



# Massachusetts Medicaid Supplemental Clinical Criteria

Policy Number: BH803MA122024  
Effective Date: December, 2024

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## Introduction & Instructions for Use

### Introduction

The following State or Contract Specific Clinical Criteria defined by state regulations or contractual requirements are used to make medical necessity determinations, mandated for members of behavioral health plans managed by Optum and U.S. Behavioral Health Plan, California (doing business as Optum Health Behavioral Solutions of California (“Optum-CA”)).

Other Clinical Criteria may apply when making behavioral health medical necessity determinations for members of behavioral health plans managed by Optum®. These may be externally developed by independent third parties used in conjunction with or in place of these Clinical Criteria when required, or when state or contractual requirements are absent for certain covered services.

### Instructions for Use

When deciding coverage, the member’s specific benefits must be referenced. All reviewers must first identify member eligibility, the member-specific benefit plan coverage, and any federal or state regulatory requirements that supersede the member’s benefits prior to using these Clinical Criteria. In the event that the requested service or procedure is limited or excluded from the benefit, is defined differently or there is otherwise a conflict between this Clinical Criteria and the member’s specific benefit, the member’s specific benefit supersedes these Clinical Criteria.

These Clinical Criteria are provided for informational purposes and do not constitute medical advice.

**Autism spectrum disorders (ASD)** are a group of neurodevelopmental disorders characterized by difficulties in social interaction, impaired communication (both verbal and nonverbal), and repetitive, restrictive behaviors that present in early childhood. ASD has heterogeneous etiology and comorbidities. Diagnostic criteria and nomenclature for these disorders has changed over the years and, while the current terminology in the Diagnostic and Statistical Manual 5 (DSM 5) uses a single category called Autism Spectrum Disorders, previous versions divided this into multiple subcategories.

**Applied Behavior Analysis (ABA)** services are defined according to the Behavior Analyst Certification Board as the following:

“ABA is a well-developed scientific discipline among the helping professions that focuses on the analysis, design, implementation, and evaluation of social and other environmental modifications to produce meaningful changes in human behavior. ABA includes the use of direct observation, measurement, and functional analysis of the relations between environment and behavior. ABA uses changes in environmental events, including antecedent stimuli and consequences, to produce practical and significant changes in behavior.”

ABA is a service that includes behavioral assessments; interpretation of behavior analytic data; development of a highly specific treatment plan; supervision and coordination of interventions; and training other interveners, including caregivers, to address specific objectives or performance goals in order to treat behaviors that interfere with the Member’s successful functioning. ABA is delivered by one or more members of a credentialed team of qualified professionals consisting of a Licensed Applied Behavior Analyst (LABA) and a Behavior Technician.

The Licensed Applied Behavior Analyst (LABA) team member is expected to complete a behavioral assessment (including observing the Member’s behavior, antecedents of behaviors, and identification of motivators); develop a highly specific behavior treatment plan; supervise and coordinate interventions; and train other interveners, including caregivers, to address specific behavioral objectives or achieve specific performance goals. This role is designed to treat behaviors that interfere with the Member’s successful functioning. The LABA develops specific behavioral objectives and interventions that are designed to develop adaptive skills and diminish, extinguish, or improve specific behaviors related to the Member’s behavioral health condition(s) and which are incorporated into the behavior management treatment plan and the risk management/safety plan.

The Behavior Technician team member’s role includes implementation of the treatment plan, monitoring the Member’s behavior, reinforcing implementation of the treatment plan by the caregiver(s)/guardian(s), and reporting to the LABA on implementation of the treatment plan and progress or challenges towards behavioral objectives or performance goals.

Types of ABA include, but are not limited to, discrete trial training, verbal behavioral intervention, and pivot response training. Parental and caregiver involvement in the process and continued use of the strategies outside of the formal sessions is important for the success of the treatment in the long-term.

ABA services are delivered through a team-based approach composed of a Licensed Applied Behavior Analyst (LABA) and Behavior Technicians. Individual ABA treatment plans are developed by the LABA. One-on-one sessions are typically provided by Behavior Technicians, with services ranging in hours of Member contact per week based on the severity of symptoms and intensity of treatment. The Behavior Technicians are supervised by LABAs.

ABA services covered under a health benefit plan are delivered by a contracted and credentialed provider in a variety of settings, such as home or in the community. ABA services can occur in any number of settings, including home, communities and as appropriate, ABA provider sites. Members can receive services in emergency departments or on medical surgical floors as appropriate. Services provided in a school setting are distinct and separate from those covered by the health plan and are typically covered by the educational system’s special education resources as part of an Individual Education Plan (IEP) pursuant to Public Law 94-142.

ABA is an intensive treatment program designed to address behavior as defined in the admission criteria below.

## Admission Criteria

- The member has a diagnosis of Autism Spectrum Disorder (DSM-5) and is under the age of 21.
- The Member’s Autism Spectrum Disorder diagnosis is made by a licensed physician (i.e. PCP, etc.), advanced practice registered nurse, physician's assistant, or psychologist experienced in the diagnosis and treatment of autism with developmental and child/adolescent expertise.
- The diagnosis is accompanied by documentation of the evidence used to make the diagnosis. The evidence may be gathered by a multidisciplinary team to assist in the diagnostic process.

- The Member exhibits behaviors related to their diagnosis of Autism Spectrum Disorder that significantly interfere with daily activities and successful functioning;
- The initial evaluation from a Licensed Applied Behavior Analyst supports the request for the ABA services; and
- Required consent for admission is obtained from the Member's guardian.

## Continuing Stay Criteria

- All of the following criteria are necessary for continued treatment at this level of care:
  - The Member's condition continues to meet admission criteria for ABA, either due to the continuation of presenting problems or the appearance of new problem(s) or symptoms
  - A formal comprehensive evaluation is completed by the ABA team within the first 4-6 week assessment period and includes:
    - complete medical history to include pre- and perinatal, medical, developmental, family, and social elements;
    - record of physical examination obtained from a licensed physician or advanced practice provider (i.e. nurse practitioner or physician assistant) which may include items such as growth parameters, head circumference, and a neurologic examination;
    - detailed behavioral and functional evaluation outlining the behaviors consistent with the diagnosis of Autism Spectrum Disorder and its associated comorbidities. The evaluation must include direct and indirect observation and formal and informal assessments;
    - confirmation of medical screening(s) and test(s) to identify the etiology of the disorder, rule out treatable causes, and identify associated comorbidities as indicated; and
    - complete Member document review to include collaboration with school, state agencies, physical health practitioners (i.e. PCPs and prescribing clinicians), any outpatient or home- or community-based behavioral health services, former treatment teams or other entities that may impact the Member's treatment
  - The treatment plan is individualized and appropriate to the Member's changing condition with realistic and specific goals and objectives stated.
  - The treatment plan is updated on a regular frequency based on treatment progress as indicated in review of treatment plans and updated comprehensive assessments as necessary, including the addition of new target behaviors.
  - The Member's progress is monitored regularly and appropriately documented by behavioral graphs, progress notes, and daily session notes. The Member's treatment plan is to be modified if there is no measurable progress toward decreasing the frequency, intensity and/or duration of the targeted behaviors or there is no measurable increase in skills for skill acquisition to achieve targeted goals and objectives.
  - There is reasonable expectation that the Member will benefit from the continuation of ABA services.
  - There is documented skills transfer to the Member and treatment transition planning from the beginning of treatment.
  - There is documented coordination of care with relevant providers/caretakers, etc., when appropriate and inclusive of community-based, prosocial, natural supports for Member and caregiver. If coordination is not successful, the reasons are documented.
  - Caregiver(s) and/or guardian(s) involvement in the training of behavioral techniques must be documented in the Member's medical record and is critical to the generalization of treatment goals to the Member's environment. This includes demonstration of how operational control is being transferred to caregivers.
  - Services are not duplicative of services that are part of an Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) when applicable.
  - Treatment intensity does not exceed the Member's functional ability to participate.
  - Treatment occurs in the setting(s) where target behaviors and skill deficits are occurring and/or where treatment is likely to have an impact on target behaviors.
  - Hours per week requested are not more than what is required to achieve the goals listed in the treatment plan and reflect the Member's, caregiver's, and provider's ability to participate in treatment unless documented as such.

## Discharge Criteria

- Any of the following criteria are sufficient for discharge from this level of care:
  - A Member's individual treatment plan and goals have been met.
  - The Member has achieved adequate stabilization of behavior(s) as defined in the admission criteria, and less intensive modes of treatment are appropriate and indicated.
  - The Member no longer meets admission criteria, or the Member meets criteria for less intensive or more intensive services.

- The Member and caregiver/guardian are not engaged in treatment. Despite multiple, documented attempts to address engagement, the lack of engagement is of such a degree that it implies withdrawn consent or treatment at this level of care becomes ineffective or unsafe.
- The Member is placed in a skilled nursing facility, psychiatric residential treatment facility, or other residential treatment setting and is not ready for discharge to a family home environment or a community setting with community-based supports.
- Required consent for treatment is withdrawn.
- Treatment is making the symptoms persistently worse.
- The Member is not making progress toward treatment goals, as demonstrated by the absence of any documented meaningful (i.e., durable and generalized) measurable improvement or stabilization of behavior(s) as defined in the admission criteria, and there is no reasonable expectation of progress.

## Exclusions/Limitations

- Any of the following criteria are sufficient for exclusion from this level of care:
  - Required consent from the Member's guardian is not obtained.
  - The Member is placed in a skilled nursing facility, psychiatric residential treatment facility, or other residential treatment setting and is not ready for discharge to a family home environment or a community setting with community-based supports.
  - The Member is receiving ongoing In-Home Behavioral Services or services similar to ABA.
  - The ABA services are primarily for school or educational purposes.
- The following services are not included within the ABA treatment process:
  - Vocational rehabilitation;
  - Supportive respite care;
  - Recreational therapy;
  - Respite care; and
  - When not part of the Member's documented treatment plan addressing specific behavioral goals:
    - Accompanying the Member to appointments or activities outside of the home (e.g. recreational activities, eating out, play activities); or
    - Transporting the Member in lieu of caregiver/guardian.

## Service Delivery

- Providers of ABA are outpatient hospitals, community health centers, community mental health centers community behavioral health centers (CBHC's), other clinics, and private agencies/individuals.
- ABA services must be delivered by a provider with demonstrated infrastructure to support and ensure:
  - Quality management and assurance;
  - Utilization management;
  - Electronic data collection/IT;
  - Clinical or psychiatric expertise; and
  - Cultural and linguistic competence.
- ABA services provided by the LABA and Behavior Technician include, but are not limited to, the following:
  - Licensed Applied Behavior Analyst (LABA):
    - Completes a written functional behavior assessment;
    - Functional Behavior Assessment: a descriptive and systematic behavioral assessment, including functional analyses, and behavior analytic interpretations of the results. In certain instances, in which a severe behavior is present, this may also involve a functional analysis for safe testing in a controlled environment.
    - Documents observations of the Member in the home and community;
    - Designs and supervises behavior analytic interventions;
    - Conducts structured interviews with the Member, family, and any identified collaterals about the Member's behavior(s);
    - Develops a focused treatment plan that identifies specific and measurable objectives or performance goals and interventions (e.g., skills training, reinforcement systems, removal of triggering stimuli, graduated exposure to triggering stimuli, etc.) that are designed to diminish, extinguish, or improve specific behaviors related to a Member's mental health condition(s);



- Develops specific objectives and interventions that are incorporated into the Member's new or existing risk management/safety plan;
- Engages caregiver(s)/guardian(s) in caregiver training, unless contraindicated or the caregiver/guardian declines.
- Works closely with the Behavior Technician to ensure the treatment plans and risk management/safety plans are implemented as developed and to make any necessary adjustments to the plan; and
- Supervises the work of those implementing behavior analytic interventions.
- Behavior Technician:
  - Monitors the Member's progress on implementation of the goals of the treatment plan developed by the LABA;
  - Provides coaching, support, and guidance to the caregiver/guardian in implementing the treatment plan;
  - Collects data and conducts certain types of assessments (e.g., stimulus preference assessments);
  - Works closely with the LABA to ensure the treatment plan and risk management/safety plan are implemented as developed and reports to the LABA if the Member is not achieving the goals and objectives set forth in the treatment plan, so that necessary modification can be made by the LABA;
  - Assists the Member in implementing the goals of the treatment plan developed by the LABA; and
  - Directly implements skill-acquisition and behavior-reduction plans developed by the LABA.
- LABA Supervision must be delivered to the Behavior Technician-level staff during direct service with Member with a minimum of one hour of case supervision for every 10 hours of direct service.
- The ABA provider must provide services in a clinically appropriate manner and be focused on the Member's behavioral and functional outcomes.
- The ABA provider develops and maintains policies and procedures relating to all components of ABA services. The ABA provider will ensure that all new and existing staff will be trained on these policies and procedures.
- The ABA provider delivers these services in the Member's home and community. In certain cases, clinic-based services may also be authorized if clinically appropriate. Rationale for chosen location of services must include consideration of the Member and caregivers' ability to engage in ABA services and must be documented.
- The ABA provider may deliver services to the Member and their family 7 days a week, 365 days per year.
- The ABA provider may deliver services and consultation via a HIPAA-compliant telehealth platform at the caregiver's request and if the service can be effectively delivered via telehealth as part of the intervention when appropriate. Rationale for telehealth service delivery must be documented.
- The ABA provider works collaboratively with schools, state agencies, physical health practitioners (i.e. PCPs and prescribing clinicians), any outpatient or home or community-based behavioral health services, Community Behavioral Health Centers (CBHCs) and other entities that may impact the Member's treatment plan including former treatment teams, subject to required consent.

## Staffing Requirements

- This service is to be provided by a staff team, including a Licensed Applied Behavioral Analyst and Behavior Technician unless clinically indicated otherwise.
- The minimum staff qualifications for each are as follows:
  - Licensed Applied Behavior Analyst:
    - Licensed as an applied behavior analyst
  - Behavior Technician:
    - Works under the direct supervision of a Licensed Applied Behavior Analyst meeting the above criteria;
    - Is 18 years of age or older; and
    - Must have:
      - A high school diploma or a general education development (GED) and have 12 months experience working with persons with developmental disabilities, children, adolescents, transitional age youth, or families; or
      - An associate's degree in either a human, social, or educational services discipline, or a degree or certification related to behavior management, from an accredited community college or educational institution and have six months experience working with persons with developmental disabilities, children, adolescents, transition age youth, or families;
      - Certification as a Registered Behavior Technician (RBT) by the Behavior Analyst Certification Board and have three months experience working with persons with developmental disabilities, children, adolescents, transitional age youth, or families.
- Staff cannot have a pre-existing non-clinical relationship to the Member receiving services.

- The ABA provider ensures that LABA staff are trained in principles of ABA. The ABA provider also ensures that all ABA staff complete training, upon employment and annually thereafter, inclusive of the following topics:
  - Overview of the clinical and psychosocial needs of the target population;
  - Systems of care principles and philosophy;
  - Ethnic, cultural, and linguistic considerations of the community;
  - Community resources and services;
  - Family-centered practice;
  - Behavior management coaching;
  - Social skills training;
  - Psychotropic medications and possible side effects;
  - Risk management/safety plans;
  - Crisis management;
  - Introduction to child-serving systems and processes (DCF, DYS, DMH, DDS, DESE, etc.);
  - Basic IEP and special education information;
  - Managed care entities' performance specifications and medical necessity criteria;
  - Overview of child/adolescent development including substance use and sexuality;
  - Conflict resolution.
- The ABA provider ensures that LABA staff provide adequate supervision to all Behavior Technicians staff and/or interns.

### **Service, Community, and Collateral Linkages**

- The ABA provider works collaboratively with the family and any existing providers (i.e., behavioral health, physical health, local education authority) to implement the Member's goals and objectives. To promote safety planning and/or in the event of an emergency, the ABA provider engages the CBHC/MCI team and supports the MCI team to implement efficacious intervention.
- The ABA provider participates in all service and care planning and coordination with agencies on behalf of, and in collaboration with, the Member's family. If the Member is admitted to an out-of-home, 24-hour level of care, the ABA provider is responsible for collaborating and supporting with bridging successful interventions and assisting with placement discharge planning.
- The ABA provider must coordinate the treatment plan with the Member's Individualized Education Program/Individualized Family Service Plan (IEP/IFSP) as appropriate.

### **Quality Management**

- The ABA provider attends meetings as required and participates in quality management activities that include fidelity monitoring.
- The ABA provider will develop and maintain a quality management plan that is consistent and that utilizes appropriate measures to monitor, measure, and improve the activities and services it provides.
- The ABA provider will engage in a continuous quality improvement process, and will include specific outcome measures and satisfaction surveys, to measure and improve the quality of care and service delivered to Members, including caregivers and Members' families.
- The ABA provider will provide clinical outcomes data upon request, which must be consistent with performance standards of this service.

### **Process Specifications**

- Assessment, Treatment Planning, and Documentation
  - Fourteen calendar days from referral is the Medicaid standard for the timely provision for services established in accordance with 42 CFR 441.56(e). The 14-day standard begins from the time at which the family has been contacted following referral regarding treatment, or if at point of authorization for onset of services if authorization is required.
  - The ABA provider will make best efforts to initiate services as soon as possible based on the clinical needs of the Member.
  - The ABA Provider must maintain a waitlist if unable to initiate services within 14 days of receipt of authorization, or if authorization is not required, within 14 days of initial contact with the family.
    - If a Member is placed on a waitlist, ABA providers will offer caregivers contact information for alternative providers in the region who are accepting new clients; and

- ABA providers will refer the Member to their local Community Behavioral Health Center (CBHC), Behavioral Health Help Line (BHHL) and/or Managed Care Entity to request assistance in accessing care.
- Following initial assessment authorization, the ABA provider will ensure there is no delay in start of services.
- Once an initial authorization is approved, the ABA provider will, within 2 business days, offer a face-to-face interview with the Member's family.
- The LABA completes a written formal comprehensive assessment, inclusive of a functional behavior assessment, which supports the need for ABA. The assessment is completed within the first 6-week assessment period and updated every 6 months or if the Member's presentation changes. The assessment must include a comprehensive history of the Member with input from caregiver/family, direct observations and evaluations of the Member, and collateral information from the Member's school (if in school), PCP, and other members of the Member's treatment team, that includes:
  - complete medical history to include pre- and perinatal, medical, developmental, family, and social elements;
  - record of physical examination obtained from licensed physician or advanced practice provider
  - confirmation of medical screening(s) and test(s) to identify the etiology of the disorder, rule out treatable causes, and identify associated comorbidities as indicated;
  - detailed behavioral and functional evaluation outlining the behaviors consistent with the diagnosis of Autism Spectrum Disorder and the rationale for ABA treatment;
  - detailed description of the Member's behavioral targets for ABA (behaviors must be interfering with daily functioning or developmental progression), including a comprehensive treatment plan for each behavioral target that includes:
    - Specific ABA methods to be employed
    - Outcome measures to be tracked, including Member and caregiver's-reported outcome measures, and goals for each measure during a 6-month intervention period
    - Intensity and nature of services being proposed during the 6-month intervention period, including rationale, and broken down by:
      - Behavior Technician vs. LABA hours
      - Individual therapy vs. family/caregiver training
      - Home vs. Center-based
    - Plan for supporting the caregiver/family, including how to help translate gains made in Member's individual therapy to the family system; and
    - Plan for coordinating ABA treatment plan with school (if the Member is in school), PCP, and other treaters.
      - Coordination with PCP must include a review of the Member's medical history to understand behavioral response to medical needs and;
      - Staff must interview caregiver about Member's response to any acute medical/dental needs.
- When requesting services, the ABA provider must coordinate the treatment plan with the Member's Individualized Education Program/Individualized Family Service Plan (IEP/IFSP) as appropriate.
- Every 6 months, in order to show continued need for ABA services, the ABA team must complete a treatment progress evaluation, which includes:
  - A review of progress on the treatment plan goals for each of the behavioral targets during the previous 6 months; and
  - A comprehensive treatment plan for the next 6 months, including all elements described above, and the following elements for each behavioral target failing to meet measurable (i.e. decrease or increase in frequency, intensity, or duration of problematic or positive skill building behaviors, respectively) and meaningful (i.e. durable and generalized) progress during the previous 6 months:
    - Changes to treatment plan, including change in proportion of LABA-provided hours and/or family-targeted interventions; and
    - Rationale for ongoing ABA treatment, including alternative treatment options considered.
- The treatment plan is individualized and includes objectives that are specific, measurable, and tailored to the Member. Interventions emphasize the elimination of risk-related behaviors and generalization of skill. Interventions should focus on the development of spontaneous social communication, adaptive skills, and appropriate behaviors and include a focus that:
  - Targets specific behaviors to increase or decrease (including frequency, rate, symptom intensity, duration);
  - Incorporates objective baseline and quantifiable progress measures; and
  - Describes detailed behavioral interventions, reinforcers, and strategies for generalization of skills beyond the ABA sessions.

- Specific and measurable caregiver goals for training and support are included in the treatment plan with documented plans that skills transfer to the caregiver will occur. If caregivers/guardians decline or are unable to participate in caregiver training, a generalization plan must be created to address Member's skill generalization across environments and people.
  - Treatment plan must include at least two specific and measurable caregiver/guardian treatment goals, and must provide instruction for the caregiver/guardian on how to implement strategies identified in the behavior management plan; Caregiver training hours must increase if the Member's goals address activities of daily living, as a ABA provider plans for transition to lower level of care within the next 6 months or, as the Member approaches one year of termination of benefits based on benefit coverage.
  - Group caregiver training must align with a prescribed curriculum and corresponding goals.
  - Treatment notes must indicate progress across identified goals within caregiver training and group caregiver training settings.
- The treatment plan must address some of the following domains as appropriate for the Member: cognitive functioning, safety skills, social skills, play and leisure skills, community integration, vocational skills, coping and tolerance skills, adaptive and self-help skills, language and communication, attending and social referencing, and reduction of interfering or inappropriate behaviors.
- For social skills group, service may be delivered by a Behavior Technician. The LABA will develop a structured social skills program which addresses individual needs, documents the curriculum being used, and maintains treatment notes that indicate progress for the Member in a group setting.
- There is documented active coordination of care with schools, state agencies, physical health practitioners (i.e. PCP and prescribing clinicians), any outpatient or home or community based behavioral health services, CBHCs and other entities that may impact the Member's treatment plan, subject to required consent. If coordination is not successful, the reasons are documented, and efforts to coordinate care continue.
- The ABA provider ensures that all services are provided in a professional manner, ensuring privacy, safety, and respect for the family's individuality and choice.
- The LABA and Behavior Technician document each contact in a progress report or notes in the ABA provider's file for the Member.
- The LABA provides the agency's after-hours emergency contact information and procedures to the caregiver/guardian. At a minimum, after-hours access includes support with the Member's treatment plan or linkage to Mobile Crisis Intervention. A voicemail directing families to 911 or the emergency department is not sufficient for this requirement.

### **Discharge Planning and Documentation**

- There is documented active discharge planning from the beginning of treatment.
- A discharge planning meeting is scheduled whenever the ABA provider and family determine that the Member has met their goals and no longer needs the service; the family no longer wants the service; or the Member no longer meets the medical necessity criteria for ABA therapy.
- The reasons for discharge and all behavior management treatment and discharge plans are clearly documented in the record.
- The LABA develops an up-to-date copy of the treatment plan, which is given to the caregiver/guardian on the last date of service and to all current providers within seven days of the last date of service.
- If an unplanned termination of services occurs, the ABA provider makes every effort to contact the caregiver/guardian to obtain their participation in ABA and to provide assistance for appropriate follow-up plans (i.e., schedule another appointment, facilitate a clinically appropriate service termination, or provide appropriate referrals). Such activity is documented in the record.

## **Children's Behavioral Health Initiative Services (CBHI)**

The Children's Behavioral Health Initiative (CBHI) is an interagency undertaking whose mission is to strengthen, expand and integrate behavioral health services for children.

Mental health and substance use disorder services provided to (MassHealth) youth members up to age 21 in a community-based setting such as home, school, or community. (e.g., CBHI Services):

- Family Support & Training (FS&T)
- In-Home Behavioral Services (IHBS)



- In-Home Therapy (IHT)
- Intensive Care Coordination (ICC)
- Intensive Hospitalization Diversion (IHD)
- Mobile Crisis Intervention (MCI)
- Therapeutic Mentoring (TM)

## CBHI: Family Support and Training

Family Support and Training A service provided to a parent or other caregiver of a child to improve the capacity of the parent or caregiver to ameliorate or resolve the child's emotional or behavioral needs and to parent; provided, however, that such service shall be provided where the child resides, including in the child's home, a foster home, a therapeutic foster home, or another community setting.

Services may include education, assistance in navigating the child serving systems (DCF, education, mental health, juvenile justice, etc.); fostering empowerment, including linkages to peer/parent support and self-help groups; assistance in identifying formal and community resources (e.g., after-school programs, food assistance, summer camps, etc.); and support, coaching, and training for the parent/caregiver.

### Admission Criteria

- A comprehensive behavioral health assessment inclusive of the MA Child and Adolescent Needs and Strengths (CANS) indicates that the member's clinical condition warrants this service in order to improve the capacity of the parent/caregiver in ameliorating or resolving the member's emotional or behavioral needs and strengthen the parent/caregiver's capacity to parent so as to successfully support the member in the home or community setting.
- The parent/caregiver requires education, support, coaching, and guidance to improve their capacity to parent in order to ameliorate or resolve the member's emotional or behavioral needs so as to improve the member's functioning as identified in the outpatient or In-Home Therapy treatment plan/ICP, for those members enrolled in ICC, and to support the member in the community.
- Outpatient services alone are not sufficient to meet the parent/caregiver's needs for coaching, support, and education.
- The parent/caregiver gives consent and agrees to participate.
- A goal identified in the member's outpatient or In-Home Therapy treatment plan or ICP, for those enrolled in ICC, with objective outcome measures pertains to the development of the parent/caregiver capacity to parent the member in the home or community.
- The member resides with or has current plan to return to the identified parent/caregiver.

### Continuing Stay Criteria

- The parent/caregiver continues to need support to improve his/her capacity to parent in order to ameliorate or resolve the member's emotional or behavioral needs as identified in the outpatient or In-Home Therapy treatment plan/ICP, for those members enrolled in ICC, and to support the member in the community.
- Care is rendered in a clinically appropriate manner and focused on the parent/caregiver's need for support, guidance, and coaching.
- All services and supports are structured to achieve goals in the most time efficient manner possible.
- For members in ICC, with required consent, informal and formal supports of the parent/caregiver are actively involved on the member's team.
- With required consent, there is evidence of active coordination of care with the member's care coordinator (if involved in ICC) and/or other services and state agencies.
- Progress in relation to specific behavior, symptoms, or impairments is evident and can be described in objective terms, but goals have not yet been achieved, or adjustments in the treatment plan/ICP to address lack of progress are evident.\

### Discharge Criteria

- The parent/caregiver no longer needs this level of one-to-one support and is actively utilizing other formal and/or informal support networks.
- The member's treatment plan/ICP indicates the goals and objectives for Family Support and Training have been substantially met.

- The parent/caregiver is not engaged in the service. The lack of engagement is of such a degree that this type of support becomes ineffective or unsafe, despite multiple, documented attempts to address engagement issues.
- The parent/guardian/caregiver withdraws consent for treatment.

### Exclusions/Limitations

- There is impairment with no reasonable expectation of progress toward identified treatment goals for this service.
- There is no indication of need for this service to ameliorate or resolve the member's emotional needs or to support the member in the community.
- The environment in which the service takes place presents a serious safety risk to the Family Support and Training Partner making visits, alternative community settings are not likely to ameliorate the risk and no other safe venue is available or appropriate for this service.
- The member is placed in a residential treatment setting with no current plans to return to the home setting.
- The member is in an independent living situation and is not in the family's home or returning to a family setting.
- The service needs identified in the treatment plan/ICP are being fully met by similar services from the same or any other agency.

## CBHI: In-Home Behavioral Services

- In-Home Behavioral Services: IHBS services is a combination of Behavior Management Therapy and Behavior Management Monitoring, and such services are provided where the member resides, including in the member's home, a foster home, a therapeutic foster home, or another community setting. Components of IHBS include:
  - Behavior Management Therapy: Addresses challenging behaviors that interfere with a member's successful functioning. Services include assessment, development of a behavior plan and supervision and coordination of interventions to address specific behavioral objectives. Development of a crisis-response strategy and short-term counseling and assistance may also be provided.
  - Behavior Management Monitoring: Is the monitoring of a member's behavior, the implementation of a behavior plan and reinforcing implementation of a behavior plan by the member's parent or other caregiver.
- For member engaged in Intensive Care Coordination (ICC), the Behavior Plan is designed to achieve a goal(s) identified in the member's Individual Care Plan (ICP). The Care Planning Team (CPT) works closely with the member, parent/guardian/caregiver and/or other individual(s) identified by the family to support adherence to the behavior plan and to sustain the gains made.

### Admission Criteria

- A comprehensive behavioral health assessment inclusive of a Functional Behavioral Assessment indicates that the member's clinical condition warrants this service in order to diminish, extinguish, or improve specific behaviors related to the member's behavioral health condition(s). If the Member has MassHealth as a secondary insurance and is being referred to services by a provider who is paid through the Member's primary insurance, the provider must conduct a comprehensive behavioral health assessment.
- Alternative behavioral health interventions have not been successful in reducing or eliminating the problem behaviors or increasing/maintaining desirable behaviors.
- A clinical evaluation suggest that the member's clinical condition, level of functioning, and intensity of need require the structure and positive behavioral supports to be applied consistently across home and school settings and warrant this level of care to successfully support the member in the home and community.
- Required consent is obtained.

### Continued Stay Criteria

- The member's clinical condition(s) continues to warrant In-Home Behavioral Services in order to maintain him/her in the community and continue progress toward goals established in the behavior plan.
- The member is actively participating in the plan of care and treatment to the extent possible consistent with his/her condition.
- With consent, the parent/guardian/caregiver, and/or natural supports are actively involved in the treatment as required by the behavior plan, or there are active efforts being made and documented to involve them.

## Discharge Criteria

- The member no longer meets admission criteria for this level of care or meets criteria for a less or more intensive level of care.
- The member's behavior plan goals and objectives have been substantially met, and continued services are not necessary to prevent the worsening of the member's behavior.
- The member and/or parent/guardian/caregiver are not engaged in treatment. The lack of engagement is of such a degree that treatment at this level of care becomes ineffective or unsafe, despite multiple, documented attempts to address engagement issues.
- The member is not making progress toward goals and objectives in the behavior plan, and there is no reasonable expectation of progress at this level of care, nor is it required to maintain the current level of functioning.
- Consent for treatment is withdrawn.

## Service Delivery

- Evaluation and service planning is member and family centered.
- The member and family/caregivers are actively being engaged in services.
- The provider helps the member and family/caregivers:
  - Identify the goals of the member and family throughout the treatment process;
  - Monitor the progress of the member toward achievement of the goals; and
  - Monitor the progress of the family toward achievement of the goals.
- The provider collaborates with other programs in planning service delivery.

## Exclusions/Limitations

- The environment in which the service takes place presents a serious safety risk to the behavior management therapist or monitor, alternative community settings are not likely to ameliorate the risk, and no other safe venue is available or appropriate for this service.
- The member is at imminent risk to harm self or others, or sufficient impairment exists that requires a more-intensive level of care beyond a community-based intervention.
- The member has medical conditions or impairments that would prevent beneficial utilization of services.
- Introduction of this service would be duplicative of services that are already in place.
- The member is in a hospital, skilled nursing facility psychiatric residential treatment facility, or other residential setting at the time of referral and is not ready for discharge to a family home environment or community setting with community-based supports.

## CBHI: In-Home Therapy

This service is delivered by one or more members of a team consisting of professional and paraprofessional staff, offering a combination of medically necessary In-Home Therapy and Therapeutic Training and Support. The main focus of IHT Services is to ameliorate the member's mental health issues and strengthen the family structures and supports. IHT Services are distinguished from traditional therapy in that services are delivered in the home and community; services include 24/7 urgent response capability on the part of the provider; the frequency and duration of a given session matches need and is not time limited; scheduling is flexible; and services are expected to include the identification of natural supports and include coordination of care.

Interventions are designed to enhance and improve the family's capacity to improve the member's functioning in the home and community and may prevent the need for the member's admission to an inpatient hospital, psychiatric residential treatment facility or other treatment setting.

In-Home Therapy is provided by a qualified clinician who may work in a team that includes one or more qualified paraprofessionals.

## Admission Criteria

- A comprehensive behavioral health assessment inclusive of the MA Child and Adolescent Needs and Strengths (MA CANS) indicates that the member's clinical condition warrants this service in order to enhance problem-solving, limit-setting, and risk management/safety planning and communication; to advance therapeutic goals or improve ineffective patterns of interaction; and to build skills to strengthen the parent/caregiver's ability to sustain the member in their home setting or to prevent the need for more-intensive levels of service such as inpatient hospitalization or other out-of-home behavioral health treatment services.
- The member resides in a family home environment (e.g., foster, adoptive, birth, kinship) and has a parent/guardian/caregiver who voluntarily agrees to participate in In-Home Therapy Services.
- Outpatient services alone are not or would not likely be sufficient to meet the member and family's needs for clinical intervention/treatment.
- Required consent is obtained.

## Continued Stay Criteria

- The member's clinical condition continues to warrant In-Home Therapy Services, and the member is continuing to progress toward identified, documented treatment plan goal(s).
- Progress toward identified treatment plan goal(s) is evident and has been documented based upon the objectives defined for each goal, but the goal(s) has not been substantially achieved.
- OR
- Progress has not been made, and the In-Home therapy team has identified and implemented changes and revisions to the treatment plan to support the goals.
- The member is actively participating in the treatment as required by the treatment plan/ICP to the extent possible consistent with his/her condition.
- The parent/guardian/caregiver is actively participating in the treatment as required by the treatment plan/ICP.

## Discharge Criteria

- The member no longer meets admission criteria for this level of care or meets criteria for a less- or more-intensive level of care.
- The treatment plan goals, and objectives have been substantially met, and continued services are not necessary to prevent worsening of the member's behavioral health condition.
- The member and parent/guardian/caregiver are not engaged in treatment. Despite multiple, documented attempts to address engagement, the lack of engagement is of such a degree that it implies withdrawn consent or treatment at this level of care becomes ineffective or unsafe.
- The member is placed in a hospital, skilled nursing facility, psychiatric residential treatment facility, or other residential treatment setting and is not ready for discharge to a family home environment or a community setting with community-based supports.
- Required consent for treatment is withdrawn.
- The member is not making progress toward treatment goals, and there is no reasonable expectation of progress at this level of care, nor is this level of care required to prevent worsening of the member's condition.

## Limitations/Exclusions

- Required consent is not obtained.
- The member is in a hospital, skilled nursing facility, psychiatric residential treatment facility, or other residential treatment setting at the time of referral and is not ready for discharge to a family home environment or community setting with community-based supports.
- The needs identified in the treatment plan that would be addressed by IHT services are being fully met by other services.
- The environment in which the service takes place presents a serious safety risk to the In-Home Therapy Service provider, alternative community settings are not likely to ameliorate the risk, and no other safe venue is available or appropriate for this service.
- The member is in an independent living situation and is not in the family's home or returning to a family setting.
- The member has medical conditions or impairments that would prevent beneficial utilization of services.



## CBHI: Intensive Care Coordination (ICC)

Intensive Care Coordination A wraparound service that facilitates care planning and coordination of services to children and adolescents under the age of 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.

ICC provides a single point of accountability for ensuring that medically necessary services are accessed, coordinated, and delivered in a strength-based, individualized, family/member-driven, and ethnically, culturally, and linguistically relevant manner. Services and supports, which are guided by the needs of the member, are developed through a Wraparound planning process that results in an individualized plan of care for the member and family. ICC is designed to facilitate a collaborative relationship among a member with SED, his/her family and involved child-serving systems to support the parent/caregiver in meeting their member's needs. The ICC care planning process ensures that a Care Coordinator organizes and matches care across providers and child serving systems to enable the member to be served in his/her home community.

### Admission Criteria

The member meets the criteria for serious emotional disturbance (SED) as defined by either Part I or II of the criteria below.  
Part I:

- The member currently has, or at any time during the past year, has had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet the diagnostic criteria specified within ICD-10 or DSM-5 of the American Psychiatric Association, with the exception of other V codes, substance use disorders, and developmental disorders, unless these disorders co-occur with another diagnosable disturbance. All of these disorders have episodic, recurrent, or persistent features; however, they vary in terms of severity and disabling effects.
- The diagnosable disorder identified above has resulted in functional impairment that substantially interferes with or limits the member's role or functioning in family, school, or community activities. Functional impairment is defined as difficulties that substantially interfere with or limit the member in achieving or maintaining developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills.
- Functional impairments of episodic, recurrent, and continuous duration are included unless they are temporary and expected responses to stressful events in the environment.
- Member who would have met functional impairment criteria during the referenced year without the benefit of treatment or other support services are included in this definition.

OR

Part II:

- The member exhibits one or more of the following characteristics over a long period of time and to a marked degree that adversely affects educational performance: an inability to learn that cannot be explained by intellectual, sensory, or health factors; an inability to build or maintain satisfactory interpersonal relationships with peers and teachers; inappropriate types of behavior or feelings under normal circumstances; a general pervasive mood of unhappiness or depression; or a tendency to develop physical symptoms or fears associated with personal or school problems.
- The emotional impairment is not solely the result of autism, developmental delay, intellectual impairment, hearing impairment, vision impairment, deaf-blind impairment, specific learning disability, traumatic brain injury, speech or language impairment, health impairment, or a combination thereof.
- The member:
  - Needs or receives multiple services other than ICC from the same or multiple provider(s); OR
  - Needs or receives services from, state agencies, special education, or a combination thereof; AND
  - Needs a care planning team to coordinate services the member needs from multiple providers or state agencies, special education, or a combination thereof.
- The person(s) with authority to consent to medical treatment for the member voluntarily agrees to participate in ICC. The assent of a member who is not authorized under applicable law to consent to medical treatment is desirable but not required.
- For member in a hospital, skilled nursing facility, psychiatric residential treatment facility or other residential treatment setting who meet the above criteria, the admission to ICC may occur no more than 180 days prior to discharge from the above settings.

## Continued Stay Criteria

- The member's clinical condition(s) continues to warrant ICC services in order to coordinate the member's involvement with state agencies and special education or multiple service providers.
- Progress toward Individualized Care Plan (ICP)-identified goals is evident and has been documented based upon the objectives defined for each goal, but the goals have not yet been substantially achieved despite sound clinical practice consistent with Wraparound and Systems of Care principles; OR
- Progress has not been made, and the Care Plan Team (CPT) has identified and implemented changes and revisions to the ICP to support the goals of the member and family.

## Discharge Criteria

- The member no longer meets the criteria for SED.
- The CPT determines that the member's documented ICP goals and objectives have been substantially met, and continued services are not necessary to prevent worsening of the member's behavioral health condition.
- Consent for treatment is withdrawn.
- The member and parent/caregiver are not engaged in treatment. Despite multiple, documented attempts to address engagement, the lack of engagement is to such a degree that it implies withdrawn consent or treatment at this level of care becomes ineffective or unsafe.
- The member is placed in a hospital, skilled nursing facility, psychiatric residential treatment facility, or other residential treatment setting and is unable to return to a family home environment or a community setting with community-based supports or ICC.
- The member turns 21.

## Service Delivery

- The Care Coordinator facilitates the development of a Care Planning Team (CPT) comprised of both formal and natural support persons who assist the family in identifying goals and developing an Individual Care Plan (ICP) and risk management/safety plan; convenes CPT meetings; coordinates and communicates with the members of the CPT to ensure the implementation of the ICP; works directly with the member and family to implement elements of the ICP; coordinates the delivery of available services; and monitors and reviews progress toward ICP goals and updates the ICP in concert with the CPT. The provision of ICC services reflects the individualized needs of member and their families. Changes in the intensity of a member's needs over time should not result in a change in Care Coordinator.
- Delivery of ICC may require Care Coordinators to team with Family Partners. In ICC, the Care Coordinator and Family Partner work together with member with SED and their families while maintaining their discrete functions. The Family Partner works one-on-one and maintains regular frequent contact with the parent(s)/caregiver(s) in order to provide education and support throughout the care planning process, attends CPT meetings, and may assist the parent(s)/caregiver(s) in articulating the member's strengths, needs, and goals for ICC to the Care Coordinator and CPT. The Family Partner educates parents/caregivers about how to effectively navigate the child-serving systems for themselves and about the existence of informal/community resources available to them and facilitates the caregiver's access to these resources.

Assessment: The Care Coordinator facilitates the development of the Care Planning Team

- (CPT), who utilize multiple tools, including a strength-based assessment inclusive of the Child and Adolescent Needs and Strengths (MA CANS version), in conjunction with a comprehensive assessment and other clinical information to organize and guide the development of an Individual Care Plan (ICP) and a risk management/safety plan. The CPT is a source for information needed to form a complete assessment of the member and family. The CPT includes, as appropriate, both formal supports, such as the Care Coordinator, providers, Case Managers from child-serving state agencies, and natural supports, such as family members, neighbors, friends, and clergy. Care Coordinator assessment activities include without limitation:
- Assisting the family to identify appropriate members of the CPT;
- Facilitating the CPT to identify strengths and needs of the member and family in meeting their needs; and
- Collecting background information and plans from other agencies.
- The assessment process determines the needs of the member for any medical, educational, social, therapeutic, or other services. Further assessments will be provided as medically necessary.

Development of an Individual Care Plan: Using the information collected through an assessment, the Care Coordinator convenes and facilitates the CPT meetings, and the CPT develops a child- and family-centered Individual Care Plan (ICP) that specifies the goals and actions to address the medical, educational, social, therapeutic, or other services needed by the member and family. The Care Coordinator works directly with the member, the family (or the authorized health care decision maker), and others to identify strengths and needs of the member and family and to develop a plan for meeting those needs and goals with concrete interventions and strategies and identified responsible persons.

Referral and related activities: Using the ICP, the Care Coordinator:

- Convenes the CPT which develops the ICP;
- Works directly with the member and family to implement elements of the ICP;
- Prepares, monitors, and modifies the ICP in concert with the CPT;
- Will identify, actively assist the member and family to obtain and monitor the delivery of available services including medical, educational, social, therapeutic, or other services;
- Develops with the CPT a transition plan when the member has achieved goals of the ICP; and
- Collaborates with the other service providers and state agencies (if involved) on the behalf of the member and family.

Monitoring and follow-up activities: The Care Coordinator will facilitate reviews of the ICP, convening the CPT as needed to update the plan of care to reflect the changing needs of the member and family. The Care Coordinator working with the CPT performs such reviews and includes:

- Whether services are being provided in accordance with the ICP;
- Whether services in the ICP are adequate; and
- Whether these are changes in the needs or status of the member and if so, adjusting the plan of care as necessary.

### **Exclusions/Limitations**

- The person(s) with authority to consent to medical treatment for the member does not voluntarily consent to participate in ICC.
- The member is in a hospital, skilled nursing facility, psychiatric residential treatment facility, or other residential treatment setting at the time of referral and is unable to return to a family home environment or community setting with community-based supports.

## **CBHI: Intensive Hospitalization Diversion (IHD)**

Intensive Hospital Diversion (IHD) is a specialized service of In-Home Therapy (IHT). As such, IHD providers are expected to adhere to IHT performance specifications in addition to those contained herein. Where there are differences between the IHT and IHD performance specifications, IHD specifications take precedence.

The Intensive Hospital Diversion (IHD) Program will provide intensive short-term (on average, 4 to 6 weeks) in-home crisis stabilization and treatment to youth and their families to support diversion from psychiatric hospitalization and other out-of-home placements. The clinical goal of this program is to provide youth under 21 and their parents/caregivers with the intensive short-term treatment and support needed to maintain the youth at home safely and to (re)connect them to ongoing outpatient and/or community-based services.

### **Admission Criteria**

- The member must meet current Medical Necessity Criteria for IHT (see In-Home Therapy section above) and have additional acute needs that cannot be met by IHT, as defined by the following:
- Member is in acute crisis and at imminent risk of 24-hour level of care and has been evaluated by a MCI team or an ED clinician.
- MCI or other crisis evaluation indicates the need for more intensive treatment than In-Home Therapy and Mobile Crisis Intervention together, and member can safely be maintained in the community with Intensive Hospital Diversion in place as agreed upon by family and crisis clinician.

## Discharge Criteria

- The youth no longer meets admission criteria for this level of care, or meets criteria for a less or more intensive level of care.
- The treatment plan goals and objectives have been substantially met and continued services are not necessary to prevent worsening of the youth's behavioral health condition.
- The youth is no longer living in a home setting.

## Exclusions/Limitations

- Concurrently receiving in-home therapy or other intensive home-based service, including those provided by other state agencies.
- Member has reached their 21st birthday.

## CBHI: Mobile Crisis Intervention

Mobile Crisis Intervention (MCI) is a short-term, mobile, on-site, face-to-face therapeutic response service that is available 24 hours a day, 7 days a week to a child experiencing a behavioral health crisis to identify, assess, treat, and stabilize a situation and reduce the immediate risk of danger to the child or others; provided, however, that the intervention shall be consistent with the child's risk management or safety plan, if any.

The service includes: A crisis assessment; development of a risk management/safety plan, if the member/family does not already have one; up to seven days of crisis intervention and stabilization services including: on-site, face-to-face therapeutic response, psychiatric consultation, and urgent psychopharmacology intervention, as needed; and referrals and linkages to all medically necessary behavioral health services and supports, including access to appropriate services along the behavioral health continuum of care.

## Admission Criteria

- The member must be in a behavioral health crisis that was unable to be resolved to the caller's satisfaction by phone triage. For member in ICC, efforts by the Care Coordinator and Care Plan Team (CPT) to triage and stabilize the crisis have been insufficient to stabilize the crisis and Emergency Services Program (ESP)/MCI has been contacted.
- Immediate intervention is needed to attempt to stabilize the member's condition safely in situations that do not require an immediate public safety response.
- The member demonstrates impairment in mood, thought, and/or behavior that substantially interferes with functioning at school, home, and/or in the community.
- AND at least one of the following:
  - The member demonstrates suicidal/assaultive/destructive ideas, threats, plans, or actions that represent a risk to self or others.
  - The member is experiencing escalating behavior(s), and, without immediate intervention, he/she is likely to require a higher intensity of services.
- AND at least one of the following:
  - The member is in need of clinical intervention in order to resolve the crisis and/or to remain stable in the community.
  - The demands of the situation exceed the parent's/guardian's/caregiver's strengths and capacity to maintain the member in his/her present living environment and external supports are required.
  - The crisis assessment and other relevant information indicate that the member needs a more- (or less-) intensive level of care, and the MCI has facilitated transfer to the next treatment setting and ensured that the risk management/safety plan has been communicated to the treatment team at that setting.
  - The member's physical condition necessitates transfer to an inpatient medical facility, and the MCI provider has communicated the member risk management/safety plan to the receiving provider.
  - Consent for treatment is withdrawn and there is no court order requiring such treatment.



## CBHI: Therapeutic Mentoring Services

Therapeutic Mentoring offers structured, one-to-one, strength-based support services between a therapeutic mentor and a member for the purpose of addressing daily living, social, and communication needs. Services are designed to support age-appropriate social functioning or to ameliorate deficits in the child's age-appropriate social functioning; provided, however, that such services may include supporting, coaching and training the child in age-appropriate behaviors, interpersonal communication, problem solving, conflict resolution and relating appropriately to other children and adolescents and to adults in recreational and social activities; and provided further, that such services shall be provided where the child resides, including in the child's home, a foster home, a therapeutic foster home or another community setting.

### Admission Criteria

- A comprehensive behavioral health assessment inclusive of the MA Child and Adolescent Needs and Strengths (MA CANS) indicates that the member's clinical condition warrants this service in order to support age-appropriate social functioning or ameliorate deficits in the member's age-appropriate social functioning.
- The member requires education, support, coaching, and guidance image-appropriate behaviors, interpersonal communication, problem-solving and conflict resolution, and relating appropriately to others to address daily living, social, and communication needs and to support the member in a home, foster home, or community setting, OR the member may be at risk for out-of-home placement as a result of the member's mental health condition OR requires support in transitioning back to the home, foster home, or community from a congregate care setting.
- Outpatient services alone are not sufficient to meet the member's needs for coaching, support, and education.
- Required consent is obtained.
- The member is currently engaged in outpatient services, In-Home Therapy, or ICC and the provider or ICC CPT determine that Therapeutic Mentoring Services can facilitate the attainment of a goal or objective identified in the treatment plan or ICP that pertains to the development of communication skills, social skills, and peer relationships.

### Continuing Stay Criteria

- The member's clinical condition continues to warrant Therapeutic Mentoring Services in order to continue progress toward treatment plan goals.
- The member's treatment does not require a more-intensive level of care.
- No less-intensive level of care would be appropriate.
- Care is rendered in a clinically appropriate manner and focused on the member's behavioral and functional outcomes as described in the treatment plan/ICP.
- Progress in relation to specific behavior, symptoms, or impairments is evident and can be described in objective terms, but goals have not yet been achieved, or adjustments in the treatment plan/ICP to address lack of progress are evident.
- The member is actively participating in the plan of care to the extent possible consistent with his/her condition.
- Where applicable, the parent/guardian/caregiver and/or natural supports are actively involved as required by the treatment plan/ICP.

### Discharge Criteria

- The member no longer meets admission criteria for this level of care or meets criteria for a less or more intensive level of care.
- The treatment plan/ICP goals and objectives have been substantially met, and continued services are not necessary to prevent worsening of the member's behavioral health condition.
- The member and parent/guardian/caregiver are not engaged in treatment. Despite multiple, documented attempts to address engagement, the lack of engagement is of such a degree that it implies withdrawn consent or treatment at this level of care becomes ineffective or unsafe.
- Required consent for treatment is withdrawn.
- The member is not making progress toward treatment goals, and there is no reasonable expectation of progress at this level of care, nor is it required to maintain the current level of functioning.
- The member is placed in a hospital, skilled nursing facility, psychiatric residential treatment facility, or other residential treatment setting and is not ready for discharge to a family home environment or a community setting with community-based supports.

## Exclusions/Limitations

- The member displays a pattern of behavior that may pose an imminent risk to harm self or others, or sufficient impairment exists that requires a more intensive service beyond community-based intervention.
- The member has medical conditions or impairments that would prevent beneficial utilization of services.
- Therapeutic Mentoring services are not needed to achieve an identified treatment goal.
- The member's primary need is only for observation or for management during sport/physical activity, school, after-school activities, or recreation, or for parental respite.
- The service needs identified in the treatment plan/ICP are being fully met by similar services.
- The member is placed in a residential treatment setting with no plans for return to the home setting.

## Community Based Acute Treatment Unit (CBAT)

Community-Based Acute Treatment for Children and Adolescents (CBAT) Mental health services provided in a secure 24-hour setting with sufficient clinical staffing to ensure safety for the child or adolescent, while providing intensive therapeutic services including, but not limited to: daily medication monitoring; psychiatric assessment; nursing availability; specializing (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.

Active family/caregiver involvement through family therapy, a key element of treatment, is expected. Discharge planning should begin at admission, including plans for reintegration into the home, school, and community. If discharge to home/family is not an option, alternative placement must be rapidly identified with regular documentation of active efforts to secure such placement.

## Admission Criteria

- The member demonstrates symptomatology consistent with a DSM-5 diagnosis, which requires and can reasonably be expected to respond to therapeutic intervention;
- The member is experiencing emotional or behavioral problems in the home, school, community, and/or treatment setting and is not sufficiently stable, either emotionally or behaviorally, to be treated outside of a highly structured, 24-hour therapeutic environment;
- The member has only poor or fair motivation and/or insight and the community supports are inadequate to support recovery;
- The family situation and functioning levels are such that the member cannot currently remain in the home environment and receive outpatient treatment; and
- The member has sufficient cognitive capacity to respond to active and time limited psychological treatment and interventions.

## Continuing Stay Criteria

- The member's condition continues to meet admission criteria at this level of care;
- The member's treatment does not require a more intensive level of care, and no less intensive level of care would be appropriate;
- Treatment planning is individualized and appropriate to the member's age and changing condition, with realistic, specific, and attainable goals and objectives stated;
- Treatment planning includes family, support systems, social, educational, occupational, and interpersonal assessments. This process should actively involve family, guardian, and/or other support systems unless contraindicated. Expected benefit from all relevant treatment modalities is documented. The treatment plan has been updated and implemented with consideration of all applicable and appropriate treatment modalities;
- All services and treatment are carefully structured to achieve optimum results in the most time-efficient manner possible consistent with sound clinical practice;
- If treatment progress is not evident, then there is documentation of treatment plan adjustments to address the lack of progress;
- Care is rendered in a clinically appropriate manner and focused on the member's behavioral and functional outcomes;

- An individualized discharge plan has been developed that includes specific realistic, objective, and measurable discharge criteria and plans for appropriate follow-up care. A timeline for expected implementation and completion is in place, but discharge criteria have not yet been met;
- The member is actively participating in treatment to the extent possible consistent with his/her condition, or there are active efforts being made that can reasonably be expected to lead to the member's engagement in treatment, improve functionality and reduce acute psychiatric/behavioral symptoms;
- Unless contraindicated, family, guardian, and/or natural supports are actively involved in the treatment as required by the treatment plan, or there are active efforts being made and documented to involve them;
- When medically necessary, appropriate psychopharmacological intervention has been prescribed and/or evaluated; and
- There is documented active coordination of care with other behavioral health providers, the PCC (primary care clinician), and other services and state agencies. If coordination is not successful, the reasons are documented and efforts to coordinate care continue.

## Discharge Criteria

- The member can be safely treated at an alternative level of care; and
- An individualized discharge plan with appropriate, realistic, and timely follow-up care is in place.
- One of the following criteria is also necessary for discharge from this level of care:
  - The member no longer meets admission criteria or meets criteria for a less or more intensive level of care;
  - The member's documented treatment plan goals and objectives have been substantially met, and/or a safe, continuing care program can be arranged and deployed at an alternate level of care;
  - The member, parent, and/or legal guardian are competent but not engaged in treatment or are not following the program rules and regulations. The lack of engagement is of such a degree that treatment at this level of care becomes ineffective or unsafe, despite multiple, documented attempts to address engagement issues. In addition, it has been determined that the member does not meet criteria for an inpatient level of care;
  - Consent for treatment is withdrawn, and it is determined that the member or parent/guardian has the capacity to make an informed decision and does not meet criteria for an inpatient level of care;
  - The member is not making progress toward treatment goals despite persistent efforts to engage him/her, and there is no reasonable expectation of progress at this level of care, nor is it required to maintain the current level of function; or
  - The member's physical condition necessitates transfer to a medical facility.

## Exclusions/Limitations

- The member exhibits severe suicidal, homicidal, or acute mood symptoms/thought disorder, which require a more intensive level of care;
- The parent/guardian does not voluntarily consent to admission or treatment;
- After initial evaluation and stabilization, it is determined that the presenting symptomatology is indicative of a DSM-5 diagnosis, which is amenable to continued treatment at this level of care. Conditions that would not be appropriate for continued treatment are:
  - permanent cognitive dysfunction without an acute psychiatric disorder
  - primary substance use disorder requiring treatment in a specialized level of care
  - medical illness requiring treatment in a medical setting
  - impairments indicate no reasonable expectation of progress toward treatment goals at this level of care
  - chronic condition with no indication of need for ongoing treatment at this level of care to maintain stability and functioning
- The member can be safely maintained and effectively treated at a less intensive level of care;
- The member has medical conditions or cognitive or psychiatric impairments that would prevent beneficial utilization of services;
- The primary problem is not psychiatric. It is a social, legal, or medical problem, without a concurrent major psychiatric episode meeting criteria for this level of care; or
- The admission is being used as an alternative to placement within the juvenile justice or protective services system, or as an alternative to specialized schooling (which should be provided by the local school system) or as respite or housing.

# CBAT for Intellectual Disability/Autism Spectrum Disorder

CBAT for Children/Adolescents with Intellectual Disabilities/Autism Spectrum Disorders (ID/ASD) are specialized CBAT services for children and adolescents with co-occurring mental health conditions and/or ID/ASD. In addition to all the clinical service components provided within CBAT, the program provides clinical expertise and intervention specifically pertaining to youth with co-occurring mental health conditions and ID/ASD.

CBAT with ID/ASD has the capacity to provide or refer to the following service components as clinically indicated by staff who have expertise in ID/ASD including neurological assessment, neuropsychological testing, and functional behavioral assessment and functional behavioral treatment planning. If clinically indicated, the program must provide, or refer, the member to the following within two days of admission: speech and language assessment, endocrinology consultations, nutritional consultations, genetic assessment if indicated by ACCAP guidelines (Journal of American Academy of Child and Adolescent Psychiatry, vol.56 (11), pp 910-913).

## Admission Criteria

All of the following criteria are necessary for admission to this level of care:

- The member demonstrates symptomatology consistent with an ID/ASD DSM-5-TR diagnosis, which requires and can reasonably be expected to respond to therapeutic intervention;
- The child/adolescent is experiencing emotional or behavioral problems in the home, school, community, and/or treatment setting and is not sufficiently stable, either emotionally or behaviorally, to be treated outside of a highly structured, 24-hour therapeutic environment;
- The member has only poor or fair motivation and/or insight and the community supports are inadequate to support recovery;
- The family situation and functioning levels are such that the child/adolescent cannot currently remain in the home environment and receive outpatient treatment; and
- The member has sufficient cognitive capacity to respond to active acute and time limited psychological treatment and interventions.

## Psychosocial and Linguistic Factors

These factors, as detailed in the introduction, may change the risk assessment and should be considered when making level of care decisions.

## Exclusion Criteria

Any of the following criteria may be sufficient for exclusions from this level of care:

- The child/adolescent exhibits severe suicidal, homicidal, or acute mood symptoms/thought disorder, which require a more-intensive level of care;
- The parent/guardian does not voluntarily consent to admission or treatment;
- After initial evaluation and stabilization, it is determined that the presenting symptomatology is indicative of an ID/ASD DSM-5-TR diagnosis, which is amenable to continued treatment at this level of care. Conditions that would not be appropriate for continued treatment are:
  - Primary substance use disorder requiring treatment in a specialized level of care;
  - Medical illness requiring treatment in a medical setting;
  - Impairments indicate no reasonable expectation of progress toward treatment goals at this level of care; or
  - Chronic condition with no indication of need for ongoing treatment at this level of care to maintain stability and functioning.
- The child/adolescent can be safely maintained and effectively treated at a less-intensive level of care;
- The primary problem is not related to ID/ASD diagnosis. It is a social, legal, or medical problem, without a concurrent major psychiatric episode meeting criteria for this level of care; or
- The admission is being used as an alternative to placement within the juvenile justice or protective services system, or as an alternative to specialized schooling (which should be provided by the local school system) or as respite or housing.

## Continued Stay Criteria

All of the following criteria are necessary for continuing in treatment at this level of care:

- The child/adolescent's condition continues to meet admission criteria at this level of care;



- The child/adolescent's treatment does not require a more-intensive level of care, and no less-intensive level of care would be appropriate;
- Treatment planning is individualized and appropriate to the child/adolescent's age and changing condition specific to their ID/ASD, with realistic, specific, and attainable goals and objectives stated. Treatment planning includes family, support systems, social, educational, occupational, and interpersonal assessments. This process should actively involve family, guardian, and/or other support systems unless contraindicated. Expected benefit from all relevant treatment modalities is documented. The treatment plan has been updated and implemented with consideration of all applicable and appropriate treatment modalities;
- All services and treatment are carefully structured to achieve optimum results in the most time-efficient manner possible consistent with sound clinical practice;
- If treatment progress is not evident, then there is documentation of treatment plan adjustments to address the lack of progress;
- Care is rendered in a clinically appropriate manner and focused on the child/adolescent's behavioral and functional outcomes;
- An individualized discharge plan has been developed that includes specific realistic, objective, and measurable discharge criteria and plans for appropriate follow-up care. A timeline for expected implementation and completion is in place, but discharge criteria have not yet been met;
- The child/adolescent is actively participating in treatment to the extent possible consistent with their condition, or there are active efforts being made that can reasonably be expected to lead to the child/adolescent's engagement in treatment, improve functionality, and reduce acute psychiatric/behavioral symptoms;
- Unless contraindicated, family, guardian, and/or natural supports are actively involved in the behavior training program as required by the treatment plan, or there are active efforts being made and documented to involve them;
- When medically necessary, appropriate psychopharmacological intervention has been prescribed and/or evaluated;
- There is documented active coordination of care with other behavioral health providers, Applied Behavior Analysis (ABA), the primary care provider (PCP), and other services and state agencies. If coordination is not successful, the reasons are documented, and efforts to coordinate care continue; and
- A data-collection check sheet is utilized and monitors the behaviors such as whole interval recording, partial interval record, or momentary time sampling.

## Discharge Criteria

The following criteria are necessary for discharge from this level of care:

- The child/adolescent can be safely treated at an alternative level of care; and
- An individualized discharge plan with appropriate, realistic, and timely follow-up care is in place.

One of the following criteria is also necessary for discharge from this level of care:

- The child/adolescent's documented treatment plan goals and objective have been substantially met, and/or a safe, continuing care program can be arranged and deployed at an alternate level of care;
- The child/adolescent, parent, and/or legal guardian is competent but not engaged to such a degree that treatment at this level of care becomes ineffective or unsafe, despite multiple, documented attempts to address engagement issues. In addition, it has been determined that the child/adolescent does not meet criteria for an inpatient level of care;
- Consent for treatment is withdrawn, and it is determined that the child/adolescent or parent/guardian has the capacity to make an informed decision and does not meet criteria for an inpatient level of care; or
- The child/adolescent's physical condition necessitates transfer to a medical facility.

## Community Support Program and Specialized CSP

Community Support Program services are provided by community-based, mobile, paraprofessional staff to members with behavioral health disorder diagnoses that interfere with their ability to access essential medical services or other basic needs which can impact community tenure. Behavioral health disorders pertain to mental health or substance use disorders as defined by the current edition of the Diagnostic and Statistical Manual of Mental Disorders.

Specialized CSP services are CSPs that provide targeted CSP services to members based on their unique situation. Specialized CSP includes:

1. Community Support Program for Homeless Individuals (CSP-HI) – a specialized CSP service to address the health-related social needs of members who are experiencing homelessness and are frequent users of acute health MassHealth services, or are experiencing chronic homelessness. CSP-HI services include pre-tenancy supports, support in transitioning into housing, and tenancy sustaining supports.

2. Community Support Program for Individuals with Justice Involvement (CSP-JI) – a specialized CSP service to address the health-related social needs of members with justice involvement who have a barrier to accessing or consistently utilizing medical and behavioral health services. CSP-JI includes behavioral health and community tenure sustainment supports.

3. Community Support Program Tenancy Preservation Program (CSP-TPP) – a specialized CSP service to address the health-related social needs of members who are at risk of homelessness and facing eviction as a result of behavior related to a disability. CSP-TPP works with the member, the Housing Court, and the member's landlord to preserve tenancies by connecting the member to community-based services in order to address the underlying issues causing the lease violation.

## Definitions

The following definitions are to be used when determining the medical necessity for CSP and Specialized CSP services.

**At Risk of Homelessness:** any member who does not have sufficient resources or support networks (e.g., family, friends, faith-based, or other social networks) immediately available to prevent them from moving to an emergency shelter or place not meant for human habitation.

**Behavioral Health Disorder:** any disorder pertaining to mental health or substance use as defined by the current edition of the Diagnostic and Statistical Manual of Mental Disorders.

**Chronic Homelessness:** as defined by the U.S. Department of Housing and Urban Development (HUD).

**Correctional Institution:** a county house of corrections, county jail, or Department of Corrections prison facility.

**Criminogenic Needs:** needs that, if addressed through targeted interventions and strategies, may lower an individual's risk of further criminal activity.

**Detainee:** a person in custody of a Correctional Institution who is not sentenced and is awaiting the outcome of a legal issue.

**Eviction:** the process of obtaining a court order to remove a tenant and other occupants from a rental property, including serving either a Notice to Quit or a request for temporary, preliminary, or permanent relief. Eviction may also refer to any instance in which such relief has been granted. This may include members under the age of 18 residing with a parent/guardian facing eviction.

- **Health Needs Based Criteria (HNBC):** an individual with a qualifying HNBC is defined as an individual who has one or more of the following.
  - Is clinically assessed to have a behavioral health need (mental health or substance use disorder) requiring improvement, stabilization, or prevention of deterioration of functioning (including the ability to live independently without support);
  - Is clinically assessed to have a complex physical health need, which is defined as persistent, disabling, or progressively life-threatening physical health condition(s), requiring improvement, stabilization, or prevention of deterioration of functioning (including the ability to live independently without support);
  - Is clinically assessed to have a need for assistance with one or more Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs);
  - Has repeated incidents of emergency department use (defined as two or more visits within six months, or four or more visits within a year);
  - Is pregnant and who is experiencing high risk pregnancy or complications associated with pregnancy, as well as such individuals in the 12-month postpartum period; and
  - Is pregnant or postpartum up to two months postpartum, without additional clinical factors.

**Homelessness:** a condition of any member who lacks a fixed, regular, and adequate nighttime residence, and who has a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping group; or who is living in a supervised publicly- or privately-operated emergency shelter designated to provide temporary living arrangements, including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state, or local government programs for low-income individuals.

**Inmate:** an individual who is in custody and held involuntarily through operation of criminal law in a Correctional Institution.

**Justice Involvement or Justice Involved:** a member who is a former inmate or detainee of a Correctional Institution who has been released from a Correctional Institution within the past year; or an individual under the supervision of the Massachusetts Probation Service, Massachusetts Parole Board, or both, as determined by Massachusetts Probation Service or the Massachusetts Parole Board.

**Mental Health Disorder:** any disorder pertaining to mental health as defined by the current edition of the Diagnostic and Statistical Manual of Mental Disorders.

**Notice to Quit:** a written notice from a landlord to a tenant that formally terminates a tenancy. Properly terminating the tenancy is the first part of the eviction process.

**Parole:** the procedure whereby certain inmates are released prior to the expiration of their sentence, permitting the remainder of their sentence to be served in the community under supervision and subject to specific rules and conditions of behavior.

**Permanent Supportive Housing (PSH):** a model of housing that combines ongoing subsidized housing matched with flexible health, behavioral health, social, and other supports.

**Probation:** the portion of a sentence that the court orders be served in the community under the supervision of the Massachusetts Probation Service.

**Restoration Center:** a designated entity that provides behavioral health services to individuals in mental health or substance use crisis, diverting individuals with behavioral health conditions from arrest or unnecessary hospitalization.

**Substance Use Disorder:** any disorder pertaining to substance use as defined by the current edition of the Diagnostic and Statistical Manual of Mental Disorders.

## General Admission Criteria

Providers must determine medical necessity for CSP and specialized CSP services using the following criteria, all of which must be present for medical necessity to be established:

1. The member has a behavioral health disorder diagnosis; and
2. The member demonstrates a need for behavioral health diversionary services and is at risk of admission to 24-hour behavioral health inpatient services as demonstrated by at least one of the following:
  - a. being discharged from a 24-hour behavioral health inpatient or diversionary level of care within the past 180 days; or
  - b. having more than one acute behavioral health services encounter, including Adult or Youth Mobile Crisis Intervention (AMCI/YMCI) services, Adult or Youth Community Crisis Stabilization (Adult CCS/YCCS) services, services provided by an Emergency Departments (ED), behavioral health services provided on an urgent care basis or at a restoration center within the past 90 days; or
  - c. having documented barriers to accessing or consistently utilizing medical and behavioral health services.
3. The member does not require a more intensive level of service, including requiring structure or supervision beyond the scope of the service, or does not have medical conditions or impairments that would prevent utilization of services, including posing an imminent risk to self or others; and
4. The member voluntarily consents to CSP or specialized CSP services and has the ability to participate in all aspects of services.

## Specialized CSP Criteria

In addition to the clinical standards above, providers must determine medical necessity for the specialized CSP services using the following criteria, all of which must be present for medical necessity to be established for that specialized CSP service.

1. CSP-HI. To receive CSP-HI services a member must meet the below:
  - a. Have a BH disorder and demonstrate a need for behavioral health diversionary services
    - for ACPP and PCACO members only: Have a Health Needs Based Criteria

b. Housing Status:

- Be experiencing chronic homelessness<sup>1</sup> (as defined by HUD) at the onset of services or
- Not meet the definition of chronically homeless, but be experiencing homelessness<sup>1</sup> at the onset of services and are frequent users of acute health MassHealth services as defined by:
  - 4+ ED visits within the past 12 months from the date of evaluation for CSP-HI services; or
  - 3+ acute and/or psychiatric hospital inpatient admissions within the past 12 months from the date of evaluation for CSP-HI services; and

c. Imminent Housing:

- Has identified a PSH opportunity and will be moving into housing within 120 days of the initiation of services;
- Is receiving Homeless Medical Respite Services; or
- Is being discharged from Homeless Medical Respite Services, has identified a PSH opportunity, and will be moving into housing within 120 days of discharge from Homeless Medical Respite Services.

b. The member must have identified a PSH opportunity and will be moving into housing within 120 days.

2. CSP-JI. To receive CSP-JI services, a member must

a. have justice involvement when the services begin; and

b. have a barrier to accessing or consistently utilizing essential medical and behavioral health services determined by at least one of the following:

- i. the member demonstrates antisocial behaviors, including criminal activity that has led, or could lead, to criminal justice involvement; lack of concern for others; antisocial cognition; diagnosis with Antisocial Personality Disorder; and/or disregard for authority, as expressed through distrust, conflict, or opposition; or
- ii. the member's behavioral health and/or substance use disorders produce cyclical relapse and justice involvement, without the opportunity for treatment; or
- iii. the member engages repetitively in behaviors that pose a risk of relapse to addiction and/or mental disorder; or
- iv. the member has insufficient community and social supports to reinforce recovery; or
- v. the member is identified as high risk, or above, of recidivism on validated risk assessments due, at least in part, to a substance use disorder, mental health or co-occurring disorder.

c. Demonstrate a need for behavioral health diversionary services and be at risk of admission to 24-hour behavioral health inpatient services as described in Section II.B.2 but with modified time frames as follows:

- i. being discharged from a 24-hour behavioral health inpatient or diversionary level of care within the past year; or
- ii. having more than one acute behavioral health services encounter, including Adult or Youth Mobile Crisis Intervention (AMCI/YMCI) services, Adult or Youth Community Crisis Stabilization (Adult CCS/YCCS) services, or services provided by Emergency Departments (ED), behavioral health services provided on an urgent care basis, or restoration centers within the past year; or
- iii. having documented barriers to accessing or consistently utilizing medical and behavioral health services.

3. CSP-TPP. To receive CSP-TPP services, a member must be at risk of homelessness and facing eviction when the services begin.

a. Have a BH disorder and demonstrate a need for behavioral health diversionary services or for ACPP and PCACO members only: Have a Health Needs Based Criteria

b. Be at risk of homelessness and facing eviction as a result of behavior related to a disability when services begin.



## Continued Stay Criteria

All of the following criteria are necessary for continuing in treatment at this level of care:

- The member continues to meet all admission criteria;
- The member is actively participating in the CSP service plan and related treatment services, to the extent possible consistent with the Member's condition;
- The member is in regular communication with the CSP staff;
- There is documented, active coordination of services with other behavioral health providers, PCP, and other services and state agencies. If coordination is not successful, the reasons are documented and efforts to coordinate services continue;
- No less-targeted intervention would be appropriate or is available;
- Progress in relation to implementing the Member's service plan is evident and can be described in objective terms, but goals of the service plan and engagement in clinical treatment services have not yet been achieved; and
- Any adjustments in the services plan to address lack of progress are documented.

## Discharge Criteria

Any of the following criteria is sufficient for discharge from this level of care:

- CSP service plan goals and objectives have been substantially met, and/or a safe, continuing care program can be arranged and deployed at a less-intensive or less-targeted level of care;
- The Member has been admitted into a 24-hour facility and discharge plan is for a longer-term hospitalization or program for which continued CSP would no longer be clinically indicated. To be determined every 60 days as to whether continued CSP would be clinically indicated;
- The Member is not utilizing or engaged in the CSP service. The lack of engagement is of such a degree that treatment at this level of care becomes ineffective or unsafe, despite multiple, documented attempts to address engagement issues; or
- Consent for the CSP services is withdrawn. The Member does not meet the criteria for a more intensive level of care.

## Exclusions Criteria

Any of the following criteria may be sufficient for exclusion from this level of care:

- The Member is receiving similar supportive services and does not require this level of care; or
- The Members does not consent to Community Support Program services.

## Documentation for CSP-HI and CSP-TPP

- Presence of an ICD 10 diagnosis code that reflects clinical eligibility criteria; or
- Documentation from a health care professional with applicable training and/or expertise to verify that the member meets clinical eligibility criteria; or
- Member attestation that they meet clinical eligibility criteria.

# Outpatient Consultation Services

## Outpatient Consultation Services

Outpatient Services providers are to utilize case consultation, family consultation, and collateral contacts to involve parents/guardians/caregivers in the planning, assessment, and treatment for members, as clinically indicated, and to educate them on mental health and substance use disorder treatment and relevant recovery issues. Additionally, with member consent and as applicable, Outpatient Services providers are to utilize case consultation and collateral contacts in order to involve the collaterals identified within the Care Coordination section of the General performance specifications in the planning, assessment, and treatment for members. All such activities are to be documented in the member's health record and releases of information obtained, as required.

### Case Consultation

A documented meeting of at least 15 minutes duration either in person or by telephone between the treating provider and other behavioral health/medical clinicians or physician, concerning a member who is a client of the behavioral health provider. Goals of case consultation are to identify and plan for additional services, coordinate a treatment plan, review the individual's progress, and revise the treatment plan, as required.

### Family Consultations

A documented meeting of at least 15 minutes duration either in person or by telephone between the treating provider and with family members or others who are significant to the member and clinically relevant to a member's treatment. Goals of family consultation are to educate, identify, and plan for additional services or resources, coordinate a treatment plan, review the individual's progress, or revise the treatment plan, as required.

### Collateral Contacts

A documented communication of at least 15 minutes duration either in-person by telephone (including voice mails), or by email. These contacts are between a provider and individuals who are involved in the care or treatment of a Member under the age of 21. This would include but is not limited to school and day care personnel, state agency staff, human services agency staff, court appointed personnel, religious or spiritual advisers, and/or other community resources.

## Admission Criteria

- The provider who submits the claim must obtain appropriate documentation, including the date and time of the consultation, names of all parties involved, purpose of consultation, and whether the consultation was in-person or telephonic. Documentation should also include what actions will occur as a result of the consultation.
- For Case Consultations, The meeting is either between two outpatient providers who do not share the same provider number or between the outpatient provider and any behavioral health provider offering services at a different level of care, or between the treating outpatient provider and a representative from a school, state, medical office, or residential provider.
- Multiple providers with different provider numbers may bill for the same consultation/collateral contact if more than one provider is present or on a phone conference.

## Service Delivery

- The scope of required service components provided includes, but is not limited to, the following:
- Treatment coordination
- Treatment planning with the member's family or identified supports
- Implementation of additional or alternative treatment
- Aftercare planning
- Termination planning
- Supporting or reinforcing treatment objectives for the member's care

# Program of Assertive Community Treatment (PACT)

The Program of Assertive Community Treatment (PACT) is a multidisciplinary service team approach to providing intensive, community-based, and recovery-oriented psychiatric treatment, assertive outreach, rehabilitation, and support to individuals with serious mental illness. The service is best suited to Members who do not effectively use less-intensive psychiatric services. The program team provides assistance to individuals to maximize their recovery, ensures consumer-directed goal setting, assists individuals in gaining hope and a sense of empowerment, and provides assistance in helping individuals become better integrated into their community. The team is the single point of clinical responsibility and assumes accountability for assisting individuals in getting their needs met while achieving their goals for recovery. The PACT team provides all clinical non-acute behavioral health and substance use disorder interventions in addition to linking Members to community-based self-help resources and providing direct rehabilitation, vocational, and housing-related services. Services are delivered in the individual's natural environment and are available on a 24-hour, seven-day-a-week basis. Services are comprehensive and highly individualized. They are modified as needed through an ongoing assessment and treatment planning process. Services are intensive but may vary based on the needs of the individuals served.

PACT services follow national program guidelines. \*

\* Substance Abuse and Mental Health Services Administration. Assertive Community Treatment (ACT) Evidence-Based Practices (EBP) Kit. DHHS Pub. No. SMA-08-4345, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health, and Human Services, 2008.

## Admission Criteria

- All of the following criteria (1-5) are necessary for admission to this level of care:
- The individual must be an adult, age 19 or older;
- The individual must have a psychiatric diagnosis as defined in the DSM-5;
- As a result of the psychiatric diagnosis, the individual has significant functional impairments as demonstrated by at least one of the following conditions:
  - Inability to consistently perform practical daily living tasks (e.g., maintaining personal hygiene; meeting nutritional needs; caring for personal financial affairs; obtaining medical, legal, and housing services; recognizing and avoiding common dangers or hazards to self and possessions; budgeting; employment or carrying out child-care responsibilities) or persistent or recurrent failure to perform daily living tasks except with significant support or assistance from others (such as friends, family, or relatives);
  - Inability to maintain a safe living situation (e.g., repeated evictions or loss of housing); or
  - High risk or recent history of criminal justice involvement (e.g., arrest and incarceration).
- One or more of the following indicators of continuous, high-service need is present:
  - Non-responsive to the Intensive Clinical Management services;
  - The Member has a history of psychiatric hospital admissions or psychiatric Emergency Services visits in the last 365 days;
  - Active, co-existing substance use disorder greater than six months' duration;
  - Currently admitted to an acute level of care or supervised community residence but able to be discharged if intensive community support services are provided;
  - In danger of requiring acute level of care if more intensive services are not available; or
  - Inability to keep office-based appointments.
- The individual and legal guardian, if appropriate, is willing to accept and cooperate with the PACT team.

## Continued Stay Criteria

All of the following criteria (1-5) are necessary for continuing treatment at this level of care:

- Severity of illness and resulting impairment continue to require this level of service;
- Treatment planning is individualized and appropriate to the individual's changing condition, with realistic and specific goals and objectives stated;
- The mode, intensity, and frequency of treatment are appropriate;
- Active treatment is occurring, and continued progress toward goals is evident; or adjustments to the treatment plan have been made to address lack of progress; and

- The individual and family (when appropriate and with consent) are participating to the extent capable with a program that is considered adequate to alleviate the signs and symptoms justifying treatment.

## Discharge Criteria

Any of the following criteria (1-5) is sufficient for discharge from this level of care:

- The individual's treatment plan and discharge goals have been substantially met;
- Consent for treatment is withdrawn;
- The individual no longer meets the admission criteria or meets criteria for a less- or more-intensive level of care;
- The Member is in an institution (state hospital or prison) for an extended period of time which precludes the PACT team's ability to maintain a relationship with the Member, or there is no planned return to the community set to occur within a reasonable time frame; or
- The Member and/or legal guardian is not engaged in or utilizing the service to such a degree that treatment at this level of care becomes ineffective or unsafe despite use of motivational techniques and multiple, documented attempts to address engagement issues. In addition, it has been determined that the Member and/or guardian has the capacity to make an informed decision, and the Member does not meet criteria for a more-intensive level of care.

## Exclusion Criteria

Any of the following criteria (1-5) is sufficient for exclusion from this level of care:

- The individual has a diagnosis of a substance use disorder only;
- The individual has a primary diagnosis of intellectual disability;
- The individual has a primary diagnosis of a neurodevelopmental or neurocognitive disorder;
- The individual is actively engaged in treatment in a Community Support Program (CSP) or similar duplicative service; or
- The individual has an impairment that requires a more-intensive level of service than community-based intervention.

## Service Delivery

- PACT team leaders/program directors participate in a referral meeting. Referrals are reviewed to ensure the Member meets PACT criteria and discuss any concerns. PACT teams are expected to take all referrals which meet criteria. Dates for admission are set at the referral meeting.
- The team leader/program director and psychiatrist meet with the Member, within three to four business days from the referral meeting, to begin an initial intake and assessment and to complete a brief initial treatment plan. The initial assessment focuses on how the team can be helpful to the Member and support his/her immediate concerns and priorities. The initial assessment and brief treatment plan are completed by the Member's primary care manager. The Member's psychiatrist, primary care manager, and individual treatment team members are assigned by the program director within a week of admission.
- A comprehensive assessment is completed within 30 days of the Member's admission. Its main focus is to understand and respect the Members' worldview and context of their lives. This includes the ways their psychiatric condition impacts their lives as a whole and how they want to be supported as they move through their own personal process of recovery.
- Comprehensive assessments are completed by individuals on the team who have expertise in the particular life area being assessed. For example, the physical health component is completed by one of the team's RNs; the substance use disorder component is completed by staff on the team with substance use disorder treatment skills; an employment specialist on the team completes the education and employment component. The primary care manager is responsible for ensuring the completion of the comprehensive assessment by team members.
  - The PACT team meets on or about day 30 after admission to compile and complete the comprehensive assessment. The team develops the 'integrated assessment summary' which pulls together all the assessment components and information from the Member about his/her experiences, current circumstances, and goals in a number of life areas:
    - Psychiatric symptoms and their effects
    - Known trauma history
    - Strengths, skills, and periods of time identified by the Member as positive
    - Treatment history, including his/her experience of past treatment and his/her perception of its benefits/limitations
    - Medical, dental, and other health needs
    - Extent and effect of drugs and/or alcohol use
    - Housing situation, conditions of daily living, housing preferences
    - Rehabilitation, employment, and educational activities and interests
    - Legal issues



- Extent and effect of criminal justice involvement
- Level of family contact and support
- Social relationships and supports
- Spiritual needs and interests
- Recent life events
- Finally, the Member and the PACT team come to agreement about the particular issues and priorities they will all work together to address. These issues are transformed into specific goals and outcomes the team will work with the Member to achieve.
- A comprehensive treatment plan is completed within 30 days of a Member's admission to the program.
  - The treatment plan states the Member's strengths, needs/problems, personal goals, and desired service outcomes; the specific interventions to be provided; names of persons providing the services; and estimated time and other resources needed to support the achievement of goals and outcomes.
  - The following life needs are addressed in treatment plans: symptom self-management and education; getting and keeping affordable, quality housing; carrying out ADLs; finding and maintaining satisfying employment or other pursuits; enriching social and interpersonal relationships, including peer support; fulfilling spiritual needs; strengthening physical health; and creating crisis prevention strategies which address a Member's preferences in the event of a serious psychiatric emergency.
  - The treatment plan includes psychosocial, educational and support services for the Member's family/significant others.
  - All areas that the Member identifies as important to address are included in the treatment plan. If it is necessary to defer a particular issue, documentation substantiating the deferral is made.
- The primary care manager is responsible for reviewing the service delivery goals and plan with the Member, at least every six months and whenever there is a major decision point in the Member's course of treatment and rehabilitation.
- The treatment plan is revised every six months. The revised treatment plan is based on a mutual evaluation between Member and staff about accomplishment of desired goals and outcomes. A reassessment of current Member needs and goals is then completed. The primary care manager prepares a written treatment plan review describing goals the Member has reached since the last treatment planning meeting and outlining his/her current strengths and areas of need. The Member, primary care manager, team leader/program director, and psychiatrist sign both the treatment plan review and the revised treatment plan.
- The PACT team conducts treatment planning meetings, convened at regularly scheduled times.
  - Treatment planning, led by each Member's "mini team," the team leader/program director and psychiatrist, represents a partnership between PACT teams, Members, and their families/significant others.
  - Treatment planning meetings occur with sufficient frequency and duration to develop written individual treatment plans and to review and revise the treatment plans every six months.
  - Each Member participates in the plan in the way he/she prefers. If the Member chooses not to attend, the team insures Member input into the plan and approval of the plan.
- The PACT team conducts daily organizational staff meetings under the supervision of the team leader/program director and the psychiatrist.
  - These meetings are held five (5) days per week at regularly scheduled times, when the greatest number of staff is present.
  - During these meetings, the team reviews the service contacts made the previous day and assesses their progress in helping Members meet desired outcomes. Acuity changes are noted and responded to that day with a specific plan incorporating the Member's own preferences and identified self-management practices. The goal is to work with Members to identify emotional changes early on so that life disrupting emergencies can be avoided.
  - During these meetings a staff person, designated as "shift manager," coordinates a schedule of services that team members need to provide that day and is the on-site contact to manage a response to unanticipated needs.
  - The meeting also provides a formal opportunity to revise treatment plans as needed, plan for emergency/crisis situations, and add treatment and service contacts to the daily schedule per the revised or crisis treatment plans.
- The provider complies with all provisions of the corresponding section in the General performance specifications.
- Discharges from the PACT program occur when Members no longer meet medical necessity criteria. The program works to engage the Member, program staff in mutual agreement of this determination and the termination of services. This generally occurs when a Member:
  - Meets his/her goals in all major role areas (work, school, social, and self-care); has extended periods of community tenure; and has successful experiences in managing emotional crises and a non- mental health provider support system;

- Moves outside of the team's geographic area of responsibility. In such cases, the PACT team arranges for the transfer of mental health service responsibility to a provider in the geographic location to which the Member is moving (preferably another PACT team). The PACT team maintains contact with the Member until this service transfer is arranged and services are established; or
- Is in an institution (e.g., state hospital or prison) for an extended period of time, precluding the PACT team's ability to maintain a relationship with the Member.
- Progress has occurred that allows for treatment to continue at a less intensive level of care; or
- Requests discharge, despite the team's best effort to develop a treatment plan acceptable to the Member. This decision is reached jointly with the referring source.
- The PACT team engages the Member in developing and implementing an aftercare plan, including but not limited to formal services and peer supports, as needed, when the Member meets the PACT discharge criteria established in his/her treatment plan.
- The aftercare plan and all discharge planning activities are document in the Member's health record.

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## Revision History

Date	Summary of Changes
03/2019	Version 1
08/2019	Version 2
01/2020	Version 3
01/2020	Added PACT Criteria
10/2020	Version 4
10/2021	Version 5
05/2022	Addition of Criteria for Community Support Program for Individuals with Justice Involvement
10/2022	Version 6 Annual Review
03/2023	Formatting of CBHI Section
09/2023	Addition of Criteria for CBAT for IDR/ASD
08/2024	Annual Review/CSP additions
09/2024	ABA Specifications
12/2024	CSP Revisions