Commonwealth of Massachusetts
Office of the State Auditor
Suzanne M. Bump
Making government work better

Official Audit Report – Issued April 3, 2017

Office of Medicaid (MassHealth)—Review of Fee-for-Service Payments for Services Covered by the Massachusetts Behavioral Health Partnership

For the period July 1, 2010 through June 30, 2015

Commonwealth of Massachusetts
Office of the State Auditor
Suzanne M. Bump
Making government work better

April 3, 2017

Ms. Marylou Sudders, Secretary
Executive Office of Health and Human Services (EOHHS)
One Ashburton Place, 11th Floor
Boston, MA 02108

Dear Secretary Sudders:

I am pleased to provide this performance audit of the Office of Medicaid's (MassHealth's) fee-for-service payments for services covered by the Massachusetts Behavioral Health Partnership. This report details the audit objectives, scope, methodology, findings, and recommendations for the audit period, July 1, 2010 through June 30, 2015. My audit staff discussed the contents of this report with management of the agency, whose comments are reflected in this report.

I would also like to express my appreciation to MassHealth for the cooperation and assistance provided to my staff during the audit.

Sincerely,

Suzanne M. Bump
Auditor of the Commonwealth

cc: Daniel Tsai, Assistant Secretary and Director
Alda Rego, Assistant Secretary, EOHHS, Administration and Finance
Teresa Reynolds, Executive Assistant to Secretary Sudders
Joan Senatore, Compliance Officer, EOHHS

TABLE OF CONTENTS

LIST OF ABBREVIATIONS

CFR	Code of Federal Regulations
CMR	Code of Massachusetts Regulations
CMS	Centers for Medicare & Medicaid Services
DMH	Department of Mental Health
EOHHS	Executive Office of Health and Human Services
ESP	emergency services program
EVS	Eligibility Verification System
FFS	fee for service
MBHP	Massachusetts Behavioral Health Partnership
MCO	managed-care organization
MMIS	Medicaid Management Information System
OCA	Office of Clinical Affairs
OSA	Office of the State Auditor
PAPE	payment amount per episode
PCC	primary-care clinician

EXECUTIVE SUMMARY

Under Chapter 118E of the Massachusetts General Laws, the Executive Office of Health and Human Services (EOHHS) is responsible for the administration of the state's Medicaid program, known as MassHealth. MassHealth provides access to healthcare services to approximately 1.9 million eligible low- and moderate-income children, families, seniors, and people with disabilities annually. In fiscal year 2015, MassHealth paid healthcare providers more than $13 billion, of which approximately 50%[1] was funded by the Commonwealth. Medicaid expenditures represent approximately 38% of the Commonwealth's total annual budget.

The Office of the State Auditor (OSA) has conducted an audit of fee-for-service (FFS) payments for services covered under the Massachusetts Behavioral Health Partnership (MBHP) contract for the audit period, July 1, 2010 through June 30, 2015. MBHP is responsible for managing behavioral-health care for MassHealth Primary Care Clinician Plan Members. The purpose of this audit was to determine whether MassHealth disallowed FFS claims for services that should have been covered by MBHP in accordance with its contract with EOHHS as well as applicable regulations and other requirements.

In order to ensure that it properly administers the MBHP contract, MassHealth must have effective controls in place, including program regulations, operating policies and procedures, monitoring activities, and enforcement action. In addition, MassHealth must have system edits to detect and deny FFS claims for services that are already covered by MBHP. Otherwise, MassHealth may pay twice for the same service (by paying a monthly fee to MBHP to provide a type of service and then paying a provider on an FFS basis when the service is actually performed).

This audit was conducted as part of OSA's ongoing independent statutory oversight of the state's Medicaid program. Several of our previously issued audit reports disclosed significant weaknesses in MassHealth's claim-processing system, which resulted in millions of dollars in unallowable and potentially fraudulent claim payments. As with any government program, public confidence is essential to the success and continued support of the state's Medicaid program.

Based on our audit, we have concluded that MassHealth paid approximately $193 million in improper or questionable FFS claims for members enrolled in MBHP during our audit period.

1. During the federal government's fiscal year 2015, the Federal Medical Assistance Percentage for Massachusetts was 50%.

Below is a summary of our findings and recommendations, with links to each page listed.

Finding 1 **Page 8**	MassHealth paid approximately $193 million in improper or questionable FFS claims for members enrolled in MBHP.
Recommendations **Page 13**	1. MassHealth should take appropriate action to recoup the approximately $93 million of payments we identified as improper. 2. MassHealth should review the approximately $100 million of claims we identified as questionable to determine whether any of this amount should be recouped from MBHP as contractually covered behavioral-health services. 3. In consultation with MBHP, MassHealth should develop a master list of covered services based on claim procedure codes, revenue codes, diagnosis codes, places of service, and procedure code modifiers. MassHealth should then use this information to create system edits in its claim-processing system to ensure that it only pays for claims that MassHealth and MBHP have specifically identified as not covered by MBHP's contract.

OVERVIEW OF AUDITED ENTITY

Under Chapter 118E of the Massachusetts General Laws, the Executive Office of Health and Human Services (EOHHS) administers the state's Medicaid program, known as MassHealth. From July 1, 2010 through June 30, 2015, MassHealth paid approximately $2.6 billion for members[2] who were enrolled in the Massachusetts Behavioral Health Partnership (MBHP), as detailed below.

Payments Made from MassHealth to MBHP

Fiscal Year	Amount Paid	Members Served	Number of Claims
2011	$ 540,488,527	510,699	34,083,499
2012	509,967,167	567,920	36,476,839
2013	540,891,796	579,495	36,616,782
2014	495,001,389	537,552	34,333,443
2015	519,562,658	551,012	33,294,907
Total	$2,605,911,537	2,746,678*	174,805,470

* Of these 2,746,678 members, the unduplicated count is 1,022,385.

Medicaid

Medicaid is a joint federal and state program created by Congress in 1965 as Title XIX of the Social Security Act. At the federal level, the Centers for Medicare & Medicaid Services (CMS), within the federal Department of Health and Human Services, administer the Medicare program and work with the state governments to administer their Medicaid programs.

Each state administers its Medicaid program in accordance with its CMS-approved state plan. States have considerable flexibility in designing and operating their Medicaid programs, but must comply with applicable federal requirements established by Section 1902 of Title XIX of the Social Security Act.

MBHP

MBHP manages behavioral-health care and substance-abuse services for MassHealth members enrolled in the Primary Care Clinician Plan,[3] which is a managed-care health plan for MassHealth members. The

2. On average, MBHP serves more than 375,000 MassHealth members a day.
3. On average, this plan serves more than 389,000 MassHealth members a day. During our audit period, an additional 1.7 million MassHealth members were served by other managed-care organizations.

Commonwealth pays MBHP a fixed monthly fee, or capitated premium,[4] for each member enrolled in MBHP. EOHHS's contract with MBHP specifies the types of service covered and not covered for MassHealth members. For example, MBHP is not required to cover long-term residential psychiatric care. Also, MBHP developed a list of specific admission, diagnosis, procedure, and revenue codes that it will pay for based on its contract. MBHP recruits and oversees networks of third-party direct care providers who assume responsibility for providing a range of covered behavioral-health care; MBHP pays the providers using the monthly capitated premiums received from the Commonwealth. Any services not covered by MBHP's contract are paid for directly by MassHealth on a fee-for-service basis. On October 1, 2012, EOHHS and MBHP signed a new five-year contract with an estimated annual value of $525 million.

Medical providers determine which members are enrolled in MBHP through MassHealth's Eligibility Verification System (EVS). According to MassHealth procedures, providers should determine, either online through the EVS or by phone, whether a member is enrolled in MBHP (and, if so, whether MBHP covers the claimed behavioral-health care) before providing any services.

MassHealth is responsible for ensuring the integrity of all Medicaid paid claims. To that end, MassHealth adjudicates, and pays for, Medicaid claims through its Medicaid Management Information System (MMIS). When processing a behavioral-health claim for a member, MMIS uses a series of system edits to determine whether the member is enrolled in MBHP and, if so, whether MBHP covers the claimed service. If it does, MMIS is designed to deny the claim.

4. The capitation rate for each member is based on factors such as actuarial estimates, the member's health risks, and the member's geographic location.

AUDIT OBJECTIVES, SCOPE, AND METHODOLOGY

In accordance with Section 12 of Chapter 11 of the Massachusetts General Laws, the Office of the State Auditor (OSA) has conducted a performance audit of the Office of Medicaid's (MassHealth's) fee-for-service (FFS) payments for services covered by the Massachusetts Behavioral Health Partnership (MBHP) for the period July 1, 2010 through June 30, 2015.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Below is our audit objective, indicating the question we intended our audit to answer, the conclusion we reached regarding the objective, and where the objective is discussed in this report.

Objective	Conclusion
1. Did MassHealth disallow FFS claims for MBHP enrollees for services that should have been covered by MBHP?	**No; see Finding 1**

To achieve our objective, we reviewed applicable state and federal laws, rules, and regulations, as well as MassHealth publications and guidelines. We also reviewed prior MassHealth audits conducted by OSA, the federal Department of Health and Human Services, and independent auditors.

We requested additional necessary documentation from MassHealth that included an internal control plan, an organization chart, and policies and procedures for MBHP, as well as a list of internal assessments performed by MassHealth's Provider Compliance Unit. Our access to these assessments was most important, since they would help determine whether MassHealth itself was ensuring that (1) MBHP complied with the terms and conditions of the behavioral-health contract; (2) the claim-processing system edits in MassHealth's Medicaid Management Information System (MMIS) accurately identified members enrolled in MBHP and, if so, denied FFS claims for MBHP covered services; and (3) MassHealth implemented recommendations made by its Provider Compliance Unit to rectify noted deficiencies. Moreover, through these assessments, we could more easily identify low- and high-risk areas and adjust the extent of our audit work accordingly. However, we did not receive the policies and

assessments until well after our MBHP testing was finished. Because we did not receive the requested documentation, we were not able to perform internal control testing to determine the adequacy of MassHealth's policies, procedures, and claim-processing system edits. However, this did not prevent us from achieving our audit objective, because we assessed the internal controls as high risk and included all FFS behavioral-health claims in our review.

A prior OSA audit had assessed the reliability of information stored in MMIS, tested selected system controls, and interviewed knowledgeable agency officials about the data. The prior audit found that the data were sufficiently reliable.

From the MMIS data warehouse, we obtained Medicaid eligibility data for members enrolled in MBHP during the audit period. The member information included, at a minimum, each member's unique MassHealth identification number, date of birth, dates of MassHealth eligibility, MBHP identifier, services received, and beginning and ending dates of MBHP enrollment.[5] We also obtained all paid FFS claim information for MBHP enrollees from MMIS during the audit period. This information included, at a minimum, each enrollee's unique MassHealth identification number and the procedure code, procedure description, provider type, service date, service category, diagnosis code, place of service, unit of service, amount billed to MassHealth, paid amount (if any), and payment date. We then obtained from MassHealth the contracts between the Executive Office of Health and Human Services (EOHHS) and MBHP. Appendix A of the contracts detailed all the services covered. If MBHP was not required under the contract to cover a service, we considered FFS an appropriate method of payment for that service in our analysis. Examples of services excluded from MBHP coverage include all non-behavioral-health medical care provided by the member's primary-care clinician. We then used each member's specific dates of enrollment and unique MassHealth identification number to identify paid FFS claims for behavioral-health care that occurred during his or her MBHP enrollment. After completing our audit testing and analysis in this area, we discussed any discrepancies with MassHealth officials.

We evaluated MassHealth's system controls, including procedural edits, to determine whether FFS claims that were for services covered for MBHP members were detected and denied. In addition, we consulted with MassHealth to gain an understanding of the services covered under the MBHP contract. Further, we met with officials from MBHP to obtain its list of covered services and associated

5. MassHealth allows members to enroll in, and withdraw from, managed-care organizations at any time. Therefore, OSA needed to identify the specific dates when members were enrolled in such organizations.

admittance, diagnosis, procedure, and revenue codes used for processing provider payments. Also, we visited two medical-service providers (Massachusetts General Hospital and the May Institute) to verify the validity of payments made to them by MassHealth and MBHP. During our audit, we also met with MassHealth and MBHP officials on several occasions to discuss our concerns and get their input.

As part of the audit, we assessed the reliability of the data in MMIS, which is maintained by EOHHS. As part of this assessment, we reviewed existing information, tested selected system controls, and interviewed knowledgeable agency officials about the data. We performed validity and integrity tests on all claim data, including (1) testing for missing data, (2) scanning for duplicate records, (3) testing for values outside a designated range, (4) looking for dates outside specific time periods, and (5) tracing a sample of claims queried to information stored in MMIS. Based on the analyses conducted, we determined that the data obtained were sufficiently reliable for the purposes of this report. Additionally, we randomly selected FFS and MBHP payments made to the two service providers visited, and we compared the payment data with information in MMIS to determine whether MMIS contained accurate and complete information.

At the end of our audit, OSA provided MassHealth with a copy of our draft report and subsequently met with MassHealth officials to discuss it. As a result of this meeting, OSA made changes to the draft that involved adjusting certain amounts of questioned costs. However, MassHealth's response to our draft report did result in changes to our basic findings.

Based on the evidence we gathered to form a conclusion on our objectives, we believe that all audit work, in particular the work referred to above, taken as a whole, is relevant, valid, reliable, and sufficient and that it supports the finding and conclusion reached in this report.

DETAILED AUDIT FINDINGS WITH AUDITEE'S RESPONSE

1. MassHealth paid approximately $193 million in improper or questionable fee-for-service claims for members enrolled in the Massachusetts Behavioral Health Partnership.

During the audit period, MassHealth paid providers $192,600,577 for improper or questionable fee-for-service (FFS) claims[6] for services that should have been paid for by the Massachusetts Behavioral Health Partnership (MBHP). The improper payments were for services that were either identified by MBHP as covered by its contract or included in system edits in MassHealth's Medicaid Management Information System (MMIS) as covered behavioral-health services. The approximately $100 million in questionable payments were for services, such as family therapy sessions, that were behavioral-health services according to the stated diagnosis code and description of services but did not perfectly align either with MBHP's Benefits Coverage Grid (which identifies covered behavioral-health services based on each claim's procedure code, revenue code, diagnosis code/s, place of service, and procedure code modifier/s) or MMIS system edits. Approximately $93 million of these claims represent duplicative spending because the Commonwealth paid twice for the same service: first as a portion of the capitated (per member) premium paid to MBHP and then through the FFS claim.

For instance, MassHealth might pay MBHP to cover a member's behavioral-health services, but also receive and pay a bill from a provider each time the member goes to a psychotherapy session.

The table below details these improper and questionable FFS payments.

Improper and Questionable FFS Behavioral-Health Claims

Identified Issue	Identified Claims	Total Payments
Not Properly Identified by MMIS Edits	282,327	$ 92,021,777
Covered by MBHP Benefits Coverage Grid	17,981	896,786
Not Aligned with MMIS Edits or MBHP Benefits Coverage Grid	611,054	99,682,014
Total	911,362	$192,600,577

6. The $192,600,577 represented 911,362 of the total 122,794,289 FFS claims paid for MBHP enrollees during the audit period.

Once we identified this problem, we immediately notified, and shared relevant claim data with, MassHealth, in accordance with Section 6.78 of the Government Accountability Office's *Government Auditing Standards*. This initial notification was provided in November 2015 and was intended to allow MassHealth to take immediate action to cease what appeared to us to be ongoing improper payments of FFS expenses.

Authoritative Guidance

MassHealth is responsible for ensuring the integrity of all claims for behavioral-health care. This includes, among other things, making sure that all behavioral-health care is properly authorized and provided, that billings are properly submitted in that they include the correct procedure codes as well as other service-delivery information, and that payments are in accordance with applicable state regulations and MBHP's contract with the Executive Office of Health and Human Services (EOHHS).

The contract between MBHP and EOHHS establishes that MBHP is responsible for ensuring the authorization and payment of all medically necessary services covered under the contract (see the appendix for a list of those services).

Section 450.124(A) of Title 130 of the Code of Massachusetts Regulations (CMR) limits the extent to which MassHealth may pay providers such as MBHP, on an FFS basis, for behavioral-health care as follows:

> *Except as provided in 130 CMR 450.124(B) and (C), all behavioral health (mental health and substance abuse) services will be authorized, provided, and paid solely by the MassHealth agency's behavioral health contractor (the Contractor). Payment for such services will be subject to the terms of the Contractor's provider contracts including, but not limited to, provisions governing service authorization and billing requirements.*

In addition, Sections 3321(2)(d)(2)(A) and (B) of Title 31 of the US Code state that duplicate payments are improper and should not be made.

Reasons for Improper or Questionable Payments

While MassHealth acknowledged that the majority of the FFS claims involved members who had received behavioral-health care, it did not have adequate system edits in place to identify, and redirect to MBHP, claims for services covered by its contract with MBHP. MassHealth also identified other reasons for its improper payments, including services received from out-of-network providers,

incorrectly coded claims submitted by providers, and FFS payments made for members who were retroactively enrolled in MBHP. However, these reasons do not justify MassHealth paying FFS behavioral-health claims for MBHP members.

We determined that another reason for these problems is that MMIS's system edits and the Benefits Coverage Grid do not align and therefore do not test for the same types of claims and related information. For example, the Benefits Coverage Grid contains procedure code S9484, which establishes an hourly rate for crisis intervention services, and procedure code 96101, which establishes an hourly rate for psychological testing. However, the edits in MMIS lack both of these MBHP-approved procedure codes, so MassHealth makes FFS payments for these services even though they are covered by MBHP. Although MBHP provided MassHealth with its Benefits Coverage Grid, MassHealth did not incorporate all of the services in the grid into MMIS's system edits and thus incurred unnecessary healthcare costs through improper FFS payments.

The types of improper or questionable payments are described below.

Claims That Were Not Properly Identified by MMIS Edits: $92,021,777

MMIS uses system edits to identify and deny behavioral-health claims that it believes MBHP should pay for members of MassHealth's Primary Care Clinician Plan. These edits are intended to deny claims for 522 primary diagnosis codes for inpatient services, 56 procedure codes for physician services, and 16 revenue codes for outpatient services.

However, our analysis of FFS claims showed that MassHealth paid for behavioral-health services that these edits should have identified and denied. These payments were for inpatient, outpatient, and physician behavioral-health services (for instance, group psychotherapy, general psychiatric treatment, individual therapy and inpatient treatment for schizophrenia, and treatment of alcohol withdrawal and post-traumatic stress disorder). These improper payments totaled $92,021,777 and are detailed below.

Improper FFS Behavioral-Health Claims

Type of Service	Identified Claims	Total Payments
Physician	253,738	$18,929,547
Inpatient	11,205	68,466,158
Outpatient	17,384	4,626,072
Total	282,327	$92,021,777

Payments That Were Covered According to MBHP's Benefits Coverage Grid: $896,786

MBHP maintains a Benefits Coverage Grid that identifies covered services based on each claim's procedure code, revenue code, diagnosis code/s, place of service, and procedure code modifier/s. It shares this grid not only with MassHealth but also with all behavioral-health providers contracted for services with MBHP. The grid is intended to ensure that covered services are paid for not on a FFS basis but rather through the capitated payment MassHealth makes to MBHP for each of its covered members. However, our analysis of FFS payments showed that MassHealth paid for covered behavioral-health services shown on the grid. These payments were for physician behavioral-health services to treat members with issues that included schizophrenia, paranoia, and opioid abuse. They totaled $886,786 and involved 17,981 behavioral-health claims. It should be noted that the improper claims identified by the MMIS edit testing results discussed above were separate and distinct from our Benefits Coverage Grid testing and did not result in any claim overlap.

Payments That Did Not Align with MMIS Edits or the Benefits Coverage Grid: $99,682,014

Our audit also identified questionable FFS claims that were clearly for behavioral health but did not exactly align with either MMIS's system edits or the Benefits Coverage Grid. These services included family therapy sessions, behavioral-health counseling, and psychological testing. These questionable payments totaled $99,682,014 and are detailed below, sorted by service setting or type.

Questionable FFS Behavioral-Health Claims

Type of Service	Identified Claims	Total Payments
Physician	609,988	$ 57,175,647
Inpatient	180	8,415,666
Outpatient	886	34,090,702
Total	611,054	$99,682,014*

* The $1 discrepancy in this total is due to rounding.

We considered multiple factors when deciding whether these claims represented behavioral-health services that MBHP should have paid for. Our analysis of the FFS claims showed that these questionable payments were associated with 14 different claim categories for behavioral health (e.g., services under a procedure code established by the federal government specifically for behavioral health, services

provided by a behavioral-health provider, or services overlapping an inpatient behavioral-health stay). Some individual claims fell into as many as 5 of the categories. We found that 95% of the questionable claims were associated with 1 or more of 7 specific categories:

- behavioral-health procedure code
- postpartum-depression-related diagnosis code
- behavioral-health evaluation and management code
- overlap with inpatient behavioral-health stay
- primary diagnosis that had a behavioral-health procedure code in MMIS
- primary diagnosis that was on the Benefits Coverage Grid
- claim submitted by a behavioral-health provider

One example of these questionable claims is counseling for antepartum and postpartum depression. During the audit period, MassHealth paid providers $6,262,326 for 1,190 FFS claims for behavioral-health services for claims related to antepartum and postpartum depression that we believe should be covered under the MBHP contract.

According to MassHealth, 10% to 20% of all new mothers experience antepartum and/or postpartum depression as a clinical significant condition. Major depressive episodes can begin during pregnancy and last up to two years after birth. In the American College of Obstetricians and Gynecologists' *Clinical Updates in Women's Health Care: Mood and Anxiety Disorders* (2008), postpartum depression is defined as follows:

> *A range of physical, emotional, and behavioral changes that many new mothers experience following the delivery of their babies, with symptoms most commonly starting 1–3 weeks after delivery. Women with postpartum depression have such strong feelings of sadness, anxiety or despair that they have trouble coping with their daily tasks. Symptoms of this condition can range from mild to severe. Postpartum depression is a serious condition which can impact the health of the infant and the mother and requires treatment. In some cases, new mothers may have postpartum psychosis, a relatively rare psychiatric emergency.*

Since the passage of Chapter 313 of the Acts of 2010, the director of MassHealth has been a member of a special legislative commission on postpartum depression. According to Chapter 313, the commission is to issue annual reports detailing its many projects promoting better screening, treatment, and

awareness of maternal mental-health challenges and its progress in developing a public-awareness campaign on postpartum depression and other perinatal mental illnesses.

However, neither the Benefits Coverage Grid nor the list of behavioral-health diagnosis codes MMIS uses to process claims contains these services and their related procedure codes, even though they are for behavioral-health services.

Recommendations

1. MassHealth should take appropriate action to recoup the approximately $93 million[7] of payments we identified as improper.
2. MassHealth should review the approximately $100 million of claims we identified as questionable to determine whether any of this amount should be recouped from MBHP as contractually covered behavioral-health services.
3. In consultation with MBHP, MassHealth should develop a master list of covered services based on claim procedure codes, revenue codes, diagnosis codes, places of service, and procedure code modifiers. MassHealth should then use this information to create system edits in its claim-processing system to ensure that it only pays for claims that MassHealth and MBHP have specifically identified as not covered by MBHP's contract.

MassHealth's Response

As noted in the "Audit Objectives, Scope, and Methodology" section of this report, at the end of our audit, the Office of the State Auditor (OSA) provided MassHealth with a copy of our draft report and subsequently met with MassHealth officials to discuss it. As a result of this meeting, OSA made changes to the draft that involved adjusting certain amounts of questioned costs. MassHealth's response, however, refers to the original questioned costs, as opposed to our adjusted figures. For example, our original total questioned cost amount (which MassHealth refers to in its response) was approximately $211.5 million, whereas our final adjusted questioned cost amount (which we refer to in our reply) is approximately $193 million. All discrepancies between the amounts MassHealth refers to and the revised amounts we refer to are explained in footnotes.

Further, it should be noted that MassHealth indicated to us that it did not actually review all of the questioned claims we provided. Therefore, the amounts of the questioned costs we refer to in the "State-Agency Claims," "OCA Edit Overrides," "Retroactive Rate Adjustments," and "Services Delivered

7. This amount includes the state-agency claims discussed in this report.

in Medical-Health Settings" sections of our reply are our estimate of the total claims that were reviewed by MassHealth in each of these categories and do not total the approximately $193 million of improper payment amounts we identified.

> ***MassHealth has determined that of the $211.5 million[8] cited in the [OSA] report, less than $1,000,000 over 5 years (or .4% of the [OSA's] findings) represents potential duplicative payments by MassHealth.*** *MassHealth will continue to analyze these ~4,000 claims to assess what portion of this $1 million (or ~$200K per year) reflects an actual duplicate payment, if any, and will recoup payments identified as improper. . . .*
>
> *We think the primary reason for our agencies' divergent analysis of the same data stems, in part, from a differing view on how to categorize medical services provided to individuals with behavioral health conditions. The analysis reflected in the [OSA's] draft report treats medical services provided to individuals with behavioral health conditions the same as behavioral health services. MassHealth disagrees with this approach, as explained in our response, and stands by our approach of maintaining the critical distinction between behavioral health services, paid for by MBHP for Primary Care Clinician Plan members, and medical services which happen to be delivered to individuals with behavioral health conditions, paid for by MassHealth on a fee-for-service basis. . . .*
>
> *These services are not included in the capitation rates MassHealth pays to MBHP. These claims were explicitly excluded in the actuarial rate build up for MBHP and are therefore excluded from the capitation rates paid to MBHP. Moreover, even if MassHealth were to change its policies and expectations for MBHP regarding coverage of the services included in the finding, MassHealth would be required by federal (CMS) rules to include those services in the actuarial rate build-up for MBHP. The result would be a corresponding increase in capitation payments to MBHP. . . .*
>
> *MassHealth disagrees with [OSA's] findings for the remaining $210.5 million. As an initial matter, [OSA] acknowledges that $115.7 million (over 50%) of the finding is questionable and not conclusive.* ***Additionally, based on its analysis, MassHealth has not identified any duplicate payments within the remaining $210.5 million of claims identified by [OSA]****. . . .*
>
> *MassHealth does agree with [OSA's] third recommendation to develop a more explicit master list of covered services and to incorporate updates, if any, into MMIS systems edits. MassHealth will be undertaking this in advance of the next MBHP contract year. However, any changes in expectations going forward for MBHP covered services would result in corresponding changes to MBHP's capitation rates. . . .*

8. Our draft report identified approximately $211.5 million in improper and questionable FFS claims based on MassHealth's MMIS system edits. However, after receiving MassHealth's response to that draft, we made adjustments based on its comments and decreased our final total to approximately $193 million.

[OSA's] first contention is that MassHealth's MMIS edits did not properly deny 278,804 claims (totaling $92,003,295). MassHealth disputes this finding. MassHealth's analysis has determined that the claims in this category were properly paid for some of the following reasons:

***State Agency claims edit bypass**—Claims from state agency providers (like the Department of Mental Health) bypass MMIS edits. Because state agencies were explicitly excluded from the scope of the MBHP contract, any services provided by state agency facilities are not paid as part of the MBHP capitation rate. Rather, the expenditure is reported to CMS in order to support federal matching based on Certified Public Expenditure methodology (i.e., no "payment" is made from MassHealth to the sister agency). . . . Contrary to [OSA's] assertion, because MMIS is coded to bypass state agency claims, these claims do not constitute a system failure or deficiency on the part of MMIS, and MassHealth disputes their inclusion in the audit finding.*

***Edit Overrides**—MMIS is also coded to apply edit overrides to claims in various situations. . . . MassHealth has determined that over 5,000 claims (totaling over $32 million and representing nearly 35% of the total value of claims in this finding category) contained an override designation. Some of the situations in which overrides occur include:*

- ***Office of Clinical Affairs edit override**—These claims were all individually reviewed by physicians in MassHealth's Office of Clinical Affairs (OCA), from Commonwealth Medicine, part of the University of Massachusetts Medical School. [OSA], without clinical involvement or chart review, has dismissed the judgment of MassHealth's clinical reviewers. As explained above, the mere presence of a behavioral health condition does not transform a medical service into a behavioral health service. Furthermore, these services are not part of the MBHP benefit, nor are these costs included in the MBHP capitation rate. Therefore, MassHealth disagrees with [OSA's] findings that these claims were improperly paid.*

- ***Retroactive rate adjustment**—This override was applied when a payment was made to a provider based on a retroactive rate adjustment. At the time of service, the member was not enrolled in MBHP, and therefore the claim was properly paid FFS. At the time of the rate adjustment, the member was enrolled in MBHP. However, because the payment refers back to the date of service, the payments do not represent new claims by an MBHP enrollee. MassHealth therefore disputes that these claims represent duplicative payments.*

- ***Linking of duplicate member IDs**—This override was applied to members who show two member ID numbers, one of which is enrolled in MBHP and one which is not. The payment made on these claims was for services rendered before the MBHP ID number was linked to that member. MassHealth therefore disputes that these claims represent duplicative payments.*

MassHealth agrees that, in this category, approximately 3,750 claims (totaling approximately $500,000, or .5% of the total value of claims in this category) should likely not have been paid fee for service. MassHealth will continue to analyze the claims included in [OSA's] analysis to determine whether recouping these claims is appropriate. . . .

[OSA] has identified 78,925 claims (totaling $3,797,471[9]) that it asserts were covered by MBHP's coverage grid based on procedure code, revenue code, diagnosis code, place of service, and procedure code modifier. Upon review, MassHealth's analysis to date has determined that the vast majority of these claims were properly paid fee for service for the following reasons.

***Services delivered by medical professionals** . . . Integration of medical and behavioral healthcare is a primary concern for MassHealth and MassHealth expects and encourages members' primary care providers and other medical professionals to involve themselves in all aspects of their patients' care—including their behavioral health needs. MassHealth pays medical professionals who provide medically necessary medical services whether that provider is serving a member with a behavioral health condition or not. Therefore, MassHealth disputes that these claims were improperly paid.*

***State agency claims edit bypass**—As discussed above, claims submitted by state agency providers bypass MMIS edits and the expenditure is reported to CMS in order to support federal matching based on Certified Public Expenditure methodology. MassHealth has identified claims of this type which have been included within this section of [OSA's] analysis. MassHealth disputes these findings for the reasons stated above.*

MassHealth agrees that, in this category, 270 claims (totaling approximately $18,000, or .4% of the total value of claims in this category) should likely not have been paid fee for service. . . .

Finally, [OSA] has suggested that an additional 1,230,137 claims (totaling $115,700,806[10]) might constitute improper payments based on its assessment that the claims "clearly" constituted behavioral health claims, yet appeared nowhere on the MMIS edit system or the MBHP coverage grid. . . . MassHealth has determined that these claims, by and large, were properly paid fee for service for some of the following reasons. . . .

***State agency claims edit bypass**—As discussed above, claims submitted by state agency providers bypass MMIS edits and the expenditure is reported to CMS in order to support federal matching based on a Certified Public Expenditure methodology. . . . MMIS is coded to bypass state agency claims, these claims do not constitute a system failure or deficiency on the part of MMIS, and MassHealth disputes their inclusion in the audit finding. . . .*

[OSA's] report suggests that MassHealth incorrectly paid claims related to members with post-partum or antepartum depression. Without any specificity, [OSA] asserts that neither MMIS nor MBHP's benefit grid recognizes "these services and their related procedure codes." On the contrary, MassHealth has a robust screening program that takes place in the context of primary care, OB/GYN visits, and pediatrician visits. That these screenings take place in the context of

9. Our draft report identified $3,797,471 million in improper and questionable FFS claims based on MBHP's Benefits Coverage Grid. However, after receiving MassHealth's response to that draft, we made adjustments based on its comments and decreased our final total to approximately $900,000.
10. Our draft report identified $115,700,806 in improper and questionable FFS claims based on claims that did not align with MMIS edits or the Benefits Coverage Grid. However, after receiving MassHealth's response to that draft, we made adjustments based on its comments and decreased our final total to approximately $104,604,271.

routine medical care is crucial to their success. Therefore, MassHealth pays these as medical claims and disputes [OSA's] suggestions that these claims should be denied by MassHealth.

MassHealth will continue to analyze the claims included in [OSA's] analysis to determine whether any claims should not have been paid fee for service. MassHealth will identify whether recouping these claims is appropriate.

Auditor's Reply

Throughout its response, MassHealth emphasizes that the approximately $193 million in claims identified in our audit were not improper, questionable, or duplicative. MassHealth supports this contention by stating that the cost of these claims was not included in the capitation payments made to MBHP. Since we did not review the process MassHealth and its actuary use to establish the capitation rates for MBHP members, we cannot comment on the accuracy of MassHealth's assertion. However, it should be noted that MassHealth provided OSA with the files it sent to the actuary that the actuary uses to establish this capitation rate. We selected a sample of claims from this information and determined that they did in fact contain state-agency claims, which indicated to us that the actuary at least receives this claim information. Regardless, contrary to MassHealth's assertion, all the claims identified in our audit are improper or questionable payments even if certain claims were not included in the MBHP capitation-rate calculation. MassHealth's FFS payments for all of these claims were contrary to state and federal laws and regulations governing the delivery of behavioral-health services by state-contracted managed-care organizations (MCOs) such as MBHP.

The claims identified in our finding were for behavioral-health services. In making this assessment, we used the various diagnosis and procedure codes that MassHealth says its uses to determine whether a claim is for behavioral-health services it should pay for. MassHealth's FFS providers, in most instances, were barred from supplying the services to MBHP enrollees outside the context of the MBHP contract. Specifically, the MassHealth All Provider regulation relevant to this question of improper payments, 130 CMR 450.124, states,

A. Behavioral Health Contractor. Except as provided in 130 CMR 450.124(B) and (C), all behavioral health (mental health and substance abuse) services will be authorized, provided, and paid solely by the MassHealth agency's behavioral health contractor (the Contractor). Payment for such services will be subject to the terms of the Contractor's provider contracts including, but not limited to, provisions governing service authorization and billing requirements. Any provider seeking a contract with the Contractor should contact the Contractor directly.

> *B. <u>Emergency Services.</u> Emergency services may be provided by any provider regardless of whether that provider has entered into an agreement with the Contractor. However, all providers of emergency services (except those provided to exempt members pursuant to 130 CMR 450.124(C)) may claim payment for such services solely from the Contractor and such payment will be subject to the Contractor's billing requirements.*

This regulation exempts certain members from having to receive their behavioral-health services from MBHP, including members who are enrolled in other MCOs contracting with MassHealth and members who have been specifically excluded from participation in an MCO. Other than these exemptions, 130 CMR 450.124(B) requires providers of emergency services for MBHP enrollees to direct their claims for those services to MBHP. Thus there is no scenario under 130 CMR 450.124 that allows a MassHealth FFS provider to bill MassHealth directly for behavioral-health services provided to an MBHP enrollee.

Federal regulations complement this prohibition. Section 438.60 of Title 42 of the Code of Federal Regulations (CFR) states,

> *The State agency must ensure that no payment is made to a network provider other than by the MCO . . . for services covered under the contract between the State and the MCO.*

MBHP is an MCO, and therefore MassHealth's claim that the improper FFS payments are not duplicative because of the actuarial process of setting MBHP's capitation rate is irrelevant, because these claims should never have been paid.

Additional factors raised by MassHealth in its response—the status of some payments as state-agency claims, Office of Clinical Affairs (OCA) edit overrides, retroactive rate adjustments, duplicate member identification numbers, services delivered in medical settings, and postpartum or antepartum services—do not justify FFS payments if the services claimed were for behavioral-health care; any FFS payments made under these circumstances were contrary to 130 CMR 450.124 because they were provided to MBHP enrollees without the management and direction of the behavioral-health contractor, MBHP.

These FFS payments reflect the fact that MassHealth has not taken appropriate measures to ensure that all the payments for, and the delivery of, behavioral-health services in the Commonwealth are proper. Specifically, its system edits did not identify improper FFS payments that were subject to denial under 130 CMR 450.124. In addition, MassHealth stated that many of these improper claims resulted from integrating behavioral-health services with medical health services within one healthcare setting. Although this approach appears beneficial to members, MassHealth has not taken the steps necessary to ensure that these FFS providers contract with, and bill, MBHP for the behavioral-health services they

provide to members as required by state regulations. In addition, under its contract, MBHP is responsible for coordinating all behavioral-health services for its enrollees. Care coordination is critical to ensure the best possible outcomes for MBHP members suffering from behavioral-health issues. However, MBHP is not coordinating the delivery of behavioral-health services provided by non-MBHP-contracted providers. In fact, in order to know that these services are provided, MBHP must review the member's provided services and paid FFS claims after the fact. Even if such reviews are performed, they do not reflect effective and efficient delivery of behavioral-health services as required under the MBHP contract.

State-Agency Claims

Regarding approximately $40 million in state-agency claims, MassHealth states in its response that "state agencies were explicitly excluded from the scope of the MBHP contract."[11] This is not correct. In fact, except in the case of certain specific services from the Department of Mental Health (DMH), state agencies' claims are included in the MBHP contract, not excluded from it. The contract defines "provider," "network provider," and "emergency services program" (ESP) in a manner that includes state agencies. It also directs the contractor to enroll these state agencies as network providers. For example, Section 1.1 of the contract and Appendix 1 read,

> *Providers—an individual, group, facility,* ***agency****, institution, organization, or business that furnishes or has furnished medical services to Covered Individuals.* (Emphasis added.)

Also, Appendix A-3 of the contract lists the entities that are required to be enrolled as ESP network providers. It includes all of the state-agency-operated ESPs, such as Corrigan Mental Health Center and the Brockton Multi-Service Center, both operated by DMH.

In addition, 42 CFR 438.60 makes no exception for state agencies such as MassHealth, and neither does 130 CMR 450.124.

It should be noted that MassHealth did not anticipate state agencies providing behavioral-health services independently of MBHP when it structured MBHP's capitation rate. Specifically, it allowed MBHP to charge the same capitation rate for members who would receive their behavioral-health

11. On March 30, 2016, OSA issued Audit Report No. 2016-0236-3O, addressing the Department of Mental Health's proposal to privatize its Southeast Emergency Services Program. OSA had no objection to this request, since the department had complied with all the provisions of Section 54 of Chapter 7 of the Massachusetts General Laws. By moving forward with this initiative, the Department of Mental Health has in effect resolved this issue.

services in the southeastern Massachusetts service area even though a portion of these services were to be provided by state agencies. MBHP received the same rate for all members despite the much lower level of services that it provided to members in this region: it received the same monthly capitation payments for 1,536 MBHP enrollees who went at least one calendar year receiving all of their covered behavioral-health services from state agencies, with no MBHP paid encounters taking place at all. For 690 of these members, this was true for the entire audit period, not just one calendar year.

OCA Edit Overrides

These inpatient claims for approximately $21 million were submitted by MassHealth providers with behavioral-health primary diagnosis codes. MMIS properly denied these claims. MassHealth states that the claims were then individually reviewed by clinicians who determined that they represented medical services, not behavioral-health services.

We examined all inpatient claims initially denied by the MMIS edit in question during the audit period. We determined that all were related to behavioral health, based on the admission diagnosis code and the later-determined primary diagnosis code, which are the very metrics used by MBHP and MassHealth to determine the appropriate payment. For example, one member had an inpatient episode at Cooley Dickinson Hospital that was overridden by OCA as a medical claim and paid improperly by MassHealth as an FFS encounter. The admission diagnosis codes for this MassHealth FFS encounter were 2989 (psychosis) and 29600 (bipolar, manic), both behavioral-health diagnosis codes. Less than a month later, the same member was again admitted as an inpatient to Cooley Dickinson Hospital on the basis of an almost identical diagnosis code, 29644 (bipolar, manic), but this claim was properly paid by MBHP as a behavioral-health encounter. The table below outlines this scenario.

Date From	Date To	Billing Provider	Claim Type	Admission Diagnosis Code
12/31	1/1	Cooley Dickinson Hospital	Inpatient	2989
1/1	1/8	Cooley Dickinson Hospital	Inpatient (Encounter)	29644

These types of inconsistencies and questionable payments were typical of the claims that we determined were improper in this category. It should be noted that OSA gave MassHealth the opportunity to provide examples of these claims in order to explain and support its assertion that these claims represent medical services including "claims submitted by podiatrists, optometrists, dentists, and other medical professionals for a wide range of medical services, including vaginal deliveries, eye exams,

postoperative follow-up visits and flu shots." However, to date, MassHealth has not provided any such documentation.

Further, it should be noted that although OSA did not review MassHealth's OCA claim-review process, our review of data related to this process revealed what appears to be a bias toward determining that claims reviewed are for medical services, not behavioral-health services, in which case MassHealth, not MBHP, should remit the payment to the provider. Specifically, our review of the 2,027 inpatient claims denied by MassHealth since August 13, 2012 showed that OCA only confirmed 5 such claims as behavioral-health claims and converted the rest to medical claims. Moreover, OCA did not confirm any of the similar denied claims as behavioral-health claims in the first seven months of 2016. Thus OCA has converted to medical claims at least 99.753% of all the inpatient behavioral-health claims it has reviewed since August 13, 2012. OSA believes that such a high conversion rate calls into question whether all of the conversions were warranted, particularly since our review of the data related to these payments indicated that in these instances, the MMIS edits appear to have properly identified the claims as behavioral-health claims based on key information in the claim, including the admission diagnosis code and primary diagnosis code.

Retroactive Rate Adjustments

MassHealth asserts that these retroactive rate adjustments totaling approximately $6 million were proper because the members were not enrolled in MBHP on the date when the original service/s were provided. However, this is not accurate. Claims in this category represent retroactive payments for services that had already been provided to a member in order to increase the amount paid for the procedure when MassHealth felt it was warranted. MassHealth indicated that it considered the provider entitled to the additional payment if the member was not enrolled in MBHP on the date of the original service. In our analysis, we removed any claims for which the member was not enrolled in MBHP on date of the original service. It should be noted that in most cases, the member had in fact been enrolled in MBHP on the original date of service, and those are the claims reported in our finding. Moreover, MassHealth made capitation payments for these members that also dated back to the time of the original services. Therefore, the retroactive payments and the original FFS payments were duplicate payments.

Duplicate Member Identification Numbers

We disagree with MassHealth's assertion that duplicate payments totaling approximately $170,000 did not occur for members with two identification numbers, one that was for services covered by MBHP and one that was not. MassHealth acknowledges that it paid for these members' behavioral-health services on a FFS basis before the MBHP identification number was linked to the members. However, once MassHealth made appropriate updates to their enrollment status, including linking them with their unique MBHP identification numbers, it did not void any previously adjudicated FFS behavioral-health claims falling within capitated-payment date ranges. Consequently, MassHealth paid twice for the same behavioral-health services (by paying a provider on an FFS basis when the service was actually performed and paying a monthly fee to MBHP to provide the same type of service).

Services Delivered in Medical-Health Settings

Regarding the approximately $34 million in payments for services in medical-health settings, MassHealth stated that its policy is to integrate medical and behavioral-health services in the same office setting. This means that it knowingly pays for behavioral-health services provided by medical professionals outside the MBHP network. Although MassHealth's move toward integrating behavioral and medical health aligns with Chapter 224 of the Acts of 2012 (An Act Improving the Quality of Health Care and Reducing Costs through Increased Transparency, Efficiency and Innovation), in doing so it must ensure compliance with its own regulations and its MBHP contract. MassHealth has not accomplished this, because it has allowed these behavioral-health services to be delivered by providers that have not been vetted, approved, and then contracted by MBHP. Moreover, under the Primary Care Clinician Plan, members are able to select a doctor or nurse practitioner from among participating MassHealth primary-care clinicians (PCCs). The member's PCC is responsible for providing and/or coordinating most of the member's medical care and, as necessary, referring the member to other MassHealth providers for non-primary-care services, including behavioral-health services through MBHP. However, in our audit, we found that many members are not appropriately referred by PCCs to MBHP for such services.

Also, the MBHP contract is intended to coordinate the delivery of all behavioral-health services for members in order to achieve the best possible outcomes. By allowing behavioral-health services, such as antepartum and postpartum services, to be provided outside the MBHP's network and without its prior knowledge, MassHealth prevents MBHP from effectively coordinating members' care, which can result in a lower quality of care. This policy results in additional costs to the Commonwealth and potential gaps

in care for members. Therefore, MassHealth needs to ensure that all future contracts with its provider of behavioral-health services, as well as its administration of these contracts, properly effect compliance with applicable state and federal regulatory requirements as well as the effective and efficient coordination of care for members.

OTHER MATTERS

Payment Amount per Episode Claims for Covered Services

For medical services provided to MassHealth members in emergency rooms, MassHealth pays the hospital a one-time payment known as a payment amount per episode (PAPE). We determined that MassHealth uses PAPE payments for individual episodes of care that involve both general medical care and behavioral-health services. Although MassHealth's use of a single PAPE payment for general medical care is appropriate, Section 438.60 of Title 42 of the Code of Federal Regulations and Section 450.124(A) of Title 130 of the Code of Massachusetts Regulations require that all behavioral-health services, including those provided in emergency rooms, be billed separately from general medical care, so that each visit produces two separate claims.

Although the scope of this audit involved behavioral-health services paid for by MassHealth on a fee-for-service (FFS) basis, we also examined all the components of each PAPE claim to determine whether the services provided during the episode of care were general medical care or behavioral-health services. Based on our examination, in addition to the improper and questionable payments for behavioral-health services that MassHealth paid on an FFS basis, we also identified an additional $10,623,476 in behavioral-health services that were included in PAPEs. MassHealth should have identified these behavioral-health services and directed them to the Massachusetts Behavioral Health Partnership (MBHP) for payment. Appropriately paying for these services would have ensured that hospitals were properly reimbursed. However, MassHealth did not have a system edit to identify behavioral-health care services within PAPEs.

In addition, by not ensuring proper payment for these behavioral-health claims, MassHealth creates a financial incentive for MBHP to allow its members to seek behavioral-health care in emergency rooms rather than through its network of managed-care providers. When behavioral-health services are improperly bundled into PAPE payments, MBHP avoids paying for them out of its own contract revenue. MassHealth's lack of differentiation between general medical care and behavioral-health services within PAPEs calls into question its controls over the adjudication process for behavioral-health claims. We believe MassHealth should ensure that it has a system edit within its claim-processing system to facilitate proper payment of PAPE claims for covered behavioral-health care.

APPENDIX

Covered Services

I. Behavioral Health Covered Services for Standard and CommonHealth Covered Individuals

A. Inpatient Services—*24-hour services, delivered in a licensed hospital setting, that provide clinical intervention for mental health or substance use diagnoses, or both.*

1. Inpatient Mental Health Services—*hospital services to evaluate and treat an acute psychiatric condition which 1) has a relatively sudden onset; 2) has a short, severe course; 3) poses a significant danger to self or others; or 4) has resulted in marked psychosocial dysfunction or grave mental disability.*

2. Inpatient Substance Use Disorder Services (Level IV)—*hospital services that provide a detoxification regimen of medically directed evaluation, care and treatment for psychoactive substance-abusing Covered Individuals in a medically managed setting.*

3. Observation/Holding Beds—*hospital services, for a period of up to 24 hours, in order to assess, stabilize, and identify appropriate resources for Covered Individuals.*

4. Administratively Necessary Day (AND) Services—*a day(s) of inpatient hospitalization provided to Covered Individuals when said Covered Individuals are clinically ready for discharge, but an appropriate setting is not available. Services shall include appropriate continuing clinical services.*

B. Diversionary Services—*those mental health and substance use disorder services that are provided as clinically appropriate alternatives to Behavioral Health Inpatient Services, or to support an Enrollee returning to the community following a 24-hour acute placement; or to provide intensive support to maintain functioning in the community. There are two categories of Diversionary Services, those provided in a 24-hour facility, and those which are provided in a non-24-hour setting or facility.*

1. 24-Hour Diversionary Services:

a. Community Crisis Stabilization—*services provided as an alternative to hospitalization, including short-term psychiatric treatment in structured, community-based therapeutic environments. Community Crisis Stabilization provides continuous 24-hour observation and supervision for Covered Individuals who do not require Inpatient Services.*

b. Community-Based Acute Treatment for Children and Adolescents (CBAT)—*mental health services provided in a staff-secure setting on a 24-hour basis, with sufficient clinical staffing to insure safety for the child or adolescent, while providing intensive therapeutic services including, but not limited to, daily medication monitoring; psychiatric assessment; nursing availability; Specialing (as needed); individual, group and family therapy; case management; family assessment and consultation; discharge planning; and psychological testing, as needed. This service may be used as an alternative to or transition from Inpatient services.*

c. Acute Treatment Services (ATS) for Substance Use Disorders (Level III.7)—*24-hour, seven days [a] week, medically monitored addiction treatment services that provide evaluation and withdrawal management. Detoxification services are delivered by nursing and counseling staff under a physician-approved protocol and physician-monitored procedures and include: bio-psychosocial assessment; individual and group counseling; psychoeducational groups; and discharge planning. Pregnant women receive specialized services to ensure substance use disorder treatment and obstetrical care. Covered Individuals with Co-occurring Disorders receive specialized services to ensure treatment for their co-occurring psychiatric conditions. These services may be provided in licensed freestanding or hospital-based programs.*

d. Clinical Support Services for Substance Use Disorders (Level III.5)—*24-hour treatment services, which can be used independently or following Acute Treatment Services for substance use disorders, and including intensive education and counseling regarding the nature of addiction and its consequences; outreach to families and significant others; and aftercare planning for individuals beginning to engage in recovery from addiction. Covered Individuals with Co-Occurring Disorders receive coordination of transportation and referrals to mental health providers to ensure treatment for their co-occurring psychiatric conditions. Pregnant women receive coordination of their obstetrical care.*

e. Transitional Care Unit (TCU)—*A community based therapeutic program offering high levels of supervision, structure and intensity of service within an unlocked setting. The program serves children and adolescents, under age 19, who are in the custody of the Department of Children and Families (DCF), who have been determined to need group care or foster care and no longer meet the clinical criteria for continued stay at an acute level of care. The TCU offers comprehensive services, including but not limited to, a therapeutic milieu, psychiatry, aggressive case management, and multidisciplinary, multi-modal therapies.*

2. Non-24-Hour Diversionary Services

a. Community Support Program (CSP)—*an array of services delivered by a community-based, mobile, multi-disciplinary team of professionals and paraprofessionals. These programs provide essential services to Covered Individuals with a long standing history of a psychiatric or substance use disorder and to their families, or to Covered Individuals who are at varying degrees of increased medical risk, or to children/adolescents who have behavioral health issues challenging their optimal level of functioning in the home/community setting. Services include outreach and supportive services, delivered in a community setting, which will vary with respect to hours, type and intensity of services depending on the changing needs of the Enrollee.*

b. Partial Hospitalization (PHP)—*an alternative to Inpatient Mental Health Services, PHP services offer short-term day mental health programming available seven days per week. These services consist of therapeutically intensive acute treatment within a stable therapeutic milieu and include daily psychiatric management.*

c. Psychiatric Day Treatment—*services which constitute a program of a planned combination of diagnostic, treatment and rehabilitative services provided to a person with mental illness who needs more active or inclusive treatment than is typically available through a weekly visit to a mental health center, individual Provider's office or hospital outpatient department, but who does not need 24-hour hospitalization.*

d. Structured Outpatient Addiction Program (SOAP)—*clinically intensive, structured day and/or evening substance use disorder services. These programs can be utilized as a transition service in the continuum of care for an Enrollee being discharged from Acute Substance Abuse Treatment, or can be utilized by individuals, who need Outpatient Services, but who also need more structured treatment for a substance use disorder. These programs may incorporate the evidence-based practice of Motivational Interviewing into clinical programming to promote individualized treatment planning. These programs may include specialized services and staffing for targeted populations including pregnant women, adolescents and adults requiring 24[-hour] monitoring.*

e. Program of Assertive Community Treatment (PACT) *shall mean a multi-disciplinary team approach to providing acute, active, ongoing, and long-term community-based psychiatric treatment, assertive outreach, rehabilitation and support. The program team provides assistance to Covered Individuals to maximize their recovery, ensure consumer-directed goal setting, assist individuals in gaining a sense of hope and empowerment, and provide assistance in helping the individuals served become better integrated into the community. Services are provided in the community and are available, as needed by the individual, 24 hours a day, seven days a week, 365 days a year.*

f. Intensive Outpatient Program (IOP)—*a clinically intensive service designed to improve functional status, provide stabilization in the community, divert an admission to an Inpatient Service, or facilitate a rapid and stable reintegration into the community following a discharge from an inpatient service. The IOP provides time-limited, comprehensive, and coordinated multidisciplinary treatment.*

C. Outpatient Services—*mental health and substance use disorder services provided in person in an ambulatory care setting such as a mental health center or substance use disorder clinic, hospital outpatient department, community health center, or practitioner's office. The services may be provided at an Enrollee's home or school.*

1. Standard Outpatient Services—*those Outpatient Services most often provided in an ambulatory setting.*

a. Family Consultation—*a meeting of at least 15 minutes' duration, either in person or by telephone, with family members or others who are significant to the Enrollee and clinically relevant to an Enrollee's treatment to: identify and plan for additional services; coordinate a treatment plan; review the individual's progress; or revise the treatment plan, as required.*

b. Case Consultation—*an in-person or by telephone meeting of at least 15 minutes' duration, between the treating Provider and other behavioral health*

clinicians or the Enrollee's primary care physician, concerning an Enrollee who is a client of the Provider, to: identify and plan for additional services; coordinate a treatment plan; review the individual's progress; and revise the treatment plan, as required. Case Consultation shall not include clinical supervision or consultation with other clinicians within the same provider organization.

c. ***Diagnostic Evaluation—****an assessment of an Enrollee's level of functioning, including physical, psychological, social, educational and environmental strengths and challenges for the purpose of diagnosis and designing a treatment plan.*

d. ***Dialectical Behavioral Therapy (DBT)—****a manual-directed outpatient treatment developed by Marsha Linehan, PhD, and her colleagues that combines strategies from behavioral, cognitive, and supportive psychotherapies for Covered Individuals with borderline personality disorder who also exhibit chronic, parasuicidal behaviors and adolescents who exhibit these symptoms. DBT may be used for other disorders if the Contractor determines that, based on available research, DBT is effective and meets the Contractor's criteria for determining medical necessity.*

e. ***Psychiatric Consultation on an Inpatient Medical Unit—****an in-person meeting of at least 15 minutes' duration between a psychiatrist or Advanced Practice Registered Nurse Clinical Specialist and an Enrollee at the request of the medical unit to assess the Enrollee's mental status and consult on a behavioral health or psychopharmacological plan with the medical staff on the unit.*

f. ***Medication Visit—****an individual visit specifically for psychopharmacological evaluation, prescription, review, and/or monitoring by a psychiatrist or [Registered Nurse] Clinical Specialist for efficacy and side effects.*

g. ***Medication Administration*** *shall mean the injection of intramuscular psychotherapeutic medication by qualified personnel.*

h. ***Couples/Family Treatment—****the use of psychotherapeutic and counseling techniques in the treatment of an Enrollee and his/her partner and/or family simultaneously in the same session.*

i. ***Group Treatment—****the use of psychotherapeutic or counseling techniques in the treatment of a group, most of whom are not related by blood, marriage, or legal guardianship.*

j. ***Individual Treatment—****the use of psychotherapeutic or counseling techniques in the treatment of an individual on a one-to-one basis.*

j. [sic] ***Inpatient-Outpatient Bridge Visit—****a single-session consultation conducted by an outpatient provider while an Enrollee remains on an Inpatient psychiatric unit. The Inpatient-Outpatient Bridge Visit involves the outpatient Provider meeting with the Enrollee and the inpatient team or designated inpatient treatment team clinician.*

k. ***Assessment for Safe and Appropriate Placement (ASAP)—****an assessment, required by [Massachusetts General Laws] 119 Sec. 33B, conducted by a diagnostician with specialized training and experience in the evaluation and treatment of sexually abusive youth or arsonists, to evaluate individuals who are in the care and custody of [the Department of Children and Families] and who have been adjudicated delinquent for a sexual offense or the commission of arson, or have admitted to such behavior, or are the subject of a documented or substantiated report of such behavior, and who are being discharged from Inpatient Psychiatric Unit or Hospital or Community-Based Acute Treatment for Children/Adolescents or Intensive Community Based Acute Treatment for Children/Adolescents to a family home care setting. Services are provided through a [Department of Children and Families] designated ASAP provider.*

l. ***Collateral Contact—****an in-person or by telephone conversation of at least 15 minutes' duration between a Provider and individuals who are involved in the care or treatment of an Enrollee under 21 years of age, including, but not limited to, school and day care personnel, state agency staff, and human services agency staff.*

m. ***Acupuncture Treatment—****the insertion of metal needles through the skin at certain points on the body, with or without the use of herbs, an electric current, heat to the needles or skin, or both, as an aid to persons who are withdrawing from dependence on substances or in recovery from addiction.*

n. ***Opioid Replacement Therapy—****medically monitored administration of methadone, Buprenorphine, or other U.S. Food and Drug Administration (FDA)–approved medications to opiate-addicted individuals, in conformance with FDA and Drug Enforcement Administration (DEA) regulations. This service combines medical and pharmacological interventions with counseling, educational and vocational services and is offered on a short-term (detoxification) and long-term (maintenance) basis.*

o. ***Ambulatory Detoxification (Level II.d)—****outpatient services for Members who are experiencing a serious episode of excessive substance use or withdrawal complications. Ambulatory Detoxification is provided under the direction of a physician and is designed to stabilize the Member's medical condition under circumstances where neither life nor significant bodily functions are threatened. The severity of the individual's symptoms will determine the setting, as well as the amount of nursing and physician supervision necessary during the course of treatment.*

p. ***Psychological Testing—****the use of standardized test instruments to assess a Covered Individual's cognitive, emotional, neuropsychological, verbal, and defensive functioning on the central assumption that individuals have identifiable and measurable differences that can be elicited by means of objective testing.*

q. ***Special Education Psychological Testing—****psychological, emotional or neuropsychological testing which is requested by school personnel responsible for initiating referrals for diagnosis and evaluation of children who qualify for special education programs pursuant to Mass Gen. Law 71B, and which shall be utilized toward the development of an Individualized*

Educational Plan (IEP). Special Education Psychological Testing shall not be administered more than once a year unless new events have significantly affected the student's academic functioning.

3. ***Intensive Home or Community-Based Services for Youth—****mental health and substance use disorder services provided to Covered Individuals in a community-based setting such as home, school, or community service agency. The services provided are more intensive than services that may be provided through a standard outpatient service.*

   a. ***Family Support and Training:*** *a service provided to the parent/caregiver of a youth (under the age of 21), in any setting where the youth resides, such as the home and other community settings. Family Support and Training is a service that provides a structured, one-to-one, strength-based relationship between a Family Support and Training Partner and a parent/caregiver. The purpose of this service is for resolving or ameliorating the youth's emotional and behavioral needs by improving the capacity of the parent/caregiver to parent the youth so as to improve the youth's functioning. Services may include education, assistance in navigating the child serving systems; fostering empowerment, including linkages to peer/parent support and self-help groups; assistance in identifying formal and community resources, support, coaching, and training for the parent/caregiver.*

   b. ***Intensive Care Coordination—****a service that provides targeted case management services to individuals under 21 with a Serious Emotional Disturbance including individuals with co-occurring conditions. This service includes assessment, development of an individualized care plan, referral and related activities to implement the care plan and monitoring of the care plan.*

   c. ***In-Home Behavioral Services—****this service usually includes a combination of behavior management therapy and behavior management monitoring, as follows:*

      C1. ***Behavior Management Therapy:*** *This service includes assessment, development of the behavior plan, and supervision and coordination of interventions to address specific behavioral objectives or performance. This service addresses challenging behaviors which interfere with the child's successful functioning. The behavior management therapist develops and monitors specific behavioral objectives and interventions, including a crisis-response strategy, which are incorporated into the child's treatment plan. The therapist may also provide short-term counseling and assistance, depending on the child's performance and level of intervention required. Phone contact and consultation may be provided as part of the intervention.*

      C2. ***Behavior Management Monitoring:*** *This service includes implementation of the behavior plan, monitoring the child's behavior, reinforcing implementation of the plan by parents or other caregivers and reporting to the behavior management therapist on implementation of the plan and progress toward behavioral objectives or performance goals. Phone contact and consultation may be provided as part of the intervention.*

d. ***In-Home Therapy Services—****This service is a therapeutic clinical intervention and ongoing training and therapeutic support, as follows:*

D1. The Therapeutic Clinical Intervention is a structured, consistent, therapeutic relationship between a licensed clinician and the child and family for the purpose of treating the child's mental health needs including improving the family's ability to provide effective support for the child to promote healthy functioning of the child within the family. The clinician develops a treatment plan and, using established psychotherapeutic techniques, works with the entire family or a subset of the family, to enhance problem-solving, limit-setting, communication, emotional support or other family or individual functions. The Therapeutic Clinical Intervention is provided by a qualified licensed clinician who will often work in a team that includes one or more qualified paraprofessionals.

D2. Ongoing Therapeutic Training and Support is a service provided by a paraprofessional to support implementation of the licensed clinician's treatment plan to achieve the goals of the treatment plan. The paraprofessional assists a licensed clinician in implementing the therapeutic objectives of the treatment plan designed to address the child's mental health and emotional challenges. This service includes teaching the child to understand, direct, interpret, manage and control feelings and emotional responses to situations, and to assist the family in supporting the child in addressing his or her emotional and mental health needs. Phone contact and consultation may be provided as part of the intervention.

e. ***Therapeutic Mentoring Services—****This service provides a structured, one-to-one mentoring relationship between a therapeutic mentor and a child or adolescent for the purpose of addressing daily living, social and communication needs. Each child or adolescent will have goals and objectives that are designed to support age-appropriate social functioning or ameliorate deficits in the child or adolescent's age-appropriate social functioning. These goals and objectives are developed by the child or adolescent, as appropriate, and his/her treatment team and are incorporated into the treatment plan. The service includes supporting, coaching and training the child or adolescent in age-appropriate behaviors, interpersonal communication, problem-solving and conflict resolution and relating appropriately to other children and adolescents, as well as adults, in recreational and social activities. The therapeutic mentor works with the child or adolescent in such settings as their home, school or social or recreational activities.*

D. Emergency Services Program (ESP)—*services provided through designated contracted ESPs, and which are available seven days per week, 24 hours per day to provide treatment of any individual who is experiencing a mental health crisis.*

1. ESP Encounter—*each 24-hour period an individual is receiving ESP Services. Each ESP Encounter shall include at a minimum: crisis assessment, intervention and stabilization.*

a. ***Assessment—****a face-to-face evaluation of an individual presenting with a behavioral health emergency, including assessment of the need for hospitalization, conducted by appropriate clinical personnel;*

b. ***Intervention—****the provision of psychotherapeutic and crisis counseling services to an individual for the purpose of stabilizing an emergency; and*

c. ***Stabilization—****short-term behavioral health treatment in a structured environment with continuous observation and supervision of individuals who do not require hospital level of care.*

In addition, medication evaluation and specialing services shall be provided if Medically Necessary.

2. ***Youth Mobile Crisis Intervention—****a short-term mobile, on-site, and face-to-face therapeutic service provided for youth experiencing a behavioral health crisis and for the purpose of identifying, assessing, treating, and stabilizing the situation and reducing the immediate risk of danger to the youth or others consistent with the youth's risk management/safety plan, if any. Mobile Crisis Intervention utilizes a multidisciplinary model, with both professional and paraprofessional staff. Services are available 24 hours a day, 7 days a week.*

E. ***Other Behavioral Health Services—****Behavioral Health Services that may be provided as part of treatment in more than one setting type.*

1. ***Electro-Convulsive Therapy (ECT)—****a therapeutic service which initiates seizure activity with an electric impulse while the individual is under anesthesia. It is administered in a facility that is licensed to provide this service by [the Department of Mental Health].*

2. ***Specialing—****therapeutic services provided to an Enrollee in a variety of 24-hour settings, on a one-to-one basis, to maintain the individual's safety.*

II. Behavioral Health Covered Services for Basic, Essential and Family Assistance Covered Individuals

A. ***Inpatient Services—****24-hour services, delivered in a licensed hospital setting, that provide clinical intervention for mental health or substance use diagnoses, or both.*

1. ***Inpatient Mental Health Services—****hospital services to evaluate and treat an acute psychiatric condition which 1) has a relatively sudden onset; 2) has a short, severe course; 3) poses a significant danger to self or others; or 4) has resulted in marked psychosocial dysfunction or grave mental disability.*

2. ***Inpatient Substance Use Disorder Services (Level IV)—****hospital services that provide a detoxification regimen of medically directed evaluation, care and treatment for psychoactive substance-abusing Covered Individuals in a medically managed setting.*

3. ***Observation/Holding Beds—****hospital services, for a period of up to 24 hours, in order to assess, stabilize, and identify appropriate resources for Covered Individuals.*

4. ***Administratively Necessary Day (AND) Services—****a day(s) of inpatient hospitalization provided to Covered Individuals when said Covered Individuals are clinically ready for discharge, but an appropriate setting is not available. Services shall include appropriate continuing clinical services.*

B. Diversionary Services—*those mental health and substance use disorder services that are provided as clinically appropriate alternatives to Behavioral Health Inpatient Services, or to support an Enrollee returning to the community following a 24-hour acute placement; or to provide intensive support to maintain functioning in the community. There are two categories of Diversionary Services, those provided in a 24-hour facility, and those which are provided in a non-24-hour setting or facility.*

1. 24-Hour Diversionary Services:

a. Community Crisis Stabilization—*services provided as an alternative to hospitalization, including short-term psychiatric treatment in structured, community-based therapeutic environments. Community Crisis Stabilization provides continuous 24-hour observation and supervision for Covered Individuals who do not require Inpatient Services.*

b. Community-Based Acute Treatment for Children and Adolescents (CBAT)—*mental health services provided in a staff-secure setting on a 24-hour basis, with sufficient clinical staffing to insure safety for the child or adolescent, while providing intensive therapeutic services including, but not limited to, daily medication monitoring; psychiatric assessment; nursing availability; Specialing (as needed); individual, group and family therapy; case management; family assessment and consultation; discharge planning; and psychological testing, as needed. This service may be used as an alternative to or transition from Inpatient services.*

c. Acute Treatment Services (ATS) for Substance Use Disorders (Level III.7)—*24-hour, seven days [a] week, medically monitored addiction treatment services that provide evaluation and withdrawal management. Detoxification services are delivered by nursing and counseling staff under a physician-approved protocol and physician-monitored procedures and include: bio-psychosocial assessment; individual and group counseling; psychoeducational groups; and discharge planning. Pregnant women receive specialized services to ensure substance use disorder treatment and obstetrical care. Covered Individuals with Co-occurring Disorders receive specialized services to ensure treatment for their co-occurring psychiatric conditions. These services may be provided in licensed freestanding or hospital-based programs.*

d. Clinical Support Services for Substance Use Disorders (Level III.5)—*24-hour treatment services, which can be used independently or following Acute Treatment Services for substance use disorders, and including intensive education and counseling regarding the nature of addiction and its consequences; outreach to families and significant others; and aftercare planning for individuals beginning to engage in recovery from addiction. Covered Individuals with Co-Occurring Disorders receive coordination of transportation and referrals to mental health providers to ensure treatment for their co-occurring psychiatric conditions. Pregnant women receive coordination of their obstetrical care.*

e. Transitional Care Unit (TCU)—*A community based therapeutic program offering high levels of supervision, structure and intensity of service within an unlocked setting. The program serves children and adolescents, under age 19, who are in the custody of the Department of Children and Families (DCF), who have been determined to need group care or foster care and no longer meet the clinical criteria for continued stay at an acute level of care. The TCU offers comprehensive services, including but not limited to, a therapeutic milieu, psychiatry, aggressive case management, and multidisciplinary, multi-modal therapies.*

2. Non-24-Hour Diversionary Services

a. Community Support Program (CSP)—*an array of services delivered by a community-based, mobile, multi-disciplinary team of professionals and paraprofessionals. These programs provide essential services to Covered Individuals with a long standing history of a psychiatric or substance use disorder and to their families, or to Covered Individuals who are at varying degrees of increased medical risk, or to children/adolescents who have behavioral health issues challenging their optimal level of functioning in the home/community setting. Services include outreach and supportive services, delivered in a community setting, which will vary with respect to hours, type and intensity of services depending on the changing needs of the Enrollee.*

b. Partial Hospitalization (PHP)—*an alternative to Inpatient Mental Health Services, PHP services offer short-term day mental health programming available seven days per week. These services consist of therapeutically intensive acute treatment within a stable therapeutic milieu and include daily psychiatric management.*

c. Psychiatric Day Treatment—*services which constitute a program of a planned combination of diagnostic, treatment and rehabilitative services provided to a person with mental illness who needs more active or inclusive treatment than is typically available through a weekly visit to a mental health center, individual Provider's office or hospital outpatient department, but who does not need 24-hour hospitalization.*

d. Structured Outpatient Addiction Program (SOAP)—*clinically intensive, structured day and/or evening substance use disorder services. These programs can be utilized as a transition service in the continuum of care for an Enrollee being discharged from Acute Substance Abuse Treatment, or can be utilized by individuals, who need Outpatient Services, but who also need more structured treatment for a substance use disorder. These programs may incorporate the evidence-based practice of Motivational Interviewing into clinical programming to promote individualized treatment planning. These programs may include specialized services and staffing for targeted populations including pregnant women, adolescents and adults requiring 24[-hour] monitoring.*

e. Program of Assertive Community Treatment (PACT) *shall mean a multi-disciplinary team approach to providing acute, active, ongoing, and long-term community-based psychiatric treatment, assertive outreach, rehabilitation and support. The program team provides assistance to Covered Individuals to maximize their recovery, ensure consumer-directed goal*

setting, assist individuals in gaining a sense of hope and empowerment, and provide assistance in helping the individuals served become better integrated into the community. Services are provided in the community and are available, as needed by the individual, 24 hours a day, seven days a week, 365 days a year.

f. Intensive Outpatient Program (IOP)—*a clinically intensive service designed to improve functional status, provide stabilization in the community, divert an admission to an Inpatient Service, or facilitate a rapid and stable reintegration into the community following a discharge from an inpatient service. The IOP provides time-limited, comprehensive, and coordinated multidisciplinary treatment.*

C. Outpatient Services—*mental health and substance use disorder services provided in person in an ambulatory care setting such as a mental health center or substance use disorder clinic, hospital outpatient department, community health center, or practitioner's office. The services may be provided at an Enrollee's home or school.*

1. Standard Outpatient Services—*those Outpatient Services most often provided in an ambulatory setting.*

a. Family Consultation—*a meeting of at least 15 minutes' duration, either in person or by telephone, with family members or others who are significant to the Enrollee and clinically relevant to an Enrollee's treatment to: identify and plan for additional services; coordinate a treatment plan; review the individual's progress; or revise the treatment plan, as required.*

b. Case Consultation—*an in-person or by telephone meeting of at least 15 minutes' duration, between the treating Provider and other behavioral health clinicians or the Enrollee's primary care physician, concerning an Enrollee who is a client of the Provider, to: identify and plan for additional services; coordinate a treatment plan; review the individual's progress; and revise the treatment plan, as required. Case Consultation shall not include clinical supervision or consultation with other clinicians within the same provider organization.*

c. Diagnostic Evaluation—*an assessment of an Enrollee's level of functioning, including physical, psychological, social, educational and environmental strengths and challenges for the purpose of diagnosis and designing a treatment plan.*

d. Dialectical Behavioral Therapy (DBT)—*a manual-directed outpatient treatment developed by Marsha Linehan, PhD, and her colleagues that combines strategies from behavioral, cognitive, and supportive psychotherapies for Covered Individuals with borderline personality disorder who also exhibit chronic, parasuicidal behaviors and adolescents who exhibit these symptoms. DBT may be used for other disorders if the Contractor determines that, based on available research, DBT is effective and meets the Contractor's criteria for determining medical necessity.*

e. Psychiatric Consultation on an Inpatient Medical Unit—*an in-person meeting of at least 15 minutes' duration between a psychiatrist or Advanced Practice Registered Nurse Clinical Specialist and an Enrollee at the request of*

the medical unit to assess the Enrollee's mental status and consult on a behavioral health or psychopharmacological plan with the medical staff on the unit.

f. ***Medication Visit—****an individual visit specifically for psychopharmacological evaluation, prescription, review, and/or monitoring by a psychiatrist or [Registered Nurse] Clinical Specialist for efficacy and side effects.*

g. ***Medication Administration—****the injection of intramuscular psychotherapeutic medication by qualified personnel.*

h. ***Couples/Family Treatment—****the use of psychotherapeutic and counseling techniques in the treatment of an Enrollee and his/her partner and/or family simultaneously in the same session.*

i. ***Group Treatment—****the use of psychotherapeutic or counseling techniques in the treatment of a group, most of whom are not related by blood, marriage, or legal guardianship.*

j. ***Individual Treatment—****the use of psychotherapeutic or counseling techniques in the treatment of an individual on a one-to-one basis.*

k. ***Inpatient-Outpatient Bridge Visit—****a single-session consultation conducted by an outpatient provider while an Enrollee remains on an Inpatient psychiatric unit. The Inpatient-Outpatient Bridge Visit involves the outpatient Provider meeting with the Enrollee and the inpatient team or designated inpatient treatment team clinician.*

l. ***Assessment for Safe and Appropriate Placement (ASAP)—****an assessment, required by [Massachusetts General Laws] 119 Sec. 33B, conducted by a diagnostician with specialized training and experience in the evaluation and treatment of sexually abusive youth or arsonists, to evaluate individuals who are in the care and custody of [the Department of Children and Families] and who have been adjudicated delinquent for a sexual offense or the commission of arson, or have admitted to such behavior, or are the subject of a documented or substantiated report of such behavior, and who are being discharged from Inpatient Psychiatric Unit or Hospital or Community-Based Acute Treatment for Children/Adolescents or Intensive Community Based Acute Treatment for Children/Adolescents to a family home care setting. Services are provided through a [Department of Children and Families] designated ASAP provider.*

m. ***Collateral Contact—****an in-person or by telephone conversation of at least 15 minutes' duration between a Provider and individuals who are involved in the care or treatment of an Enrollee under 21 years of age, including, but not limited to, school and day care personnel, state agency staff, and human services agency staff.*

n. ***Acupuncture Treatment—****the insertion of metal needles through the skin at certain points on the body, with or without the use of herbs, an electric current, heat to the needles or skin, or both, as an aid to persons who are withdrawing from dependence on substances or in recovery from addiction.*

o. Opioid Replacement Therapy—*medically monitored administration of methadone, Buprenorphine, or other U.S. Food and Drug Administration (FDA)–approved medications to opiate-addicted individuals, in conformance with FDA and Drug Enforcement Administration (DEA) regulations. This service combines medical and pharmacological interventions with counseling, educational and vocational services and is offered on a short-term (detoxification) and long-term (maintenance) basis.*

p. Ambulatory Detoxification (Level II.d)—*outpatient services for Members who are experiencing a serious episode of excessive substance use or withdrawal complications. Ambulatory Detoxification is provided under the direction of a physician and is designed to stabilize the Member's medical condition under circumstances where neither life nor significant bodily functions are threatened. The severity of the individual's symptoms will determine the setting, as well as the amount of nursing and physician supervision necessary during the course of treatment.*

q. Psychological Testing—*the use of standardized test instruments to assess a Covered Individual's cognitive, emotional, neuropsychological, verbal, and defensive functioning on the central assumption that individuals have identifiable and measurable differences that can be elicited by means of objective testing.*

r. Special Education Psychological Testing—*psychological, emotional or neuropsychological testing which is requested by school personnel responsible for initiating referrals for diagnosis and evaluation of children who qualify for special education programs pursuant to Mass. Gen. Law 71B, and which shall be utilized toward the development of an Individualized Educational Plan (IEP). Special Education Psychological Testing shall not be administered more than once a year unless new events have significantly affected the student's academic functioning.*

2. Intensive Home or Community-Based Services for Youth—*mental health and substance use disorder services provided to Covered Individuals in a community-based setting such as home, school, or community service agency. The services provided are more intensive than services that may be provided through a standard outpatient service.*

a. In-Home Therapy Services. *This service is a therapeutic clinical intervention and ongoing training and therapeutic support, as follows:*

A1. The Therapeutic Clinical Intervention is a structured, consistent, therapeutic relationship between a licensed clinician and the child and family for the purpose of treating the child's mental health needs including improving the family's ability to provide effective support for the child to promote healthy functioning of the child within the family. The clinician develops a treatment plan and, using established psychotherapeutic techniques, works with the entire family or a subset of the family, to enhance problem-solving, limit-setting, communication, emotional support or other family or individual functions. The Therapeutic Clinical Intervention is provided by a qualified licensed clinician who will often work in a team that includes one or more qualified paraprofessionals.

A2. Ongoing Therapeutic Training and Support is a service provided by a paraprofessional to support implementation of the licensed clinician's treatment plan to achieve the goals of the treatment plan. The paraprofessional assists a licensed clinician in implementing the therapeutic objectives of the treatment plan designed to address the child's mental health and emotional challenges. This service includes teaching the child to understand, direct, interpret, manage and control feelings and emotional responses to situations, and to assist the family in supporting the child in addressing his or her emotional and mental health needs. Phone contact and consultation may be provided as part of the intervention.

D. Emergency Services Program (ESP)—*services provided through designated contracted ESPs, and which are available seven days per week, 24 hours per day to provide treatment of any individual who is experiencing a mental health crisis.*

1. ESP Encounter—*each 24-hour period an individual is receiving ESP Services. Each ESP Encounter shall include at a minimum: crisis assessment, intervention and stabilization.*

a. Assessment—*a face-to-face evaluation of an individual presenting with a behavioral health emergency, including assessment of the need for hospitalization, conducted by appropriate clinical personnel;*

b. Intervention—*the provision of psychotherapeutic and crisis counseling services to an individual for the purpose of stabilizing an emergency; and*

c. Stabilization—*short-term behavioral health treatment in a structured environment with continuous observation and supervision of individuals who do not require hospital level of care.*

In addition, medication evaluation and specialing services shall be provided if Medically Necessary.

2. Youth Mobile Crisis Intervention—*a short term mobile, on-site, and face-to-face therapeutic service provided for youth experiencing a behavioral health crisis and for the purpose of identifying, assessing, treating, and stabilizing the situation and reducing the immediate risk of danger to the youth or others consistent with the youth's risk management/safety plan, if any. Mobile Crisis Intervention utilizes a multidisciplinary model, with both professional and paraprofessional staff. Services are available 24 hours a day, 7 days a week.*

E. Other Behavioral Health Services—*Behavioral Health Services that may be provided as part of treatment in more than one setting type.*

1. Electro-Convulsive Therapy (ECT)—*a therapeutic service which initiates seizure activity with an electric impulse while the individual is under anesthesia. It is administered in a facility that is licensed to provide this service by [the Department of Mental Health].*

2. Specialing—*therapeutic services provided to an Enrollee in a variety of 24-hour settings, on a one-to-one basis, to maintain the individual's safety.*

III. ESP Services for Uninsured Individuals and Persons Covered by Medicare Only

The Contractor shall deliver the following Medically Necessary Services to Uninsured Individuals and persons covered by Medicare only:

Emergency Services Program (ESP) Services—*services that are provided through designated contracted ESPs, and which are available seven days per week, 24 hours per day to provide treatment of any individual who is an Uninsured Individual or an individual insured by Medicare only and is experiencing a mental health crisis.*

1. ***ESP Encounter*** *shall mean each 24-hour period an individual is receiving ESP Services. Each ESP Encounter shall include, at a minimum: Crisis Assessment, Intervention, and Stabilization.*

    a. ***Crisis Assessment:*** *a face-to-face evaluation of an individual presenting with a Behavioral Health emergency, including assessment of the need for hospitalization, conducted by appropriate clinical personnel;*

    b. ***Intervention:*** *the provision of psychotherapeutic and crisis counseling services to an individual for the purpose of stabilizing an emergency;*

    c. ***Stabilization:*** *short-term Behavioral Health treatment in a structured environment with continuous observation and supervision of individuals who do not require a hospital Level of Care.*

    In addition, medication evaluation and specialing services shall be provided if medically necessary.

2. ***Youth Mobile Crisis Intervention*** *shall mean a short-term, mobile, on-site, and face-to-face therapeutic service provided for youth experiencing a Behavioral Health crisis and for the purpose of identifying, assessing, treating, and stabilizing the situation and reducing the immediate risk of danger to the youth or others consistent with the youth's risk management/safety plan, if any. Such services are available 24 hours a day, seven days a week.*