Conduct two to three working sessions convening key stakeholders from across EOHHS and other relevant agencies, including the Department of Children and Families (DCF), Department of Public Health (DPH), Department of Mental Health (DMH), Department of Developmental Services (DDS), Department of Youth Services (DYS) and the Massachusetts Commission for the Deaf and Hard of Hearing (MCDHH).
    2) Develop detailed performance specifications and medical necessity guidelines, quality metrics and credentialing requirements based on the Program Specifications provided by EOHHS.
    3) As further specified by EOHHS, contract with CSAs by July 31, 2025, or on a date specified by EOHHS.

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

"N. M-CAAP Training

The Contractor shall collaborate with MASOC (Massachusetts Society for a World Free of Sexual Harm by Youth) in the development and delivery of training of clinicians about the Massachusetts Child and Adolescent Assessment Protocol (M-CAAP) for sexual behaviors. The training shall include the delivery of an in person, one day training on the assessment and treatment of sexualized behavior in children and adolescents."

Section 2.8.B.6 is hereby amended by adding after "all" the phrase "diagnostic needs and provide care to all". It is further amended by striking "as diagnostic needs" and replacing it with "conditions".

Section 2.8.F.10.b is hereby amended by striking the phrase "In return for such CBHCs collaborating with the Contractor,"

Section 2.8.I.4 is hereby amended by deleting it in its entirety and replacing it with the following language:

"4. Proposed education and training topics, including but limited to:

a. evidence-based practices for behavioral health clinicians;

b. new changes to policies and procedures prior to their implementation;

c. basics of MassHealth coverage and payment requirements;

d. cultural and linguistic competency;

e. quality improvement efforts and the Network Provider's role, including linkages across Behavioral Health and physical health services; and

f. Health Equity in which the Contractor or designee ensures that meaningful and appropriate trainings to advance Health Equity are periodically received by all staff and Network Providers (contracted or directly employed) that interact with Medicaid Enrollees (through operations, delivery of services, or other Member-facing roles, e.g., security officer or receptionist). The Contractor shall document staff participation in required training and address staff non-compliance with training policies. The training content shall include, at minimum, the following:

1) An overview of the organization's Health Equity strategy, including populations prioritized for intervention:

a) The role(s) trainees can play to promote and achieve Health Equity;

b) The importance of and best practices related to:

i) Collecting self-report social risk factors data such as race, ethnicity, language, disability (RELD), sexual orientation and gender identity (SOGI);

ii) Addressing inequities experienced by Covered Individuals with social risk factors, including RELD and SOGI;

iii) Adherence to CLAS standard as described in **Section 2.20.E**;

iv) The role of trauma-informed practices for marginalized individuals;

v) Identifying and mitigating the impact of implicit biases on delivery of high quality, equitable health care;

vi) Anti-racism, as further specified by EOHHS, including topics such as, but not limited to, the role of structural and institutional racism in health care.

2) A description of how the content reinforces the Contractor's mission, values, and priorities and how trainees have applied or are expected to apply the training to their work.
   a) The Contractor shall make its Health Equity, Anti-Racism Implicit Bias and related training available to all its sub-contracted Community Partners.

   b) As part of the Health Quality and Equity Strategic Plan and Report, the Contractor shall provide an overview of its Health Equity training.

   c) EOHHS may require the Contractor to implement additional training programs related to Health Equity.

   d) As directed by EOHHS, The Contractor shall evaluate the effectiveness of its training programs on an annual basis.

Section 2.9.C.4.b is hereby amended by striking "IOP" and renumbering the section accordingly.

Section 2.10.C.2 is hereby amended by striking "**Section 2.20.D**" and replacing it with "Section 2.**8.I.4.f**".

Section 2.14.L.1.a. is hereby amended by adding at the end therein the following:

"6) Names of the required Appendix E-1 reports using the following naming convention: 'BH-##-report name-cadence-submission date'."

Section 2.15.B.3 is hereby amended by deleting it in its entirety and replacing it with 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 extent legally permissible, in a manner that prevents the creditors of the Contractor 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. Subject to EOHHS approval, the Contractor may transfer deposits for the BH Covered Services Capitation Rate out of the DSRA to a separate bank account established and maintained by the Contractor for the purposes of processing covered services claims from services providers.
f. The Contractor shall transmit all interest income from the DSRA and from any bank account maintained by the Contractor to which BH covered services capitation deposits are transferred, 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 capitated expenditures.
g. The Contractor shall perform a reconciliation of funds transferred from the DSRA to

claims payments from the Contractor's bank account every six months and shall transfer any unspent BH services capitation funds to the DSRA.

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

i. 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 and any funds the Contractor transfers from the DSRA into another bank account maintained by the Contractor;
   b) Care Management Engagement payment;
   c) All Performance Incentive Arrangement payments;
   d) PCC Plan Support Services payments;
   e) DMH Specialty Services payments;
   f) DMH Administrative payments;
   g) DCF MCI Payments; and
   h) DPH 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 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 Support Services are made from deposits received from EOHHS for the PCC Plan Support Services;
   d) All payments from the DSRA for DMH Specialty Programs are made from deposits received from EOHHS for DMH Specialty Programs;
   e) All DCF payments from the DSRA are made from deposits from EOHHS for MCI Wrap Services; and
   f) All DPH programs payments are made from deposits from EOHHS.
3) Tracking the interest earned on all deposits into the DSRA and all funds the Contractor transfer from DSRA to another Contractor-owned bank account.

j. Except as specifically set forth in this **Section 2.15.B.3** the Contractor shall not withdraw funds from the DSRA except to transfer to the bank account used by the Contractor to pay Claims properly submitted by Providers for Covered Services authorized by the Contractor pursuant to the Contract.
k. 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 2.15.C is hereby amended by adding at the end therein the following:

4. The Contractor shall require Material Subcontractors to which the Contractor delegates risk, as reported in accordance with Appendix E-4, to meet the MLR requirements set forth above and include such requirements in its subcontracts with its Material Subcontractors; provided, however that Material Subcontractor shall comply with the remittance requirement above no later than January 1, 2025. In addition:
    a. The Contractor shall require that Material Subcontractors report to the Contractor its MLR consistent with reporting requirements set forth in 42 CFR 438.8. The Contractor shall submit such data to EOHHS in a form and format specified by EOHHS; and
    b. The Contractor shall confirm to EOHHS, in a form and format specified by EOHHS, that its Material Subcontracts satisfy the requirements set forth in this Section.

Section 2.19.C.1.b is hereby amended by adding at the end therein the following:

"8) A review of the PCC Plan Contract."

Section 2.19.C.2 is hereby amended by striking the second sentence and replacing it with the following "The Contractor shall review the needs of the PCC, PCC Service Location, or EOHHS prior to scheduling a site visit, including PCC-specific and/or PCC Service Location-specific data, and shall conduct site visits to PCCs and PCC Service Locations as appropriate, or as requested by the PCC or PCC Service Location."

Section 2.19.C.2.d is hereby amended by striking the word "involve" and replacing it with the word "inform". This Section is further amended by striking "in" and replacing it with "of".

Section 2.19.C.2.k is hereby amended by adding at the end therein the following sentence: "The Contractor will submit a Standard Operating Procedures/Policies and Procedures with details of the in-person site visits agreed upon with EOHHS."

Section 2.19.D.1.a is hereby amended by striking ";" and replacing it with ". The population included in the PCC Performance Dashboard shall only be Covered Individuals who are PCC Panel Enrollees. It shall not include Covered Individuals who are members enrolled in a Primary Care ACO, Children in the Care and/or Custody of the Commonwealth, and members in MassHealth Standard or CommonHealth with other insurance;".

Section 2.19.D.1.f is hereby amended by striking "provided by" and replacing it with "agreed to by".

Section 2.19.D.1.h is hereby amended by striking "password accessible website" and replacing it with "secure platform".

Section 2.19.D.3.a is hereby amended by adding after "defined by EOHHS" the following language, "and the Contractor".

Section 2.20 is hereby amended by deleting it in its entirety and replacing it with the following **Section 2.20**:

"Section 2.20 Health Equity

A. Health Quality and Equity Committee

1. At all times during the Contract Term, the Contractor shall maintain a Health Quality and Equity Committee (HQEC) designated by, and accountable to a governing board. Such Health Quality and Equity Committee may be an existing Health Equity committee, so long as the committee meets the criteria of this **Section 2.20**.

2. The composition of the Health Quality and Equity Committee shall, to the extent possible, include individuals that represent the diversity of the MassHealth population. The HQEC shall have representation from various stakeholders of the Contractor, including but not limited to:
    a. Representatives from Network Providers that are high performers in Health Equity as determined by the Contractor;
    b. At least two MassHealth Covered Individuals or family members of Covered Individuals;
    c. Providers; and
    d. Frontline staff (e.g., Community Health Workers).

3. Responsibilities of the Health Quality and Equity Committee include but are not limited to:
    a. Developing and steering implementation of the Contractor's Health Equity strategy;
    b. Monitoring progress towards addressing inequities;
    c. Developing Health Equity reporting in accordance with **Appendix E-1**; and
    d. Sharing all relevant information with the Contractor's PFAC.

B. Population and Community Needs Assessment

1. The Contractor shall conduct a population and community needs assessment that provides an initial description of the Contractor's Covered Individual population, including:

    a. A brief description of the population of Covered Individuals the Contractor serves and the communities in which they live;

    b. A description of the characteristics of such population and communities, including, at a minimum:

        1) The approximate number of Covered Individuals in the population;

        2) The population's demographic characteristics, including but not limited to, age, race, ethnicity, languages spoken, disability status, sexual orientation, and gender identity; and

        3) A description of any other salient characteristics of the population that informs the Contractor's strategy for improving the quality and cost of Covered Individuals care, such as any particular public or environmental health concerns.

    c. A description of the health, functional, and other care needs of such population and communities, including but not limited to:

        1) A list and description of prevalent conditions in the population, including chronic diseases;

        2) A description of the population's behavioral health needs;

        3) A description of the population's Health Related Social Needs;

        4) A description of the community resources that currently exist in such communities.

2. The Contractor shall conduct an updated Population and Community Needs Assessment prior to the start of Contract Year 3.

3. The Contractor must submit this Population and Community Needs Assessment upon EOHHS request.

4. The Contractor may leverage existing community needs assessments to develop its Population and Community Needs Assessment, as long as the assessment meets the requirements of this **Section 2.20.B.**

C. Health Quality and Equity Strategic Plan and Reporting

The Contractor with input from its Health Quality and Equity Committee shall create, monitor, and update as needed a five-year Health Quality and Equity Strategic Plan, which shall be submitted to EOHHS for review and approval in accordance with **Appendix E-1.** In developing the Contractor's Health Quality and Equity Strategic Plan, the Contractor shall seek input from the Health Quality and Equity Committee, providers representing the composition of the Contractor's Provider Network, Covered Individuals, and Covered Individual's families.

1. The Health Quality and Equity Strategic Plan shall describe:

a. How the Contractor sought and incorporated input from the Health Quality and Equity Committee, Providers representing the composition of the Contractor's Provider Network, Covered Individuals, and Covered Individuals' families;

b. How the Contractor partners with hospitals affiliated with the Contractor for the purposes of the Hospital Health Equity incentive program to further joint Health Equity goals, including a description of joint priorities and how they were determined, as well as joint governance over any included workstreams;

c. The Contractor's approach to establishing a culture of equity that recognizes and prioritizes the elimination of inequities through respect, fairness, cultural competency, and advocacy, including through the provision of trainings for Health Equity, implicit bias, anti-racism, and related trainings to all staff (contracted or directly employed) that interact with Medicaid enrollees;

d. The Contractor's approach to ensure all Contractor policy and procedures consider health inequities and are designed to promote Health Equity where possible and in accordance with all federal and state laws, including but not limited to:

1) marketing strategy;

2) enrollment and disenrollment;

3) medical, behavioral health, and other health services policies;

4) enrollee and provider outreach;

5) PFACs;

6) grievances and appeals;

7) utilization management; and

8) the Flexible Services program;

e. How the Contractor used its Population and Community Needs Assessment to inform the Health Quality and Equity Strategic plan;

f. The Contractor's planned approach to maintaining robust structures to identify and understand inequities to support the implementation of evidence-based interventions, including to:

1) Engage Covered Individuals and communities to inform Health Equity initiatives;

2) Achieve complete and comprehensive member-reported social risk factor data as further specified by EOHHS (e.g., race, ethnicity, language, disability, sexual orientation, gender identity, Health-Related Social Needs);

g. The Contractor's planned interventions to reduce inequities, including how it will:

1) Collaborate and partner with other sectors that influence the health of individuals;

2) Ensure equitable access to healthcare;

3) Deliver high-quality care that continuously reduces inequities.

2. The Contractor shall include in the plan an executive summary, in a form and format as further specified by EOHHS, and include an overview of all the key sections of the plan.

3. In accordance with **Appendix E-1**, the Contractor shall regularly report to EOHHS, in a form and format as further specified by EOHHS, on items related to its Health Quality and Equity Strategic Plan, including but not limited to:

a) Any modifications to the organization's Health Quality and Equity Strategic Plan;

b) Health Quality and Equity Committee composition, activities, and how MassHealth Covered Individual and front-line staff feedback is incorporated

into decision making processes or otherwise utilized as part of the Health Equity work;

c) PFAC composition, summary of activities, and a summary of how consumer feedback is utilized;

d) Progress towards targeted milestones and any other achievements in the preceding year and since the beginning of the contract period related to:

1) Establishing a culture of equity, as described in **Section 2.20.D**;

2) Establishing necessary structures and partnerships, including but not limited to, with community providers and community hospitals, to support Health Equity;

e) Progress towards targeted milestones in the preceding year and since the beginning of the contract period on implementing interventions related to:

1) Collaborating and partnering with other sectors that impact the health of individuals;

2) Ensuring equitable access;

3) Delivering high quality care that continuously reduces the inequities;

4) Other interventions to reduce health inequities experienced by MassHealth Covered Individuals.

f) Progress towards annual improvement targets for specified Health Equity improvement key performance indicators, supplemented by a description of what contributed to successful achievement of annual targets;

g) Gaps in achievement of targeted annual Health Quality and Equity Strategic Plan goals, observed barriers to achieving goals, and specific plans for the upcoming year to overcome such gaps.

4. At EOHHS's request, the Contractor shall meet with EOHHS to discuss its reporting on items in this **Section 2.20.C**;

5. The Contractor shall publicly post the executive summaries of its Health Quality

and Equity Strategic Plan on its website, and make these documents available to EOHHS for posting on EOHHS' website.

D. Health Equity, Anti-Racism, Implicit Bias, and Related Trainings

The Contractor shall ensure that meaningful and appropriate trainings to advance Health Equity are periodically received by all staff and Network Providers (contracted or directly employed) that interact with Covered Individuals (through operations, delivery of services, or other patient interfacing roles (e.g., security officer or receptionist)), in accordance with **Section 2.8.I.4.e** and as further specified by EOHHS.

E. Culturally and Linguistically Appropriate Services (CLAS) Standards

1. The Contractor shall ensure its Provider Network provides Culturally and Linguistically Appropriate Services (CLAS) to Covered Individuals.
2. In a form and format to be determined by EOHHS, the Contractor shall describe how it intends to assess and address the needs of the populations and communities it intends to serve, including:
    a. The linguistic accessibility needs of its Covered Individual population, including Covered Individuals' preferred languages, the needs of Covered Individuals' who are Deaf or hard of hearing, and Covered Individuals' needs related to health literacy. Such linguistic accessibility shall also include access to the Contractor's Provider Network via newer communication modalities, including telehealth;
    b. The cultural accessibility needs of its Covered Individuals populations;
    c. The needs of Covered Individuals for accessible medical and diagnostic equipment;
    d. The process utilized to verify that their Provider directories accurately capture member accommodations capabilities; and
    e. Demonstrating current adoption of national CLAS standards within the organization and proposing how it shall further develop CLAS and evaluate gaps in achieving CLAS, including:
        1) Training and assessing staff for cultural competencies, including reporting the name of the training curriculum to EOHHS if any;
        2) Selecting a CLAS Champion (any individual, clinical or non-clinical, who is knowledgeable about CLAS Standards and can serve as a subject matter expert to support and train others).
3. The Contractor shall have clear and user-friendly processes and policies in place for Covered Individuals to request linguistic interpreters and other linguistic or physical accommodations. The Contractor shall, at a minimum, post such policies on its website and include such policies in its Covered Individual Handbook as set forth in **Section 2.10.A.3**. They shall also offer this option on their customer service lines, including

understanding processes for how to request interpreter services and accommodations. The Contractor shall include a description of Covered Individual rights including but not limited to those Covered Individual rights described in **Section 5.1.L,** in its Covered Individual Handbook and on its website.

4. The Contractor shall complete a CLAS Standards self-evaluation annually, which can be used as a quality improvement tool to support efforts to implement CLAS and to assess performance and continuous improvement. The Self-Evaluation shall include the following metrics:

    a. The percentage of calls conducted in a language other than English, the percentage of Covered Individual-facing materials available in languages other than English, and the number of languages available for real-time interpreter services;

    b. Number and types of language or accommodation requests, including any denials;

    c. Number of grievances on this topic and/or related to discrimination based on race, ethnicity, language, disability, sexual orientation, gender identity or other characteristics;

    d. Number of staff who receive training in culturally and linguistically appropriate service delivery; and

    e. Member satisfaction data to inform culturally and linguistically appropriate services.

5. The Contractor shall take immediate action to improve the delivery of CLAS when deficiencies are identified.

F. Quality and Equity Incentive Program Arrangements

The Contractor shall participate in the MBHV Quality and Equity Incentive Program Arrangement, as set forth in **Appendix G**.

G. Data Collection

The Contractor shall ensure that every Covered Individual is given an opportunity to update their social risk factor data (e.g., race, ethnicity, language, disability, sexual orientation and gender identity) as requested.

Section 4. Payment and Financial Provisions

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

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

EOHHS shall pay the Contractor for AMCI/YMCI including follow-up, CCS and three units of outpatient bundle services provided by CBHC providers to Uninsured Individuals

and persons with Medicare only according to the methodology set forth in **Section 4.2.L and Section 4.2.V.** EOHHS shall pay the Contractor for AMCI/YMCI including follow-up CCS, and three units of outpatient bundle services provided by CBHC 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 for in **Section 4.2.S."**

Section 4.2.A.6 is hereby amended by striking the word "Management".

Section 4.2.A.7 is hereby amended by adding at the end therein the following language: "These funds may be used to support MCPAP's role in the expansion of MCPAP for ASD-ID to support pediatric primary care providers, as long as the use of the funds for this purpose has no impact on MCPAP for ASD-ID's ability to fully meet all program requirements."

Section 4.2.L.1.a is hereby amended by adding at the end therein the following language:

"1) The Contractor shall ensure that providers make diligent efforts to identify and obtain payment from all other liable parties, including insurers;

2) If a third-party resource is identified, the Contractor shall ensure that the Provider bills all third-party resources before resubmitting a Claim to the Contractor;

3) The Contractor shall not pay Providers who do not make diligent efforts to obtain payment from other liable parties."

Section 4.2.L.1.d is hereby amended by striking it in its entirety.

Section 4.2.O.1.a is hereby amended by inserting after "operationalizing", the following language: "inpatient mental health acute care beds,".

Section 4.2.R is hereby amended by striking it in its entirety and replacing it with the following language:

"R. Payment Provision for AMCI/YMCI, CCS, and urgent outpatient CBHC bundle services Provided to Individuals without Mobile Crisis Coverage

1. General Provision

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**.

1) The Contractor shall ensure that providers make diligent efforts to identify and obtain payment from all other liable parties including insurers;

2) If a third-party resource is identified, the Contractor shall ensure that the Provider bills all third-party resources before resubmitting a Claim to the Contractor;

3) The Contractor shall not pay Providers who do not make diligent efforts to obtain payment from other liable parties.

b. For CBHCs, utilize the rate for AMCI and YMCI services including follow-up, CCS and outpatient CBHC bundle, 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, CCS, and outpatient CBHC bundle services for Individuals without Mobile Crisis Coverage.

1) For AMCI and YMCI services including follow-up, CCS, and urgent outpatient CBHC bundle services the Contractor shall pay the difference between rates as described in **Appendix H-1 Section L** and the amount covered by a third-party resource.

c. Not utilize the Mobile Crisis Intervention Uncompensated Care Payment except to pay for AMCI and YMCI, CCS, and up to three units of outpatient CBHC bundle services delivered to Individuals without Mobile Crisis Coverage.

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 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.

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

"V. Payment Provision for urgent outpatient CBHC bundle services for Uninsured Individuals and Persons with Medicare Only

1. General Provision

The Contractor shall:

a. For outpatient CBHC bundle services provided to Uninsured Individuals and persons covered by Medicare only who are experiencing a behavioral health crisis, require CBHCs to bill other insurance (TPL), where available and consistent with **Section 2.18** and the Health Safety Net in accordance with applicable law.

    1) The Contractor shall ensure that providers make diligent efforts to identify and obtain payment from all other liable parties, including insurers;

    2) If a third-party resource is identified, the Contractor shall ensure that the Provider bills all third-party resources before resubmitting a Claim to the Contractor;

    3) The Contractor shall not pay Providers who do not make diligent efforts to obtain payment from other liable parties.

b. Pay CBHCs the rate for outpatient CBHC bundle services established by EOHHS and, as further directed by EOHHS, implement all policies and procedures with regard to payments and payment methodologies to outpatient CBHC bundle services for Uninsured Individuals and persons with Medicare only who are experiencing a behavioral health crisis delivered under the Contract.

    1) For outpatient CBHC bundle services for persons with Medicare only who are experiencing a behavioral health crisis, the Contractor shall pay the difference between rates as described in **Appendix H-1 Section M.1** and the amount covered by a third-party resource.

c. Not utilize the Outpatient Crisis Payment except to pay up to three units of outpatient CBHC bundle services delivered to Uninsured Individuals and persons with Medicare only who are experiencing a behavioral health crisis.

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.

        1) Based on the Contractor's invoice for expenditures, EOHHS shall make payments in accordance with Appendix H-1.
        2) Notwithstanding any other provision of this Contract, EOHHS shall not be required to make any payments for outpatient CBHC bundle 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.

W. HRSN Supplemental Services Payment Pursuant to **Section 2.6.D.12.g**

1. The non-risk arrangement for payment of HRSN Supplemental Services shall be as follows:

a. On a quarterly basis, or at a frequency to be specified by EOHHS, EOHHS shall pay the Contractor a prospective lump sum amount for HRSN Supplemental Services, as described in **Section 2.6.D.12** and set forth in **Appendix H-1**, for the upcoming quarter or other applicable time period. Such amount shall be based on enrollment of Covered Individuals enrolled in a PCACO and be for the provision of HRSN Supplemental Services and the administrative amount of such services.

b. For each Contract Year, EOHHS shall perform an annual reconciliation after the end of the Contract Year to correct the amount of any payments described above. EOHHS shall remit to the Contractor the full amount of any underpayments it identifies. As directed by EOHHS, the Contractor shall remit to EOHHS the full amount of any overpayment EOHHS made to the Contractor for HRSN Supplemental Services for the Contract Year, as identified by EOHHS. Such payments shall be made either through a check or, at the discretion of EOHHS, through addition to or recoupment from future HRSN Supplemental Services payments and/or reconciliation payments described in **Section 4.2**."

X. Children's Behavioral Health Initiative Provider Payments

As part of efforts to support the CBHI and CSA provider networks, EOHHS shall provide funding to the Contractor in support of CBHI provider infrastructure and workforce support. The Contractor shall disperse the funding to CBHI and CSA providers as directed by EOHHS."

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

"E. Quality and Incentive Arrangement

1. EOHHS shall pay the Contractor a payment based on the Contractor's Quality Score as set forth in **Appendix G**. In CY23-24, such payment shall equal no more than $1,500,000. In CY25, such payment shall not exceed 0.5 percent of total capitation revenue. For CY25, the total amount of the Quality Incentive Program referenced in this section and the Quality and Equity Incentive Program referenced in Appendix G shall not exceed the amount stipulated in Appendix H-1.

2. The Contractor shall make all appropriate efforts to meet a set of performance targets for individual Quality Measures as set forth in **Appendix G.**

3. EOHHS shall calculate, annually, the Contractor's Quality Score based on the Contractor's performance with respect to the Quality Measures set forth in **Appendix G**.

   a. Such score shall be based on the Contractor's meeting or improvement towards meeting the targets and a statewide performance metric, as further specified by EOHHS and as set forth in **Appendix G.**

   b. Such score shall be a number between zero (0) and one (1).

4. For such calculations described above, EOHHS shall use data reported by the Contractor, or other data as further specified by EOHHS.

5. Based on the Contractor's performance, EOHHS shall pay the Contractor in accordance with **Section 4.6.A.**

F. Quality and Equity Incentive Program Arrangement

EOHHS shall pay the Contractor a payment based on the Contractor's Health Equity Score described in **Section 4.6.E.2.a** and as further set forth in **Appendix G**. Such payment shall equal no more than 0.75 percent of total capitation.

1. The Contractor shall make all appropriate efforts to meet a set of performance targets for individual Health Equity measures as set forth in **Appendix G.**

2. EOHHS shall calculate, annually, the Contractor's Health Equity Score based on the Contractor's performance with respect to the Health Equity measures set forth in **Appendix G**. This calculation will consider:
    a. Collection of complete and accurate self-reported social risk factor data for its Covered Individuals, which may include race, ethnicity, language, disability status, sexual orientation, and gender identity;
    b. Identification and monitoring of health care inequities through stratified reporting of performance metrics as further specified by EOHHS; and
    c. Reduction of identified disparities through targeted and evidence-based interventions as demonstrated through performance metrics as further specified by EOHHS.
    d. Such scores shall be a number between zero (0) and one (1).
3. For calculations described above, EOHHS shall use data reported by the Contractor or other data as further specified by the EOHHS.

4. Based on the Contractor's performance, EOHHS shall pay the Contractor in accordance with **Section 4.6.A.**

Section 4.7.C is hereby amended by deleting the phrase "Applied Behavioral Analysis" and replacing it with the phrase "Applied Behavior Analysis".

Section 4.12 is hereby amended by renumbering "**Sections 4.12.1** and **4.12. 2**" as "**Sections 4.12.A** and **4.12.B**", respectively.

Section 5. Additional Terms and Conditions

Section 5.2.G is hereby amended by striking "2.7.K" and replacing it with "2.7.J".

Section 5.3.L.10.c is hereby amended by striking it in its entirety and replacing it with the following:

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

Section 5.11 is hereby amended by striking

"Massachusetts Behavioral Health Partnership
200 State Street
Boston, MA 02118" and inserting in lieu thereof

"Massachusetts Behavioral Health Partnership
200 State Street
Boston, MA 02109"

APPENDICES

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 **LIST OF APPENDICES** is hereby amended by adding at the end therein the following:
APPENDIX O: HEALTH RELATED SOCIAL NEED (HRSN) – Related Payments.

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. Claims-based reports shall allow for a 90-day (three month) Claims lag and report time. If a due date falls on a non-business day, submission shall take place by the next business day. All references to "annual" or "year-to-date" reports or data refer to the Contract Year, unless otherwise specified.

Report Cadence	Reports Due (*by close of business*)
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.
Weekly Deliverables	Deliverables due by close of business/COB on Fridays
Monthly Deliverables	Deliverables due on a monthly basis, by the last day of the month, following the month included in the data, unless otherwise specified by EOHHS. Claims-based reports due on the last day of the third month following the month included in the data (*e.g.* January reporting period due last day of April)
Quarterly Deliverables	Deliverables due on a contract year (CY) quarterly basis, by the last business day of the month following the end of each quarter, unless otherwise specified. ○ CY Quarter 1: January 1 – March 31 ○ CY Quarter 2: April 1 - June 30 ○ CY Quarter 3: July 1 – September 30 ○ CY Quarter 4: October 1 – December 31
Semi-Annual Deliverables	Deliverables due by the last business day of the month following the end of the reporting period, unless otherwise specified. The semi-annual reporting periods are as follows: ○ January 1 – June 30 ○ July 1 – December 31
Annual Deliverables	Deliverables due by the last business day of the month following the end of the reporting period (Contract Year: January 1 -- December 31), unless otherwise specified by EOHHS.

Biennial Deliverables	Deliverables due in designated biennial years, by the last business day of the month following the end of the reporting period, unless otherwise specified. Specific years are noted in the report descriptions.
Ad-Hoc Deliverables	Deliverables are due whenever the Contractor has relevant changes or information to report, or upon EOHHS request related to Behavioral Health, Contract Management, Financial, Quality, Pharmacy, and Operations deliverables as applicable.

Filenaming Convention

All reports submitted to EOHHS shall adhere to the following filenaming convention:

1. **File Upload Folders** shall include the reporting year, reporting cadence, and reporting period. For example:
    - Quarterly: CY24_Quarterly-1, CY24_Quarterly-2, etc.
    - Monthly: CY24_Monthly_01-Jan, CY24_Monthly_02-Feb, etc.
    - CY24_Annual, CY24_Semi-Annual
2. **Filenames** shall be identical to the report titles in this appendix, inclusive of the Contract Exhibit numbers. For example:
    - BH-27_ Provider-Concerns-Report
    - PI-05_ Summary-of-Provider-Overpayments
3. **Sub-Deliverables** assigned a letter/number designation shall follow the filename to indicate the specific sub-deliverable. If sub-deliverables include a title, the title should be included following an underscore. For example:
    - BH-18_BH-Provider-Network-Access-and-Availability_A
    - CQuarterly-MCPAP-Program-Utilization-stratified-by-Month_A_MCPAP-Activity-3Yr-Trending
4. **Character Usage:** For the purpose of data storage, spaces shall not be used in filenames. Underscores shall be instead of spaces to separate data elements, while dashes shall be used in place of spaces within report filenames and sub-deliverables.

By adhering to this filenaming convention, the Contractor will ensure consistent and efficient organization of report submissions.

Reportable Adverse Incidents

1. BH-01 - Behavioral Health Reportable Adverse Incidents and Roster of Reportable Adverse Incidents – Daily Incident Delivery Report

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

One-time, Periodic and Ad Hoc Reports

2. BH-N/A - Authorization Reports for CBHI Services

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. RESERVE

15. BH-26 - 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.

17. Weekly CCS Utilization

Report detailing the number of available beds, by week, and the daily census (occupancy rates) for Adult Community Crisis Stabilization (ACCS) and Youth Community Crisis Stabilization (YCCS) programs.

18. Weekly Police Drop-off and Direct Admits

The total count of weekly police drop-offs at CBHCs, by site and region, as well as total count of direct admissions from CBHCs to an inpatient psychiatric unit.

19. **IHD Enrollment**

Number of youth enrolled in IHD and the referral source.

20. CSA Enrollment data

Admits and Discharges to Intensive Care Coordination for the purposes of creating a flag in EVS to avoid duplicate TCM services enrollments (e.g. CARES, CP, etc.)

Monthly Reports

21. BH-N/A - CBHI Services Provider Monitoring Reports

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

1. "MABH Access (Availability and Waitlist Report)- IHT": Self-reported provider-level data
2. "MABH Access (Availability and Waitlist Report)- TM": Self-reported provider-level data
3. "MABH Access (Availability and Waitlist Report)- IHBS": Self-reported provider-level data
4. "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.

1. "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.
2. "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)

1. "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
2. "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.

22. BH-N/A - CSA Reported and Aggregated Data

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

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

b. "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.

c. "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.

d. "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.

23. BH-N/A - CBHC Snapshot

High-level overview of each CBHC's ability to meet access standard thresholds for Core Clinic, Mobile Crisis Intervention, and Community Crisis Stabilization. This report includes site-reported access data from E-Reporting, as well as qualitative insights provided by MBHP Provider Quality Managers (PQMs).

24. BH-27 Provider Concerns Report

Report of all concerns reported by Network Providers to the vendor or directly to EOHHS; 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

25. BH-29 - PCC and BH Networks Site Visit Report

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

26. BH-30 - PCC Plan Support Services Report

Report of PCC Plan 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

27.BH-N/A - Care Management Report

Report of all Care Management, Integrated Care Management and Practice-Based Care Management, stratified by month, 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.

a. "ICMP PBCM": Excel sheet detailing count and percentage
b. "ICMP PBCM Narrative": Details engagement, disenrollment, high-risk identification, noticeable changes, opportunities for improvement, interventions/next steps for ICMP and PBCM

28. Care Management – PBCM Report

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

29. Claims Processing Report

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

a. "Denied Claims": Summarizes the number of claims and claim dollars by denial reasons

b. “Pended Claims”: Summarizes the number of claims and claim dollars by pend reasons
c. “Claims Activity”: Summarizes claims received and paid/denied/pended, an analysis, and action items/next steps
d. “253A”: Pie chart describing percentage of claims denied, paid, and pended every month
e. “253B”: Pie chart describing percentage of claims denied, paid, and pended for the year
f. “253C”: Pie chart describing percentage of claims denied, paid, and pended from 2023

30. Network Management Activities Report

Number and types of meetings for CBHI (ICC, IHT, IHBS, TM, and FS&T) services

31. MBHP IHD Discharge reports

Youth discharged from IHD with disposition.

Quarterly Reports

32. BH-19 - Telephone Statistics

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.

33. BH-14 - CANS Compliance:

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

“BH-14 CANS Compliance_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

34. BH-13 - Behavioral Health Clinical Operations/Inpatient and Acute Service Authorization, Diversions, Modification and Denial Report

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:

a. Covered Individuals enrolled in PACT;
b. Covered Individuals enrolled in PACT who assessed psychiatric inpatient level of care;
c. Covered Individuals enrolled in PACT who assessed Crisis Stabilization Services; and

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

35. BH-23 -Substance Use Disorder Clinical Ops/Inpatient Authorization Report

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

36. Massachusetts Consultation Service for the Treatment of Addiction and Pain (MCSTAP)

Quarterly summary (stratified by months and year to date) including Total Consultation, % of Substance Use Disorder (SUD), % of Chronic Pain, % of SUD and Chronic Pain, % of Chronic Pain and Mental Health, and SUD and Mental Health.

37. BH-15 - Behavioral Health Utilization and Cost Report

A summary of Behavioral Health costs and utilization.

38. BH-N/A - EC - Massachusetts Child Psychiatry Access Project Report

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

36. Quarterly MCPAP Program Utilization, stratified by Month

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

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

39. 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.

40. 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.

41. 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.

42. 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.

43. 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.

44. RESERVE

45. EC-MCPAP and ASD-ID Outreach and Training

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

a. 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.

b. 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)

a. "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

b. "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.

c. "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.

48. Payment Suspension

Notification of payment suspensions for a provider.

49. CBHC Staffing Report

Assessment of vacant positions which CBHCs are hiring for, including the role (i.e. nursing, prescribers, clinicians, supervisors, peer support specialists, etc), the service type (Core, MCI, CCS), the shift, and the number of FTE's needed.

50. Secret Shopper Summary

Overview of Secret Shopper calls completed within the quarter for Core Clinic and Mobile Crisis Intervention services. The report includes quantitative and qualitative experience ratings, as well as narratives and descriptions of the calls completed.

Semi-Annual Reports

51. BH-N/A - BOH Appeals Report

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.

52. BH-22 - Grievance and Internal Appeals Report

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.

53. BH-N/A - Coordination of Benefits/Third-Party Liability Report

a. Third-party health insurance cost avoidance Claims amount, by carrier
b. Third-party health insurance total recovery savings, by carrier.
    1. "Coordination of Benefits": Contractor's actual savings via Third Party Insurance Benefit Coordination and the actual cost of avoidance via the denial of claims
    2. "TPLSAV": Savings amounts per month
    3. "353_ORA": Historical list of savings
    4. "4669_ORA": Quarterly report of total claim lines and total claimed
    5. "5630_ORA": Monthly payment timeliness report including total claims, average days for payment, SD days for payment, and #/% claims paid within 30 days

54. CSA reported and aggregated data

a. “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.

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

55. PI-05 - Summary of Provider Overpayments (semi-annual)

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

56. BH-08 - Behavioral Health Clinical Operations and Acute Service Authorization, Diversions, Modification and Denial Report (ABA)

Summary report, including Clinical Ops Data and Graphs, on ABA authorizations, diversions, modifications, and service denials.

57. Health Quality and Equity Strategic Report

Report on items related to the Contractor's Health Quality and Equity Strategic Plan, including but not limited to requirements found in **Section 2.2.C.1.a.1.h**

Annual Reports

58. BH-N/A - Network Management Strategies Report

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.

59. BH-02 - Behavioral Health Adverse Incident Summary Report

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.

60. BH-04 - Behavioral Health Ambulatory Continuing Care Rate

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.

61. BH-03 - Behavioral Health Readmission Rates Report

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.

62. Behavioral Health Urgent Care Program – annual report

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

63. BH-N/A - Pay for Performance Incentive Reporting

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

64. BH-11 - Medical Records Review Report

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

65. BH-33 - PCC Plan Management Support Services Report

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.**

66. BH-34 - PCC Compliance with PCC Provider Agreement

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

67. BH-N/A - Provider Preventable Conditions

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

68. 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**.

69. 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**.

70. BH-N/A - Mobile Crisis Intervention/Runaway Assistance Program (MCI/RAP) Outcome and Output Measures Report

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.**

71. BH-35 - PCC Plan Management Support Services Training

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.

a. "MCPAP FYXXQX Insurance Report"
b. "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

a. "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.
b. "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

85. BH-18 - BH Provider Network Access and Availability Reports:

Reports on the list of behavioral health providers in the Contractors network across the state and on the ability of MBHP to comply with the time and distance standards set forth in Section 2.9.C. The BH-18 reports shall include the below information in a form and format specified by EOHHS.

a. An analysis of the Contractors BH Network Geographic Access
b. Lists of contracted providers and a summary of significant changes to the provider network
c. A summary of appointment availability
d. A summary of the use of out-of-network providers
e. For each of the contracted service areas (as specified by EOHHS):
    1. A summary of the methods used to collect and examine network adequacy data
    2. An analysis and summary of the reports
    3. A summary of the management actions or next steps that will be taken based on the findings of the analysis

Biennial Reports

86. BH-32 - Satisfaction Survey Summary

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.

a. Network Provider Satisfaction Survey

Due in odd-numbered years (e.g. 2023, 2025, etc.)

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**.

b. PCC Provider Satisfaction Survey

Due in even-numbered years (e.g. 2024, 2026, etc.)

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**.

c. Covered Individual Satisfaction Survey

Due in even-numbered years (e.g. 2024, 2026, etc.)

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

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.

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 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, CCS, and three units of urgent outpatient CBHC bundle 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.

17. QUARTERLY REPORT FOR URGENT OUTPATIENT CBHC BUNDLE SERVICES PROVIDED TO UNINSURED INDIVIDUALS AND PERSONS WITH MEDICARE ONLY

Quarterly the Contractor shall provide EOHHS with a report of the Contractor's actual expenditures for urgent outpatient CBHC bundle services provided to Uninsured Persons and Persons with Medicare Only, up to three units per individual following an initial crisis evaluation.

18. Behavioral Health Access and Crisis Intervention Trust Fund Report

Provide monthly the Behavioral Health Access and Crisis Intervention Trust Fund Report in a form and format specified by EOHHS.

EXHIBIT 1: FINANCIAL RATIO DEFINITIONS

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

FINANCIAL INDICATOR	FORMULA
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
MANAGED BEHAVIORAL HEALTH VENDOR QUALITY INCENTIVE PROGRAM & QUALITY & EQUITY INCENTIVE PROGRAM (MBHV-QEIP)

Effective Calendar Year 2025

Introduction

This Appendix details how EOHHS will determine the Contractor's Quality and Health Equity Performance as described in the Contract. EOHHS may modify the methodology set forth herein after the execution of the Contract by written amendment. The following information is included. For the purposes of this document, "Performance Year" or "PY" shall mean "Contract Year" as defined in Section 1 of the Contract, unless otherwise specified by EOHHS.

The performance-based quality incentive program and Quality and Equity Incentive Program (QEIP) for the managed behavioral health vendor (MBHV) Contractor for Calendar Years 2023-2027 (henceforth referred to as CY23-27) is summarized below. The summary includes strategic goals, methodology, 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 goals. The measure of the Contractor's success for each performance-based incentive is described in detail below. The Contractor shall only be paid the single amount calculated for each measure based on the measurement methodologies, and not to exceed the maximum annual incentive for each performance incentive.

Section I. Quality Incentive Program

A. <u>Measure Benchmarks and Goals</u>

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 all non-HEDIS measures, the Contractor shall follow the 2024 technical specifications for each measure steward identified by EOHHS. In CY24, EOHHS 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 (CY23-27). 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.

B. Methodology

The Contractor shall assess their performance for CY25 on the measures outlined below. Goals for each measure have been set for a five-year period (CY23-CY27) and a modified gap-to-goal analysis will determine the improvement targets for each of the five performance 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 CMS Adult Core Set Measure, EOHHS has used 2022 data for the benchmarks outlined below. For the HEDIS and IPFQR measure, the Contractor shall calculate its performance for CY23, which shall serve as the base year performance for the purpose of improvement goal calculation for CY25. The Contractor shall receive two thirds of the maximum eligible incentive ($2,000,000) at the end of CY25, with the last one third ($1,000,000) reserved for reconciliation of the final CY25 performance calculation, to be conducted by the end of Q2 2026 when all claims from calendar year 2025 can be reviewed. Data should be stratified by PCC members, Primary Care ACO, and others.

C. Performance Assessment Methodology

In CY25, 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 (5 x 10= 50). 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.

D. Measures

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%	$3,000,000
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]	74%	81%	1%	

1= HEDIS Measure (or subset); Contractor to use HEDIS Technical Specifications
2= CMS IPFQR Measure; Contractor to use CMS IPFQR Technical Specifications
3= CMS Adult Core Set Measure; Contractor to use CMS Technical Specifications

Section II. Quality and Equity Incentive Program (QEIP)

A. Background and Overview of the Managed Behavioral Health Vendor Quality and Equity Incentive Program (MBHV-QEIP)

Massachusetts shifted the delivery system at scale to value-based care under the previous MassHealth section 1115 demonstration approval period, transitioning over 80 percent of eligible Medicaid members into accountable care organizations (ACOs) that are at risk to deliver better health outcomes, lower cost, and improved member experience through integrated, coordinated care.

A key goal of the Commonwealth's in this demonstration period is to improve quality of care and advance health equity, with a focus on initiatives addressing health-related social needs (HRSN) and health disparities demonstrated by variation in quality performance. To support achievement of this goal, Massachusetts is centering equity alongside quality as a pillar of value-based care and as a priority for the state's health care system.

To that end, MassHealth will implement aligned quality and equity initiatives across delivery system settings including but not limited to MassHealth's Managed Care Organizations (MCOs), Accountable Care Partnership Plans (ACPPs) and Primary Care ACOs (together "ACOs"), Managed Behavioral Health Vendor (MBHV), and acute hospitals.

Together, this constellation of coordinated quality and equity initiatives will support Massachusetts in achieving its demonstration goal to improve quality of care and advance health equity.

B. PY1 Implementation Plan for the MBHV-QEIP

1. Scope of this Implementation Plan

This Performance Year 1 Implementation Plan provided additional detail related to implementation of MassHealth's MBHV-QEIP for the first Performance Year (PY) from January 1, 2023-December 31, 2023. Information pertaining to subsequent performance years (PY) 2-5, representing Calendar Years 2024-2027, will be forthcoming.

2. MBHV Quality and Equity Incentive Program (MBHV-QEIP) Domains and Goals

a. Overview of Targeted Domains for Improvement in the MBHV-QEIP

For the MBHV-QEIP, the MBHV is incentivized to pursue performance improvements in the domains specified in Table 1.

Table 1. Overview of Targeted Domains for Improvement for the MBHV-QEIP

Domain 1: Demographic and Health-Related Social Needs Data	The MBHV will be assessed on the completeness of beneficiary-reported demographic and health-related social needs data submitted in accordance with the Commonwealth's data requirements. Demographic and health-related social needs data will include at least the following categories: race, ethnicity, primary language, disability status, sexual

	orientation, gender identity, and health-related social needs. Data completeness will be assessed separately for each data element.
Domain 2: Equitable Quality and Access	The MBHV will be assessed on performance and demonstrated improvements on access and quality metrics, including associated reductions in disparities. Metrics will focus on overall access.
Domain 3: Capacity and Collaboration	The MBHV will be assessed on improvements in metrics such as provider and workforce capacity and collaboration with health system partners to improve quality and reduce health care disparities.

b. Goals for each Domain of the MBHV-QEIP

Anticipated goals for the period from 2023-2027 for each MBHV-QEIP domain are summarized below:

1) Demographic and Health-Related Social Needs Data Collection Domain Goals

a) The MBHV is incentivized to achieve certain milestones to meet an interim goal of 80 percent data completeness for self-reported race and ethnicity data for attributed MassHealth members by the end of Performance Year 3 (CY 2025).

b) The MBHV is incentivized to achieve certain milestones to achieve at least 80 percent data completeness for beneficiary-reported other demographic data (including but not limited to primary language, disability status, sexual orientation, and gender identity) for attributed MassHealth members by the end of Performance Year 5 (CY 2027).

c) The MBHV is incentivized to meaningfully improve rates of HRSN screenings from the baseline period (CY 2024) by the end of Performance Year 5 (CY 2027). To meet this goal, the MBHV must not only conduct screenings of beneficiaries, but also establish the capacity to track and report on screenings and referrals.

2) Equitable Quality and Access Domain Goals

a) . The MBHV is incentivized for performance on metrics such as those related to access to care (including for individuals with limited English proficiency and/or disability); care for behavioral health conditions; care coordination; and patient experience.

b) . For up to the first three Performance Years (PY 2023 through PY 2025), MBHV performance will be based on:

i. Reporting on access and quality metric performance, including reports stratified by demographic factors (such as race, ethnicity, language, disability, sexual orientation, and gender identity); health related social needs; and/or defined by other individual- or community-level markers or indices of social risk;

ii. Developing and implementing interventions aimed at improving quality and reducing observed disparities on metrics that account for clinical and social risk factors.

c). For at least the last two Performance Years (PY2026 and PY2027), MBHV performance will be based on improving quality and/or closing disparities as measured through performance on a subset of access and quality metrics.

3) Capacity and Collaboration Domain Goals

The MBHV is incentivized to improve service capacity, workforce development, and health system collaboration to improve quality and reduce disparities. The metrics that assess improvement in this domain may relate to provider cultural competence, support for language needs, disability accommodations, and achievement of externally validated equity standards.

3. MBHV-QEIP Performance Year 1 Metrics

To establish a robust foundation for quality and equity improvement and to begin making progress towards five-year health equity goals, the first performance year of the MBHV-QEIP holds the MBHV accountable to metrics listed in Table 2 evaluating contributory health system level interventions in each performance domain.

Table 2. MBHV-QEIP Performance Year 1 Metrics

Subdomain	**Metric (*Steward)***	**Performance Year 1 status***
Domain 1. Demographic and Health-Related Social Needs Data		
Demographic Data Collection	Race, Ethnicity, Language, Disability, Sexual Orientation, & Gender Identity Data Completeness (*EOHHS)*	Pay for Reporting (P4R)
Health-Related Social Needs Screening	Screening for Social Drivers of Health (*CMS*): *Preparing for Reporting Beginning in PY2*	P4R
Domain 2. Equitable Quality and Access		

Equity Reporting	Stratified Reporting of Quality Data (*EOHHS*)	P4R
Access	Meaningful Access to Healthcare Services for Persons with Limited English Proficiency (*Oregon Health Authority*)	P4R
Access	Disability Competencies (*EOHHS*)	P4R
Access	Accommodation Needs Met *(EOHHS)*	P4R
Domain 3. Capacity and Collaboration		
Capacity	Achievement of External Standards for Health Equity (EOHHS)	P4R
	Member Experience Survey: Cultural Competency, Language Services, and Disability Accommodations	P4R

*Reporting/performance requirements for each measure described in relevant metric technical specifications.

Recognizing that taking on accountability for equity is new for the MBHV, interim and annual goals for Performance Year 1 are designed to promote essential foundational capacity and readiness to assume progressive risk for health quality and equity performance in Performance Year 2-5. Summarized performance expectations are described in Table 3; detailed performance expectations are described in metric technical specifications.

Table 3. Summary of MBHV-QEIP Metric Performance Requirements Performance Year 1

Metric	Performance Expectations for Performance Year 1	Deadline
Domain 1. Demographic and Health-Related Social Needs Data		
Race, Ethnicity, Language, Disability, Sexual Orientation, & Gender Identity Data Completeness (*EOHHS)*	Race, Ethnicity, Language, Disability status (RELD) Sexual Orientation, Gender Identity (SOGI) Assessment – Timely and complete submission to EOHHS of an initial assessment of: 1) beneficiary-reported demographic data adequacy and completeness, and 2) a plan for collecting	August 31, 2023

	demographic data including data sources and collection questions.	
	Complete and timely submission to the MassHealth Data Warehouse (DW) of monthly Member Files as specified (beginning no later than August 31, 2023). The DW will reject monthly Member File submissions that are non-compliant with the specified format (e.g. previously compliant formats) anticipated no later than Q4 2023. Data collected by the MBHV will be submitted via the existing encounter submission process, using the enhanced Member File Specification.	Anticipated beginning no later than Q4 2023
Screening for Social Drivers of Health (*CMS): Preparing for Reporting Beginning in PY2*	Complete and timely submission of a report to EOHHS describing: Health-Related Social Needs (HRSN) Assessment – Timely and complete submission to EOHHS of an initial assessment of 1) beneficiary-reported HRSN data adequacy and completeness, and 2) strategies employed to provide information about referrals including to community resources and support services 2) One or more health-related social needs screening tool(s) selected by MBHV for intended use in screening members beginning in PY2; the selected tool(s) must meet requirements for screening tools for the "Screening for Social Drivers of Health" metric; and 3) An implementation plan to begin screening for health-related social needs in Q1 2024 in order to have capacity to report on the "Screening for Social Drivers of Health" metric beginning in Performance Year 2.	Anticipated October 27, 2023
Domain 2. Equitable Access and Quality		
Stratified Reporting of Quality Data (*EOHHS*)	Complete and timely submission to EOHHS of performance data, including	No earlier than April 1, 2024

	member-level race and ethnicity for clinical measures selected by EOHHS for stratification from the Appendix G-Incentive 1, Promotion of High Quality Care measure slate.	
Meaningful Access to Healthcare Services for Persons with Limited English Proficiency (*Oregon Health Authority*)	Complete and timely reporting of an organizational self-assessment of capacity related to providing access to high quality language services to members.	December 31, 2023.
Disability Competencies (*EOHHS*)	Complete and timely submission to EOHHS of MBHV's DCC Team's completed RIC **Disability-Competent Care Self-Assessment Tool (DCCAT)** report	Anticipated December 1, 2023
Accommodation Needs Met (*EOHHS)*	Complete and timely submission to EOHHS of a report describing MBHV's current practice and future plans for the following: • Screening members for accommodation needs at least annually, including at time of enrollment or Health Needs Assessment, and how the results of this screening is documented. • Other methods, if any, for documenting accommodation needs, at least annually. • Asking members to report if their accommodation needs were met during behavioral health care encounters. • Analyses that are performed at the organizational level to understand whether accommodation needs have been met.	Anticipated December 1 2023
Domain 3. Capacity and Collaboration		
Achievement of External Standards for Health Equity (*EOHHS)*	Complete and timely submission to EOHHS a report outlining the ways in which MBHV has started the process of attaining NCQA Health Equity Accreditation status by the end of PY3 (2025)	December 31, 2023
Member Experience Survey: Cultural Competency, Language Services, and Disability Accommodations	Complete and timely submission to EOHHS of draft version of MBHV Member Experience Survey for PY2 (Measurement Year 2024), and comprehensive plan for survey administration	October 1, 2023

	Complete and timely submission to EOHHS of final version of MBHV Member Experience Survey for PY2 with newly incorporated questions submitted by EOHHS.	December 31, 2023

4. MBHV-QEIP Payment for Performance Year 1

EOHHS will pay MBHV the full maximum eligible incentive amount for each metric described in Table 4 if the specified requirements are met. If any of the specified requirements are not met, or if any of the requirements are not met by the outlined deadline, the MBHV may be ineligible to earn full incentive payment for that specific measure, as determined by EOHHS.

5. MBHV-QEIP Accountability Framework for Performance Year 1

EOHHS will hold MBHV individually accountable for its performance on the MBHV-QEIP performance measures. Total incentive amounts for MBHV for Performance Year 1 will be distributed according to the weighting described in Table 4. Performance expectations for each metric are summarized in Table 3 above and detailed further in technical specifications.

Table 4. Performance Year 1 MBHV-QEIP

***Metric Weights* Subdomain**	**MBHV Quality and Equity Incentive Program Metric (*Steward)***	**Performance Year 1 Weight (%)**	**Maximum Eligible Incentive**
Domain 1. Demographic and Health-Related Social Needs Data		**27.8**	**$278,000**
Demographic Data Collection	Race, Ethnicity, Language, Disability, Sexual Orientation, & Gender Identity Data Completeness (*EOHHS)*	16.7	$167,000
Health-Related Social Needs Screening	Screening for Social Drivers of Health (*CMS*)	11.1	$111,000
Domain 2. Equitable Access and Quality		**44.4**	**$444,000**

Equity Reporting	Stratified Reporting of Quality Data (*EOHHS*)	11.1	$111,000
Access	Meaningful Access to Healthcare Services for Persons with Limited English Proficiency (*Oregon Health Authority*)	16.7	$167,000
	Disability Competencies (*EOHHS*)	8.3	$83,000
	Accommodation Needs Met (EOHHS)	8.3	$83,000
Domain 3. Capacity and Collaboration		**27.8**	**$278,000**
Capacity	Pending Further Guidance From NCQA	13.9	$139,000
	Member Experience Survey: Cultural Competency, Language Services, and Disability Accommodations	13.9	$139,000

C. PY2-5 Implementation Plan for the MBHV-QEIP

1. Scope of this PY2-5 Implementation Plan for the MBHV Quality and Equity Incentive Program

This MBHV Quality and Equity Incentive Program (MBHV-QEIP) Implementation Plan provides additional detail related to implementation of MassHealth's MBHV-QEIP for MBHV Performance Years (PYs) 2-5 from January 1, 2024 – December 31, 2027 of the MBHV contract. Additional detail may be forthcoming for future program years.

2. MBHV Quality and Equity Incentive Program (MBHV-QEIP) Domains and Goals

A. Overview of Targeted Domains for Improvement in the MBHV-QEIP

For the MBHV-QEIP, the MBHV is incentivized to pursue performance improvements in the domains specified in Table 1.

Table 1. Overview of Targeted Domains for Improvement for the MBHV-QEIP

Domain 1: Demographic and Health-Related Social Needs Data	The MBHV will be assessed on the completeness of beneficiary-reported demographic and health-related social needs data submitted in accordance with the Commonwealth's data requirements. Demographic and health-related social needs data will include at least the following categories: race, ethnicity, language, disability status, sexual orientation, gender identity, and health-related social needs. Data completeness will be assessed separately for each data element.
Domain 2: Equitable Quality and Access	The MBHV will be assessed on performance and demonstrated improvements on access and quality metrics, including associated reductions in disparities. Metrics will focus on overall access; access for individuals with disabilities and/or a preferred language other than English; care for behavioral health; and care coordination.
Domain 3: Capacity and Collaboration	The MBHV will be assessed on improvements in metrics such as provider and workforce capacity and collaboration with health system partners to improve quality and reduce health care disparities.

B. Goals for each Domain of the MBHV-QEIP

Goals for each MBHV-QEIP domain are summarized below:

1) Demographic and Health-Related Social Needs Data Collection Domain Goals

a) The MBHV is incentivized to achieve certain milestones to meet an interim goal of 80 percent data completeness for self-reported race and ethnicity data for attributed MassHealth members by the end of Performance Year 3 (CY 2025).

b) The MBHV is incentivized to achieve certain milestones to achieve at least 80 percent data completeness for beneficiary-reported other demographic data (including at least preferred written and spoken language, disability status, sexual orientation, and gender identity) for attributed MassHealth members by the end of Performance Year 5 (CY 2027).

c) The MBHV is incentivized to meaningfully improve rates of HRSN screenings from the baseline period by the end of Performance Year 5 (CY 2027). To meet this goal, the MBHV must not only conduct screenings of beneficiaries, but also establish the capacity to track and report on screenings and referrals.

2) Equitable Quality and Access Domain Goals

a) The MBHV is incentivized for performance on metrics such as those related to access to care (including for individuals with a preferred language other than English and/or disability); behavioral health; care coordination; and patient experience.

b) Metric performance expectations shall include, at a minimum:

i. Reporting on access and quality metric performance, including stratified by demographic factors (such as race, ethnicity, language, disability, sexual orientation, and gender identity); health-related social needs; and/or defined by other individual- or community-level markers or indices of social risk;

ii. Improving quality and/or closing disparities as measured through performance on a subset of access and quality metrics.

c) For up to the first three PYs, performance will be based on expectations described in 2(b)(i) above. For at least the last two PYs, performance will also be based on expectations described in 2(b)(ii), above.

3) Capacity and Collaboration Domain Goals

a) The MBHV is incentivized to improve service capacity, workforce development, and health system collaboration to improve quality and reduce disparities. The metrics that assess improvement in this domain may relate to provider communication, courtesy, respect, and achievement of externally validated equity standards.

3. MBHV-QEIP Performance Year 2-5 Metrics

Performance Years 2-5 of the MBHV-QEIP will hold the MBHV accountable to metrics evaluating performance in each MBHV-QEIP domain. These metrics were developed with input from health systems and providers through requests for information and comment, public meetings, and ongoing stakeholder engagement. Technical specifications for the MBHV-QEIP PY2-5 metrics may be updated annually or more frequently as necessary. A summary of the MBHV-QEIP metrics and anticipated payment status in PY2-5 are provided in Table 2.

Table 2. MBHV-QEIP PY 2-5 Metrics

Subdomain	**Metric (*Steward)***	**Anticipated payment status***			
		2024	**2025**	**2026**	**2027**
Domain 1. Demographic and Health-Related Social Needs Data					
Demographic Data Collection	Race, Ethnicity, Language, Disability, Sexual Orientation, & Gender Identity Data Completeness (*EOHHS)*	P4R	P4P	P4P	P4P

Health-Related Social Needs Screening	Health-Related Social Needs Screening (EOHHS)	P4R	P4P	P4P	P4P
Domain 2. Equitable Access and Quality					
Equity Reporting	Quality Performance Disparities Reduction (*EOHHS*)	P4R	P4R	P4P	P4P
Access	Meaningful Access to Healthcare Services for Persons with a Preferred Language other than English (*EOHHS*)	P4R	P4P	P4P	P4P
	Disability Competencies (*EOHHS*)	P4P	P4P	P4P	P4P
	Disability Accommodation Needs Screening and Intervention *(EOHHS)*	P4R	P4P	P4P	P4P
Domain 3. Capacity and Collaboration					
Capacity	Achievement of External Standards for Health Equity (EOHHS/*NCQA*)	P4R	P4P	P4R	P4R
	Member Experience: Communication, Courtesy, and Respect (EOHHS*)*	P4R	P4P	P4P	P4P

*P4R= Pay for Reporting, P4P= Pay for Performance. Specific performance trajectories are subject to change. Reporting/performance requirements for each measure described in forthcoming metric technical specifications.

The anticipated reporting expectations for PY2 are summarized in Table 3; detailed reporting and performance expectations for PY2 are included in metric technical specifications. Each report outlined in Table 3 shall be submitted by the MBHV in a form, format, and frequency to be further specified by EOHHS. Additional and/or revised reporting expectations for PY3-5 will be provided prior to the start of each performance year.

Table 3. Anticipated Reporting Expectations for PY2

Measure Name	Anticipated Reporting Expectations for PY2 (to be further specified by EOHHS)
Domain 1: Demographic & HRSN Data	
RELDSOGI Data Completeness	1. Submission of "Member Data and Member Enrollment" file 2. Submission of RELDSOGI Mapping Report inclusive of a plan to develop capacity to capture date stamps by PY5
Health-Related Social Needs Screening	1. Submission of administrative and/or supplemental HRSN data
Domain 2: Equitable Access & Quality	

Quality Performance Disparities Reduction	1. Submission of quality data stratified by race and ethnicity
Meaningful Access to Healthcare Services for Persons with a Preferred Language other than English	1. Submission of Language Access Self-Assessment Survey 2. Submission of Provision of Interpreter Services Data
Disability Competencies	1. Submission of Disability Competency Training Plan 2. Submission of Disability Competency Training Report
Disability Accommodation Needs Screening and Intervention	1. Submission of a Disability Accommodation Needs Report
Domain 3: Capacity & Collaboration	
Achievement of External Standards for Health Equity	1. Submission of Accreditation Status Report
Member Experience: Communication, Courtesy, and Respect	*Reporting expectations are satisfied through the annual MBHV member experience survey, administered by the MBHV.*

4. MBHV-QEIP Payment for Performance Years 2-5

In PY3-5, MassHealth will pay the MBHV based on its health equity score in accordance with Section 4.6 of the MBHV Contract. EOHHS will make a one-time payment to the MBHV after the health equity score has been finalized.

5. MBHV-QEIP Accountability Framework for Performance Year 2-5

MBHV Accountability to MassHealth for the MBHV-QEIP

MassHealth will hold the MBHV accountable for its performance on the MBHV-QEIP performance measures. MassHealth's anticipated framework for the MBHV-QEIP Performance Assessment Methodology (PAM), which may be adjusted annually as needed (for example to transition measures from pay-for-reporting to pay-for-performance, accommodate new contextual inputs, address extenuating circumstances impacting performance, etc.), is described below. Measure-specific PAM, including benchmarks, improvement targets and measure score calculation approach, will be described in each forthcoming measure specification.

A. **Benchmarking:** MassHealth will establish performance targets or benchmarks no later than the start of the first pay-for-performance period for the metric.

   1) Benchmarks for quantitative measures will include an attainment threshold and goal benchmark and will be set to apply to the full applicable performance period.

   2) Establishment of benchmarks will be informed by inputs such as initial MBHV-QEIP performance data, historical MBHV data/performance, external data/trends, and/or predetermined performance targets determined by MassHealth.

B. **Improvement Targets:** MassHealth will establish performance improvement targets for performance metrics, as applicable, no later than the start of the first pay-for-performance period for the metric.

1) Specific improvement targets and the approach for each measure will be set to apply to the full applicable performance period.

2) The approach and actual improvement target may differ by measure based on factors such as performance trends or type of measure; approaches may include year-over-year self-improvement, gap-to-goal percentage point increase, absolute percentage point increases, set milestones and/or goals for improvement.

C. **Performance Measure Score Calculation**: The performance measure scoring approach will be consistent, as applicable, with other MassHealth incentive programs or other incentive program practices. MassHealth will establish a methodology for performance measure scoring for each measure, to be specified in technical specifications, no later than the first day of the performance period to which the methodology applies.

1) **Pay-for reporting (P4R) measures.** P4R measures will be assessed on a pass/fail basis for which the MBHV, who reports according to each measure's technical specifications, will receive full points or credit for the metric.

2) **Pay-for-performance (P4P) measures.** The performance measure scoring and approach will be consistent, as applicable, with other MassHealth incentive programs or other incentive program practices, described below.

a) Measure scoring will include the following components for each measure:

i. Attainment points ranging from 0-10 points

ii. Improvement points ranging from 0-10 points

iii. Potential bonus points (with a cap) to ensure the MBHV has incentive to improve

b) Performance measure scores for each measure will be defined as a ratio between 0-1. Scores will be calculated by the sum of the points earned for each measure divided by the maximum number of points allowable for the measure. The maximum number of points allowable for the measure is the sum of the attainment, improvement and potential bonus points with a determined cap. The score will be calculated as follows:

Performance Measure Score = Points earned for each measure / Maximum number of points allowable for the measure.

c) Some performance measures may have identified sub-measures for which sub-measure performance scores will be calculated in the same manner, but then typically equally weighted to calculate a composite performance measure score. For sub-measures the score is calculated as follows:

Performance Measure Score = Sum of each (Sub-measure Score X Sub-measure Weighting).

D. **Domain Score Calculation**: The domain scoring and approach will, as applicable, be consistent with other MassHealth incentive programs or other incentive program practices. Domain scoring includes the following components:

1) Using the predetermined weights specified in Table 3, a domain score will be calculated by taking each performance measure score in the domain and calculating the sum of each performance measure score multiplied by its respective performance measure weight:

Domain Score = Sum of each (Performance Measure Score Performance Measure Weight).*

2) If the MBHV is not eligible for a measure (e.g., does not meet the denominator criteria or minimum volume), the weighting will be redistributed equally to the eligible performance measures in the domain.

E. **Health Equity Score Calculation**: The overall Health Equity Scoring approach will, as applicable, be consistent with other MassHealth incentive programs or other incentive program practices. The overall Health Equity Score includes the following components. Using the predetermined weights specified in Table 3, a health equity score will be calculated by taking each domain score and calculating the sum of each domain score multiplied by its respective domain weight:

*Health Equity Score = Sum of each (Domain Score * Domain Weight).*

The final Health Equity Score will be used to calculate the MBHV's earned incentive payment.

Table 4. PY 2-5 MBHV-QEIP Metric Weights

Domain*	Measure Name	Anticipated Measure Weight (%) by Performance Year				Domain Weight (%)
		2024	2025	2026	2027	
DHRSN	Race, Ethnicity, Language, Disability, Sexual Orientation, & Gender Identity Data Completeness	10	10	15	15	25
	Health-Related Social Needs (HRSN) Screening	15	15	10	10	
EAQ	Quality Performance Disparities Reduction	15	15	20	20	50
	Meaningful Access to Healthcare Services for Persons with a Preferred Language other than English	15	15	15	15	
	Disability Competent Care	10	10	5	5	
	Disability Accommodation Needs	10	10	10	10	
CC	Achievement of External Standards for Health Equity	15	15	10	10	25

	Member Experience: Communication, Courtesy, and Respect	10	10	15	15	
TOTAL						**100**

*DHRSN=Demographic and Health-Related Social Needs Data; EAQ=Equitable Access and Quality; CC=Capacity and Collaboration

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 2025 (CY25)

1. PCC and TPL: PMPM ($) Rates January 1, 2025 - December 31, 2025

Rating Category	Medical services PMPM	ABA PMPM	SUD PMPM	Admin PMPM	Total PMPM
Rating Category I Child :	$ 128.65	$ 19.44	$ 0.39	$ 6.09	$ 154.57
Rating Category I Adult :	$ 72.88	$ -	$ 5.74	$ 6.37	$ 84.99
Rating Category I TPL:	$ 21.27	$ 5.56	$ 0.06	$ 6.27	$ 33.16
Rating Category II Child :	$ 371.55	$ 213.21	$ 0.71	$ 13.54	$ 599.01
Rating Category II Adult :	$ 260.45	$ -	$ 12.01	$ 13.25	$ 285.71
Rating Category II TPL:	$ 52.18	$ 46.42	$ 0.32	$ 10.79	$ 109.71
Rating Category IX :	$ 95.35	$ -	$ 9.10	$ 6.43	$ 110.88
Rating Category X :	$ 473.78	$ -	$ 157.59	$ 18.17	$ 649.54

2. Primary Care ACO: PMPM ($) Rates January 1, 2025 - December 31, 2025

Rating Category	Medical services PMPM	ABA PMPM	SUD PMPM	Admin PMPM	Total PMPM
Rating Category I Child :	$ 64.38	$ 11.50	$ 0.21	$ 4.85	$ 80.94
Rating Category I Adult :	$ 69.00	$ -	$ 7.80	$ 5.15	$ 81.95
Rating Category II Child :	$ 336.72	$ 244.01	$ -	$ 11.11	$ 591.84
Rating Category II Adult :	$ 319.51	$ -	$ 28.87	$ 12.38	$ 360.76
Rating Category IX :	$ 113.26	$ -	$ 17.15	$ 5.30	$ 135.71
Rating Category X :	$ 602.69	$ -	$ 264.75	$ 14.97	$ 882.41

B. Risk Sharing Corridors for Contract Period CY25, 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 2025. 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 2025. 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 CY25 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 CY25. 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 CY25. 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 2025 effective January 1, 2025, through December 31, 2025, 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 2025, 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 2025, 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 2025, 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 2025. 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 2025. 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 2025, 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. Quality Incentive Program and Quality and Equity Incentive Program Arrangements

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

The CY2025 Payments for performance incentives detailed in Appendix G to the Contract shall be $6,000,000.00, subject to attainment of attainment of reporting and performance measures.

C. PCC Plan Support

For CY25, EOHHS shall pay the Contractor a fixed amount of $850,000 for PCC Plan 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 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.

D. HRSN Supplemental Services and HRSN administration Payment (pursuant to Section 4.2.W. of the Contract)

In CY25, EOHHS shall issue lumpsum payments to the contractor for the provision of HRSN supplemental services to primary Care ACO enrollees in the amount of $8,859,349.19. Additionally EOHHS shall issue lumpsum payments to the contractor for administrative costs associated with the delivery of HRSN services in the amount of $2,000,000.

The payments will be issued on a quarterly basis or in other frequency to be determined by EOHHS, as described in **Section 4.2W.**

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.N**.

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 2025 in support of the ASD-ID for MCPAP activities. These funds may be used to support MCPAP's role in expansion of MCPAP for ASD-ID to support pediatric primary care providers, as long as the use of the funds for this purpose has no impact on MCPAP for ASD-ID's ability to fully meet all program requirements

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 $529,823 in Calendar Year 2025 in support of the Early Childhood (EC) MCPAP activities.

1. The Contractor's EC MCPAP program spending in CY2025 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 2025. This amount will be paid out in monthly installments determined by EOHHS.

E. [Reserved]

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 2025 and paid out in monthly installments to be determined by EOHHS.

G. Community Crisis Administration Payment

The CY25 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.O of the Contract)

Contingent upon receipt of funding from DPH, EOHHS shall pay the Contractor $1,250,000 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. 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 either a rate of $1,024.64 for an adult mobile non-emergency department encounter, $1075.87 for a youth non-emergency department encounter or $695.29 for a community-based encounter for such individual or the difference between the aforementioned rates and the amount covered by Third Party Liability, whichever is lower.

2. For each individual for which the Contractor pays for the mobile crisis intervention follow-up pursuant to **Section 2.6.B.1** of the Contract, EOHHS shall pay the Contractor either the following rates or the difference between the below rates and the amount covered by Third Party Liability, whichever is lower:
    i. $30.57 per 15 minutes for AMCI provided at CBHC site by a Paraprofessional or Bachelor's level staff. Follow up interventions provided up to the third day following initial evaluation.
    ii. $33.94 per 15 minutes for YMCI provided at CBHC site by a Paraprofessional or Bachelor's level staff. Follow up interventions provided up to the seventh day following initial evaluation.
    iii. $39.70 per 15 minutes for AMCI provided at CBHC site by a Master's level Clinician. Follow-up interventions provided up to the third day following initial evaluation.
    iv. $44.33 per 15 minutes for YMCI provided at CBHC site by a Master's level clinician. Follow-up interventions provided up to the seventh day following initial evaluation.
    v. $33.94 per 15 minutes for AMCI provided at a community-based site of service outside of the CBHC site by a Paraprofessional or Bachelor's level staff. Follow-up interventions provided up to the third day following initial evaluation.
    vi. $33.94 per 15 minutes for YMCI provided at a community-based site of service outside of the CBHC site by a Paraprofessional or Bachelor's level staff. Follow-up interventions provided up to the seventh day following initial evaluation.
    vii. $44.33 per 15 minutes for AMCI provided at a community-based site of service outside of the CBHC site by a Master's level clinician. Follow-up interventions provided up to the third day following initial evaluation.
    viii. $44.33 per 15 minutes for YMCI provided at a community-based site of service outside of the CBHC site by a Master's level clinician. Follow-up interventions provided up to the seventh day following initial evaluation.
3. For each individual for which the Contractor pays for Community Crisis Stabilization (CCS) pursuant to **Section 2.6.B.1** of the Contract, EOHHS shall pay the Contractor either a rate of $632.05 per unit of Adult CCS or $930.73 per unit of Youth CCS or the difference between the aforementioned rates and the amount covered by Third Party Liability, whichever is lower.
4. For each unit of outpatient CBHC bundle for which the Contractor pays pursuant to **Section 2.6.B.1** of the Contract, up to three units per individual, EOHHS shall pay

the Contractor either a rate of $233.90 for a CBHC Adult Services encounter bundle or $241.86 for a CBHC Child/Adolescent Services encounter bundle or the difference between the aforementioned rates and the amount covered by Third Party Liability, whichever is lower.

5. 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**.

J. 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**.

K. CBHI Provider Payments (pursuant to Section 4.2.X of the Contract)

In CY2025, EOHHS shall issue payments to the Contractor in the amount of $15,000,000, in support of the Children's Behavioral Health Initiative (CBHI) and Community Service Agency (CSA) provider networks. The Contractor's spending on CBHI and CSA activities described in **Section 4.2.X** shall not exceed the funding provided in Contract Year 2025. Any unspent funds shall be returned to EOHHS, unless otherwise directed by EOHHS.

L. DCF M—CAAP Training Payment (Pursuant to Section 2.7.N)

In CY25 EOHHS will pay the Contractor $6898.80 for M-CAAP training conducted in October 2024 and as described in **Section 2.7.N.**

M. Outpatient Crisis Payment (pursuant to Section 2.6.B.2 of the Contract)

1. For each unit of outpatient CBHC bundle for which the Contractor pays pursuant to **Section 2.6.B.2** of the Contract, up to three units per individual, EOHHS shall pay the Contractor either a rate of $233.90 for a CBHC Adult Services encounter bundle or $241.86 for a CBHC Child/Adolescent Services encounter bundle or the difference between the aforementioned rates and the amount covered by Third Party Liability, whichever is lower.
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				
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	Psychiatric Diagnostic Evaluation	$ 130.48
MH and SA OP Services	90791	U3 - Intern (PhD, PsyD, EdD)	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
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

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MH and SA OP Services	90832	HO - Master's Level	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)	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	Individual Psychotherapy, approximately 45 minutes	$ 95.46
MH and SA OP Services	90834	U3 - Intern (PhD, PsyD, EdD)	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
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	Psychotherapy, 60 minutes	$ 125.69
MH and SA OP Services	90837	U3 - Intern (PhD, PsyD, EdD)	Psychotherapy, 60 minutes	$ 68.87
MH and SA OP Services	90837	U4-Intern (Master's)	Psychotherapy, 60 minutes	$ 60.77

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Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
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	Family Psychotherapy (without patient present)	$ 101.43
MH and SA OP Services	90846	U3 - Intern (PhD, PsyD, EdD)	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	Family Psychotherapy (conjoint psychotherapy) (with patient present)	$ 101.43
MH and SA OP Services	90847	U3 - Intern (PhD, PsyD, EdD)	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

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Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	90849	HO - Master's Level	Multi-family group psychotherapy	$ 27.69
MH and SA OP Services	90849	U3 - Intern (PhD, PsyD, EdD)	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
MH and SA OP Services	90853	HO - Master's Level	Group psychotherapy (other than of a multiple-family group)	$ 33.12
MH and SA OP Services	90853	U3 - Intern (PhD, PsyD, EdD)	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	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)	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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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	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)	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

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Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
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

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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

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Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
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
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

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

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Unique Code/Modifier Combinations				
Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
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
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

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Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
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
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)	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	H0010		Alcohol and/or drug services; sub-acute detoxification (residential addiction program inpatient) (Clinically Managed Detoxification Services)	101 CMR 346
Diversionary Services	H0011		Alcohol and/or drug services; acute detoxification (residential addiction program inpatient) (medically monitored inpatient detoxification services)	101 CMR 346

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Unique Code/Modifier Combinations				
Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
Diversionary Services	H0015	TF	Alcohol and/or drug services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan) including assessment, counseling; crisis intervention, and activity therapies or education. (Enhanced Structured Outpatient Addiction Program - SOAP with Motivational Interviewing Counseling)	101 CMR 444
Diversionary Services	H0015	N/A	Alcohol and/or drug services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan) including assessment, counseling; crisis intervention, and activity therapies or education. (Structured Outpatient Addiction Program - SOAP with Motivational Interviewing)	101 CMR 444
Diversionary Services	H0037	*N/A*	Community Psychiatric Supportive Treatment Program, per diem (Community Based Acute Treatment - CBAT)	$847.46
Diversionary Services	H0037	U2-Autism Diagnosis	Community Psychiatric Supportive Treatment Program, per diem (CBAT Autism Speciality)	$ 1,291.59
Diversionary Services	H2012	+	Behavioral Health Day Treatment, per hour (Psychiatric Day Treatment)	Effective 10/1/23 through 2/29/24: $28.77 Effective 3/1/24: 101 CMR 307
Diversionary Services	H2012	U1	Behavioral Health Day Treatment, per hour (Psychiatric Day Treatment, preadmission evaluation visit)	Effective 10/1/23 through 2/29/24: $80.13 Effective 3/1/24: 101 CMR 307
Diversionary Services	H2015	HF-Substance Abuse Program	Recovery Support Navigator , per 15-minute units	101 CMR 444
Diversionary Services	H2015	*N/A*	Comprehensive community support services, per 15 minutes (Community Support Program)	101 CMR 362

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Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
Diversionary Services	H2016	HH-Integrated Mental Health/Substance Abuse Program	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
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
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	*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*	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

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Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
Crisis Intervention Services	S9485	*HA-Child/Adolescent Program; U1-MCI - Mobile Non-Emergency Department*	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	U1-ESP - Mobile Non-Emergency Department	Crisis intervention mental health service, per diem (Emergency Service Program Adult Mobile Crisis Intervention, Community based location Non-Emergency Department - Uninsured)	$ 1,024.64
Crisis Intervention Services	S9485	*HA-Child/Adolescent Program; U1-MCI - Mobile Non-Emergency Department*	Crisis intervention mental health service, per diem (Emergency Service Program Youth Mobile Crisis Intervention, Community-based location Non-Emergency Department - Uninsured)	$ 1,075.87
Crisis Intervention Services	S9485	HE-Mental Health Program	Crisis intervention mental health services, per diem (Emergency Service Program Mobile Crisis Intervention SiteCommunity 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
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

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Unique Code/Modifier Combinations				
Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
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	$ 107.49
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	$ 121.84
Other Outpatient	96133	AH-Doctoral Level (PhD, PsyD, EdD)	Add-On Code; Each additional hour (List separately in addition to code for primary procedure)	$ 100.53
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)	$ 50.27
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	$ 37.75
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)	$ 37.75
Other Outpatient	H0032	HO-Master's Level	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

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Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
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	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)	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 306
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--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
Diversionary Services	S9480	N/A	Intensive outpatient psychiatric services, per diem	101 CMR 306

Exhibit 2: Behavioral Health Outpatient Services Provided by a Mental Health Center Minimum Fee Schedule			
Procedure Code	**Modifier Group**	**Procedure Description**	**Unit Cost**
90791	UG - Doctoral Level (Child Psychiatrist)	Psychiatric Diagnostic Evaluation	$229.10
90791	U6 - Doctoral Level (MD / DO)	Psychiatric Diagnostic Evaluation	$183.87
90791	AH - Doctoral Level (PhD, PsyD, EdD)	Psychiatric Diagnostic Evaluation	$157.83
90791	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Psychiatric Diagnostic Evaluation	$159.13
90791	HO - Master's Level	Psychiatric Diagnostic Evaluation	$143.53
90791	U3 - Intern (PhD, PsyD, EdD)	Psychiatric Diagnostic Evaluation	$90.01
90791	U4 - Intern (Master's)	Psychiatric Diagnostic Evaluation	$79.42
90791	HA - CANS; UG-Doctoral Level (Child Psychiatrist)	CANS - Psychiatric Diagnostic Evaluation, Members under 21	$245.60
90791	HA - CANS; U6-Doctoral Level (MD / DO)	CANS - Psychiatric Diagnostic Evaluation, Members under 21	$200.37
90791	HA - CANS; AH-Doctoral Level (PhD, PsyD, EdD)	CANS - Psychiatric Diagnostic Evaluation, Members under 21	$174.33
90791	HA - CANS; SA, UF -Nurse Practitioner/Board Certified RNCS and APRN-BC	CANS - Psychiatric Diagnostic Evaluation, Members under 21	$175.63
90791	HA - CANS; HO-Master's Level	CANS - Psychiatric Diagnostic Evaluation, Members under 21	$160.03
90791	HA - CANS; U3-Intern (PhD, PsyD, EdD)	CANS - Psychiatric Diagnostic Evaluation, Members under 21	$106.51
90791	HA - CANS; U4-Intern (Master's)	CANS - Psychiatric Diagnostic Evaluation, Members under 21	$95.92
90792	UG - Doctoral Level (Child Psychiatrist)	Psychiatric Diagnostic Evaluation with Medical Services	$144.98
90792	U6-Doctoral Level (MD / DO)	Psychiatric Diagnostic Evaluation with Medical Services	$125.74
90792	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Psychiatric Diagnostic Evaluation with Medical Services	$115.03
90832	UG - Doctoral Level (Child Psychiatrist)	Individual Psychotherapy, approximately 20-30 minutes	$76.56
90832	U6 - Doctoral Level (MD / DO)	Individual Psychotherapy, approximately 20-30 minutes	$76.56
90832	AH - Doctoral Level (PhD, PsyD, EdD)	Individual Psychotherapy, approximately 20-30 minutes	$65.08
90832	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Individual Psychotherapy, approximately 20-30 minutes	$65.08
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	$57.42
90832	U7 - Certified Addiction Counselor / Certified Alcohol & Drug Abuse Counselor	Individual Psychotherapy, approximately 20-30 minutes	$57.42
90832	U3 - Intern (PhD, PsyD, EdD) / or MAT	Individual Psychotherapy, approximately 20-30 minutes	$39.04

90832	U4 - Intern (Master's)	Individual Psychotherapy, approximately 20-30 minutes	$34.45
90833	U6 - Doctoral Level (MD / DO)	Psychotherapy, 30 minutes, when Performed with an Evaluation and Management Service	$70.21
90833	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Psychotherapy, 30 minutes, when Performed with an Evaluation and Management Service	$59.68
90834	UG - Doctoral Level (Child Psychiatrist)	Individual Psychotherapy, approximately 45 minutes	$127.27
90834	U6 - Doctoral Level (MD / DO)	Individual Psychotherapy, approximately 45 minutes	$111.83
90834	AH - Doctoral Level (PhD, PsyD, EdD)	Individual Psychotherapy, approximately 45 minutes	$105.48
90834	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Individual Psychotherapy, approximately 45 minutes	$105.01
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	$105.01
90834	U3 - Intern (PhD, PsyD, EdD) / or MAT	Individual Psychotherapy, approximately 45 minutes	$52.78
90834	U4 - Intern (Master's)	Individual Psychotherapy, approximately 45 minutes	$51.99
90836	U6 - Doctoral Level (MD / DO)	Psychotherapy, 45 minutes, when Performed with an Evaluation and Management Service	$91.19
90836	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Psychotherapy, 45 minutes, when Performed with an Evaluation and Management Service	$91.19
90837	UG - Doctoral Level (Child Psychiatrist)	Psychotherapy, 60 minutes	$148.54
90837	U6 - Doctoral Level (MD / DO)	Psychotherapy, 60 minutes	$148.54
90837	AH - Doctoral Level (PhD, PsyD, EdD)	Psychotherapy, 60 minutes	$140.28
90837	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Psychotherapy, 60 minutes	$138.26
90837	HO - Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Psychotherapy, 60 minutes	$138.26
90837	U3 - Intern (PhD, PsyD, EdD) / or MAT	Psychotherapy, 60 minutes	$75.76
90837	U4 - Intern (Master's)	Psychotherapy, 60 minutes	$66.85
90846	UG - Doctoral Level (Child Psychiatrist)	Family Psychotherapy (without patient present)	$155.56
90846	U6 - Doctoral Level (MD / DO)	Family Psychotherapy (without patient present)	$118.38
90846	AH - Doctoral Level (PhD, PsyD, EdD)	Family Psychotherapy (without patient present)	$110.52
90846	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Family Psychotherapy (without patient present)	$107.31

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)	$111.57
90846	U3 - Intern (PhD, PsyD, EdD) / or MAT	Family Psychotherapy (without patient present)	$55.25
90846	U4 - Intern (Master's)	Family Psychotherapy (without patient present)	$53.65
90847	UG - Doctoral Level (Child Psychiatrist)	Family Psychotherapy (conjoint psychotherapy) (with patient present)	$155.56
90847	U6 - Doctoral Level (MD / DO)	Family Psychotherapy (conjoint psychotherapy) (with patient present)	$118.38
90847	AH - Doctoral Level (PhD, PsyD, EdD)	Family Psychotherapy (conjoint psychotherapy) (with patient present)	$111.57
90847	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Family Psychotherapy (conjoint psychotherapy) (with patient present)	$111.57
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)	$111.57
90847	U3 - Intern (PhD, PsyD, EdD) / or MAT	Family Psychotherapy (conjoint psychotherapy) (with patient present)	$55.25
90847	U4 - Intern (Master's)	Family Psychotherapy (conjoint psychotherapy) (with patient present)	$53.65
90849	UG - Doctoral Level (Child Psychiatrist)	Multi-family group psychotherapy	$50.92
90849	U6 - Doctoral Level (MD / DO)	Multi-family group psychotherapy	$42.72
90849	AH - Doctoral Level (PhD, PsyD, EdD)	Multi-family group psychotherapy	$39.45
90849	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Multi-family group psychotherapy	$36.30
90849	HO - Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Multi-family group psychotherapy	$30.46
90849	U3 - Intern (PhD, PsyD, EdD) / or MAT	Multi-family group psychotherapy	$19.76
90849	U4 - Intern (Master's)	Multi-family group psychotherapy	$18.15
90853	UG - Doctoral Level (Child Psychiatrist)	Group psychotherapy (other than of a multiple-family group)	$50.92
90853	U6 - Doctoral Level (MD / DO)	Group psychotherapy (other than of a multiple-family group)	$42.72
90853	AH - Doctoral Level (PhD, PsyD, EdD)	Group psychotherapy (other than of a multiple-family group)	$39.45
90853	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Group psychotherapy (other than of a multiple-family group)	$36.43

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)	$36.43
90853	U3 - Intern (PhD, PsyD, EdD) / or MAT	Group psychotherapy (other than of a multiple-family group)	$19.76
90853	U4 - Intern (Master's)	Group psychotherapy (other than of a multiple-family group)	$18.15
90882	UG - Doctoral Level (Child Psychiatrist)	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions.	$56.22
90882	U6 - Doctoral Level (MD / DO)	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions.	$48.76
90882	AH - Doctoral Level (PhD, PsyD, EdD)	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions.	$26.37
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.	$42.20
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.	$25.99
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.	$13.20
90882	U4 - Intern (Master's)	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions.	$12.99
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	$87.11
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	$87.11

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	$74.05
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	$74.05
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	$65.34
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	$44.43
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	$39.20
99202	UG - Doctoral Level (Child Psychiatrist)	Evaluation and Management for New Patient, 15-29 minutes	$82.78
99202	U6 - Doctoral Level (MD / DO)	Evaluation and Management for New Patient, 15-29 minutes	$74.70
99202	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for New Patient, 15-29 minutes	$66.86
99203	UG - Doctoral Level (Child Psychiatrist)	Evaluation and Management for New Patient, 30-44 minutes	$119.41
99203	U6 - Doctoral Level (MD / DO)	Evaluation and Management for New Patient, 30-44 minutes	$114.02
99203	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for New Patient, 30-44 minutes	$96.92
99204	UG - Doctoral Level (Child Psychiatrist)	Evaluation and Management for New Patient, 45-59 minutes	$180.40
99204	U6 - Doctoral Level (MD / DO)	Evaluation and Management for New Patient, 45-59 minutes	$169.28
99204	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for New Patient, 45-59 minutes	$146.58
99205	UG - Doctoral Level (Child Psychiatrist)	Evaluation and Management for New Patient, 60-74 minutes	$224.06
99205	U6 - Doctoral Level (MD / DO)	Evaluation and Management for New Patient, 60-74 minutes	$223.64
99205	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for New Patient, 60-74 minutes	$190.09
99211	UG - Doctoral Level (Child Psychiatrist)	Evaluation and Management for an Established Patient, 5 minutes	$24.27

99211	U6 - Doctoral Level (MD / DO)	Evaluation and Management for an Established Patient, 5 minutes	$24.27
99211	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for an Established Patient, 5 minutes	$20.63
99212	UG - Doctoral Level (Child Psychiatrist)	Evaluation and Management for an Established Patient, 10-19 minutes	$58.00
99212	U6 - Doctoral Level (MD / DO)	Evaluation and Management for an Established Patient, 10-19 minutes	$58.00
99212	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for an Established Patient, 10-19 minutes	$49.30
99213	UG - Doctoral Level (Child Psychiatrist)	Evaluation and Management for an Established Patient, 20-29 minutes	$92.52
99213	U6 - Doctoral Level (MD / DO)	Evaluation and Management for an Established Patient, 20-29 minutes	$92.52
99213	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for an Established Patient, 20-29 minutes	$78.64
99214	UG - Doctoral Level (Child Psychiatrist)	Evaluation and Management for an Established Patient, 30-39 minutes	$158.38
99214	U6 - Doctoral Level (MD / DO)	Evaluation and Management for an Established Patient, 30-39 minutes	$130.36
99214	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for an Established Patient, 30-39 minutes	$110.80
99215	UG - Doctoral Level (Child Psychiatrist)	Evaluation and Management for an Established Patient, 40-54 minutes	$183.23
99215	U6 - Doctoral Level (MD / DO)	Evaluation and Management for an Established Patient, 40-54 minutes	$183.23
99215	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for an Established Patient, 40-54 minutes	$155.74
99417	U6 - Doctoral Level (MD / DO)	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	$28.69
99417	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	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	$28.69

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	$132.51
96121	AH - Doctoral Level (PhD, PsyD, EdD)	Each additional hour (List separately in addition to code for primary procedure)	$132.51
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	$118.24
96131	AH - Doctoral Level (PhD, PsyD, EdD)	Each additional hour (List separately in addition to code for primary procedure)	$100.53
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	$134.02
96133	AH - Doctoral Level (PhD, PsyD, EdD)	Each additional hour (List separately in addition to code for primary procedure)	$110.58
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)	$55.30
96137	AH - Doctoral Level (PhD, PsyD, EdD)	Each additional 30 minutes (List separately in addition to code for primary procedure) (Test administration and scoring by professional)	$50.27
96138	Technician	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes	$41.53

96139	Technician	Each additional 30 minutes (List separately in addition to code for primary procedure) (Test administration and scoring by technician)	$41.53
99402	AH - Doctoral Level (PhD, PsyD, EdD)	Preventative Medicine Counseling, 30 minutes (Psychological Testing)	$45.08
99402	U3 - Intern (PhD, PsyD, EdD) / or MAT	Preventative Medicine Counseling, 30 minutes (Psychological Testing)	$22.55
99404	U6 - Doctoral Level (MD / DO)	Preventative Medicine Counseling, 60 minutes (Counseling and/or Risk Factor Reduction Intervention)	$214.30
99404	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Preventative Medicine Counseling, 60 minutes (Counseling and/or Risk Factor Reduction Intervention)	$185.46
H2020	+	Therapeutic behavioral services, per diem (Dialectical Behavior Therapy)	$29.15
S9484	+	Crisis intervention mental health services, per hour (Urgent Outpatient Services)	$162.33
90870	+	Electroconvulsive therapy (includes necessary monitoring)	$694.05
H0032	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)	$183.34
H0046	UG - Doctoral Level (Child Psychiatrist)	Mental health services, not otherwise specified (Collateral Contact)	$51.11
H0046	U6 - Doctoral Level (MD/DO)	Mental health services, not otherwise specified (Collateral Contact)	$44.33
H0046	AH - Doctoral Level (PhD, PsyD, EdD)	Mental health services, not otherwise specified (Collateral Contact)	$23.97
H0046	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Mental health services, not otherwise specified (Collateral Contact)	$38.36
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)	$23.63
H0046	U7 - Certified Addiction Counselor / Certified Alcohol & Drug Abuse Counselor	Mental health services, not otherwise specified (Collateral Contact)	$23.63
H0046	U3 - Intern (PhD, PsyD, EdD) / or MAT	Mental health services, not otherwise specified (Collateral Contact)	$12.00
H0046	U4 - Intern (Master's)	Mental health services, not otherwise specified (Collateral Contact)	$11.81

H0015	N/A	Alcohol and/or drug services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan) including assessment, counseling; crisis intervention, and activity therapies or education. (Structured Outpatient Addiction Program - SOAP with Motivational Interviewing)	101 CMR 444
H0015	TF	Alcohol and/or drug services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan) including assessment, counseling; crisis intervention, and activity therapies or education. (Enhanced Structured Outpatient Addiction Program - SOAP with Motivational Interviewing Counseling)	101 CMR 444
H2015	HF - Substance Abuse Program	Recovery Support Navigator, per 15-minute units	101 CMR 444
H2016	HM - Less than bachelor's 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
H0046	HE-Mental Health Program	Mental health services, not otherwise specified (Certified Peer Specialist) (Enrolled client day)	101 CMR 306
S9480	N/A	Intensive outpatient psychiatric services, per diem	101 CMR 306

Exhibit 3: Behavioral Health Outpatient Services Subject to 15% Uniform Dollar Increase For services provided by Mental Health Centers designated as Behavioral Health Urgent Care Provider sites, in accordance with Section 2.6.D.10.c, when billed with modifer GJ.

Procedure Code	Modifier Group	Procedure Description
90791	UG - Doctoral Level (Child Psychiatrist)	Psychiatric Diagnostic Evaluation
90791	U6 - Doctoral Level (MD / DO)	Psychiatric Diagnostic Evaluation
90791	AH - Doctoral Level (PhD, PsyD, EdD)	Psychiatric Diagnostic Evaluation
90791	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Psychiatric Diagnostic Evaluation
90791	HO - Master's Level	Psychiatric Diagnostic Evaluation
90791	U3 - Intern (PhD, PsyD, EdD)	Psychiatric Diagnostic Evaluation
90791	U4 - Intern (Master's)	Psychiatric Diagnostic Evaluation
90791	HA-CANS; UG-Doctoral Level (Child Psychiatrist)	CANS - Psychiatric Diagnostic Evaluation, Members under 21
90791	HA-CANS; U6-Doctoral Level (MD / DO)	CANS - Psychiatric Diagnostic Evaluation, Members under 21
90791	HA-CANS; AH-Doctoral Level (PhD, PsyD, EdD)	CANS - Psychiatric Diagnostic Evaluation, Members under 21
90791	HA-CANS; SA, UF -Nurse Practitioner/Board Certified RNCS and APRN-BC	CANS - Psychiatric Diagnostic Evaluation, Members under 21
90791	HA-CANS; HO-Master's Level	CANS - Psychiatric Diagnostic Evaluation, Members under 21
90791	HA-CANS; U3-Intern (PhD, PsyD, EdD)	CANS - Psychiatric Diagnostic Evaluation, Members under 21
90791	HA-CANS; U4-Intern (Master's)	CANS - Psychiatric Diagnostic Evaluation, Members under 21
90792	UG - Doctoral Level (Child Psychiatrist)	Psychiatric Diagnostic Evaluation with Medical Services
90792	U6-Doctoral Level (MD / DO)	Psychiatric Diagnostic Evaluation with Medical Services
90792	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Psychiatric Diagnostic Evaluation with Medical Services
90832	UG - Doctoral Level (Child Psychiatrist)	Individual Psychotherapy, approximately 20-30 minutes
90832	U6 - Doctoral Level (MD / DO)	Individual Psychotherapy, approximately 20-30 minutes
90832	AH - Doctoral Level (PhD, PsyD, EdD)	Individual Psychotherapy, approximately 20-30 minutes
90832	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Individual Psychotherapy, approximately 20-30 minutes

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
90832	U7 - Certified Addiction Counselor / Certified Alcohol & Drug Abuse Counselor	Individual Psychotherapy, approximately 20-30 minutes
90832	U3 - Intern (PhD, PsyD, EdD) / or MAT	Individual Psychotherapy, approximately 20-30 minutes
90832	U4 - Intern (Master's)	Individual Psychotherapy, approximately 20-30 minutes
90833	U6 - Doctoral Level (MD / DO)	Psychotherapy, 30 minutes, when Performed with an Evaluation and Management Service
90833	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Psychotherapy, 30 minutes, when Performed with an Evaluation and Management Service
90834	UG - Doctoral Level (Child Psychiatrist)	Individual Psychotherapy, approximately 45 minutes
90834	U6 - Doctoral Level (MD / DO)	Individual Psychotherapy, approximately 45 minutes
90834	AH - Doctoral Level (PhD, PsyD, EdD)	Individual Psychotherapy, approximately 45 minutes
90834	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Individual Psychotherapy, approximately 45 minutes
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
90834	U3 - Intern (PhD, PsyD, EdD) / or MAT	Individual Psychotherapy, approximately 45 minutes
90834	U4 - Intern (Master's)	Individual Psychotherapy, approximately 45 minutes
90836	U6 - Doctoral Level (MD / DO)	Psychotherapy, 45 minutes, when Performed with an Evaluation and Management Service
90836	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Psychotherapy, 45 minutes, when Performed with an Evaluation and Management Service
90837	UG - Doctoral Level (Child Psychiatrist)	Psychotherapy, 60 minutes
90837	U6 - Doctoral Level (MD / DO)	Psychotherapy, 60 minutes
90837	AH - Doctoral Level (PhD, PsyD, EdD)	Psychotherapy, 60 minutes
90837	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Psychotherapy, 60 minutes

90837	HO - Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Psychotherapy, 60 minutes
90837	U3 - Intern (PhD, PsyD, EdD) / or MAT	Psychotherapy, 60 minutes
90837	U4 - Intern (Master's)	Psychotherapy, 60 minutes
90846	UG-Doctor Level (Child Psychiatrist)	Family Psychotherapy (without patient present)
90846	U6-Doctor Level (MD/DO)	Family Psychotherapy (without patient present)
90846	AH-Doctoral Level (PhD, PsyD, EdD)	Family Psychotherapy (without patient present)
90846	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Family Psychotherapy (without patient present)
90846	HO - Master's Level	Family Psychotherapy (without patient present)
90846	U3 - Intern (PhD, PsyD, EdD)	Family Psychotherapy (without patient present)
90846	U4-Intern (Master's)	Family Psychotherapy (without patient present)
90847	UG - Doctoral Level (Child Psychiatrist)	Family Psychotherapy (conjoint psychotherapy) (with patient present)
90847	U6 - Doctoral Level (MD / DO)	Family Psychotherapy (conjoint psychotherapy) (with patient present)
90847	AH - Doctoral Level (PhD, PsyD, EdD)	Family Psychotherapy (conjoint psychotherapy) (with patient present)
90847	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Family Psychotherapy (conjoint psychotherapy) (with patient present)
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)
90847	U3 - Intern (PhD, PsyD, EdD) / or MAT	Family Psychotherapy (conjoint psychotherapy) (with patient present)
90847	U4 - Intern (Master's)	Family Psychotherapy (conjoint psychotherapy) (with patient present)
90849	UG-Doctor Level (Child Psychiatrist)	Multi-family group psychotherapy
90849	U6-Doctor Level (MD/DO)	Multi-family group psychotherapy
90849	AH-Doctoral Level (PhD, PsyD, EdD)	Multi-family group psychotherapy

90849	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Multi-family group psychotherapy
90849	HO - Master's Level	Multi-family group psychotherapy
90849	U3 - Intern (PhD, PsyD, EdD)	Multi-family group psychotherapy
90849	U4-Intern (Master's)	Multi-family group psychotherapy
90853	UG - Doctoral Level (Child Psychiatrist)	Group psychotherapy (other than of a multiple-family group)
90853	U6 - Doctoral Level (MD / DO)	Group psychotherapy (other than of a multiple-family group)
90853	AH - Doctoral Level (PhD, PsyD, EdD)	Group psychotherapy (other than of a multiple-family group)
90853	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Group psychotherapy (other than of a multiple-family group)
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)
90853	U3 - Intern (PhD, PsyD, EdD) / or MAT	Group psychotherapy (other than of a multiple-family group)
90853	U4 - Intern (Master's)	Group psychotherapy (other than of a multiple-family group)
90882	UG - Doctoral Level (Child Psychiatrist)	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions.
90882	U6 - Doctoral Level (MD / DO)	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions.
90882	AH - Doctoral Level (PhD, PsyD, EdD)	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions.
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.
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.

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.
90882	U4 - Intern (Master's)	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions.
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
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
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
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
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
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
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

99202	UG - Doctoral Level (Child Psychiatrist)	Evaluation and Management for New Patient, 15-29 minutes
99202	U6 - Doctoral Level (MD / DO)	Evaluation and Management for New Patient, 15-29 minutes
99202	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for New Patient, 15-29 minutes
99203	UG - Doctoral Level (Child Psychiatrist)	Evaluation and Management for New Patient, 30-44 minutes
99203	U6 - Doctoral Level (MD / DO)	Evaluation and Management for New Patient, 30-44 minutes
99203	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for New Patient, 30-44 minutes
99204	UG - Doctoral Level (Child Psychiatrist)	Evaluation and Management for New Patient, 45-59 minutes
99204	U6 - Doctoral Level (MD / DO)	Evaluation and Management for New Patient, 45-59 minutes
99204	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for New Patient, 45-59 minutes
99205	UG - Doctoral Level (Child Psychiatrist)	Evaluation and Management for New Patient, 60-74 minutes
99205	U6 - Doctoral Level (MD / DO)	Evaluation and Management for New Patient, 60-74 minutes
99205	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for New Patient, 60-74 minutes
99211	UG - Doctoral Level (Child Psychiatrist)	Evaluation and Management for an Established Patient, 5 minutes
99211	U6 - Doctoral Level (MD / DO)	Evaluation and Management for an Established Patient, 5 minutes
99211	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for an Established Patient, 5 minutes
99212	UG - Doctoral Level (Child Psychiatrist)	Evaluation and Management for an Established Patient, 10-19 minutes
99212	U6 - Doctoral Level (MD / DO)	Evaluation and Management for an Established Patient, 10-19 minutes
99212	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for an Established Patient, 10-19 minutes
99213	UG - Doctoral Level (Child Psychiatrist)	Evaluation and Management for an Established Patient, 20-29 minutes
99213	U6 - Doctoral Level (MD / DO)	Evaluation and Management for an Established Patient, 20-29 minutes
99213	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for an Established Patient, 20-29 minutes

99214	UG - Doctoral Level (Child Psychiatrist)	Evaluation and Management for an Established Patient, 30-39 minutes
99214	U6 - Doctoral Level (MD / DO)	Evaluation and Management for an Established Patient, 30-39 minutes
99214	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for an Established Patient, 30-39 minutes
99215	UG - Doctoral Level (Child Psychiatrist)	Evaluation and Management for an Established Patient, 40-54 minutes
99215	U6 - Doctoral Level (MD / DO)	Evaluation and Management for an Established Patient, 40-54 minutes
99215	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for an Established Patient, 40-54 minutes
S9484	+	Crisis intervention mental health services, per hour (Urgent Outpatient Services)
H0046	UG - Doctoral Level (Child Psychiatrist)	Mental health services, not otherwise specified (Collateral Contact)
H0046	U6 - Doctoral Level (MD/DO)	Mental health services, not otherwise specified (Collateral Contact)
H0046	AH - Doctoral Level (PhD, PsyD, EdD)	Mental health services, not otherwise specified (Collateral Contact)
H0046	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Mental health services, not otherwise specified (Collateral Contact)
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)
H0046	U7 - Certified Addiction Counselor / Certified Alcohol & Drug Abuse Counselor	Mental health services, not otherwise specified (Collateral Contact)
H0046	U3 - Intern (PhD, PsyD, EdD) / or MAT	Mental health services, not otherwise specified (Collateral Contact)
H0046	U4 - Intern (Master's)	Mental health services, not otherwise specified (Collateral Contact)

Exhibit 4: Behavioral Health Outpatient Services Subject to 15% Uniform Dollar Increase

For services provided by Mental Health Centers that have not been designated as a Behavioral Health Urgent Care Provider site, in accordance with **Section 2.7.F.3.v** when billed with modifer GJ.

Procedure Code	Modifier Group	Procedure Description
90791	UG - Doctoral Level (Child Psychiatrist)	Psychiatric Diagnostic Evaluation
90791	U6 - Doctoral Level (MD / DO)	Psychiatric Diagnostic Evaluation
90791	AH - Doctoral Level (PhD, PsyD, EdD)	Psychiatric Diagnostic Evaluation
90791	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Psychiatric Diagnostic Evaluation
90791	HO - Master's Level	Psychiatric Diagnostic Evaluation
90791	U3 - Intern (PhD, PsyD, EdD)	Psychiatric Diagnostic Evaluation
90791	U4 - Intern (Master's)	Psychiatric Diagnostic Evaluation
90792	UG - Doctoral Level (Child Psychiatrist)	Psychiatric Diagnostic Evaluation with Medical Services
90792	U6-Doctoral Level (MD / DO)	Psychiatric Diagnostic Evaluation with Medical Services
90792	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Psychiatric Diagnostic Evaluation with Medical Services
90832	UG - Doctoral Level (Child Psychiatrist)	Individual Psychotherapy, approximately 20-30 minutes
90832	U6 - Doctoral Level (MD / DO)	Individual Psychotherapy, approximately 20-30 minutes
90832	AH - Doctoral Level (PhD, PsyD, EdD)	Individual Psychotherapy, approximately 20-30 minutes
90832	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Individual Psychotherapy, approximately 20-30 minutes
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
90832	U7 - Certified Addiction Counselor / Certified Alcohol & Drug Abuse Counselor	Individual Psychotherapy, approximately 20-30 minutes
90832	U3 - Intern (PhD, PsyD, EdD) / or MAT	Individual Psychotherapy, approximately 20-30 minutes
90832	U4 - Intern (Master's)	Individual Psychotherapy, approximately 20-30 minutes
90833	U6 - Doctoral Level (MD / DO)	Psychotherapy, 30 minutes, when Performed with an Evaluation and Management Service
90833	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Psychotherapy, 30 minutes, when Performed with an Evaluation and Management Service
90834	UG - Doctoral Level (Child Psychiatrist)	Individual Psychotherapy, approximately 45 minutes

90834	U6 - Doctoral Level (MD / DO)	Individual Psychotherapy, approximately 45 minutes
90834	AH - Doctoral Level (PhD, PsyD, EdD)	Individual Psychotherapy, approximately 45 minutes
90834	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Individual Psychotherapy, approximately 45 minutes
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
90834	U3 - Intern (PhD, PsyD, EdD) / or MAT	Individual Psychotherapy, approximately 45 minutes
90834	U4 - Intern (Master's)	Individual Psychotherapy, approximately 45 minutes
90836	U6 - Doctoral Level (MD / DO)	Psychotherapy, 45 minutes, when Performed with an Evaluation and Management Service
90836	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Psychotherapy, 45 minutes, when Performed with an Evaluation and Management Service
90837	UG - Doctoral Level (Child Psychiatrist)	Psychotherapy, 60 minutes
90837	U6 - Doctoral Level (MD / DO)	Psychotherapy, 60 minutes
90837	AH - Doctoral Level (PhD, PsyD, EdD)	Psychotherapy, 60 minutes
90837	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Psychotherapy, 60 minutes
90837	HO - Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Psychotherapy, 60 minutes
90837	U3 - Intern (PhD, PsyD, EdD) / or MAT	Psychotherapy, 60 minutes
90837	U4 - Intern (Master's)	Psychotherapy, 60 minutes
90847	UG - Doctoral Level (Child Psychiatrist)	Family Psychotherapy (conjoint psychotherapy) (with patient present)
90847	U6 - Doctoral Level (MD / DO)	Family Psychotherapy (conjoint psychotherapy) (with patient present)
90847	AH - Doctoral Level (PhD, PsyD, EdD)	Family Psychotherapy (conjoint psychotherapy) (with patient present)
90847	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Family Psychotherapy (conjoint psychotherapy) (with patient present)

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)
90847	U3 - Intern (PhD, PsyD, EdD) / or MAT	Family Psychotherapy (conjoint psychotherapy) (with patient present)
90847	U4 - Intern (Master's)	Family Psychotherapy (conjoint psychotherapy) (with patient present)
90853	UG - Doctoral Level (Child Psychiatrist)	Group psychotherapy (other than of a multiple-family group)
90853	U6 - Doctoral Level (MD / DO)	Group psychotherapy (other than of a multiple-family group)
90853	AH - Doctoral Level (PhD, PsyD, EdD)	Group psychotherapy (other than of a multiple-family group)
90853	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Group psychotherapy (other than of a multiple-family group)
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)
90853	U3 - Intern (PhD, PsyD, EdD) / or MAT	Group psychotherapy (other than of a multiple-family group)
90853	U4 - Intern (Master's)	Group psychotherapy (other than of a multiple-family group)
99202	UG - Doctoral Level (Child Psychiatrist)	Evaluation and Management for New Patient, 15-29 minutes
99202	U6 - Doctoral Level (MD / DO)	Evaluation and Management for New Patient, 15-29 minutes
99202	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for New Patient, 15-29 minutes
99203	UG - Doctoral Level (Child Psychiatrist)	Evaluation and Management for New Patient, 30-44 minutes
99203	U6 - Doctoral Level (MD / DO)	Evaluation and Management for New Patient, 30-44 minutes
99203	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for New Patient, 30-44 minutes
99204	UG - Doctoral Level (Child Psychiatrist)	Evaluation and Management for New Patient, 45-59 minutes
99204	U6 - Doctoral Level (MD / DO)	Evaluation and Management for New Patient, 45-59 minutes
99204	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for New Patient, 45-59 minutes
99205	UG - Doctoral Level (Child Psychiatrist)	Evaluation and Management for New Patient, 60-74 minutes
99205	U6 - Doctoral Level (MD / DO)	Evaluation and Management for New Patient, 60-74 minutes
99205	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for New Patient, 60-74 minutes

99211	UG - Doctoral Level (Child Psychiatrist)	Evaluation and Management for an Established Patient, 5 minutes
99211	U6 - Doctoral Level (MD / DO)	Evaluation and Management for an Established Patient, 5 minutes
99211	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for an Established Patient, 5 minutes
99212	UG - Doctoral Level (Child Psychiatrist)	Evaluation and Management for an Established Patient, 10-19 minutes
99212	U6 - Doctoral Level (MD / DO)	Evaluation and Management for an Established Patient, 10-19 minutes
99212	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for an Established Patient, 10-19 minutes
99213	UG - Doctoral Level (Child Psychiatrist)	Evaluation and Management for an Established Patient, 20-29 minutes
99213	U6 - Doctoral Level (MD / DO)	Evaluation and Management for an Established Patient, 20-29 minutes
99213	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for an Established Patient, 20-29 minutes
99214	UG - Doctoral Level (Child Psychiatrist)	Evaluation and Management for an Established Patient, 30-39 minutes
99214	U6 - Doctoral Level (MD / DO)	Evaluation and Management for an Established Patient, 30-39 minutes
99214	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for an Established Patient, 30-39 minutes
99215	UG - Doctoral Level (Child Psychiatrist)	Evaluation and Management for an Established Patient, 40-54 minutes
99215	U6 - Doctoral Level (MD / DO)	Evaluation and Management for an Established Patient, 40-54 minutes
99215	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for an Established Patient, 40-54 minutes

List of Modifier Groups relating to Licensure Level
UG-Doctoral Level (Child Psychiatrist)
U6-Doctoral Level (MD / DO)
AH-Doctoral Level (PhD, PsyD, EdD)
SA-Nurse Practitioner/Board Certified RNCS and APRN-BC
HO-Master's Level
U3-Intern (PhD, PsyD, EdD)
U4-Intern (Master's)
U7-CAC/CADAC

Appendix O

Exhibit 1: HRSN Supplemental Services

Exhibit 1.1: HRSN Category 1 Supplemental Nutrition Services

	Coverage Types		
Service	**MassHealth Standard & CommonHealth Covered Individuals**	**MassHealth Family Assistance Covered Individuals**	**CarePlus**
Medically Tailored Food Boxes – Selection of minimally prepared grocery items that meet appropriate nutritional standards.	✓	✓	✓
Nutritionally Appropriate Food Boxes – Minimally prepared grocery items or a Community Supported Agricultural (CSA) share.	✓	✓	✓
Medically Tailored Food Prescriptions and Vouchers – Nutrition vouchers and grocery store gift cards to procure healthy food from an approved purchase list.	✓	✓	✓
Nutritionally Appropriate Food Prescriptions and Vouchers – Nutrition vouchers and grocery store gift cards to procure healthy food.	✓	✓	✓
Medically Tailored Home Delivered Meals – Prepared medically tailored meals that reflect appropriate nutritional needs based on defined medical diagnosis and standards reflecting evidence-based practice guidelines, deliver to the Covered Individual.	✓	✓	✓
Nutritionally Appropriate Home Delivered Meals – Healthy, well-balanced meals delivered to the Covered Individual.	✓	✓	✓

Exhibit 1.2: HRSN Category 2 Supplemental Nutrition Services

	Coverage Types		
Service	**MassHealth Standard & CommonHealth Covered Individuals**	**MassHealth Family Assistance Covered Individuals**	**CarePlus**
Kitchen Supplies – Provision of and assistance with obtaining cooking supplies (e.g., pots and pans, utensils, refrigerator) to meet the Covered Individual's nutritional and dietary needs.	✓	✓	✓
Nutrition Counseling – Provision of nutrition counseling for the purposes of meeting the Covered Individual's nutritional and dietary needs.	✓	✓	✓
Nutrition Education Classes and Skills Development – Provision of nutrition education classes and skills development (e.g., cooking classes as education) for the purposes of meeting the Covered Individual's nutritional and dietary needs.	✓	✓	✓

Exhibit 1.3: HRSN Supplemental Housing Services

	Coverage Types		
Service	**MassHealth Standard & CommonHealth Covered Individuals**	**MassHealth Family Assistance Covered Individuals**	**CarePlus**
Healthy Homes – Goods and/or remediation services proven to improve housing conditions related to health needs that are not the responsibility of the housing owner/landlord.	✓	✓	✓
Housing Navigation – Assistance to help a Covered Individual experiencing housing instability to access benefits, negotiate with landlords, seek out legal assistance, apply for new housing (if needed), or take other actions in order to help stabilize a Covered Individual's housing situation.	✓	✓	✓
Housing Search - Assistance to help a Covered Individual, ages 55 and over, experiencing homelessness locate, move into, and maintain housing.	✓	✓	✓
Transitional Goods – Move-in costs (e.g., security deposits, first month's rent, movers), furnishings, and other items necessary to make new housing habitable and comfortable.	✓	✓	✓

Exhibit 1.4 – Items and Services Excluded from HRSN Supplemental Services

In the course of providing HRSN Supplemental Services, the Contractor shall not provide:

- Construction costs (bricks and mortar) or capital investments;
- Room and board outside of specifically enumerated care or housing transitions;
- Research grants and expenditures not related to monitoring and evaluation;
- Costs for services in prisons, correctional facilities or services for people who are civilly committed and unable to leave an institutional setting, except those HRSN-related case management services provided as part of an approved reentry demonstration initiative;
- Services provided to individuals who are not lawfully present in the United States or are undocumented;
- Expenditures that supplant services and activities funded by other state and federal governmental entities;
- School-based programs for children that supplant Medicaid state plan programs, or that are funded under the Department of Education and/or state or the local education agency; or
- Any other projects or activities not specifically approved by CMS as qualifying for coverage as a HRSN item or service under this demonstration.

Appendix O, Exhibit 2

The Contractor shall work with each PCACO, as listed below, to provide the following HRSN Supplemental Services in accordance with **Section 2.6.D.12** and all other applicable sections of the Contract:

A. Community Care Cooperative's (CCC) HRSN Supplemental Services

HRSN Supplemental Service	CCC's Selected HRSN Supplemental Service (as indicated by "X")
HRSN Category 1 Supplemental Nutrition Services	
Medically Tailored Food Boxes	
Nutritionally Appropriate Food Boxes	
Medically Tailored Food Prescriptions and Vouchers	
Nutritionally Appropriate Food Prescriptions and Vouchers	
Medically Tailored Home Delivered Meals	
Nutritionally Appropriate Home-Delivered Meals	
HRSN Category 2 Supplemental Nutrition Services	
Kitchen Supplies	
Nutrition Counseling	
Nutrition Education Classes and Skills Development	
HRSN Supplemental Housing Services	
Healthy Homes	
Housing Navigation	
Housing Search	
Transitional Goods	

B. Revere Health Choice's HRSN Supplemental Services

HRSN Supplemental Service	Revere Health Choice's Selected HRSN Supplemental Service (as indicated by "X")
HRSN Category 1 Supplemental Nutrition Services	
Medically Tailored Food Boxes	
Nutritionally Appropriate Food Boxes	
Medically Tailored Food Prescriptions and Vouchers	
Nutritionally Appropriate Food Prescriptions and Vouchers	
Medically Tailored Home Delivered Meals	
Nutritionally Appropriate Home-Delivered Meals	
HRSN Category 2 Supplemental Nutrition Services	
Kitchen Supplies	
Nutrition Counseling	
Nutrition Education Classes and Skills Development	
HRSN Supplemental Housing Services	
Healthy Homes	
Housing Navigation	
Housing Search	
Transitional Goods	