Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
www.mass.gov/masshealth

Managed Care Entity Bulletin 110

DATE: February 2024

TO: Managed Care Entities Participating in MassHealth

FROM: Mike Levine, Assistant Secretary for MassHealth

RE: **Updates to Policies Pertaining to Members' Behavioral Health Needs in Acute Medical Settings and Inpatient Psychiatry Settings**

Applicable Managed Care Entities and PACE Organizations

☐ Accountable Care Partnership Plans (ACPPs)
☐ Managed Care Organizations (MCOs)
☐ MassHealth's behavioral health vendor
☒ One Care Plans
☒ Senior Care Organizations (SCOs)
☒ Program of All-inclusive Care for the Elderly (PACE) Organization

Background

MassHealth has developed and is implementing a multi-pronged set of policies to support how hospitals meet the behavioral health (BH) needs of members in acute medical settings and inpatient psychiatry settings through a multi-year effort. Initiatives have included:

- Beginning January 3, 2023, acute hospitals are required to provide or arrange for BH crisis evaluations for individuals presenting to the emergency department (ED) in a BH crisis, as detailed in Managed Care Entity Bulletin 93 and per the requirements in M.G.L. c. 111 s. 51 3/4.
- Beginning May 1, 2022, and most recently extended through September 30, 2023, in the Rate Year (RY) 2023 Acute Hospital RFA (Request for Application), acute hospitals were eligible for a Supplemental Payment to Promote Hospital Capacity to Provide Enhanced ED Psychiatric Services for members awaiting inpatient psychiatric hospitalization. This payment is not applicable for RY 2024 Acute Hospital RFA.
- Beginning October 1, 2022, MassHealth implemented a per inpatient admission rate in addition to the inpatient psychiatric per diem rate for care provided in a Department of Mental Health (DMH)-licensed inpatient psychiatry unit.

New and Updated Policies Effective October 1, 2023

In furtherance of these efforts, MassHealth has implemented the following updated and expanded initiatives to support how hospitals meet the BH needs of members in acute medical settings and inpatient psychiatry settings.

- Effective October 1, 2023, MassHealth pays for BH crisis evaluations for individuals who experience a BH crisis after admission to a medical/surgical setting.
- Effective October 1, 2023, MassHealth pays for BH crisis management services provided to individuals in both the ED and in an inpatient medical/surgical setting who have ongoing needs related to a BH crisis, on days after the initial BH crisis evaluation.
- MassHealth is focused on ensuring access to critical substance use disorder treatment services for members, including medication for the treatment of opioid use disorders (MOUD). Effective October 1, 2023, MassHealth pays for both the initiation of MOUD via the add-on code G2213 in the ED, and Recovery Support Navigation (RSN) services in the ED and in an inpatient medical/surgical setting.
- Effective October 1, 2023, MassHealth updated the minimum rate Accountable Care Partnership Plans, Managed Care Organizations, and MassHealth's behavioral health vendor are required to pay for specialized inpatient psychiatric services to members younger than 21 years of age with Autism Spectrum Disorder-Intellectual Disability (ASD-ID) in specialized ASD-ID inpatient psychiatric treatment settings.
- Effective October 1, 2023, MassHealth updated payment methodologies for specialized inpatient psychiatric services for members with an eating disorder diagnosis in specialized eating disorder inpatient psychiatric treatment settings. MassHealth is also expanding the per admission rate policy to include diagnoses of an eating disorder, effective October 1, 2023.

This bulletin sets forth expectations for One Care Plans and Senior Care Organizations (SCOs) (collectively, Integrated Care Plans) regarding the delivery of BH crisis evaluations and crisis management services in EDs and medical/surgical settings, including the required procedure code and minimum rate for service delivery. Integrated Care Plan contracts will be updated, as necessary, to reflect these changes.

MassHealth encourages Program of All-inclusive Care for the Elderly (PACE) organizations to follow the direction herein.

Update to Payment for Acute Hospital Behavioral Health Crisis Evaluations

As part of EOHHS' Roadmap for Behavioral Health Reform ("Roadmap"), MassHealth made changes to the delivery of behavioral health crisis services in order to expand access to community-based and mobile crisis intervention and improve member experience of care. Historically, crisis assessments have been provided by Emergency Service Program (ESP) providers and Mobile Crisis Intervention (MCI) teams in both community-based settings and in emergency departments (EDs). Starting in January 2023, a statewide network of Community Behavioral Health Centers (CBHCs) provide 24/7 community and mobile crisis intervention services, and hospitals provide or arrange for behavioral health crisis evaluations in their EDs.

Beginning on January 3, 2023, Integrated Care Plans are required to pay acute hospitals directly for BH crisis evaluations in EDs. In addition, Integrated Care Plans are required to direct acute

hospitals to deliver ED-based BH crisis evaluations in accordance with the standards in Appendix I of the Acute Hospital RFA.

Effective for dates of service on or after October 1, 2023, Integrated Care Plans are required to pay acute hospitals for BH crisis evaluations provided in medical/surgical settings. Acute hospitals may choose to subcontract these services to appropriately trained and experienced BH providers; however, whether medical/surgical-based BH crisis evaluations are provided by acute hospital staff directly or through subcontracted providers, Integrated Care Plans must require acute hospitals to submit claims for these services to the Integrated Care Plans, and Integrated Care Plans must pay acute hospitals for these services.

Effective for dates of service on or after October 1, 2023, Integrated Care Plans must require acute hospitals to use the per diem code S9485 for ED and medical/surgical BH crisis evaluations and must pay no less than the amount in the RY 2024 Acute Hospital RFA for ED and medical/surgical BH crisis evaluations, currently $695.29. As set forth in the RY 2024 Acute Hospital RFA, providers may bill for no more than one unit per day, no more than once per acute hospital stay. Note that this code and rate must be carved out of the Adjudicated Payment per Episode of Care (APEC) and the Adjudicated Payment Amount per Discharge (APAD), if plans utilize an APEC or APAD for payment to acute hospitals, and is separate and distinct from other billing mechanisms in place (e.g., billing for facility fees, billing for professional services rendered in the ED or medical/surgical settings, etc.).

Payment for Acute Hospital Behavioral Health Crisis Management Services

Effective for dates of service on or after October 1, 2023, Integrated Care Plans are required to pay acute hospitals for BH crisis management services provided in the ED or in medical/surgical settings.

BH crisis management services are for individuals experiencing a BH crisis who have ongoing needs for crisis supports after the initial BH crisis evaluation, either in the ED or while admitted to a medical/surgical setting.

Integrated Care Plans must implement the specifications in the RY24 Acute Hospital RFA, Appendix K. As set forth in Appendix K, acute hospitals may bill one of the following two options on any one calendar day:

1. Level 1 Behavioral Health Crisis Management Services:

   S9485, V1 modifier, no more than one unit per day. This option should be used for the provision of Behavioral Health Crisis Management Services, in accordance with Operational Standards for Behavioral Health Crisis Management Services (Appendix K, Section II), for members requiring ongoing safety monitoring but without the need for active safety interventions on the billing calendar day.

2. Level 2 Behavioral Health Crisis Management Services:

   S9485, V2 modifier, no more than one unit per day. This option should be used for the provision of Behavioral Health Crisis Management Services, in accordance with Operational Standards for Behavioral Health Crisis Management Services

(Appendix K, Section II), for members requiring active staff safety monitoring and intervention to prevent, or respond to, attempts of self-injury or aggression in the hospital on the billing calendar day (i.e., arms-length 1:1 safety observation or interventions of equal or higher intensity).

Acute hospitals may choose to subcontract these services to appropriately trained and experienced BH providers; however, whether ED and medical/surgical-based BH crisis management services are provided by acute hospital staff directly or through subcontracted providers, Integrated Care Plans must require acute hospitals to submit claims for these services to the Integrated Care Plans, and Integrated Care Plans must pay acute hospitals for these services.

Integrated Care Plans must require acute hospitals to use the per diem code S9485 with either V1 or V2 modifier for ED and medical/surgical crisis management services.

Effective for dates of service on or after January 1, 2024, Integrated Care Plans must pay no less than the amounts in the RY 2024 Acute Hospital RFA for these code/modifier combinations, currently $325.64 for S9485-V1 and $653.64 for S9485-V2. Note that this code and rate must be carved out of the APEC and the APAD, if plans utilize an APEC or APAD for payment to acute hospitals, and is separate and distinct from other billing mechanisms in place (e.g., billing for facility fees, billing for professional services rendered in the ED or medical/surgical settings, etc.).

Payment for Medication for Opioid Use Disorder in Emergency Department Settings

Beginning October 1, 2023, Integrated Care Plans are required to pay acute hospitals for initiation of medication for opioid use disorder in the ED for members who consent to initiation.

Integrated Care Plans must implement the specifications set forth in the RY 2024 Acute Hospital RFA, Appendix M. As set forth in Appendix M, Integrated Care Plans must ensure that acute hospitals bill no more than one unit per day of the following when the service is provided in the ED:

Code	Description
G2213	Initiation of medication for the treatment of opioid use disorder in the emergency department setting, including assessment, referral to ongoing care, and arranging access to supportive services (List separately in addition to code for primary procedure).

The G2213 add-on code can be billed for initiating buprenorphine in the ED for individuals who have signs or symptoms of untreated opioid use disorder. The G2213 add-on code must be billed in addition to evaluation and management in the ED setting of the patient's presenting condition. Note that this code must be carved out of the APEC if plans utilize an APEC for

payment to acute hospitals, and is separate and distinct from other billing mechanisms in place (e.g., billing for facility fees, billing for professional services rendered in the ED, etc.).

Integrated Care Plans must allow any healthcare practitioners who are eligible to prescribe buprenorphine and are working in the ED setting to provide the evaluation and initiation of MOUD, as covered by the G2213 code. All health care practitioners with a standard DEA controlled medication registration that includes Schedule III prescribing authority are able to prescribe buprenorphine for opioid use disorders. Controlled substance prescribing must comply with DEA requirements.

Integrated Care Plans must implement and adhere to the standards and requirements in this bulletin in the delivery of services by their network providers. It is expected that Integrated Care Plans will work with MassHealth to ensure that network hospitals and provider organizations are able to bill Integrated Care Plans using the G2213 code for services rendered in the ED setting.

Payment for Recovery Support Navigator Services in Acute Hospital Settings

Beginning October 1, 2023, Integrated Care Plans are required to pay hospitals for Recovery Support Navigator (RSN) services provided in the ED or medical/surgical settings.

RSN services are for members who are interested in entering substance use disorder (SUD) treatment services after their discharge from the ED. If the presenting condition is significant enough that the member must be admitted to a medical/surgical setting from the ED, and the member still expresses interest in receiving SUD treatment services after their discharge, the patient may receive RSN services in the medical/surgical setting.

Integrated Care Plans must implement the specifications in the RY 2024 Acute Hospital RFA, Appendix N. As specified in Appendix N, acute hospitals may bill the following when the service is provided in the ED or medical/surgical settings:

Code	Description
H2015 TF	A paraprofessional or peer specialist who receives specialized training in the essentials of substance use disorder and evidence-based techniques such as motivational interviewing, and who supports members in accessing and navigating the substance use disorder treatment system through activities that can include care coordination, case management, and motivational support.

Integrated Care Plans must ensure that RSN services are billed according to the procedure code and modifier in 101 CMR 444.00. Integrated Care Plans must configure their billing systems to align with the billing details in the RY 2024 Acute Hospital RFA.

Note that this code must be carved out of the APEC and the APAD, if plans utilize an APEC or APAD for payment to acute hospitals, and is separate and distinct from other billing mechanisms in place (e.g., billing for facility fees, billing for professional services rendered in the ED or medical/surgical settings, etc.).

Integrated Care Plans may establish a contractual relationship with any type of provider organization that meets credentialing requirements for the purpose of providing RSN services. Integrated Care Plans may not establish contractual relationships with individual RSNs as solo practitioners; rather, network contracts must be with organizations that employ RSNs to provide RSN services.

Integrated Care Plans must implement and adhere to the standards and requirements in this bulletin and in their contracts in the delivery of services by their network providers. It is expected that Integrated Care Plans will work with MassHealth to ensure that RSN service (H2015-TF) is billable in the ED setting and in the medical/surgical setting. Plans should update the performance specifications for RSN services to include these new settings of operation.

Integrated Care Plans must continue to adhere to all existing contractual and program requirements for RSN services, including ensuring that the authorization procedures established for RSN services allow for at least the first 90 days of service to occur without prior approval, provided however that Integrated Care Plans may establish notification or registration procedures during the first 90 days of such services. Integrated Care Plans must allow a 14-day window for providers to submit a notification of admission when members begin services.

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Questions

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