Massachusetts Behavioral Health Partnership (MBHP)/
Health New England Be Healthy (HNE BH)
2014 Performance Specifications Revisions: Summaries of Changes

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Revisions made across all service specifications:

1. General language and/or term revisions, e.g., substance abuse to substance use or substance use disorder, where applicable; mental retardation to intellectual disabilities; pervasive developmental disorders (PDD) to pervasive developmental disorders/autism spectrum disorders (PDD/ASD); board-certified or board-eligible psychiatrist or psychiatric nurse mental health clinical specialist (PNMHCS) to one that meets MBHP/HNE BH’s credentialing criteria; critical incident to adverse incident; medical record or behavioral health record to health record; advanced practice registered nurse (APRN) or clinical nurse specialist to PNMHCS; facility to provider or program, as appropriate; rehabilitation to wellness; DSM IV/DSM IV diagnosis to DSM-5/DSM-5 diagnosis, inclusive of psychosocial and contextual factors and disability, as applicable, where appropriate; risk management/safety plan to crisis prevention plan, and/or safety plan as part of the Crisis Planning Tools for youth, and, for all substance use disorder-related services, the addition of and/or relapse prevention plans, as applicable; toxicology to drug screening/testing

2. Slight modification of the titles of specific services (applicable to: Acute Treatment Services (ATS) for Substance Use Disorders Level III.7, which had been Acute Treatment Services for Substance Abuse Level IIIA; Observation/Holding Beds, which had been Observation Beds up to 24 Hours; Clinical Stabilization Services (CSS) for Substance Use Disorders Level III.5, which had been Clinical Support Services for Substance Use Disorders Level III.5; Dialectical Behavioral Therapy (DBT), which had been Dialectical Behavior Therapy; Psychiatric Consultation on an Inpatient Medical Unit, which had been Psychiatric Consultation on a Medical/Surgical Unit)

3. From future tense to present tense

4. Increased utilization of recovery-oriented language, e.g., client/patient/individual/consumer to Member; persons to individuals

5. Consolidation of language, removal of redundant/repetitive language, and movement of language to the most appropriate section


7. Addition of the following at the beginning of each section: “The provider complies with all provisions of the corresponding section in the General performance specifications.”

8. Addition of the following at the beginning of the Staffing section: “The provider complies with the staffing requirements of the applicable licensing body, the staffing requirements in the MBHP/HNE BH service-specific performance specifications, and the credentialing criteria outlined in the MBHP/HNE BH Provider Manual, Volume I, as referenced at www.masspartnership.com.”

9. Addition of language to “specialty” service specifications, or specifications that are a subset of other specifications, noting where there are differences between the regular service and the specialty service performance specifications, the specialty service specifications take precedence.

10. Addition of language to all service specifications noting that the requirements outlined within the service-specific performance specifications take precedence over those in the General performance specifications.

11. Addition of language referencing the per diem/service definition in the Components of Service section

12. Movement of the Process Specifications section to directly follow the Staffing Requirements section
13. Activities that have timeframes associated with them have been placed in chronological order in the Process Specifications section
14. Addition of MCI (Mobile Crisis Intervention) wherever Emergency Services Program (ESP) is noted, as applicable
15. For all applicable services, addition of language relative to: the development and maintenance of acting working relationships with each of the local ESPs/MCIs who are high-volume referral sources for the provider; on a Member-specific basis, collaboration with any involved ESP/MCI providers around evaluation and treatment recommendations and crisis prevention and/or safety plans (and/or relapse prevention plans for all substance use disorder-related services)
16. Reference that all activities are documented in the Member’s health record
17. Spelling out of various acronyms
18. Revision of the names of certain state agencies (e.g., DSS to DCF, DMR to DDS, etc.)
19. Addition of caregiver wherever parent/guardian is noted
20. Inclusion of language pertaining to Children’s Behavioral Health Initiative (CBHI) services, specifically for youth enrolled in Intensive Care Coordination (ICC), where relevant
21. Inclusion of language relative to the requirement for providers who see Members under the age of 21 to utilize the Child and Adolescent Needs and Strengths (CANS) during the assessment, throughout treatment, and as part of the discharge planning process, including the appropriate documentation and sharing, with consent, including the addition of the clarifier “Even” in front of “without consent” per recommendation of MassHealth (applicable to: Outpatient Services, Inpatient Mental Health, Community-Based Acute Treatment (CBAT) for Children and Adolescents, Transitional Care Unit (TCU))
22. Omission of reference to Intensive Observation Beds up to 72 hours
23. Addition of standard language relative to the credentialing criteria waiver process
24. Insertion of language clarifying that the provider provides all staff with supervision in compliance with MBHP/HNE BH’s credentialing criteria
25. Omission of language regarding the referral of all pregnant, substance abusing females to MBHP/HNE BH’s Care Management Program
26. Addition of language requiring providers to ensure each Member has access to medications prescribed for physical and behavioral health conditions (applicable to Inpatient Mental Health (responsible for supplying the medications) and the 24-hour diversionary LOCs – Community Crisis Stabilization (CCS), CBAT, ATS, ATS for Pregnant Women, Enhanced Acute Treatment Services (E-ATS) for Individuals with Co-occurring Mental Health and Substance Use Disorders, CSS, and TCU)
27. Addition of language requiring providers to engage in the process of medication reconciliation (applicable to Inpatient Mental Health, the 24-hour diversionary LOCs [CCS, CBAT, ATS, ATS for Pregnant Women, E-ATS, CSS, and TCU], Outpatient Services, and Partial Hospitalization Program (PHP))
28. Addition of language, in the Components of Service section, relative to the development and/or updating of a crisis prevention plan, and/or safety plan as part of the Crisis Planning Tools for youth, as clinically indicated (applicable to any level of care where one might be indicated, and supported by provider and stakeholder feedback) (definition of the plan has been added to the General specs)
29. Addition of language, in the Components of Service section for all substance use disorder-related services that references the “development and/or updating of crisis prevention plans, and/or safety plans as part of the Crisis Planning Tools for youth, and/or relapse prevention plans, as applicable”
30. Addition of language, in the Discharge section, clarifying that at the time of discharge, and as clinically indicated, the provider ensures that the Member has a current crisis prevention plan, and/or safety plan, and/or relapse prevention plan in place, that he/she has a copy of it, as well as clarifying the details relative to that process, including sending a copy of it to the ESP/MCI Director at the Member’s local ESP/MCI provider with Member consent (applicable to any level of care where one might be indicated)

31. Addition of language clarifying the provider’s responsibilities relative to the Massachusetts Behavioral Health Access (MABHAccess) website, e.g., updating available capacity, keeping all administrative and contact information up to date, and training staff on the use of the website to locate other services for Members, particularly in planning aftercare services (applicable to: Inpatient Mental Health, CBAT, CCS, ATS, and E-ATS)

32. Addition (or modification) of language in the specs of all 24-hour levels of care (and omission from all other specs) referencing: a) the provider’s responsibility for assisting Members in obtaining post-discharge appointment (e.g., within 7 calendar days for outpatient therapy services (which may be an intake appointment for therapy services), if necessary, and within 14 calendar days for medication monitoring, if necessary); b) to whom this function may not be designated; and c) the provider’s responsibilities relative to barriers to accessing covered services

33. Omission of language, in the Quality Management section of all substance use disorder-related specifications, that references the submission of data to the Department of Public Health (DPH) and the tracking by referral source

34. Modification of treatment plan to treatment/recovery plan in all substance use disorder-related specs

35. Modification of the timeframe in which attempts are made by the provider to contact parent/guardian/significant other(s) (from “within 24 hours of admission” to “within 48 hours of admission” (applicable to: 24-hour levels of care, with the exception of CCS whose timeframe remains “within 24 hours of admission” per recommendation of MassHealth)

36. Addition of language differentiating between urgent and non-urgent consultation services, as well as specifying that routine medical care (not required for the diagnosis related to the presenting problem) may be deferred, when appropriate, if the length of stay on the inpatient unit is brief (applicable to: 24-hour levels of care, clarifier added per recommendation of MassHealth)

37. Modification of language regarding the provision of a handbook to the Member that is specific to the program (as opposed to a patient handbook) (applicable to: 24-hour levels of care)

38. Addition of language indicating that the provider has adequate psychiatric coverage to ensure all performance specifications related to psychiatry are met (applicable mostly to inpatient and 24-hour levels of care)

39. Omission of language requiring the provider to conduct a discharge interview, and addition of the requirement for the provider to engage the Member in developing and implementing an aftercare plan, as needed, when the Member meets the discharge criteria established in his/her treatment/recovery plan, to provide the Member with a copy of the plan upon his/her discharge, and to document these activities in the Member’s health record (applicable to all substance use disorder-related specs; “as needed” omitted per recommendation from MassHealth)

40. Addition of language regarding the provider’s collaboration in the transfer, referral, and/or discharge planning process to ensure continuity of care if a Member is referred to another treatment setting (applicable mostly to inpatient and 24-hour levels of care)
41. Modification of language relative to the provision or arrangement of transportation for services required external to the program during the admission and, upon discharge, for placement into a step-down 24-hour level of care (applicable mostly to inpatient and 24-hour levels of care)

42. Addition of language clarifying the provider’s responsibility to collaborate with the Member’s primary care clinician (PCC) as delineated in the Primary Care Clinician Integration section of the General performance specifications (applicable to: substance use disorder-related specs and others as indicated)

43. Omission of language regarding Member choice for an attending psychiatrist, as well as the provider’s acknowledgement of MBHP/HNE BH’s right to exclude certain individuals from acting as the attending psychiatrist for Members (applicable to: mostly 24-hour levels of care and others where indicated)

**Corresponding rationales for these revisions:**

1. Consistency with corresponding acronyms; consistency with current MBHP/HNE BH language; consistency with the relevant per diem definition; reinforcement of integrated care; consistency with changes within the greater behavioral health field, substance use disorder field, and/or the credentialing field
2. Consistency with contract language
3. Reinforcement of current requirements and procedures
4. Reinforcement of recovery-oriented practices
5. Language consolidation, efficiency, and relevance
6. Efficiency
7. Provider clarification of requirements
8. Provider clarification of requirements
9. Provider clarification of requirements
10. Provider clarification of requirements
11. Provider clarification of requirements
12. Enhanced flow of information
13. Clarification and enhanced flow of information
14. Reinforcement of requirements applicable to both ESP and MCI
15. Reinforcement of the importance of collaboration and continuity of care for the Member, supported by provider feedback
16. Reinforcement of the need for documentation of policies, procedures, and activities
17. Clarification
18. Consistency with changes within the greater behavioral health/substance use disorder field
19. Relevance
20. Consistency with changes within the greater behavioral health field
21. Provider clarification of requirements
22. The service is no longer a covered MBHP/HNE BH service
23. Provider clarification and reinforcement of requirements and procedures
24. Consistency with current MBHP/HNE BH language
25. Not applicable/relevant (Note: Female Members who are pregnant and using substances are identified via other means and subsequently referred to an appropriate program, as appropriate.)
26. Provider clarification; reinforcement of requirements and procedures; appropriateness given the levels of care
27. Provider clarification; compliance with contract deliverable; reinforcement of: requirements and procedures, the importance of collaboration, continuity of care for the Member, and quality of care
28. Reinforcement of continuity of care for the Member
29. Provider clarification; reinforcement of requirements and procedures; appropriate expectation for the substance use disorder-related levels of care
30. Provider clarification; reinforcement of: requirements, the importance of collaboration and integrated care, continuity of care for the Member, and quality of care; also supported by provider feedback
31. Provider clarification; reinforcement of: requirements and procedures, access to care, and continuity of care for the Member
32. Provider clarification; compliance with contract deliverable, National Committee for Quality Assurance (NCQA), and the Healthcare Effectiveness Data and Information Set (HEDIS®) measures; reinforcement of: requirements and procedures, access to care, continuity of care for the Member, and quality of care; supported by provider feedback
33. Not applicable/relevant
34. Provider clarification; consistency with changes within the greater substance use disorder field
35. Consistency with the Department of Mental Health (DMH) inpatient mental health regulations, supported by provider feedback
36. Clarification; reinforcement of requirements; supported by provider feedback
37. Clarification; reinforcement of requirements; supported by provider feedback
38. Clarification; reinforcement of: requirements, quality of care, and oversight
39. Clarification; relevance; reinforcement of requirements
40. Clarification; relevance; reinforcement of continuity of care for the Member; and consistency with language used in other specs
41. Clarification; reinforcement of requirements and continuity of care for the Member; supported by provider feedback
42. Clarification; reinforcement of: requirements, continuity of care for the Member, the need for collaboration and integrated care
43. Elimination of redundancy/Member preference is referenced in the General specs, relevance, and supported by provider feedback)
General performance specifications

Major revisions made:

1. In Philosophy section, addition of language ensuring that in any setting in which behavioral health levels of care or both behavioral health and non-behavioral health levels of care are co-located, all performance specs are met for the contracted level(s) of care.

2. In Recovery and Wellness section, addition of language noting it is considered best practice to have the capability to accept and treat Members presenting with various co-morbid conditions.

3. In Cultural Competence section, addition of language relative to making best efforts to meet the needs of various populations, i.e., those with special needs, e.g., those who are deaf and hard of hearing, those who are homeless, etc., directly or by referral.

4. In Cultural Competence section, modification of language relative to the availability and translation of documentation for Members, and addition of language noting it is considered best practice to have the capability to translate such materials into the Member’s preferred language when requested by the Member.

5. In Staffing section, addition of language emphasizing if there are discrepancies between MBHP/HNE BH performance specs and any licensing body, the requirements of the licensing body take precedence.

6. In Staffing section: modification of language regarding staff participation in supervision and consultation, appropriate to their degree and licensure level, and in compliance with MBHP/HNE BH’s credentialing criteria and service-specific performance specs; addition of language relative to the provider’s responsibility to maintain documentation of staff supervision and consultation policies and procedures as well as provider compliance with those policies and procedures, and, upon request, providing this documentation to MBHP/HNE BH.

7. In Staffing section, addition of language specifying which staff can provide clinical information to MBHP/HNE BH during clinical reviews, and who is expected to participate during physician to physician reviews with MBHP/HNE BH.

8. In Access and Assessment section, addition of language regarding hours of operation being comparable to those offered to individuals with commercial insurance or to Medicaid Fee-for-Service if only MassHealth Members are seen.

9. In Access and Assessment section, addition of language relative to the reporting of bed/service availability as required by MBHP/HNE BH on the MABHAccess website for all levels of care included in the website.

10. In Access and Assessment section, addition of language relative to provider responsibilities if there are barriers to accessing covered services.

11. In Access and Assessment section, addition of language relative to: what is included in the assessment and initial treatment plan; reference to the timeframes for completion of the initial treatment plan as delineated in each of the service-specific performance specs, assignment of a multi-disciplinary treatment team to each Member within the timeframes delineated in each of the service-specific performance specifications, and the responsibilities of the multi-disciplinary treatment team.

12. In Access and Assessment section, addition of language relative to: the provider informing the MBHP/HNE BH integrated care manager of the Member’s treatment status for those Members participating in MBHP/HNE BH’s Integrated Care Management Program (ICMP), and the referral process to MBHP/HNE BH’s ICMP when additional or complex integrated care coordination may be needed for Members.
13. In Discharge section, addition of language relative to various aspects of the discharge planning process – assistance with barrier identification, making best efforts to ensure that the discharge plan (or other such document(s) that contain the required elements) is consistent with the Member’s benefit coverage, scheduling of follow-up appointments with primary care, development and sharing of the discharge plan (or other such document(s) that contain the required elements), updating of the crisis prevention plan, and/or safety plan (including the link to the MBHP/HNE BH website relative to the Crisis Planning Tools), and/or relapse prevention plan, making best efforts for a smooth transition for youth under age 21, and requirements relative to Members who are homeless

14. In Service, Community, and Collateral Linkages section, addition of language regarding the development of a working relationship with the ESP/MCI provider that covers the catchment area in which the program is located and the various responsibilities the provider has relative to this relationship

15. In Primary Care Clinician (PCC) Integration section, addition of language relative to: “throughout the course of treatment, as applicable, and with appropriate consent, to ensure integration of care” the provider assesses and “make inquiries about” the Member’s “medical”/health status, utilization of medical visits and compliance with medical treatment “through: self-report; communication with the Member’s PCC and/or other relevant healthcare professionals identified by the Member; and communication with MBHP/HNE BH;” ensuring the Member has a PCC; the collaborative relationship developed with the Member’s PCC; communication with the PCC and reasons for such communication; and the purposes of maintaining ongoing communication and collaboration with the PCC

16. In Quality Management section, addition of language noting: the expectation for providers to work with MBHP/HNE BH to improve services based on data derived from Member and provider satisfaction surveys conducted by MBHP/HNE BH; the encouragement of providers to conduct satisfaction survey(s) including Members, family members, and other stakeholders; and the encouragement of Members to utilize data derived from satisfaction surveys to inform the provider’s quality improvement efforts

Corresponding rationales for these major revisions:

1. Provider clarification; reinforcement of requirements and quality of care
2. Provider clarification; consistency with best practices within the greater behavioral health field; reinforcement of quality and continuity of care for the Member
3. Compliance with contract language; provider clarification; reinforcement of requirements and continuity of care for the Member
4. Compliance with contract language; provider clarification; reinforcement of requirements and continuity of care for the Member; consistency with best practices within the greater behavioral health field
5. Provider clarification; consistency with licensing bodies; reinforcement of quality of care
6. Provider clarification; reinforcement of requirements and quality of care; consistency with licensing bodies
7. Provider clarification; reinforcement of requirements, quality of care, and oversight
8. Compliance with contract language; provider clarification; reinforcement of requirements and continuity of care for the Member
9. Compliance with contract language; provider clarification; reinforcement of requirements and continuity of care for the Member
10. Provider clarification; reinforcement of requirements and quality of care
11. Compliance with contract language; provider clarification; reinforcement of requirements and continuity of care for the Member
12. Compliance with contract language; provider clarification; reinforcement of requirements, continuity of care for the Member, and integration
13. Compliance with contract language; provider clarification; reinforcement of requirements, continuity of care for the Member, and integration; incorporation of MassHealth’s recommendation (e.g., consistency with Member’s benefit coverage, and the sharing of the discharge plan with the Member prior to his/her discharge)
14. Provider clarification; reinforcement of requirements, collaboration, and continuity of care for the Member
15. Compliance with contract language; provider clarification; reinforcement of requirements, quality and continuity of care for the Member, and integration; incorporation of MassHealth’s recommendation (e.g., how the provider assesses the Member’s medical/health status)
16. Compliance with contract language; provider clarification; reinforcement of requirements, quality of care for the Member, and collaboration

Input sought:

MBHP/HNE BH Internal Review
1. First level review: Gina Battaglia, Joe Passeneau, Alex Forster, Andrea Gewirtz, Clara Carr, Jane Ryan, Moira Muir
2. Second level review: Nancy Norman, MD, Anne Pelletier Parker
3. Third level review after provider input was obtained: Anne Pelletier Parker, Tamara Lange, Stephanie Brown, John Straus, MD
4. Final review/approval: Stephanie Brown, Mike Curry, Erin Donohue, Alex Forster, Andrea Gewirtz, Janice Harrington, Terri Hubbard, Carol Kress, Tamara Lange, Evan Morse, Moira Muir, Nancy Norman, MD, Elisabeth Okrant, Joe Passeneau, Anne Pelletier Parker, Garland Russell, George Smart, John Straus, MD, Scott Taberner, Kenneth Talbot, James Thatcher, MD

External Review
1. MBHP/HNE BH engaged in a cross-walk of these specs with the Department of Public Health (DPH) Outpatient Mental Health regulations, the DPH Bureau of Substance Abuse Services regulations, the Department of Mental Health (DMH) licensing regulations for mental health facilities, and with our contract.
2. MBHP/HNE BH disseminated the draft revised General performance specifications to providers of the following levels of care and incorporated many areas of their feedback: Inpatient Mental Health Services, Partial Hospitalization Program, Community-Based Acute Treatment (CBAT), Community Support Program (CSP).
3. MBHP/HNE BH disseminated the draft revised General performance specifications to members of the Family Advisory Council (FAC) and the Consumer Advisory Council (CAC) and incorporated many areas of their feedback.
Notable feedback received from the provider network and other stakeholders:

Areas where MBHP/HNE BH incorporated provider and stakeholder feedback

1. Obtaining Member consent relative to active involvement of family/guardian/natural supports in treatment and discharge planning
2. Language noting it is considered best practice to have the capability to accept and treat Members presenting with various co-morbid conditions
3. Language relative to making best efforts to meet the needs of various populations, i.e., those with special needs, e.g., those who are deaf and hard of hearing, those who are homeless, etc.
4. Making written documentation, especially discharge documents, available for Members, and language noting it is considered best practice to have the capability to translate such materials into the Member’s preferred language when requested by the Member
5. Language noting if there are discrepancies between MBHP/HNE BH performance specifications and any licensing body, the requirements of the licensing body take precedence
6. Language noting staff participation in supervision and consultation appropriate to their degree and licensure level
7. Language relative to the maintenance of documentation of staff supervision and consultation policies and procedures
8. Language relative to the provider’s responsibility to manage services to reduce and eliminate the necessity of waiting lists
9. Language noting that information in the assessment may be gathered from the Member and others
10. Timeframes for communication with the Member’s primary care clinician (PCC), dependent on level of care provided
11. Inclusion of language relative to obtaining post-discharge outpatient therapy and medication monitoring appointments in only the specs for those levels of care for which the requirements apply
12. Language relative to making best efforts to ensure a smooth transition for the return to home or discharge location, and to the next service, if any
13. Language relative to the completion of a discharge plan, or other such document(s) that contain the required elements, prior to the Member’s discharge from any inpatient service or, if appropriate, any other behavioral health service
14. Language defining a crisis prevention plan, or safety plan as part of the Crisis Planning Tools for youth
15. Language outlining options a provider may take to assist the Member if he/she does not have an identified PCC
16. Language modification from “refuses” to “declines” relative to a release of information for contact with the PCC, emphasizing a person-centered and strengths-based perspective
17. Omission of the requirement to write an annual Quality Improvement Plan (QIP)
18. Omission of the requirement to conduct annual satisfaction surveys

Areas where MBHP/HNE BH did not incorporate provider and stakeholder feedback

1. Utilization of an appropriately MBHP/HNE BH-credentialed clinician for all clinical reviews with MBHP/HNE BH for a designated service
2. Language relative to offering hours of operation comparable to those offered to individuals with commercial insurance or to Medicaid Fee-for-Service if only MassHealth Members are served
3. The completion and submission to DMH, within two business days of admission, of a DMH Service Authorization packet for Members who are homeless who appear to meet DMH clinical criteria for service eligibility
Inpatient Services
Covered Service: Inpatient Eating Disorders Services

Major revisions made:

1. In the description of the service (first page) (and throughout the specs), modification of language relative to this specialty service, including that these services “represent the most intensive level of psychiatric care” for adults and adolescents with eating disorder diagnoses, that the program provides “a structured treatment milieu” and “evidence-based approaches” specifically “tailored” to “the treatment of” eating disorders, and that the goal of these services is to avoid eating disordered behaviors such as food restricting, purging, over-exercising, or use of laxatives/diet pills/diuretics, to avoid imminent serious harm due to medical consequences or co-morbid medical or psychiatric complications such as complications of refeeding syndrome

2. In the Staffing Requirements section, addition of “experience” relative to the qualifications of the attending psychiatrist

3. In the Staffing Requirements section, addition of language relative to the provider ensuring that mandatory trainings related to the clinical needs of this specialty population are available for all staff directly responsible for providing any treatment component during a Member’s stay, and modification of language relative to what the trainings include

4. In the Assessment section, addition of language specifying that all required assessments include the assessment of the Member’s eating disorder, co-occurring psychiatric and eating disorders, and potential medical complications, and that all treatment plans and treatment plan reviews and updates include goals and interventions specific to the Member’s eating disorder, co-occurring psychiatric and eating disorders, and potential medical complications

5. In the Assessment section, addition of language relative to arrangements made to obtain appropriate laboratory tests and cardiac monitoring, “when indicated, and that physicians are available for consultation relative to medical complications, if any”

6. In the Assessment section, modification of language relative to the assignment to each Member of a primary clinician and/or treatment team that develops a treatment and a rehabilitation and recovery program, and coordinates ongoing treatment interventions for his or her eating disorder(s)

7. In the Discharge section, addition of language specifying that the provider ensures all discharge planning activities address eating disorder recovery issues, and that the discharge and/or aftercare plan includes aftercare services that address eating disorder recovery

8. In the Discharge section, addition of language that the provider specifically ensures that the Member’s primary care clinician (PCC) is involved in discharge planning and is provided with a copy of the discharge summary (or other such document(s) that contain the required elements) within required timeframes

Corresponding rationales for these major revisions:

1. Clarification, reinforcement of: requirements, intent of this specialty service, and quality of care, consistency with language in Inpatient Mental Health Services specs, and per recommendation by MassHealth

2. Correction of missing language, consistency with language in other inpatient specialty specs, reinforcement of requirements

3. Relevance, consistency with revisions made in other specs (and supported by provider feedback), and reinforcement of quality of care
4. Clarification, reinforcement of requirements and quality of care
5. Consistency with language in other inpatient specialty specs, reinforcement of: requirements, the need for collaboration and integrated care, quality of care, and oversight
6. Clarification, reinforcement of requirements and quality of care
7. Reinforcement of: requirements, quality of care, continuity of care for the Member
8. Reinforcement of: requirements, the need for collaboration and integrated care, quality of care, continuity of care for the Member

Input sought:

**MBHP/HNE BH Internal Review**

1. First level review: Gina Battaglia
2. Second level review: Hisla Bates, MD, Anne Pelletier Parker
3. Final review/approval: Stephanie Brown, Mike Curry, Erin Donohue, Alex Forster, Andrea Gewirtz, Janice Harrington, Terri Hubbard, Carol Kress, Tamara Lange, Evan Morse, Moira Muir, Nancy Norman, MD, Elisabeth Okrant, Joe Passeneau, Anne Pelletier Parker, Garland Russell, George Smart, John Straus, MD, Scott Taberner, Kenneth Talbot, James Thatcher, MD

**External Review**

1. MBHP/HNE BH obtained extensive provider input into the original drafting of the performance specifications when they were developed for most levels of care at the start of the MBHP/HNE BH PCC Plan contract. During this revision, as MBHP/HNE BH informed MassHealth, we sought provider input into the specifications only for major levels of care in which we were drafting significant changes. The performance specifications for this level of care did not contain substantive changes to warrant vetting with the provider network or other stakeholders.
2. MBHP/HNE BH engaged in a cross-walk of these specs with: the DMH inpatient mental health regulations, the Centers for Medicare & Medicaid Services (CMS) regulations, with our contract, and with the ValueOptions clinical criteria for Acute Inpatient Eating Disorder Services.
Covered Service: Inpatient Mental Health Services

Major revisions made:
1. In the description of the service (first page), addition of language specifying that these specs apply to providers that serve Members of all ages, and that specific requirements for those providers serving youth are noted throughout.
2. In the Components of Service section, modification of language relative to the admission of adolescents under 18 years old.
3. In the Components of Service section, addition of language, consistent with 603 CMR 28.02(9) and 28.03(3)(c), relative to youth ages 3-21 who remain in the hospital 14 days or more, specifying the responsibility of the provider’s physician, or appropriate designee (provider feedback incorporated), to complete a DESE form 28R/3 and submit it to the student’s principal or other appropriate program administrator, who shall arrange for provision of educational services in the home or hospital.
4. In the Components of Service section, modification of the list of required service components: addition of “bio-psychosocial evaluation,” “medical history,” and “physical evaluation/medical assessment,” and addition of “development of crisis prevention plans, or safety plans as part of the Crisis Planning Tools for youth.”
5. In the Staffing Requirements section, addition of language reflecting the provider’s need to have staff to accept admissions 24/7/365 and to conduct discharges 7/365.
6. In the Staffing Requirements section, addition of language reflecting the requirement to appoint a medical director, his/her responsibilities, and the requirements for providers with units for children and/or adolescents (with additional revisions noted within the Notable feedback received from the provider network and other stakeholders section).
7. In the Staffing Requirements section, addition of language clarifying the requirement for an on-site attending psychiatrist to be assigned to each Member.
8. In the Staffing Requirements section, addition of language clarifying the conditions under which an inpatient hospital may utilize a psychiatry or child psychiatry fellow/trainee to perform psychiatry functions.
9. In the Staffing Requirements section, addition of language clarifying the conditions under which an inpatient hospital may utilize a psychiatric nurse mental health clinical specialist (PNMHCS) to perform psychiatry functions.
10. In the Staffing Requirements section, addition of clarifying language regarding the need for a physician (MD) to be on the hospital grounds 24/7/365 to respond to medical emergencies.
11. In the Staffing Requirements section, omission of language allowing an APRN to provide on-call backup coverage for medical emergencies during weeknights, weekends, and holidays.
12. In the Staffing Requirements section, addition of language reflecting the need to have trained nursing staff on site 24/7/365 to perform functions related to but not limited to medical assessment and triage, admissions, and medication management and monitoring.
13. In the Staffing Requirements section, modification of the youth’s age under which the attending psychiatrist must meet MBHP/HNE BH’s credentialing criteria for a child/adolescent psychiatrist (from “under the age of 16” to “under the age of 14”).
14. In the Staffing Requirements section, addition of clarifying language reflecting the degree, training, and experience required for staff who are involved in the assessment and treatment of Members whose diagnoses include those related to substance use disorders and/or co-occurring disorders.
15. In the Assessment section, clarification of language indicating that the PNMHCS may conduct the comprehensive psychiatric evaluation of the Member only on weekends and holidays, after which the attending psychiatrist must evaluate the Member on the next business day
16. In the Assessment section, addition of language specifying that on weekends and holidays, the initial evaluation may be completed by a covering psychiatrist, or a psychiatric resident or PNMHCS or psychiatry or child psychiatry fellow/trainee, all acting under the attending psychiatrist’s or the medical director’s Member-specific supervision, and that in such situations, the attending psychiatrist must evaluate the Member on the next business day
17. In the Assessment section, addition of language requiring a physical examination/medical assessment within 24 hours of admission by a physician who may be a psychiatrist or a non-psychiatrist physician
18. In the Assessment section, addition of language clarifying the daily responsibilities of the attending psychiatrist and to whom the psychiatrist may designate some of his/her functions when he/she is not scheduled to work or is out for any reason, e.g., another psychiatrist or psychiatric resident acting under the attending psychiatrist’s or medical director’s Member-specific supervision
19. In the Assessment section, addition of language clarifying the requirement for daily individual contact with unit staff
20. In the Discharge section, addition of clarifying language reflecting the need to conduct discharges 7 days per week, 365 days per year
21. In the Discharge section, addition of language reflecting the requirement of the provider (as opposed to the medical director) to ensure active and differential discharge planning is implemented for each Member
22. In the Discharge section, addition of language reflecting the provider’s responsibility for a written discharge summary, or other such document(s) that contain the required elements, to whom the discharge summary should be sent, and what it includes
23. In the Discharge section, addition of language reflecting the need to submit discharge information required by MBHP/HNE BH to MBHP/HNE BH electronically via ProviderConnect no later than within 7 days of the Member’s discharge and that best practice calls for the submission of this information within 24 hours of the Member’s discharge, so that MBHP/HNE BH and/or aftercare providers may outreach to the Member and facilitate compliance with aftercare services within 7 days
24. In the Service, Community, and Collateral Linkages section, addition of language reflecting the provider’s responsibility to contact the appropriate local education authority (LEA) if the school system is involved with the Member around educational planning, curriculum, and/or resources
25. In the Service, Community, and Collateral Linkages section, addition of language reflecting the provider’s responsibility to maintain acting working relationships with the step-down programs for adults, children, and adolescents, but not limited to Children’s Behavioral Health Initiative (CBHI) services, especially with local providers of those levels of care who refer high volumes of Members to the inpatient provider and/or to which the inpatient provider refers high volumes of Members, and that it is considered best practice to maintain written Affiliation Agreements or Memoranda of Understanding (MOU) with such providers (provider feedback incorporated relative to best practice)

Corresponding rationales for these major revisions:
1. Clarification
2. Clarification, reinforcement of requirements, and access to care
3. Clarification, reinforcement of requirements and the need for collaboration
4. Reinforcement of requirements, consistency with existing per diem, relevance
5. Clarification, reinforcement of: requirements, quality of care, access to care
6. Clarification, reinforcement of: requirements, quality of care, and oversight, consistency with best practices within the greater behavioral health field
7. Clarification, reinforcement of: requirements, quality of care, and oversight
8. Clarification, consistency with the Accreditation Council for Graduate Medical Education (ACGME) requirements, reinforcement of: requirements, quality of care, collaboration, and oversight, and supported by provider feedback
9. Clarification, reinforcement of: requirements, quality of care, collaboration, and oversight, supported by provider feedback, and per recommendation of MassHealth
10. Clarification, reinforcement of: requirements, quality of care, and oversight
11. Compliance with DMH inpatient mental health regulations
12. Compliance with DMH licensure requirements
13. Clarification, reinforcement of requirements
14. Reinforcement of: requirements, oversight, quality of care, collaboration and integrated care, and consistency with best practice in the greater behavioral health field
15. Clarification, reinforcement of: requirements, quality of care, and oversight
16. Clarification, reinforcement of: requirements, quality of care, and oversight
17. Clarification, reinforcement of: requirements, quality of care
18. Clarification, reinforcement of: requirements, quality of care, and oversight
19. Clarification, reinforcement of: requirements, quality of care
20. Clarification, reinforcement of: requirements, quality of care, access to care, and continuity of care for the Member
21. Clarification, reinforcement of: requirements, quality of care, and continuity of care for the Member (and supported by provider feedback)
22. Compliance with contract requirement (and supported by provider feedback relative to the “other such document(s)” and “upon discharge and [no later than within two weeks of the Member’s discharge]”)
23. Clarification, reinforcement of: requirements, quality of care, access to care, and continuity of care for the Member (and supported by provider feedback)
24. Clarification, reinforcement of: requirements, quality of care, the need for collaboration, and access to care
25. Reinforcement of: the need for collaboration, integrated care, and continuity of care for the Member (and supported by provider feedback)

Input sought:

MBHP/HNE BH Internal Review
1. First level review: Gina Battaglia
3. Third level review before written stakeholder input was obtained: Carol Kress, Anne Pelletier Parker, James Thatcher, MD
4. Fourth level review before the convening of a focus group to obtain additional stakeholder input: Carol Kress, Anne Pelletier Parker, James Thatcher, MD, Moira Muir
5. Fifth level review before final additional stakeholder input was obtained: Carol Kress, Anne Pelletier Parker, James Thatcher, MD, Moira Muir
6. Sixth level review after final additional stakeholder input was obtained: Carol Kress, Anne Pelletier Parker, James Thatcher, MD
7. Final review/approval: Stephanie Brown, Mike Curry, Erin Donohue, Alex Forster, Andrea Gewirtz, Janice Harrington, Terri Hubbard, Carol Kress, Tamara Lange, Evan Morse, Moira Muir, Nancy Norman, MD, Elisabeth Okrant, Joe Passeneau, Anne Pelletier Parker, Garland Russell, George Smart, John Straus, MD, Scott Taberner, Kenneth Talbot, James Thatcher, MD

**External Review**

1. MBHP/HNE BH engaged in a cross-walk of these specs with: the DMH inpatient mental health regulations, the Centers for Medicare & Medicaid Services (CMS) regulations, our contract, and our credentialing criteria.
2. MBHP/HNE BH sought and incorporated the feedback of MBHP/HNE BH’s Family Advisory Council (FAC) and Consumer Advisory Council (CAC) early on in the process.
3. MBHP/HNE BH disseminated the draft revised Inpatient Mental Health Services performance specs to inpatient providers twice throughout the revision process, as well as convened a focus group of these providers to gather additional input. Along with inpatient providers, MBHP/HNE BH also included David Matteodo, Executive Director of the Massachusetts Association of Behavioral Health Systems (MABHS), and Anuj Goel, VP of Regulations and Staff Counsel, Massachusetts Hospital Association (MHA). MBHP/HNE BH incorporated many areas of their feedback, i.e., after each of the two disseminations to providers for feedback and after the subsequent fourth and fifth level of internal review, as noted above.
4. MBHP/HNE BH engaged in ongoing discussions with select inpatient providers throughout this revision process, which also helped to inform the final draft revised performance specs.
5. MBHP/HNE BH referenced the article titled “Physician Leadership in Residential Treatment for Children and Adolescents” from *Child and Adolescent Psychiatric Clinics of North America* (Vol. 19, Issue 1, pages 21-30, January 2010), by Christopher Bellonci, MD, to help inform the language relative to the medical director.

**Notable feedback received from the provider network and other stakeholders:**

Areas where MBHP/HNE BH incorporated provider and stakeholder feedback, specifically from inpatient providers and representatives from MABHS and MHA

1. Addition of language allowing Members to speak with family members in their native language
2. Modification of language relative to the provision of therapeutic programming (with omission of “full”) 7 days per week, with sufficient professional staff to maintain an appropriate milieu and conduct the services based on individualized Member needs
3. Modification of language relative to the provision of psychological testing, if clinically indicated for stabilization and/or to address diagnostic and treatment questions central to the inpatient assessment, treatment, and discharge planning process
4. Inclusion of language referencing MBHP/HNE BH’s credentialing criteria for psychiatrists, which states that they must be board-certified in general psychiatry by the American Board of Psychiatry and

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*Effective July 1, 2014*
Neurology (ABPN) within two years of contracting with MBHP/HNE BH unless a waiver of this requirement is requested and received within two years of contracting with MBHP/HNE BH
5. Addition of language relative to the delegation to other attending psychiatrists of some of the medical director’s functions, as well as roles he/she shares in collaboration with the clinical leadership team
6. Omission of proposed language that prescribes how frequently the medical director attends multi-disciplinary team meetings
7. Omission of language specifying that Member choice as to an attending psychiatrist is considered by both MBHP/HNE BH and the provider
8. Addition of the definition of a crisis prevention plan, and/or safety plan as part of the Crisis Planning Tools for youth, to the General specs for clarification/guidance
9. Inclusion of other staff, in addition to the medical director or other psychiatrists who are board-certified and/or who meet MBHP/HNE BH’s credentialing criteria, who may provide psychiatric care, e.g., a psychiatry or child psychiatry fellow/trainee, under the medical director’s or another attending psychiatrist’s supervision, and in conformance with the ACGME, and in compliance with all CMS guidelines for supervision of trainees by attending physicians; a PNMHCS, within the scope of their licenses, and under the supervision of the medical director or another attending psychiatrist; or a psychiatric resident, under the supervision of the medical director or another attending psychiatrist
10. Slight modification of language clarifying the on-call psychiatric consultation requirement if the coverage for after 5:00 p.m. and on weekends and holidays is provided by a non-psychiatrically trained physician
11. Addition of language regarding Member access to milieu and clinical staff as clinically indicated
12. Addition of staff with specific substance use disorder-related licenses and/or certifications, and that supervision and/or consultation relative to substance use disorders is made available to staff as needed
13. Modification of language relative to the confirmation of bed availability by the provider and the provider making best efforts to accept the Member as soon as possible and no later than within 30 minutes
14. Omission of proposed language requesting the ESP/MCI to send its completed evaluation to the hospital
15. Language allowing a psychiatrist (preferably but not necessarily the attending psychiatrist to be assigned to the Member) to conduct a comprehensive evaluation of each Member within 24 hours of admission
16. Addition of language allowing an abbreviated treatment team to develop the treatment plan on weekends and holidays, with a review by the full treatment team on the next business day
17. Addition of language clarifying the disciplines which must comprise the multi-disciplinary treatment team, e.g., a psychiatrist and one or more other disciplines
18. Addition of language clarifying the provision of individual, group, and family therapy at a frequency determined in each Member’s individualized treatment plan
19. Addition of language clarifying the provider’s responsibility for coordination with all involved collaterals regarding treatment and care coordination issues, specifically with Member consent and the establishment of the clinical need for such communication
20. Omission of proposed language relative to the responsibilities for the provider’s prescribers relative to medication issues
Areas where MBHP/HNE BH did not incorporate provider and stakeholder feedback, specifically from inpatient providers and representatives from MABHS and MHA

1. Request to modify the no-reject policy, with an understanding of the limitations of inpatient units to manage the complex needs presented by Members
2. Request to remove more of the “prescriptiveness” of the medical director’s role, despite the revisions made within these specs
3. Eliminating the ability of a PNMHCS to conduct the initial comprehensive psychiatric evaluation within 24 hours of admission
4. Request to allow a PNMHCS, acting under the attending psychiatrist’s or the medical director’s Member-specific supervision, to conduct the physical examination/medical assessment within 24 hours of admission
Covered Service: Inpatient Mental Health Services for Children/Adolescents with Intellectual Disabilities/Pervasive Developmental Disorders/Autism Spectrum Disorders (ID/PDD/ASD)

Major revisions made:
1. In the description of the service (first page) and throughout the specs, modification of language relative to this specialty service
2. In the Components of Service section, omission of language throughout the specs, including service components, already included in the Inpatient Mental Health Services specs and per diem
3. In the Components of Service section, addition of the following three service components which the program has the capacity to provide, or refer to, as clinically indicated: speech and language assessment, endocrinology consultation, and nutritional consultation
4. In the Components of Service section, addition of language specifying that the provider admits and has the capacity to treat Members with co-occurring mental health conditions and ID/PDD/ASD, and ensures specific staffing, services and programming to meet the clinical and milieu needs of this population
5. In the Staffing Requirements section, omission of language referencing that Members have access to a pediatrician seven days a week in order to assess and manage non-acute physical conditions
6. In the Staffing Requirements section, addition of language specifying that the provider has access to medical consultation with expertise in assessing the medical condition and needs of Members with co-occurring disorders, and regularly screens for such conditions, as appropriate
7. In the Staffing Requirements section, addition of language that the provider ensures the attending psychiatrist is actively engaged in relevant training to maintain current expertise and relevant certification
8. In the Staffing Requirements section, addition of language specifying that the program utilizes a multi-disciplinary staff who have attained and maintain the established skills, training, and/or expertise in the treatment of Members with mental health conditions and ID/PDD/ASD
9. In the Staffing Requirements section, addition of language that the provider ensures that mandatory staff trainings related to the clinical needs of this specialty population are available for all staff directly responsible for providing any treatment component during a Member’s stay, and that trainings include common co-morbid conditions and concerns (e.g., obesity, Post Traumatic Stress Disorder, etc.)
10. In the Assessment section, addition of language specifying that all required assessments include the consideration of the impact and special needs related to the Member’s ID/PDD/ASD, and that all treatment plans and treatment plan reviews and updates include goals and interventions specific to the Member’s needs related to their ID/PDD/ASD
11. In the Assessment section, addition of language relative to Individual Care Plans (ICPs) for youth enrolled in the Intensive Care Coordination (ICC) service, when applicable
12. In the Assessment section, modification of language relative to the inclusion, with appropriate consent and as applicable, of staff from the local education authority (LEA), Department of Developmental Services (DDS), Department of Children and Families (DCF), and/or other state agencies and providers in treatment and discharge planning processes and meetings (with omission of the requirement to contact these entities within 24 hours of admission)
13. In the Discharge section, addition of language specifying that the provider ensures that all discharge planning activities address the Member’s needs related to their co-occurring psychiatric conditions and medical conditions.
ID/PDD/ASD, and that the discharge and/or aftercare plan includes aftercare services that offer appropriate services to this population and their caregiving families

14. In the Service, Community, and Collateral Linkages section, addition of language relative to the provider’s responsibility to work collaboratively with the local education authorities and involved state agencies including but not limited to DDS, DCF, and others to coordinate treatment and discharge planning

**Corresponding rationales for these major revisions:**

1. Reinforcement of intent of service
2. Elimination of redundancy
3. Relevance, reinforcement of quality of care, consistency with the complex needs of these Members and best practice within the greater behavioral health field
4. Reinforcement of: requirements, quality of care, access to care
5. Language contained within the Inpatient Mental Health Services specs covers this (including “Routine medical care may be deferred, when appropriate, if the length of stay on the inpatient unit is brief”)
6. Relevance, reinforcement of: requirements, the need for collaboration and integrated care, quality of care, and oversight
7. Relevance, reinforcement of requirements and quality of care, consistency with best practice within the greater behavioral health field (American Board of Psychiatry and Neurology (ABPN))
8. Relevance, reinforcement of requirements and quality of care, consistency with best practice within the greater behavioral health field (ABPN)
9. Relevance, consistency with revisions made in other specs (and supported by provider feedback), reinforcement of quality of care, and consistency with best practice within the greater behavioral health field
10. Clarification, reinforcement of requirements and quality of care
11. Clarification, reinforcement of requirements and quality of care
12. Clarification, reinforcement of: requirements, the need for collaboration and integrated care, and quality of care
13. Reinforcement of: requirements, quality of care, continuity of care for the Member, the importance of family support and involvement
14. Reinforcement of: requirements, the need for collaboration and integrated care, quality of care, and continuity of care for the Member

**Input sought:**

**MBHP/HNE BH Internal Review**

1. First level review: Gina Battaglia
2. Second level review: Donald Sherak, MD, Anne Pelletier Parker
3. Final review/approval: Stephanie Brown, Mike Curry, Jaclyn Devine, Erin Donohue, Alex Forster, Andrea Gewirtz, Janice Harrington, Jonna Hopwood, Terri Hubbard, Carol Kress, Tamara Lange, Evan Morse, Moira Muir, Nancy Norman, MD, Elisabeth Okrant, Joe Passeneau, Anne Pelletier Parker, Garland Russell, George Smart, John Straus, MD, Scott Taberner, Kenneth Talbot, James Thatcher, MD
External Review

1. MBHP/HNE BH obtained extensive provider input into the original drafting of the performance specifications when they were developed for most levels of care at the start of the MBHP/HNE BH PCC Plan contract. During this revision, as MBHP/HNE BH informed MassHealth, we sought provider input into the specifications only for major levels of care in which we were drafting significant changes. The performance specifications for this level of care did not contain substantive changes to warrant vetting with the provider network or other stakeholders.

2. MBHP/HNE BH reviewed and incorporated information from the ABPN pertaining to credentials and maintenance of certification.
Covered Service: Inpatient Mental Health Services for Individuals with Intellectual Disabilities (ID)

Major revisions made:

1. In the description of the service (first page) and throughout the specs, modification of language relative to this specialty service
2. In the Components of Service section, omission of language throughout the specs, including service components, already included in the Inpatient Mental Health Services specs and per diem
3. In the Components of Service section, addition of the following four service components which the program has the capacity to provide, or refer to, as clinically indicated: speech and language assessment, endocrinology consultation, nutritional consultation, and smoking cessation assessment
4. In the Components of Service section, addition of language specifying that the provider admits and has the capacity to treat Members with co-occurring mental health conditions and ID, and ensures specific staffing, services and programming to meet the clinical and milieu needs of this population
5. In the Staffing Requirements section, omission of language referencing that Members have access to an internist (medical doctor) seven days a week in order to assess and manage non-acute physical conditions
6. In the Staffing Requirements section, addition of language specifying that the provider has access to medical consultation with expertise in assessing the medical condition and needs of Members with co-occurring disorders, and regularly screens for such conditions, as appropriate
7. In the Staffing Requirements section, addition of language that the provider ensures the attending psychiatrist is actively engaged in relevant training to maintain current expertise and relevant certification
8. In the Staffing Requirements section, addition of language specifying that the program utilizes a multi-disciplinary staff who have attained and maintain the established skills, training, and/or expertise in the treatment of Members with mental health conditions and ID
9. In the Staffing Requirements section, addition of language that the provider ensures that mandatory staff trainings related to the clinical needs of this specialty population are available for all staff directly responsible for providing any treatment component during a Member’s stay, and that trainings include common co-morbid conditions and concerns (e.g., obesity, Post Traumatic Stress Disorder, substance use disorders, etc.)
10. In the Assessment section, addition of language specifying that all required assessments include the consideration of the impact and special needs related to the Member’s ID, and that all treatment plans and treatment plan reviews and updates include goals and interventions specific to the Member’s needs related to their ID
11. In the Assessment section, modification of language relative to the inclusion, with appropriate consent and as applicable, of staff from the local education authority (LEA), Department of Developmental Services (DDS), Department of Children and Families (DCF), Department of Mental Health (DMH), and/or other state agencies and providers in treatment and discharge planning processes and meetings (with omission of the requirement to contact these entities within 24 hours of admission)
12. In the Discharge section, addition of language specifying that the provider ensures that all discharge planning activities address the Member’s needs related to their co-occurring psychiatric conditions and ID, and that the discharge and/or aftercare plan includes aftercare services that offer appropriate services to this population and their caregiving families
13. In the Service, Community, and Collateral Linkages section, addition of language relative to the provider’s responsibility to work collaboratively with the local education authorities and involved state agencies including but not limited to DDS, DMH, DCF, and others to coordinate treatment and discharge planning

**Corresponding rationales for these major revisions:**

1. Reinforcement of intent of service
2. Elimination of redundancy
3. Relevance, reinforcement of quality of care, consistency with the complex needs of these Members and best practice within the greater behavioral health field
4. Reinforcement of: requirements, quality of care, access to care
5. Access to medical consultation (#6 above) covers this, as does existing language within the Inpatient Mental Health Services specs (“Routine medical care may be deferred, when appropriate, if the length of stay on the inpatient unit is brief”)
6. Relevance, reinforcement of: requirements, the need for collaboration and integrated care, quality of care, and oversight
7. Relevance, reinforcement of requirements and quality of care, consistency with best practice within the greater behavioral health field (American Board of Psychiatry and Neurology (ABPN))
8. Relevance, reinforcement of requirements and quality of care, consistency with best practice within the greater behavioral health field (ABPN)
9. Relevance, consistency with revisions made in other specs (and supported by provider feedback), reinforcement of quality of care, and consistency with best practice within the greater behavioral health field
10. Clarification, reinforcement of requirements and quality of care
11. Clarification, reinforcement of: requirements, the need for collaboration and integrated care, and quality of care
12. Reinforcement of: requirements, quality of care, continuity of care for the Member, the importance of family support and involvement
13. Reinforcement of: requirements, the need for collaboration and integrated care, quality of care, and continuity of care for the Member

**Input sought:**

**MBHP/HNE BH Internal Review**

1. First level review: Gina Battaglia
2. Second level review: Donald Sherak, MD, Anne Pelletier Parker
3. Final review/approval: Stephanie Brown, Mike Curry, Jaclyn Devine, Erin Donohue, Alex Forster, Andrea Gewirtz, Janice Harrington, Jonna Hopwood, Terri Hubbard, Carol Kress, Tamara Lange, Evan Morse, Moira Muir, Nancy Norman, MD, Elisabeth Okrant, Joe Passeneau, Anne Pelletier Parker, Garland Russell, George Smart, John Straus, MD, Scott Taberner, Kenneth Talbot, James Thatcher, MD

**External Review**
1. MBHP/HNE BH obtained extensive provider input into the original drafting of the performance specifications when they were developed for most levels of care at the start of the MBHP/HNE BH PCC Plan contract. During this revision, as MBHP/HNE BH informed MassHealth, we sought provider input into the specifications only for major levels of care in which we were drafting significant changes. The performance specifications for this level of care did not contain substantive changes to warrant vetting with the provider network or other stakeholders.

2. MBHP/HNE BH reviewed and incorporated information from the ABPN pertaining to credentials and maintenance of certification.
Covered Service: Inpatient Substance Use Disorder Services
(Level IV Detoxification Services)

Major revisions made:
1. In Components of Service section, the following modifications to the list of service components: addition of components contained within the existing per diem definition but missing from these specs (medical history and physical evaluation, nursing assessment and 24-hour nursing care/services, substance use disorder assessment and treatment services); addition of daily medical management
2. In Components of Service section, addition of language relative to the provision of at least four hours of service programming per day
3. In Staffing section, addition of language relative to the provider’s designation of a physician licensed to practice medicine in the Commonwealth of Massachusetts as Medical Director, that physician’s clinical experience or continuing education credit, and details relative to the Medical Director’s role
4. In Staffing section, addition of clarifying language: 1) that a physician “(MD)” is on call 24/7/365 “to respond to medical emergencies” is available for a phone consultation “to staff” within 15 minutes of request, and is available for a face-to-face consultation within 60 minutes of request (clarification, consistency with IP MH specs, and per recommendation by MassHealth); 2) that during weekday business hours, the physician is a psychiatrist who meets MBHP/HNE BH’s credentialing criteria, that after 5pm weekdays and on weekends and holidays the on-site physician available for emergency coverage may be a psychiatrically or non-psychiatrically trained physician capable of responding to, assessing, and treating medical emergencies within 15 minutes of being notified, and that if this staffing requirement is provided at any time by a non-psychiatrically trained physician psychiatric consultation is provided by a psychiatrist on call who responds by telephone to a call within 15 minutes and, when needed, who has the capacity to come to the facility in person within 60 minutes of being notified
5. In Staffing section, addition of language relative to the staffing pattern requirements as outlined in the Department of Public Health (DPH) regulations inclusive of specific positions
6. In Staffing section, addition of language relative to documentation of monthly, scheduled in-service training sessions provided over the course of a year, as required by the DPH regulations
7. In Staffing section, addition of language relative to staff supervision, including the supervision of nursing staff by a registered nurse
8. In Assessment section, addition of language relative to conducting a brief physical assessment of each Member immediately upon admission
9. In Assessment section, addition of language relative to the completion of a thorough physical examination within 24 hours of admission by a physician and what it includes
10. In Assessment section, addition of language relative to the requirement for an initial clinical assessment by a senior clinician and what it includes
11. In Assessment section, modification of language relative to which staff sees the Member daily and consults to the treatment team and with the outpatient psychiatrist prior to medication changes (from “psychiatrist” to “physician”)
12. In Assessment section, addition of language relative to what the treatment plan includes
13. In Assessment section, addition of language clarifying, with Member consent and the establishment of the clinical need for such communication, the provider’s responsibility for coordination with all involved collaterals regarding treatment and care coordination issues
14. In Discharge section, modification of language relative to the scheduling of post-discharge outpatient therapy and medication monitoring appointments, documentation of aftercare appointments, and how to address barriers to accessing covered services
15. In Discharge section, addition of language relative to the provider’s responsibility for a written discharge summary, or other such document(s) that contain the required elements, the timeframe, to whom the discharge summary should be sent, and what it includes
16. In Discharge section, addition of language relative to the arrangement of aftercare services
17. In Service, Community, and Collateral Linkages section, addition of language reflecting the provider’s responsibility to provide or arrange transportation for services required external to the hospital during the admission and, upon discharge, for placement into a step-down 24-hour level of care, if applicable, and that the provider also makes reasonable efforts to assist Members upon discharge to the community and/or non-24-hour levels of care with identifying transportation options when needed, including public transportation. Prescription for Transportation (PT-1) forms, etc.
18. In Service, Community, and Collateral Linkages section, addition of language relative to the provider’s collaboration with the Member’s primary care clinician (PCC) as delineated in the PCC Integration section of the General performance specifications

Corresponding rationales for these major revisions:
1. Consistency with the per diem definition; compliance with licensing bodies (DPH Bureau of Substance Abuse Services (BSAS) regulations); reinforcement of requirements
2. Compliance with licensing bodies (DPH BSAS regulations); provider clarification of requirements
3. Compliance with licensing bodies (DPH BSAS regulations); provider clarification of requirements
4. Provider clarification; consistency with Inpatient Mental Health Services specs, and per recommendation by MassHealth
5. Compliance with licensing bodies (DPH BSAS regulations); provider clarification of requirements
6. Compliance with licensing bodies (DPH BSAS regulations); provider clarification of requirements
7. Compliance with licensing bodies (DPH BSAS regulations); provider clarification of requirements
8. Compliance with licensing bodies (DPH BSAS regulations); provider clarification of requirements
9. Compliance with licensing bodies (DPH BSAS regulations); provider clarification of requirements
10. Compliance with licensing bodies (DPH BSAS regulations); provider clarification of requirements
11. Compliance with licensing bodies (DPH BSAS regulations); provider clarification; reinforcement of the medical focus of the service
12. Compliance with licensing bodies (DPH BSAS regulations); provider clarification of requirements
13. Reinforcement of requirements, integrated care, collaboration, and quality of care for the Member
14. Provider clarification; compliance with contract language relative to 24-hour levels of care
15. Provider clarification; compliance with contract language relative to inpatient levels of care
16. Compliance with licensing bodies (DPH BSAS regulations); provider clarification of requirements
17. Provider clarification of requirements; appropriate expectation given the level of care, consistency with Inpatient Mental Health specs)
18. Provider clarification; reinforcement of requirements, integrated care, collaboration, and quality of care for the Member
Input sought:

**MBHP/HNE BH Internal Review**
1. First level review: Gina Battaglia, Jonna Hopwood, James Thatcher, MD, Kevin Weir, Steve Zessis, Moira Muir, Elizabeth O’Brien
2. Second level review: Anne Pelletier Parker
3. Final review/approval: Stephanie Brown, Mike Curry, Erin Donohue, Alex Forster, Andrea Gewirtz, Janice Harrington, Terri Hubbard, Carol Kress, Tamara Lange, Evan Morse, Moira Muir, Nancy Norman, MD, Elisabeth Okrant, Joe Passeneau, Anne Pelletier Parker, Garland Russell, George Smart, John Straus, MD, Scott Taberner, Kenneth Talbot, James Thatcher, MD

**External Review**
1. MBHP/HNE BH obtained extensive provider input into the original drafting of the performance specifications when they were developed for most levels of care at the start of the MBHP/HNE BH PCC Plan contract. During this revision, as MBHP/HNE BH informed MassHealth, we sought provider input into the specifications only for major levels of care in which we were drafting significant changes. The performance specifications for this level of care did not contain substantive changes to warrant vetting with the provider network or other stakeholders.
2. MBHP/HNE BH engaged in a cross-walk of these specs with the DPH BSAS regulations, and with our contract.
Covered Service: Observation/Holding Beds

Major revisions made:
1. In the description of the service (first page), modification of the title of this specialty service (“Observation Beds up to 24 Hours” to “Observation/Holding Beds”)
2. In the description of the service (first page) and throughout the specs, modification of language clarifying this specialty inpatient service and its goal, including changing “extended evaluation period” to “observation period”
3. In the Components of Service section, slight modification of language within required service components – from “intense” to “intensive” relative to case management and collateral contact, and addition of “as indicated” to “meetings with family/significant others”
4. In the Assessment section, addition of clarifying language relative to the activities that take place upon admission and within certain timeframes, e.g., modification of “bio-psychosocial”; omission of “multidisciplinary” relative to the initial treatment plan; addition of “discharge plan” to “development of initial treatment plan”; modification of “evaluation by RN” to “nursing assessment”; addition of clarifying language relative to “medical history and physical examination” and omission of “complete systems review”; addition of “discharge planning” to the “coordination of all treatment planning”
5. In the Assessment section, omission of language relative to the provider’s adherence to the DMH regulations if a Member is admitted to an acute facility on a 12a
6. In the Assessment section, modification of language relative to the provider’s responsibility to determine a disposition and plan and coordinate all treatment services needed after the observation period of up to 24 hours

Corresponding rationales for these major revisions:
1. Compliance with contract language
2. Consistency with language in the Inpatient Mental Health Services specs and with the title
3. Relevance, reinforcement of requirements
4. Clarification, consistency with existing per diem, relevance, reinforcement of quality of care, elimination of redundancy
5. Covered in Inpatient Mental Health Services specs, of which these specs are a subset and with which they must comply
6. Clarification, reinforcement of requirements

Input sought:

MBHP/HNE BH Internal Review
1. First level review: Gina Battaglia
2. Second level review: Anne Pelletier Parker, Shelley Baer
3. Final review/approval: Stephanie Brown, Mike Curry, Erin Donohue, Alex Forster, Andrea Gewirtz, Janice Harrington, Terri Hubbard, Carol Kress, Tamara Lange, Evan Morse, Moira Muir, Nancy Norman, MD, Elisabeth Okrant, Joe Passeneau, Anne Pelletier Parker, Garland Russell, George Smart, John Straus, MD, Scott Taberner, Kenneth Talbot, James Thatcher, MD
External Review

1. MBHP/HNE BH obtained extensive provider input into the original drafting of the performance specifications when they were developed for most levels of care at the start of the MBHP/HNE BH PCC Plan contract. During this revision, as MBHP/HNE BH informed MassHealth, we sought provider input into the specifications only for major levels of care in which we were drafting significant changes. The performance specifications for this level of care did not contain substantive changes to warrant vetting with the provider network or other stakeholders.

2. MBHP/HNE BH engaged in a cross-walk of these specs with: the DMH inpatient mental health regulations, the Centers for Medicare & Medicaid Services (CMS) regulations, and with our contract.
24-Hour Diversionary Services
Covered Service: Acute Treatment Services (ATS) for Pregnant Women

Major revisions made:
1. In the Components of Service section, omission of language relative to two service components: fetal monitoring and obstetric/gynecological nurse case management
2. In the Components of Service section and throughout the specs, addition of language relative to documentation, e.g., of Affiliation Agreements, medical protocols, consultations, etc.
3. In the Staffing Requirements section, addition of language specifying that the program’s medical and nursing staff are responsible for ensuring that program staff coordinate care with the Member’s primary care clinician (PCC) and obstetrician/gynecologist (OB/GYN), and consult with those physicians as needed
4. In the Staffing Requirements section, omission of language requiring the availability of one full-time RN with formal training and prior medical experience in OB/GYN, the additional .25 FTE RN with OB/GYN experience, and other professional and medical staff with skills, training, and experience in OB/GYN
5. In the Assessment section, modification of language specifying that the assessment and discharge plans also address prenatal care issues and are developed in consultation with the Member’s PCC and/or OB/GYN, in addition to this being addressed in the treatment/recovery plan
6. In the Service, Community, and Collateral Linkages section, omission of language requiring the notification to MBHP/HNE BH upon admission of pregnant Members for referral to MBHP/HNE BH’s care management program
7. In the Service, Community, and Collateral Linkages section, modification of language relative to linkage to services “based on individual Member needs”

Corresponding rationales for these major revisions:
1. Consistency with the recent decision from the Department of Public Health (DPH) Bureau of Substance Abuse Services (BSAS) that all ATS programs should provide access to pregnant women, and the discontinuation of ATS for Pregnant Women as an enhanced service as well as elimination of the requirement for these two components within the service
2. Clarification, reinforcement of requirements
3. Clarification, reinforcement of: requirements, the need for collaboration and integrated care, and quality of care
4. Consistency with the recent decision from the Department of Public Health (DPH) Bureau of Substance Abuse Services (BSAS) that all ATS programs should provide access to pregnant women, and the discontinuation of ATS for Pregnant Women as an enhanced service as well as elimination of the requirement for these two components within the service
5. Clarification, reinforcement of: requirements, the need for collaboration and integrated care, and quality of care
6. Not applicable/relevant (Note: female Members who are pregnant and using substances are identified via other means and are subsequently referred to an appropriate program based on their needs, as indicated)
7. Clarification, reinforcement of quality of care
Input sought:

**MBHP/HNE BH Internal Review**
1. First level review: Gina Battaglia
2. Second level review: Anne Pelletier Parker, James Thatcher, MD, Jonna Hopwood, Kevin Weir, Steve Zessis, Elizabeth O’Brien, Moira Muir
3. Third level review: Anna Pelletier Parker, Jonna Hopwood, Garland Russell, Bernie Ouimet
4. Final review/approval: Stephanie Brown, Mike Curry, Erin Donohue, Alex Forster, Andrea Gewirtz, Janice Harrington, Terri Hubbard, Carol Kress, Tamara Lange, Evan Morse, Moira Muir, Nancy Norman, MD, Elisabeth Okrant, Joe Passeneau, Anne Pelletier Parker, Garland Russell, George Smart, John Straus, MD, Scott Taberner, Kenneth Talbot, James Thatcher, MD

**External Review**
1. MBHP/HNE BH obtained extensive provider input into the original drafting of the performance specifications when they were developed for most levels of care at the start of the MBHP/HNE BH PCC Plan contract. During this revision, as MBHP/HNE BH informed MassHealth, we sought provider input into the specifications only for major levels of care in which we were drafting significant changes. The performance specifications for this level of care did not contain substantive changes to warrant vetting with the provider network or other stakeholders.
2. MBHP/HNE BH engaged in a cross-walk of these specs with the DPH BSAS regulations, with our credentialing criteria, and with our contract.
3. MBHP/HNE BH participated in a meeting in late fall 2013 hosted by DPH BSAS to discuss Medication Assisted Treatment for pregnant Members, and the information gathered helped to inform the revisions of these specs and the specs for ATS for Substance Use Disorders and E-ATS.
Covered Service: Acute Treatment Services (ATS) for Substance Use Disorders
Level III.7

Major revisions made:
1. In the description of the service (first page) and throughout the specs, modification of language to clarify the service and what it incorporates, e.g., medically monitored inpatient detoxification treatment, delivered under the consultation of a licensed physician, to monitor an individual’s withdrawal from alcohol and other drugs to alleviate symptoms, not requiring medically managed detoxification service
2. In the Components of Service section, omission of the following language: “the provider agrees, subject to bed availability and clinical appropriateness, to admit adult persons who require acute, 24-hour substance abuse treatment and who are referred to his or her facility by an ESP regardless of the person’s ability to pay”
3. In the Components of Service section, modification of language relative to the provision of therapeutic programming (omission of “full”) and to the maintenance of an appropriate milieu and conducting the required services based on individualized Member needs
4. In the Components of Service section, modification of the list of required service components: “bio-psychosocial evaluation” (rather than “psychosocial evaluation, monitoring, and treatment”); addition of medical history and physical examination, nursing assessment, and substance use disorder assessment, omission of rehab counseling, and addition of case management and routine medications
5. In the Components of Service section, modification of the number of hours of service programming per day (from “three or more” to “at least four”)
6. In the Staffing Requirements section, addition of clarifying language relative to the utilization of physicians for psychiatric and pharmacological consultation (in the paragraph relative to utilization of a multi-disciplinary staff)
7. In the Staffing Requirements section, addition of language clarifying that the provider ensures that supervision of nursing staff is overseen by a registered nurse
8. In the Staffing Requirements section, addition of language relative to the provider designating the consulting physician or another physician licensed to practice medicine in the Commonwealth of MA as medical director with demonstrated training, experience, and expertise in the treatment of substance use disorders, who is responsible for overseeing all medical services performed by the program, and is responsible for clinical and medical oversight, quality of care, and clinical outcomes, in collaboration with the nursing and clinical leadership team
9. In the Assessment section, omission of “following a face-to-face evaluation by an identified MBHP/HNE BH provider” relative to the provider making a decision within 15-30 minutes of the request for admission
10. In the Assessment section, addition of language relative to coverage when the RN is not scheduled to work or is out for any reason, e.g., designation of a consistent substitute to ensure the Member receives continuity of care, and that this function may be designated to an LPN acting under an RN’s or the physician’s Member-specific supervision
11. In the Assessment section, addition of language specifying the completion of a treatment/recovery plan, as delineated in the General performance specifications, and in conjunction with the Member, and that the provider makes best efforts to also involve other relevant collaterals in the treatment planning process
12. In the Assessment section, modification of the timeframe in which the multi-disciplinary treatment team meets to review the assessment and develop an initial treatment/recovery plan and initial discharge plan (from “within 24 hours” to “within 48 hours of admission”)

13. In the Assessment section, addition of language clarifying that on weekends and holidays, the treatment/recovery plan may be developed by an abbreviated treatment team, with review by the full treatment team on the next business day

14. In the Assessment section, addition of language specifying that the provider ensures that a physical examination which conforms to the principles established by the American Society of Addiction Medicine (ASAM) is completed for all Members within 24 hours of admission, and that if the examination is conducted by a qualified health professional who is not a physician, the results and any recommendations arising from the examination are reviewed by the nursing supervisor prior to implementation

15. In the Assessment section, addition of language specifying that the treatment/recovery and discharge plans are reviewed at least every 48 hours (a maximum of 72 hours between reviews on weekends) and updated accordingly, based on each Member’s individualized progress

16. In the Assessment section, addition of language specifying, with Member consent and the establishment of the clinical need for such communication, the provider’s responsibility for coordination with all involved collaterals regarding treatment and care coordination issues

17. In the Assessment section, addition of language specifying for pregnant women, the provider coordinates care with her PCC and OB/GYN, and consults with those physicians as needed

18. In the Service, Community, and Collateral Linkages section, modification of language specifying the staff members’ familiarity with all the levels of care/services noted within the specs (including omission of the requirement for formal, active, affiliation agreements with the levels of care/services), the maintenance of written Affiliation Agreement with local providers of these levels of care that refer a high volume of Members to their program and/or to which the program refers a high volume of Members, and modification of the list of levels of care/services

19. In the Service, Community, and Collateral Linkages section, addition of language specifying that the provider also makes reasonable efforts to assist Members upon discharge to the community and/or non-24-hour levels of care with identifying transportation options when needed, including public transportation, Prescription for Transportation (PT-1) forms, etc.

Corresponding rationales for these major revisions:
1. Consistency with the Department of Public Health’s (DPH) Bureau of Substance Abuse Services (BSAS) regulations, reinforcement of requirements
2. Correction (ESP's are not the gatekeeper, and ability to pay is not a factor)
3. Clarification, reinforcement of requirements, consistency with language used in other levels of care, and supported by provider feedback
4. Clarification, reinforcement of requirements, and consistency with existing per diem
5. Clarification, reinforcement of requirements, and consistency with DPH BSAS regulations
6. Clarification, reinforcement of requirements, and consistency with existing per diem
7. Clarification, reinforcement of requirements, and consistency with DPH BSAS regulations
8. Clarification, reinforcement of requirements, and consistency with DPH BSAS regulations
9. Clarification that ATS admissions do not require an Emergency Services Program (ESP) or any other evaluation
10. Clarification, reinforcement of requirements and the need for oversight
11. Clarification, reinforcement of: requirements, quality of care, and the need for collaboration and integrated care
12. Clarification, reinforcement of requirements, consistency with contract requirements
13. Clarification, reinforcement of requirements, consistency with language used in other 24-hour levels of care, and supported by provider feedback
14. Clarification, reinforcement of requirements, and consistency with DPH BSAS regulations
15. Clarification, reinforcement of requirements, consistency with language used in other 24-hour levels of care, and supported by provider feedback
16. Clarification, reinforcement of: requirements, quality of care, and the need for collaboration and integrated care, consistency with language used in other levels of care, and supported by provider feedback
17. Reinforcement of: requirements, the need for collaboration and integrated care, and quality of care
18. Relevance, reinforcement of requirements and continuity of care for the Member, and consistent with consistency with language and LOCs/services used in other substance use disorder-related specs
19. Clarification, reinforcement of requirements and quality of care, and consistency with language used in other substance use disorder-related specs

Input sought:

**MBHP/HNE BH Internal Review**
1. First level review: Gina Battaglia
2. Second level review: Anne Pelletier Parker, James Thatcher, MD, Jonna Hopwood, Kevin Weir, Steve Zessis, Elizabeth O’Brien, Moira Muir
3. Third level review: Anne Pelletier Parker, Jonna Hopwood, Garland Russell
4. Final review/approval: Stephanie Brown, Mike Curry, Erin Donohue, Alex Forster, Andrea Gewirtz, Janice Harrington, Terri Hubbard, Carol Kress, Tamara Lange, Evan Morse, Moira Muir, Nancy Norman, MD, Elisabeth Okrant, Joe Passeneau, Anne Pelletier Parker, Garland Russell, George Smart, John Straus, MD, Scott Taberner, Kenneth Talbot, James Thatcher, MD

**External Review**
1. MBHP/HNE BH obtained extensive provider input into the original drafting of the performance specifications when they were developed for most levels of care at the start of the MBHP/HNE BH PCC Plan contract. During this revision, as MBHP/HNE BH informed MassHealth, we sought provider input into the specifications only for major levels of care in which we were drafting significant changes. The performance specifications for this level of care did not contain substantive changes to warrant vetting with the provider network or other stakeholders.
2. MBHP/HNE BH engaged in a cross-walk of these specs with the DPH BSAS regulations, with our credentialing criteria, and with our contract.
3. MBHP/HNE BH participated in a meeting late fall 2013 hosted by DPH BSAS to discuss Medication Assisted Treatment for pregnant Members and the information gathered helped to inform the revisions of these specs, the specs for ATS for Pregnant Women, and the specs for E-ATS.
Covered Service: Clinical Stabilization Services (CSS) for Substance Use Disorders Level III.5

Major revisions made:
1. Throughout the specs, modification of the title of this service from “CSS for Substance Abuse Level III.5” to “CSS for Substance Use Disorders Level III.5”
2. Throughout the specs, modification of the ATS title, referenced within these specifications, from “Acute Treatment Services for Substance Abuse Level IIIA” to “Acute Treatment Services for Substance Use Disorders Level III.7”
3. Throughout the specs, addition and/or modification of substance use-related language (e.g., “clinically managed detoxification services”; “provided in a non-medical setting”; “services include supervision, observation, and support”; “a minimum of 15 psycho-educational groups per week”; staffing requirements for nursing “depending on bed capacity”; Recovery Specialist-to-Member ratio on day/evening/overnight shifts; the availability of a physician for consultation to staff 24 hours per day, seven days per week; “ensuring active, post-discharge follow-up plans, supports, and referrals by care coordinators”; “the provision or arrangement of transportation for the Member”)
4. In the description of the service (first page), addition of language clarifying that Members may be admitted to CSS directly from the community or as a transition from inpatient services
5. In the Components of Service section, addition of service components noted in the existing per diem but not in the original performance specs (medical history, physical examination, substance use disorder assessment/treatment services, nursing assessment/services), and modification of two service components (psychiatric consultation “by referral” and psychopharmacological consultation “by referral”)
6. In the Components of Service section, addition of language clarifying the documented attempts the provider makes to contact the Member’s parent, guardian, family members and/or significant others within 24 hours of admission, unless clinically or legally contraindicated, and what information is provided to them
7. In the Components of Service section, addition of language clarifying that the provider complies with the Department of Public Health’s (DPH) implementation of the Culturally and Linguistically Appropriate Services (CLAS) Standards
8. In the Assessment section, modification of the timeframe within which providers must make a decision to admit Members (from “within 15-30 minutes” to “within 20 minutes”)
9. In the Assessment section, addition of language specifying: treatment/recovery plan completion requirements (“as delineated within the General performance specifications”); assignment of a multi-disciplinary treatment team (“within 24 hours of admission”); development and review of the assessment and initial treatment/recovery and discharge plans (“within 48 hours of admission”); the review of treatment/recovery and discharge plans (“at least every 48 hours”); and the updating of treatment/recovery and discharge plans (“accordingly, based on each Member’s individualized needs”)
10. In the Assessment section, addition of language specifying that the provider ensures that a physical examination which conforms to the principles established by the American Society of Addiction Medicine (ASAM) is completed for all Members within 24 hours of admission, and that if the examination is conducted by a qualified health professional who is not a physician, the results and any recommendations arising from the examination are reviewed by the nursing supervisor prior to implementation
Corresponding rationales for these major revisions:

1. Consistency with changes within the greater substance use disorder field
2. Consistency with changes within the greater substance use disorder field
3. Consistency with requirements within the DPH BSAS regulations for this service
4. Provider clarification and reinforcement of requirements and procedures
5. Reinforcement of existing service component requirements in the per diem; provider clarification and reinforcement that these service components are not required to be provided in-house; and development and/or updating of crisis prevention/safety plan and/or relapse prevention plan is a reasonable expectation for most LOCs and supports continuity of care for the Member
6. Provider clarification, reinforcement of requirements and procedures, to ensure quality of care, and to emphasize the important of the involvement of relevant individuals in the Member’s life in the treatment and discharge planning process
7. Provider clarification, reinforcement of requirements and procedures, to ensure consistency with DPH BSAS regulations
8. Provider clarification of requirements and procedures, and reinforcement of access to care
9. Provider clarification of requirements and procedures, to ensure compliance with contract language, and to ensure quality of care
10. Provider clarification, reinforcement of requirements, and consistency with the BSAS regs

Input sought:

MBHP/HNE BH Internal Review
1. First level review: Jonna Hopwood, Andrea Gewirtz, James Thatcher, MD, Elizabeth O’Brien, Steve Zessis, Kevin Weir
2. Second level review: Anne Pelletier Parker
3. Final review/approval: Stephanie Brown, Mike Curry, Erin Donohue, Alex Forster, Andrea Gewirtz, Janice Harrington, Terri Hubbard, Carol Kress, Tamara Lange, Janet Leopold, Evan Morse, Moira Muir, Nancy Norman, MD, Elisabeth Okrant, Joe Passeneau, Anne Pelletier Parker, Garland Russell, George Smart, John Straus, MD, Scott Taberner, Kenneth Talbot, James Thatcher, MD

External Review
1. MBHP/HNE BH obtained extensive provider input into the original drafting of the performance specifications when they were developed for most levels of care at the start of the MBHP/HNE BH PCC Plan contract. During this revision, as MBHP/HNE BH informed MassHealth, we sought provider input into the specifications only for major levels of care in which we were drafting significant changes. The performance specifications for this level of care did not contain substantive changes to warrant vetting with the provider network or other stakeholders.
Covered Service: Community-Based Acute Treatment (CBAT) Services for Children and Adolescents

Major revisions made:

1. Throughout the specs, modification of “psychiatrist” or “attending psychiatrist” to “child psychiatrist” or “attending child psychiatrist,” respectively

2. On the first page, slight modification of the description of the service: inclusion of ages of youth appropriate for the service (up to the age of 18, with clarification that youth ages 19-20 may be eligible for admission based on a program’s licensing requirements and a Member’s clinical needs); clarification of the primary function (short-term crisis stabilization, therapeutic intervention, and specialized programming) and goal (supporting the rapid and successful transition of the child/adolescent back to the community) of the service; clarification of the environment as staff-secure; modification of “intensive” to “acute” to describe the therapeutic services; modification of “case management” to “care coordination”; modification of psychiatric assessment “and treatment”; modification of “medication monitoring” to “pharmacological assessment, monitoring, and treatment”; omission of “family assessment”; omission of “psychological testing as needed”; and clarification regarding the two ways in which youth may be admitted to CBAT (“directly from the community or as a transition from inpatient services”)

3. In the Components of Service section, modification of the list of required service components: addition of “development of safety plans as part of the Crisis Planning Tools for youth”; omission of “medical evaluation” and addition of “medical history and medical assessment (basic physical examination to assess for medical issues)”; addition of “inclusive of the MA Child and Adolescent Needs and Strengths (CANS) tool completed by a CANS-certified clinician as part of discharge planning” relative to psychiatric evaluation and treatment; addition of “(excluding weekends and holidays)” relative to the educational component

4. In the Components of Service section, modification of the “capacity to provide, or refer to” list: addition of the clarifier “if clinically indicated for stabilization and/or to address diagnostic and treatment questions central to the CBAT assessment, treatment, and discharge planning process” relative to psychological testing; addition of “Assessment for Safe and Appropriate Placement” to the list; and addition of “neuropsychological testing”

5. In the Staffing section, addition of language reflecting the requirement for a CBAT program director or supervisor, his/her credentials, and his/her responsibilities

6. In the Staffing section, addition of language reflecting the requirement to appoint a medical director who is fully integrated into the administrative and leadership structure of the CBAT program and is responsible for clinical and medical oversight, quality of care, and clinical outcomes across all CBAT service components, in collaboration with the program director or supervisor and the clinical leadership team

7. In the Staffing section, addition of language relative to: a) the qualifications of the medical director (a child fellowship-trained psychiatrist who is board-certified and/or who meets MBHP/HNE BH’s credentialing criteria for a child/adolescent psychiatrist, with a note added relative to MBHP/HNE BH’s credentialing criteria for child and adolescent psychiatrists); and b) the responsibilities of the medical director, including ensuring that psychiatric practice is consistent with the best available evidence-based practices and parameters developed by the American Academy of Child and Adolescent Psychiatry (AACAP)
8. In the Staffing section, addition of language reflecting who may provide psychiatric care to Members (medical director, other child fellowship-trained psychiatrists, a child psychiatry fellow/trainee (including the website for the Accreditation Council for Graduate Medical Education (ACGME)), or a psychiatric nurse mental health clinical specialist (PNMHCS)), and what this consists of.

9. In the Staffing section, addition of language clarifying the situations in which a child psychiatrist conducts initial face-to-face psychiatric evaluations of Members.

10. In the Staffing section, addition of language clarifying the conditions under which a program may utilize a child psychiatry fellow/trainee to perform psychiatry functions.

11. In the Staffing section, addition of language clarifying the conditions under which a program may utilize a PNMHCS to perform psychiatry functions.

12. In the Staffing section, addition of clarifying language relative to presentation of the youth to the attending child psychiatrist, or other child psychiatrist on duty, within 24 hours if the face-to-face evaluation is conducted by a child psychiatry fellow/trainee or PNMHCS.

13. In the Staffing section, addition of language regarding: a) the utilization of trained nursing staff (RN or LPN), or the program’s psychiatry and/or PNMHCS staff, to perform functions related to the admission process, including engage in a medication reconciliation process as outlined within the Components of Service section of these specifications; b) when these staff are expected to be available (during day and evening shifts as needed); and c) the on-call child psychiatrist who can be consulted after hours relative to medical issues and concerns.

14. In the Staffing section, addition of language regarding collaboration with the Member’s PCC and/or access to a consulting pediatrician via an Affiliation Agreement for medical consultation, as clinically indicated, when ordered by the attending child psychiatrist or otherwise needed.

15. In the Staffing section, addition of language clarifying that the program ensures adequate staffing of master’s-level clinicians certified to administer the MA CANS tool.

16. In the Assessment section, addition of language clarifying: a) the program’s need to respond within 30 minutes to requests for admission (timeframe unchanged) (including evenings and weekends); b) at a minimum, when the program accepts and admits Members (during first and second shifts from 7:00 a.m. to 11:00 p.m., 7 days per week, 365 days per year); c) that it is best practice to have mechanisms to accept referrals 24 hours per day; and d) that it is an additional best practice to admit Members 24 hours per day.

17. In the Assessment section, addition of language clarifying the conditions under which an initial face-to-face evaluation must occur by a child psychiatrist, PNMHCS, or child psychiatry fellow/trainee within 24 hours of admission and also within 48 hours of admission, including the oversight provided if the initial evaluation is completed by a PNMHCS or child psychiatry fellow/trainee.

18. In the Assessment section, addition of language regarding requirements for admissions who meet the criteria for the 48-hour timeframe and whose 48 hours falls on a weekend or holiday.

19. In the Assessment section, addition of language clarifying: a) what the psychiatric evaluation consists of – medical history (new), assessment of psychiatric, pharmacological, and treatment needs of the Member, and a clinical formulation; b) who preferably performs the evaluation (the Member’s attending child psychiatrist, or another child psychiatrist, a PNMHCS, or a child psychiatry fellow/trainee (language in the current/existing specs refers to an attending psychiatrist)); and c) the option of contacting the parent/guardian/caregiver by telephone as part of the initial evaluation (new).

20. In the Assessment section, addition of language relative to the key components in clinical assessments.
21. In the Assessment section, addition of clarifying language regarding: a) the assignment of a multi-disciplinary treatment team to each Member within 24 hours of admission, and b) the review of the assessments and the initial treatment and initial discharge plans (changed from “within 72 hours of admission” to “within 48 hours of admission”; language in the current/existing specs refers to the provisional treatment plan being established “within 24 hours of admission”)

22. In the Assessment section, addition of treatment and discharge plan language reflecting the identification of anticipated services to facilitate and support the Member’s rapid return to the community, including the clinical appropriateness of referrals for CBHI services with the consent of the parent/guardian/caregiver

23. In the Assessment section, addition of clarifying language regarding the need for the assessment and treatment plan to address the possible barriers to the Member’s successful return to his/her living situation prior to the CBAT admission, including treatment strategies and other efforts to mitigate those barriers

24. In the Assessment section, addition of clarifying language regarding: a) the requirement for reviews of treatment plans and discharge plans (every 48 hours; the current/existing specs are silent on this); b) updating the plans accordingly, based on each Member’s individualized progress; and c) the CBAT program’s responsibilities during treatment plan reviews

25. In the Discharge section, addition of language reflecting the requirement of the provider (as opposed to the medical director) to ensure that active and differential treatment and discharge planning is implemented for each Member by qualified and knowledgeable staff

26. In the Discharge section, addition of language relative to the discharge planning process, including plans for reintegration or integration into the home or other living situation, school, and community

27. In the Discharge section, addition of language reflecting the provider’s responsibility for a written discharge summary, or other such document(s) that contain the required elements, to whom the discharge summary should be sent, and what it includes

28. In the Service, Community, and Collateral Linkages section, addition of language reflecting the provider’s responsibility to maintain, via Affiliation Agreements or Memoranda of Understanding (MOU), linkages with the step-down programs for adults, children, and adolescents, including but not limited to Transitional Care Units (TCUs) and Children’s Behavioral Health Initiative (CBHI) services, to which the program refers high volumes of Members, to enhance continuity of care for the member

29. In the Service, Community, and Collateral Linkages section, addition of language reflecting the provider’s responsibility to contact the appropriate local education authority (LEA) if the school system is involved with the Member around educational planning, curriculum, and/or resources

**Corresponding rationales for these major revisions:**

1. Clarification, reinforcement of requirements, and ensuring that services and oversight are provided by a child psychiatrist
2. Clarification, consistency with the title of the specs and reinforcement that this is an acute service, consistency with edits made in other specs and per feedback from MassHealth, consistency with the per diem, and per recommendation by MassHealth
3. Clarification, appropriate expectation, reinforcement of: requirements, continuity of care for the Member, and state requirements, ensuring consistency with the per diem, and supported by provider feedback
4. Clarification, appropriate expectation, ensuring consistency with the per diem, and reinforcement of requirements, and supported by provider feedback
5. Clarification, appropriate expectation, reinforcement of: requirements, quality of care, and oversight, and supported by provider feedback
6. Clarification, reinforcement of: requirements, quality of care, oversight, and collaboration, consistency with language used in other specs where a medical director is referenced, and supported by provider feedback
7. Clarification, consistency with best practices within the greater behavioral health field, and reinforcement of: requirements, quality of care, oversight, and collaboration, and supported by provider feedback
8. Clarification, reinforcement of: requirements, quality of care, and oversight, and supported by provider feedback
9. Clarification, reinforcement of requirements and quality of care
10. Clarification, consistency with ACGME requirements, reinforcement of: requirements, quality of care, collaboration, and oversight, and supported by provider feedback
11. Clarification, reinforcement of: requirements, quality of care, collaboration, and oversight, supported by provider feedback, and per recommendation of MassHealth
12. Clarification, reinforcement of: requirements, quality of care, and oversight, and supported by provider feedback
13. Clarification, reinforcement of: requirements, quality of care, continuity of care, and oversight, and supported by provider feedback
14. Clarification, reinforcement of: requirements, quality of care, collaboration and integrated care, and supported by provider feedback
15. Clarification, reinforcement of requirements, consistency with state requirements
16. Clarification, reinforcement of: requirements, quality of care, access to care, ensuring responsiveness to needs of youth/families, consistency with best practices in the greater behavioral health field, and supported by provider feedback
17. Clarification, reinforcement of: requirements, quality of care, and oversight, and supported by provider feedback
18. Clarification, reinforcement of: requirements, quality of care, and oversight, and supported by provider feedback
19. Clarification, reinforcement of: requirements, quality of care, oversight, and ensuring responsiveness to needs of youth/families, and supported by provider feedback
20. Clarification, reinforcement of: requirements, quality of care, and continuity of care
21. Clarification, consistency with contract requirements, and reinforcement of: requirements, quality of care, collaboration, and oversight
22. Clarification, reinforcement of: requirements, quality of care, continuity of care, and ensuring responsiveness to needs of youth/families, and supported by provider feedback
23. Clarification, reinforcement of: requirements, quality of care, and continuity of care, ensuring responsiveness to needs of youth/families
24. Clarification, reinforcement of: requirements, quality of care, collaboration, and continuity of care, and supported by provider feedback
25. Clarification, reinforcement of: requirements, quality of care, and continuity of care for the Member (and supported by provider feedback that responsibility has been transferred from the medical director to the provider in general)
26. Clarification, reinforcement of: requirements, quality of care, continuity of care
27. Compliance with contract requirement for providers of IP and CBAT services (and supported by provider feedback relative to the “other such document(s)” and “upon discharge and [no later than within two weeks of the Member’s discharge]”)
28. Reinforcement of: the need for collaboration, integrated care, and continuity of care for the Member; the AAs and MOU were also supported by provider feedback
29. Clarification, reinforcement of: requirements, quality of care, the need for collaboration, and access to care

Input sought:

MBHP/HNE BH Internal Review
1. First level review: Gina Battaglia
3. Third level review before written stakeholder input was obtained: Carol Kress, Anne Pelletier Parker, James Thatcher, MD
4. Fourth level review before the convening of a focus group to obtain additional stakeholder input: Carol Kress, Anne Pelletier Parker, James Thatcher, MD, Moira Muir, Steve Feldman, MD, Hisla Bates, MD
5. Fifth level review after focus group had convened: Anne Pelletier Parker, James Thatcher, MD, Steve Feldman, MD, Hisla Bates, MD, Moira Muir
6. Final review/approval: Stephanie Brown, Mike Curry, Erin Donohue, Alex Forster, Andrea Gewirtz, Janice Harrington, Terri Hubbard, Carol Kress, Tamara Lange, Evan Morse, Moira Muir, Nancy Norman, MD, Elisabeth Okrant, Joe Passeneau, Anne Pelletier Parker, Garland Russell, George Smart, John Straus, MD, Scott Taberner, Kenneth Talbot, James Thatcher, MD

External Review
1. MBHP/HNE BH engaged in a cross-walk of these specs with: the DMH inpatient mental health regulations, our contract, and our credentialing criteria.
2. MBHP/HNE BH sought and incorporated the feedback of MBHP/HNE BH’s Family Advisory Council (FAC) early on in the process.
3. MBHP/HNE BH disseminated the draft revised CBAT performance specs to CBAT providers during the revision process, as well as convened a focus group of these providers to gather additional input. Along with CBAT providers, MBHP/HNE BH also included Vic DiGravio, President/CEO of the Association for Behavioral Healthcare (ABH). MBHP/HNE BH incorporated many areas of their feedback, i.e., after the dissemination to providers for feedback and after the subsequent fifth level of internal review, as noted above.
4. MBHP/HNE BH referenced the article titled “Physician Leadership in Residential Treatment for Children and Adolescents” from Child and Adolescent Psychiatric Clinics of North America (Vol. 19, Issue 1, pages 21-30, January 2010), by Christopher Bellonci, MD, to help inform the language relative to the medical director.
Notable feedback received from the provider network and other stakeholders:
Areas where MBHP/HNE BH incorporated provider and stakeholder feedback, specifically from CBAT providers and representatives from ABH

1. Modification of language as follows: “therapeutic programming is provided seven days per week, including weekends and holidays, with sufficient professional staff to maintain an appropriate milieu and conduct the services below, based on individualized Member needs” (language in current/existing specs reads “full therapeutic programming is supplied with sufficient professional staff to manage a therapeutic milieu of services seven days per week, including weekends and holidays”)

2. Addition of language relative to allowing Members to speak with family members in their native language (feedback from the MBHP/HNE BH FAC)

3. Addition of language regarding Member access to supportive milieu and clinical staff as clinically indicated

4. Addition of clarifying language relative to the “short-term, episodic,” one-to-one staffing for observation and management “of significant clinical and/or safety issues that may arise, when clinically indicated, and/or as included in the treatment plan. Members for whom one-to-one staffing for extended periods of time is required may, upon further evaluation, be more appropriate and meet the criteria for a higher level of care than CBAT.”

5. Omission of proposed language relative to the medical director’s approval and signing orders for Schedule II prescriptions

6. Addition of clarifying language relative to a) who is available for phone consultation with staff when a child psychiatrist is not on-site (another child psychiatrist or a child psychiatry fellow/trainee or PNMHCS who has access to a child psychiatrist for consultation; language in current/existing specs refers to the psychiatrist); b) modification of the timeframe in which the individuals noted in “a)” must be available for phone consultation (from “within 15 minutes of a request” to “within 30 minutes of a request”); c) who can provide the face-to-face psychiatric evaluation (the medical director, another child psychiatrist, a child psychiatry fellow/trainee, a PNMHCS, or the local ESP/MCI psychiatrist through an affiliation with the ESP/MCI or other Affiliation Agreement; language in current/existing specs refers to an on-site psychiatrist or one through an affiliation with an ESP); and d) the determination of the need for the on-site, face-to-face psychiatric evaluation of a Member when there is a significant change in his/her clinical presentation (warranted by an assessment by a master’s-level or doctoral-level or nurse clinician and consultation with clinical and nursing supervisory and/or on call staff)

7. Addition of clarifying language relative to: a) the availability expectations of the master’s-level clinician (a minimum of eight hours a day during the week, and as needed to conduct admission assessments on weekends and holidays); b) clinicians “making best efforts to flexibly offer hours outside of normal business hours and on weekends when needed to accommodate families’ schedules and to be responsive to the needs of youth and families;” (per recommendation by MassHealth) and c) the availability expectations of a master’s-level or doctoral-level clinical supervisor for telephonic consultation within 30 minutes when a master’s-level clinician is not on-site

8. Addition of language clarifying that staff “directly responsible for providing any treatment components during a youth’s stay” receive documented, program-related training
9. Addition of clarifying language relative to the completion of a psychosocial evaluation within 24 hours of admission, “or as soon as the youth and family are able to participate in the process”, recognizing that the crisis may delay the family’s capacity to fully participate in the evaluative process.

10. Addition of language clarifying the requirement for a medical assessment of each Member “by a qualified staff” for youth who are evaluated within 24 and within 48 hours of admission.

11. Addition of clarifying language relative to a) who may be designated as a consistent substitute, when the child psychiatrist is not scheduled to work or is out for any reason, to perform the functions of meeting with the Member and writing psychiatry notes in the Member’s health record (another child psychiatrist, or a PNMHCS or child psychiatry fellow/trainee under the Member-specific supervision of the medical director or another attending child psychiatrist) (language in the current/existing specs refers to a clinical nurse specialist or alternate psychiatrist); and b) the active role the medical director or other attending child psychiatrist maintains within the CBAT program.

12. Addition of language relative to the medical director’s oversight and consultation to the PNMHCS or child psychiatry fellow/trainee, if a program utilizes such staff.

13. Addition of language clarifying the disciplines within the multi-disciplinary treatment team, e.g., a psychiatrist and one or more other disciplines.

14. Addition of language clarifying that on weekends the assessments and treatment and discharge plans may be reviewed by the multi-disciplinary treatment team on the next business day.

15. Addition of language clarifying the provider’s responsibility, “with Member consent and the establishment of the clinical need for such communication,” for coordination with all involved collaterals relative to treatment and care coordination issues.

16. Omission of proposed language relative to the responsibilities for the provider’s prescribers relative to medication issues.

Areas where MBHP/HNE BH did not incorporate provider and stakeholder feedback, specifically from CBAT providers and representatives from ABH

1. Not applicable
Covered Service: Community Crisis Stabilization (CCS)

Major revisions made:
1. Replacement of “care management” with “care coordination” throughout
2. In the Staffing Requirements section, addition of language clarifying that the nurse manager is a registered nurse
3. In the Staffing Requirements section, addition of language clarifying the conditions under which a program may utilize a psychiatric nurse mental health clinical specialist (PNMHCS)
4. In the Assessment section, modification of the timeframe for completion and review of an assessment and initial treatment and initial discharge plans by the multi-disciplinary treatment team, from “within 24 hours of admission” to “within 48 hours of admission”

Corresponding rationales for these major revisions:
1. Correction of language to ensure the specifications are consistent with the per diem definition
2. Provider clarification of requirements and procedures, and reinforcement of the level of oversight required
3. Provider clarification, reinforcement of: requirements, quality of care, collaboration, and oversight, and per recommendation of MassHealth
4. Provider clarification of requirements and procedures, to ensure compliance with contract language, and to ensure quality of care

Input sought:

MBHP/HNE BH Internal Review
1. First level review: Doug Kozlowski, Moira Muir, Shelley Baer
2. Second level review: Anne Pelletier Parker, James Thatcher, MD, Carol Kress
3. Final review/approval: Stephanie Brown, Mike Curry, Erin Donohue, Alex Forster, Andrea Gewirtz, Janice Harrington, Terri Hubbard, Carol Kress, Tamara Lange, Janet Leopold, Evan Morse, Moira Muir, Nancy Norman, MD, Elisabeth Okrant, Joe Passeneau, Anne Pelletier Parker, Garland Russell, George Smart, John Straus, MD, Scott Taberner, Kenneth Talbot, James Thatcher, MD

External Review
1. In 2009, MBHP/HNE BH obtained extensive input from providers and other stakeholders, as well as input from the Department of Mental Health (DMH) and MassHealth.
Covered Service: Enhanced Acute Treatment Services (E-ATS) for Individuals with Co-occurring Mental Health and Substance Use Disorders

Major revisions made:

1. In the description of the service (first page) and throughout the specs, modification of the description of the service relative to its focus, the individuals whom the service is intended to benefit, including that E-ATS are available for both adolescents and adults, and that individuals may be admitted to an E-ATS program directly from the community, including referrals from Emergency Services Program/Mobile Crisis Intervention (ESP/MCI) providers, or as a transition from inpatient services

2. In the Components of Service section, omission of the following language: “The provider agrees, subject to bed availability and clinical appropriateness, to admit adult persons who require acute, 24-hour addiction and psychiatric treatment and/or stabilization and who are referred to their facility by an ESP, regardless of the person’s ability to pay”

3. In the Components of Service section, modification of the list of required service components: “bio-psychosocial evaluation” (rather than “monitoring and treatment”); medical “history” (rather than medical “evaluation”); addition of “physical examination”; addition of “including substance use disorder, relapse prevention and communicable diseases” to psycho-education; and omission of “education”; omission of “rehab counseling”; addition of “initial substance use disorder assessment” and “initial nursing assessment”; addition of “development of” relative to “behavioral treatment/recovery plans”; omission of relapse prevention; addition of “case management” to “discharge planning”

4. In the Staffing Requirements section, addition of language relative to the provider’s utilization of a multi-disciplinary staff, including the addition of “case aides and case management staff” to “Licensed practical nurse (LPN).”

5. In the Staffing Requirements section, addition of language referencing the need to designate a physician as medical director licensed to practice medicine in the Commonwealth of MA, including his/her responsibilities, in collaboration with the nursing and clinical leadership team

6. In the Staffing Requirements section, addition of language specifying: 1) that the attending psychiatrist provides psychiatric consultation and psychopharmacological services to Members in the E-ATS program, 2) that the medical director may also provide on-site psychopharmacological services in consultation with the psychiatrist, 3) that the program may also utilize a psychiatric nurse mental health clinical specialist (PNMHCS) to provide on-site psychopharmacological services to Members, within the scope of his/her license and under the supervision of the medical director or other attending psychiatrist, as outlined within these performance specifications, 4) that the program may also utilize a psychiatry fellow/trainee to provide on-site psychopharmacological services to Members, in conformance with the Accreditation Council for Graduate Medical Education (ACGME, www.acgme.org), in compliance with all Centers for Medicare & Medicaid Services (CMS) guidelines for supervision of trainees by attending physicians, and under the supervision of the medical director or another attending psychiatrist, as outlined within these performance specifications, and 5) the staff who may perform these functions when the attending is not scheduled to work or is out for any reason (a covering psychiatrist, or a PNMHCS or a psychiatry fellow/trainee acting under the psychiatrist’s or medical director’s Member-specific supervision)
7. In the Staffing Requirements section, addition of language relative to requirements (i.e., safeguards) for programs that utilize a psychiatry fellow/trainee to perform psychiatry functions.

8. In the Staffing Requirements section, addition of language relative to requirements (i.e., safeguards) for programs that utilize a PNMHCS to perform psychiatry functions.

9. In the Staffing Requirements section, addition of language specifying that a psychiatrist is on call 24 hours a day, seven days a week, and is available for a phone consultation within 60 minutes of request.

10. In the Staffing Requirements section, addition of topics to the list of topics relative to the regularly scheduled, in-service training sessions the provider must document for all staff.

11. In the Assessment section, omission of “following a face-to-face evaluation by an identified MBHP/HNE BH provider” relative to admissions.

12. In the Assessment section, addition of language, relative to direct admissions from the community, requiring the provider to ensure that a comprehensive medical history and a physical examination which conforms to the principles established by the American Society of Addiction Medicine is conducted and documented for each Member within 24 hours of admission, who may conduct the examination, and what it includes.

13. In the Assessment section, addition of language specifying: for direct admissions from the community, a psychiatric evaluation of the Member is completed either on the day of the admission or within 24 hours of the admission by a psychiatrist, or by a PNMHCS or a psychiatry fellow/trainee under the supervision of the medical director or another attending psychiatrist; and for admissions of Members transitioning from other 24-hour levels of care, a psychiatric evaluation of the Member is completed within 48 hours of the admission by a psychiatrist, or by a PNMHCS or a psychiatry fellow/trainee under the supervision of the medical director or another attending psychiatrist.

14. In the Assessment section, addition of language regarding the signing of all medical orders by the medical director or a designated licensed physician.

15. In the Assessment section, addition of language regarding completion of an initial assessment of each Member conducted by a senior clinician, physician, nurse practitioner or physician assistant within 24 hours of admission and what this includes.

16. In the Assessment section, modification of language relative to the assignment of the multidisciplinary treatment team to each Member (changed from “within 48 hours” to “within 24 hours”), their responsibilities, contents of the treatment/recovery plan, its review of the plan, and timeframe for treatment/recovery plan development on weekends and holidays.

17. In the Assessment section, modification of language relative to the psychiatrist consulting with the treatment team, making best efforts to consult with outpatient prescribers prior to any psychotropic medication changes, that these changes are made if indicated, and that other psychiatrists and/or a PNMHCS may also be available to consult with other members of the treatment team.

18. In the Assessment section, addition of language specifying, with Member consent and the establishment of the clinical need for such communication, the provider’s responsibility for coordination with all involved collaterals regarding treatment and care coordination issues.

19. In the Assessment section, addition of language specifying that for pregnant women, the provider coordinates care with her PCC and OB/GYN, and consults with those physicians as needed.

20. In the Service, Community, and Collateral Linkages section, addition of language relative to the provider collaborating in the transfer, referral, and/or discharge planning process to ensure continuity of care, with Member consent, if a Member is referred to another treatment setting.
21. In the Service, Community, and Collateral Linkages section, modification of language relative to active working relationships with the step-down programs for adults and adolescents, especially with local providers of those levels of care that refer high volumes of Members to the E-ATS program and/or to which the E-ATS program refers high volumes of Members, noting that it is considered best practice to maintain Affiliation Agreements or Memoranda of Understanding (MOU)

Corresponding rationales for these major revisions:
1. Clarification, reinforcement of the intent of the service, consistency with similar admission language in CBAT specs, supported by provider/stakeholder feedback, and per recommendation by MassHealth
2. Correction (the no-reject policy is not applicable to this level of care)
3. Clarification, reinforcement of requirements, elimination of redundancy, consistency with existing per diem, and relevance/consistency with language used in other substance use disorder-related specs
4. Clarification, reinforcement of requirements, consistency with DPH BSAS regulations
5. Clarification, reinforcement of requirements, consistency with DPH BSAS regulations as well as with language used in the specs for other services that utilize a medical director
6. Clarification, reinforcement of: requirements, quality of care, and oversight, supported by provider and stakeholder feedback, and consistent with language in the CBAT specs
7. Clarification, reinforcement of: requirements, quality of care, and oversight, supported by provider and stakeholder feedback, and consistent with language in the CBAT specs
8. Clarification, reinforcement of: requirements, quality of care, and oversight, supported by provider and stakeholder feedback, and consistent with language in the CBAT specs
9. Clarification, reinforcement of: requirements, quality of care, and oversight
10. Clarification, reinforcement of requirements, consistency with DPH BSAS regulations
11. Clarification, reinforcement of requirements
12. Clarification, reinforcement of requirements, consistency with DPH BSAS regulations
13. Clarification, reinforcement of: requirements, quality of care, and oversight, supported by provider and stakeholder feedback, and consistent with language in the CBAT specs
14. Clarification, reinforcement of requirements and oversight, consistency with DPH BSAS regulations
15. Clarification, reinforcement of requirements, consistency with DPH BSAS regulations
16. Clarification, reinforcement of: requirements, compliance with contract requirements, consistency with DPH BSAS regulations and with language used in other specs
17. Clarification, reinforcement of: requirements, the need for collaboration and integrated care, and quality of care, supported by provider and stakeholder feedback, and consistent with language in the CBAT specs
18. Clarification, reinforcement of requirements and quality of care, consistency with language used in other specs
19. Reinforcement of: requirements, the need for collaboration and integrated care, quality of care, and continuity of care for the Member
20. Clarification, reinforcement of: requirements, the need for collaboration and integrated care, quality of care, and continuity of care for the Member, and consistent with language used in the ATS specs
21. Reinforcement of: requirements, the need for collaboration and integrated care, quality of care, and continuity of care for the Member, consistent with language used in other substance use disorder-related specs
Input sought:

**MBHP/HNE BH Internal Review**
1. First level review: Gina Battaglia
2. Second level review: Anne Pelletier Parker, James Thatcher, MD, Jonna Hopwood, Kevin Weir, Steve Zessis, Elizabeth O’Brien, Moira Muir
3. Third level review before written provider and stakeholder input was obtained: Anne Pelletier Parker, Jonna Hopwood, Garland Russell
4. Fourth level review: Stephanie Brown, Mike Curry, Erin Donohue, Alex Forster, Andrea Gewirtz, Janice Harrington, Terri Hubbard, Carol Kress, Tamara Lange, Evan Morse, Moira Muir, Nancy Norman, MD, Elisabeth Okrant, Joe Passeneau, Anne Pelletier Parker, Garland Russell, John Straus, MD, Scott Taberner, Kenneth Talbot, James Thatcher, MD
5. Fifth level review after written provider and stakeholder input was incorporated: James Thatcher, MD, Anne Pelletier Parker, Jonna Hopwood, Moira Muir
6. Final review/approval: Stephanie Brown, Mike Curry, Erin Donohue, Alex Forster, Andrea Gewirtz, Janice Harrington, Terri Hubbard, Carol Kress, Tamara Lange, Evan Morse, Moira Muir, Nancy Norman, MD, Elisabeth Okrant, Anne Pelletier Parker, Garland Russell, John Straus, MD, Scott Taberner, Kenneth Talbot, James Thatcher, MD

**External Review**
1. MBHP/HNE BH engaged in a cross-walk of these specs with the DPH BSAS regulations, with our credentialing criteria, and with our contract.
2. MBHP/HNE BH staff participated in a meeting late fall 2013 hosted by DPH BSAS to discuss Medication Assisted Treatment for pregnant Members, and the information gathered helped to inform the revisions of these specs, the specs for ATS for Substance Use Disorders, and the specs for ATS for Pregnant Women.
3. MBHP/HNE BH disseminated the revised E-ATS performance specs to E-ATS providers to gather their input, after the revised specs were initially submitted to MassHealth. Along with E-ATS providers, MBHP/HNE BH also included Vic DiGravio, President/CEO of the Association for Behavioral Healthcare (ABH). MBHP/HNE BH incorporated several areas of their feedback.

**Notable feedback received from the provider network and other stakeholders:**
Areas where MBHP/HNE BH incorporated provider and stakeholder feedback, specifically from E-ATS providers and representatives from ABH
1. Slight modification of language relative to the requirement for the program to admit and have the capacity to treat Members who are currently “on” (as opposed to “receiving”) methadone “maintenance” (added clarifying language) or “receiving” (added clarifying language) other opioid replacement treatments
2. Slight modification of language, in the Discharge section, relative to crisis prevention plans and/or safety plans and/or relapse prevention plans, i.e., emphasizing that they are developed with Member consent and as applicable

Areas where MBHP/HNE BH did not incorporate provider and stakeholder feedback, specifically from E-ATS providers and representatives from ABH

*2014 MBHP/HNE BH Performance Specifications Revisions: Summaries of Changes*
*Effective July 1, 2014*
1. Requirement for inclusion of an LPN within the program’s multi-disciplinary staff (Note: Provider may not be aware that, for the ATS level of care, the BSAS regulations require an LPN, in addition to other disciplines. Although E-ATS is not a recognized level of care by BSAS, MBHP/HNE BH supports this ATS requirement for the E-ATS level of care.)

2. No allowance for a psychiatric mental health nurse practitioner (PMHNP) to perform various functions, i.e., psychiatric consultation to/with the treatment team, psychopharmacological services, completion of medical history and physical examination, and completion of psychiatric evaluation (Note: A PMHNP completes between 2-4 years of training after completion of a bachelor’s degree; in contrast, physicians specializing in psychiatry spend a minimum of 4 years in medical school and 4-5 years in psychiatry residency training after completion of a bachelor’s degree.)

3. No allowance for a PNMHCS (in addition to a psychiatrist) to be on call 24/7 and available for phone consultation to staff within 60 minutes of request

4. Requirement for inclusion of specific topics (at a minimum) in regularly scheduled, in-service trainings for all staff (Note: Provider has referenced a list of mandatory training topics not in the BSAS regulations for ATS and recommends that the list of topics required for E-ATS should be optional.)

5. The timeframe (on the day of admission or within 24 hours of the admission) for completion of a psychiatric evaluation for direct admissions from the community (Note: Provider has requested that this timeframe be consistent with the timeframe for admissions of Members transitioning from other 24-hour levels of care (within 48 hours of the admission), as it’s more appropriate for an acute residential setting.)

6. No consideration to allow a maximum of 72 hours “on holidays” (in addition to “on weekends”) for reviews of treatment/recovery plans and discharge plans by the multi-disciplinary treatment team

7. Requirement that the function of assisting the Member in obtaining post-discharge appointments not be designated to aftercare providers or to the Member to be completed before or after the Member’s discharge (Note: Per stakeholder, for providers who do not have post-detox step-down and/or OP within their system of care, they must still discharge with a plan whether appointments were made within the specified timeframe or not.)
Non-24-Hour Diversionary Services
Covered Service: Community Support Program (CSP)

Major revisions made:
1. In the description of the service (first page), addition of two services (CSP-Cultural Broker for the Refugee Population and CSP-ATS) to which the CSP specifications pertain
2. In the description of the service, addition of language clarifying that CSPs do not provide clinical treatment services, but rather provide outreach and support services to enable Members to utilize clinical treatment services and other supports, which has led to some other changes throughout the document.
3. In the description of the service and throughout the specs, addition of language clarifying that the CSP service plan and the CSP service assists the Member with attaining and/or implementing his/her goals in his/her clinical treatment plan in outpatient services and/or other levels of care, and works to mitigate barriers to doing so
4. In the Components of Service section, addition of the following required service components: development and/or updating of crisis prevention plan and/or safety plan; needs assessment (rather than bio-psychosocial assessment), CSP service plan (rather than treatment plan)
5. In the Components of Service section, addition of language clarifying service coordination and linkage, relative to services included in the Member’s individualized CSP service plan as well as to the activities listed in the Service, Community, and Collateral Linkages section
6. In the Components of Service section, modification of language relative to the accessibility (removal of the 24-hour accessibility requirement) and delivery (during and outside business hours) of the service, to be more consistent with a non-clinical service
7. In the Components of Service section, modification of “care management” to “service coordination” relative to the activities the provider provides
8. In the Staffing Requirements section, addition of language requiring bachelor-level staff, at a minimum, for the provision of the CSP service(has always been in our credentialing criteria but not delineated in the specs), inclusion of social work as an additional field of study for the degree, reference to staff who may have lived experience, and addition of language regarding the application for a waiver if staff do not meet the staffing criteria
9. In the Staffing Requirements section, elimination of the requirement for psychiatric consultation with either a psychiatrist or a psychiatric nurse mental health clinical specialist, and addition of language specifying that the CSP staff and supervisor access additional consultation and services, as needed, through collaboration with the Member’s existing treatment team/providers/collaterals
10. In the Assessment section, addition of language specifying that the goals of the CSP service plan support the Member’s use of outpatient and/or other clinical treatment services and attainment of his/her treatment plan goals in those settings, and that the CSP service plan goals also address barriers to the Member’s ability to do so

Corresponding rationales for these major revisions:
1. Clarification of requirements for CSP service with specialty populations; changes supported by provider feedback
2. Reinforcement of the original intent of the service; changes supported by provider feedback
3. Clarification; reinforcement of the intent of the service; per recommendation by MassHealth
4. Development/updating of crisis prevention/safety plan is a reasonable expectation for most LOCs; and
the renaming of “bio-psychosocial assessment” to “needs assessment” and “treatment plan” to “service
plan” reinforces that CSP is not a clinical service; changes supported by provider feedback
5. Clarification; reinforcement of the intent of the service; per recommendation by MassHealth
6. Reinforcement that CSP is not a clinical service; administrative simplification/provider cost reduction;
changes supported by provider feedback
7. Clarification; reinforcement of the intent of the service; per recommendation by MassHealth
8. Clarification; incorporation of credentialing criteria and waiver process into specifications to reinforce
requirements and procedures
9. Clarification; reinforcement that CSP is not a clinical service; administrative simplification/provider
cost reduction; changes supported by provider feedback
10. Clarification, reinforcement of the intent of the service; per recommendation of MassHealth

Input sought:

MBHP/HNE BH Internal Review
1. First level review: Anne Pelletier Parker, James Thatcher, MD, Elisabeth Okrant, Joanne Waithaka,
   Moira Muir, George Smart, James Farrell
2. Second level review: Anne Pelletier Parker, James Thatcher, MD, Carol Kress
3. Final review/approval after vetting with providers: Stephanie Brown, Mike Curry, Erin Donohue, Alex
   Forster, Andrea Gewirtz, Janice Harrington, Terri Hubbard, Carol Kress, Tamara Lange, Janet
   Leopold, Evan Morse, Moira Muir, Nancy Norman, MD, Elisabeth Okrant, Joe Passeneau, Anne
   Pelletier Parker, Garland Russell, George Smart, John Straus, MD, Scott Taberner, Kenneth Talbot,
   James Thatcher, MD

External Review
1. CSP provider network; feedback received from 15 individuals

Notable feedback received from the provider network and other stakeholders:
Areas where MBHP/HNE BH incorporated provider feedback
1. Language that requirements in service-specific specifications take precedence over those in the
   General specifications
2. Guidance relative to the type of document to use for the crisis prevention plan and the needs
   assessment
3. Clarification relative to the 24-hour treatment settings into which high-risk individuals may be
   readmitted
4. Accessibility (24-hour requirement) and delivery (during/outside business hours)
5. Actions CSP staff may take if a Member experiencing a behavioral health crisis contacts them
6. Utilization of staff with lived experience to offer their expertise as a peer
7. Additional consultation to staff through collaboration with existing providers/collaterals
8. Incorporation of CSP-specific training as part of the statewide meetings to assist CSP staff in
   addressing some of the more clinically complex needs presented by Members in CSP that often lead to
   more frequent hospitalizations
9. How to manage referrals from non-behavioral health sources
10. Timeframe in which to schedule first appointment with the Member
11. Support and oversight provided by the supervisor relative to service components
12. Frequency for updating the service plan
13. MOU with the local ESP/MCI

**Areas where MBHP/HNE BH did not incorporate provider feedback**

1. Modification of credentialing criteria to allow A.S. degree or 5+ years of experience
2. Omission of requirement for licensed supervisor

*Please note: these issues were discussed in the MBHP/HNE BH CSP statewide meeting on 12/2/13, and we did not receive any negative response from providers.*
Covered Service: Enhanced Psychiatric Day Treatment

Major revisions made:
1. Replacement of “consumer” with “peer specialist” to describe the individuals who deliver this peer support component
2. Requirement of: supervision by a senior Certified Peer Specialist (CPS) or other senior peer worker, and documentation of the supervision and training of peer specialists
3. Omission of language referencing specific training programs that teach individuals how to lead/co-lead group services that promote wellness and recovery

Corresponding rationales for these major revisions:
1. Reinforcement of recovery-oriented practices
2. Provider clarification of requirements and procedures; reinforcement of the need for supervisory oversight
3. The training programs that had been listed in the specifications are no longer in existence. Specific training programs are not specified in the revised draft, as there are now many options available.

Input sought:

MBHP/HNE BH Internal Review
1. First level review: George Smart, Carol Kress
2. Second level review: Anne Pelletier Parker, James Thatcher, MD, Carol Kress
3. Final review/approval: Stephanie Brown, Mike Curry, Erin Donohue, Alex Forster, Andrea Gewirtz, Janice Harrington, Terri Hubbard, Carol Kress, Tamara Lange, Janet Leopold, Evan Morse, Moira Muir, Nancy Norman, MD, Elisabeth Okrant, Joe Passeneau, Anne Pelletier Parker, Garland Russell, George Smart, John Straus, MD, Scott Taberner, Kenneth Talbot, James Thatcher, MD

External Review
1. MBHP/HNE BH obtained extensive provider input into the original drafting of the performance specifications when they were developed for most levels of care at the start of the MBHP/HNE BH PCC Plan contract. During this revision, as MBHP/HNE BH informed MassHealth, we sought provider input into the specifications only for major levels of care in which we were drafting significant changes. The performance specifications for this level of care did not contain substantive changes to warrant vetting with the provider network or other stakeholders.
Covered Service: Enhanced Structured Outpatient Addiction Program (SOAP)
For Adolescents

Major revisions made:
1. In the Components of Service section (and throughout the specs), omission of language contained in the SOAP performance specs
2. In the Components of Service section, addition of clarifying language relative to “referral to family therapy, if needed” and omission of “integrated mental health and addiction programming”
3. In the Components of Service section, modification of “School consultation, as needed” to “Case consultation with school personnel, as needed”
4. In the Staffing section, addition of clarifying language relative to the specific staff training “and/or experience” in adolescent behavior, development, clinical issues, “and substance use disorder treatment with this population”
5. In the Assessment section, addition of language emphasizing that the Enhanced SOAP for Adolescents makes best efforts to actively engage parents/guardians/caregivers throughout the service delivery process
6. In the Service, Community, and Collateral Linkages section, addition of “(also known as Enhanced Acute Treatment Services (E-ATS) for Adolescents)” after “Youth Stabilization Service Program”

Corresponding rationales for these major revisions:
1. Elimination of redundancy
2. Clarification that this covered service does not include mental health services but Members can be referred to needed mental health services; establishment of consistency with the per diem definition
3. Clarification, and per recommendation of MassHealth
4. Establishment of expectations that staff providing this covered service have training and/or experience in substance use disorder treatment with the adolescent population; reinforcement of quality of care
5. Reinforcement that parents/guardians/caregivers should be involved in services provided to youth; reinforcement of quality of care
6. Clarification

Input sought:

MBHP/HNE BH Internal Review
1. First level review: Gina Battaglia, Anne Pelletier Parker, Jonna Hopwood, Steve Zessis, Elizabeth O’Brien, Kevin Weir, Moira Muir, James Thatcher, MD
2. Second level review: Anne Pelletier Parker
3. Final review/approval: Stephanie Brown, Mike Curry, Erin Donohue, Alex Forster, Andrea Gewirtz, Janice Harrington, Terri Hubbard, Carol Kress, Tamara Lange, Evan Morse, Moira Muir, Nancy Norman, MD, Elisabeth Okrant, Joe Passeneau, Anne Pelletier Parker, Garland Russell, George Smart, John Straus, MD, Scott Taberner, Kenneth Talbot, James Thatcher, MD

External Review
1. MBHP/HNE BH obtained extensive provider input into the original drafting of the performance specifications when they were developed for most levels of care at the start of the MBHP/HNE BH

2014 MBHP/HNE BH Performance Specifications Revisions: Summaries of Changes
Effective July 1, 2014
PCC Plan contract. During this revision, as MBHP/HNE BH informed MassHealth, we sought provider input into the specifications only for major levels of care in which we were drafting significant changes. The performance specifications for this level of care did not contain substantive changes to warrant vetting with the provider network or other stakeholders.
Covered Service: Enhanced Structured Outpatient Addiction Program (SOAP)
For Members who are Homeless

Major revisions made:

1. In the description of services on the first page, modification of language clarifying the service, including the addition of Members who may benefit from the service, e.g., those being stepped down from Clinical Stabilization Services (CSS)
2. In the description of services on the first page, modification of language emphasizing that Members in Enhanced SOAP meet continued stay criteria for the clinical services offered by the program based on medical necessity criteria
3. In the Components of Service section (and throughout the specs), omission of language contained in the SOAP performance specs
4. In the Components of Service section, modification of list of required service components: omission of individual motivational interviewing sessions (not in the per diem definition), relapse prevention education, including structuring of time outside the program (added to SOAP specs), and nutrition education and counseling (not in the per diem definition)
5. In the Components of Service section, addition of language relative to assisting Members with arranging and/or utilizing community-based transportation resources (e.g., public transportation resources, PT-1 forms, etc.), and making best efforts to directly provide transportation to essential appointments (i.e., medical, behavioral health, etc.) temporarily, while transitioning to these community-based transportation resources
6. In the Components of Service section, addition of language relative to assisting the Member in accessing medical services, including obtaining a primary care clinician (PCC) if there is none, according to the requirements delineated in the General specs
7. In the Components of Service section, addition of “(i.e., Supplemental Nutrition Assistance Program)” after “food stamps”
8. In the Staffing section, addition of language relative to the knowledge the staff have of local resources and needs faced by this population, specifically vocational and transportation

Corresponding rationales for these major revisions:

1. Clarification of target population for this service
2. Reinforcement that medical necessity for this clinical service must be met, separate from the need for housing
3. Elimination of redundancy
4. Establishment of consistency with the per diem definition
5. Reinforcement of the need to assist the homeless population with transportation; reinforcement of a skill building approach to enable Members to utilize available resources independently
6. Reinforcement of integrated care, particularly for this population in which Members may not have been able to consistently access primary care services
7. Clarification, and per recommendation of MassHealth
8. Clarification that staff working with Members who are homeless should be knowledgeable about resources they may especially need; reinforcement of quality of care
Input sought:

**MBHP/HNE BH Internal Review**
1. First level review: Gina Battaglia, Anne Pelletier Parker, Jonna Hopwood, Steve Zessis, Elizabeth O'Brien, Kevin Weir, Moira Muir, James Thatcher, MD
2. Second level review: Anne Pelletier Parker
3. Final review/approval: Stephanie Brown, Mike Curry, Erin Donohue, Alex Forster, Andrea Gewirtz, Janice Harrington, Terri Hubbard, Carol Kress, Tamara Lange, Evan Morse, Moira Muir, Nancy Norman, MD, Elisabeth Okrant, Joe Passeneau, Anne Pelletier Parker, Garland Russell, George Smart, John Straus, MD, Scott Taberner, Kenneth Talbot, James Thatcher, MD

**External Review**
1. MBHP/HNE BH obtained extensive provider input into the original drafting of the performance specifications when they were developed for most levels of care at the start of the MBHP/HNE BH PCC Plan contract. During this revision, as MBHP/HNE BH informed MassHealth, we sought provider input into the specifications only for major levels of care in which we were drafting significant changes. The performance specifications for this level of care did not contain substantive changes to warrant vetting with the provider network or other stakeholders.
Covered Service: Intensive Outpatient Program (IOP)

Major revisions made:
1. In Components of Service section, addition of language relative to ensuring access to medication evaluation and medication management services if they are not provided within the IOP.
2. In Components of Service section, modification to the accessibility/delivery of IOP services (during and outside business hours) specifying telephonic coverage outside business hours and actions the provider may take if a Member experiencing a behavioral health crisis contacts him/her during or outside business hours (e.g., refer to his/her OP provider; refer him/her to an ESP/MCI for emergency behavioral health crisis assessment, intervention, and stabilization; and/or implement other interventions to support and enable him/her to remain in the community, when clinically appropriate).
3. In Staffing section, modification of language specifying that staffing requirements are appropriate to the program specifications authorized by MBHP/HNE BH for the particular IOP, and will include but not be limited to licensed, master’s-level clinicians.
4. In Assessment section, modification of language clarifying the service, including omission of a behavioral management plan (not relevant), and addition of medication evaluation and medication management provided by the IOP or by referral.
5. In Assessment section, modification of the timeframe for completion of a bio-psychosocial evaluation, an initial treatment plan, and a preliminary discharge plan (e.g., from within two business days to within 48 hours of admission).
6. In Service, Community, and Collateral Linkages section, addition of language relative to the development and maintenance of written Affiliation Agreements or Memoranda of Understanding (MOUs) with other providers for the purpose of the provision of medication evaluation and medication management services if not provided within the IOP, inclusive of the referral process.

Corresponding rationales for these major revisions:
1. Provider clarification; reinforcement of: requirements and procedures, the importance of collaboration, and continuity of care for the Member.
2. Provider clarification; consistency with expectations for other non-24-hour diversionary levels of care (e.g., CSP and Day Treatment); reinforcement of: requirements, procedures, and continuity of care.
3. Provider clarification; reinforcement of: requirements, procedures, and quality of care.
4. Provider clarification; reinforcement of: requirements, procedures, and intent of the service.
5. Provider clarification; reinforcement of requirements and procedures; consistency with contract requirements for non-24 hour diversionary levels of care.
6. Provider clarification; reinforcement of: requirements and procedures, collaboration, and quality of care.

Input sought:

MBHP/HNE BH Internal Review
1. First level review: Gina Battaglia, Anne Pelletier Parker and Moira Muir
2. Final review/approval: Stephanie Brown, Mike Curry, Erin Donohue, Alex Forster, Andrea Gewirtz, Janice Harrington, Terri Hubbard, Carol Kress, Tamara Lange, Evan Morse, Moira Muir, Nancy
External Review

1. MBHP/HNE BH obtained extensive provider input into the original drafting of the performance specifications when they were developed for most levels of care at the start of the MBHP/HNE BH PCC Plan contract. During this revision, as MBHP/HNE BH informed MassHealth, we sought provider input into the specifications only for major levels of care in which we were drafting significant changes. The performance specifications for this level of care did not contain substantive changes to warrant vetting with the provider network or other stakeholders.
Covered Service: Intensive Outpatient Program for Members who are Deaf and Hard of Hearing (IOP for DHOH)

Major revisions made:
1. In Components of Service section, omission of language relative to reimbursement rate for the service
2. In Components of Service section, addition of clarifying language relative to the technological capacity of the provider to respond to Members
3. In Staffing section, addition of language clarifying that staff are trained in deaf culture and in meeting the clinical needs of individuals who are deaf and hard of hearing

Corresponding rationales for these major revisions:
1. Information is not relevant for specs
2. Provider clarification; consistency with best practices within the greater behavioral health/deaf and hard of hearing field; reinforcement of: requirements, procedures, and quality of care
3. Provider clarification; consistency with best practices within the greater behavioral health/deaf and hard of hearing field; reinforcement of: requirements, procedures, and quality of care

Input sought:

MBHP/HNE BH Internal Review
1. First level review: Gina Battaglia, Anne Pelletier Parker and Moira Muir
2. Final review/approval: Stephanie Brown, Mike Curry, Erin Donohue, Alex Forster, Andrea Gewirtz, Janice Harrington, Terri Hubbard, Carol Kress, Tamara Lange, Evan Morse, Moira Muir, Nancy Norman, MD, Elisabeth Okrant, Joe Passeneau, Anne Pelletier Parker, Garland Russell, George Smart, John Straus, MD, Scott Taberner, Kenneth Talbot, James Thatcher, MD

External Review
1. MBHP/HNE BH obtained extensive provider input into the original drafting of the performance specifications when they were developed for most levels of care at the start of the MBHP/HNE BH PCC Plan contract. During this revision, as MBHP/HNE BH informed MassHealth, we sought provider input into the specifications only for major levels of care in which we were drafting significant changes. The performance specifications for this level of care did not contain substantive changes to warrant vetting with the provider network or other stakeholders.
Covered Service: Partial Hospitalization Program (PHP)

Major revisions made:

1. In the Components of Service section, modification of the list of required service components: addition of “bio-psychosocial evaluation”, “medical history” and “physical evaluation/medical assessment (to assess for medical issues)”, “case and family consultation”; and addition of “development of crisis prevention plans, or safety plans as part of the Crisis Planning Tools for youth”

2. In the Components of Service section, modification of language regarding the provision of emergency services to the Member, e.g., steps the provider can take if a Member experiencing a behavioral health crisis contacts him/her, during business hours or outside business hours, based on his/her assessment of the Member’s needs and under the guidance of his/her supervisor

3. In the Staffing Requirements section, addition of language referencing the requirement of a PHP Director or Supervisor and his/her credentials and responsibilities

4. In the Staffing Requirements section, addition of language reflecting the requirement to appoint a Medical Director and a description of his/her roles/responsibilities, some of which are supported by provider feedback, as noted below

5. In the Staffing Requirements section, modification of the youth’s age under which the attending psychiatrist must meet MBHP/HNE BH’s credentialing criteria for a child/adolescent psychiatrist (from “under age 16” to “under age 14”)

6. In the Staffing Requirements section, addition of language relative to the specific requirements for PHPs that utilize a psychiatric nurse mental health clinical specialist (PNMHCS) for medication management

7. In the Staffing Requirements section, addition of language relative to the specific requirements for PHPs that utilize a psychiatry fellow/trainee for medication management

8. In the Staffing Requirements section, addition of clarifying language reflecting the degree, training, and experience required for staff who are involved in the assessment and treatment of Members whose diagnoses include those related to substance use and/or co-occurring disorders

9. In the Assessment section, addition of language specifying that a best practice is for PHPs to have mechanisms to accept referrals 7 days per week, so that Members and referral sources do not need to wait until the next business day to make a referral, and that PHPs conduct admissions at least five days per week

10. In the Assessment section, modification of language clarifying what the comprehensive evaluation consists of, and that the attending psychiatrist reviews the evaluation within one business day when a psychiatrist other than the Member’s attending psychiatrist conducts the initial evaluation

11. In the Assessment section, modification of language regarding assignment of the multidisciplinary treatment team to each Member, their responsibilities, the treatment plan development (as delineated within the General performance specs) and discharge plan development, and its review of the plan

12. In the Assessment section, addition of language clarifying the responsibilities of the attending psychiatrist, the requirement to provide, at a minimum, medication management to each Member at least two days per week and up to daily as needed, and that if a PHP psychiatrist determines that the Member’s clinical presentation does not warrant him/her being seen at least two days per week the Member’s health record documents the rationale and the Member may be seen once per week

13. In the Assessment section, addition of language clarifying that medication management notes are written and documented in the Member’s health record whenever he/she is seen
14. In the Discharge section, addition of language clarifying the provider’s responsibility to give the Member a written discharge plan, listing his/her medications upon discharge and outlining all aftercare services arranged by the PHP and/or those in which the Member is already engaged.

15. In the Discharge section, addition of language ensuring that providers coordinate the discharge plans for Members who are state agency-involved.

16. In the Service, Community, and Collateral Linkages section, addition of language reflecting the provider’s responsibility to maintain linkages with step-down programs for adults, children, and adolescents, including but not limited to Children’s Behavioral Health Initiative (CBHI) services, that refer a high volume of Members to the provider and/or to which the provider refers a high volume of Members.

17. In the Service, Community, and Collateral Linkages section, modification of language clarifying that the provider develops a working relationship with the Emergency Services Program/Mobile Crisis Intervention (ESP/MCI) provider that covers the catchment area in which the PHP is located, as delineated in the Service, Community, and Collateral Linkages section of the General performance specs.

Corresponding rationales for these major revisions:
1. Reinforcement of requirements, consistency with existing per diem, relevance
2. Provider clarification, reinforcement of requirements and continuity of care for the Member, consistency with expectations for other levels of care
3. Reinforcement of oversight and quality of care
4. Reinforcement of: requirements, oversight, quality of care, and the need for collaboration and integrated care
5. Clarification, reinforcement of requirements
6. Reinforcement of: requirements, oversight, quality of care, and the need for collaboration and integrated care, consistency with best practice in the greater behavioral health field, and per recommendation of MassHealth
7. Reinforcement of: requirements, oversight, quality of care, and the need for collaboration and integrated care, consistency with best practice in the greater behavioral health field, and per recommendation of MassHealth
8. Reinforcement of: requirements, oversight, quality of care, collaboration and integrated care, and consistency with best practice in the greater behavioral health field
9. Reinforcement of requirements and quality of care, and consistency with best practices within the greater behavioral health field
10. Reinforcement of: requirements, quality of care, and oversight
11. Reinforcement of requirements and quality of care, consistency with contract requirements
12. Reinforcement of: requirements, oversight, and quality of care, consistency with Medicare regulations, and supported by provider and stakeholder feedback (see below)
13. Reinforcement of requirements and quality of care
14. Reinforcement of: requirements, quality of care, and continuity of care for the Member
15. Reinforcement of requirements, consistency with contract requirements
16. Reinforcement of: requirements, the need for collaboration, and continuity of care for the Member
17. Reinforcement of: requirements, the need for collaboration, and continuity of care for the Member.
Input sought:

**MBHP/HNE BH Internal Review**

1. First level review: Gina Battaglia
3. Third level review before written stakeholder input was obtained: Carol Kress, Anne Pelletier Parker, James Thatcher, MD
4. Fourth level review before the convening of a focus group to obtain additional stakeholder input: Carol Kress, Anne Pelletier Parker, James Thatcher, MD
5. Fifth level review before final additional stakeholder input was obtained: Carol Kress, Anne Pelletier Parker, James Thatcher, MD
6. Sixth level review after final additional stakeholder input was obtained: Carol Kress, Anne Pelletier Parker, James Thatcher, MD
7. Final review/approval: Stephanie Brown, Mike Curry, Erin Donohue, Alex Forster, Andrea Gewirtz, Janice Harrington, Terri Hubbard, Carol Kress, Tamara Lange, Evan Morse, Moira Muir, Nancy Norman, MD, Elisabeth Okrant, Joe Passeneau, Anne Pelletier Parker, Garland Russell, George Smart, John Straus, MD, Scott Taberner, Kenneth Talbot, James Thatcher, MD

**External Review**

1. MBHP/HNE BH engaged in a cross-walk of these specs with: the DMH inpatient mental health regulations, the Centers for Medicare & Medicaid Services (CMS) regulations, our contract, and our credentialing criteria.
2. MBHP/HNE BH disseminated the draft revised PHP performance specs to PHP providers twice throughout the revision process, as well as convened a focus group of these providers to gather additional input. Along with PHP providers, MBHP/HNE BH also included David Matteodo, Executive Director of the Massachusetts Association of Behavioral Health Systems (MABHS), and Anuj Goel, VP of Regulations and Staff Counsel, Massachusetts Hospital Association (MHA).
   MBHP/HNE BH incorporated many areas of their feedback, i.e., after each of the two disseminations to providers for feedback and after the subsequent fourth and fifth level of internal review, as noted above.
3. MBHP/HNE BH engaged in ongoing discussions with select PHP providers throughout this revision process, which also helped to inform the final draft revised performance specs

**Notable feedback received from the provider network and other stakeholders:**

Areas where MBHP/HNE BH incorporated provider and stakeholder feedback, specifically from PHP providers and representatives from MABHS and MHA

1. Addition of language throughout the specs clarifying the service and the provision of it components, including omission of language referencing daily psychiatric management and replacement with medication management, with the capacity for daily
2. Omission of the provision of psychological testing and vocational counseling from the list of required service components, as well as omission of the following disciplines – occupational therapy, psychologists, and mental health counselors (with inclusion of mental health professional)
3. Modification of the nursing assessment and services component, to allow for a similar service provided by the program’s MD staffing
4. Modification of language relative to the need for a crisis prevention and/or safety plan for every Member, as applicable, and in collaboration with the Member
5. Addition of language relative to the specific roles/responsibilities of the Medical Director, e.g., clinical and medical oversight, attendance at daily rounds and treatment team meetings, conducting a face-to-face psychiatric evaluation of each Member prior to his/her discharge from the program (or the attending psychiatrist), and other functions in collaboration with the PHP Director or Supervisor and clinical leadership team
6. Inclusion of language referencing MBHP/HNE BH’s credentialing criteria for psychiatrists, which states that they must be board-certified in general psychiatry by the American Board of Psychiatry and Neurology (ABPN) within two years of contracting with MBHP/HNE BH, unless a waiver of this requirement is requested and received within two years of contracting with MBHP/HNE BH
7. Omission of language specifying that Member choice as to an attending psychiatrist is considered by both MBHP/HNE BH and the provider, given this is not realistic in a PHP with one part-time psychiatrist assigned to the program
8. Inclusion of other staff, in addition to the Medical Director or the attending or other psychiatrist, who may provide psychiatric care in the PHP, e.g., a psychiatry fellow/trainee, a psychiatric resident, or a PNMHCS, as well as the designation of some of functions of the Medical Director or the attending or other psychiatrist to these other staff, all under the Medical Director’s or attending psychiatrist’s supervision, and in conformance with the appropriate licensing/overseeing body for that discipline
9. Utilization of the term “collaborative agreement” rather than “supervision” relative to the relationship between the Medical Director and the PNMHCS and the oversight provided to him/her by the Medical Director
10. Modification of language specifying that staff directly responsible for providing any treatment components during a Member’s stay receive documented, program-related training, rather than all program staff
11. Addition of staff with specific substance use related licenses and/or certifications, and that supervision and/or consultation relative to substance use disorders is made available to staff as needed
12. Modification of language clarifying that the PHP’s admission procedures ensure timely admission of Members commensurate with meeting each Member’s individual needs (rather than ensuring admission within one business day of referral)
13. Language allowing a psychiatrist, not necessarily the attending psychiatrist, to be assigned to the Member, to conduct a comprehensive evaluation of each Member, and a change in the timeframe for this evaluation (from “within 24 hours of admission” to “on the Member’s first day in the PHP”)
14. Language allowing a covering psychiatrist, a psychiatric resident, a psychiatry fellow/trainee, or PNMHCS to conduct the initial evaluation of the Member if the PHP is open on weekends and holidays (however, the medical director or an attending psychiatrist is available for consultation by phone, as needed, until the psychiatrist conducts the face-to-face evaluation of the Member)
15. Language allowing a PNMHCS (in addition to an MD) to conduct a physical examination/medical assessment on the Member’s first day in the PHP to assess for medical issues
16. Modification of the frequency of treatment and discharge plan reviews from “at least every 48 hours” to “at least every 72 hours”, to differentiate PHP from inpatient levels of care
17. Language allowing a PHP psychiatrist to make the determination to see a Member less frequently than the requirement of at least two days per week if the Member’s clinical presentation does not warrant it
18. Addition of language clarifying the provision of individual, group, and family therapy at a frequency determined in each Member’s individualized treatment plan
19. Addition of language specifying the provider’s responsibility for coordination with all involved collaterals regarding treatment and care coordination issues, specifically with Member consent and the establishment of the clinical need for such communication
20. Transfer of the responsibility from the Medical Director to the provider in general relative to ensuring that active and differential discharge planning is implemented for each Member

Areas where MBHP/HNE BH did not incorporate provider and stakeholder feedback, specifically from PHP providers and representatives from MABHS and MHA

1. Some providers continued to allude to the prescriptiveness of the Medical Director’s role, despite the revisions made above
Covered Service: Partial Hospitalization Program (PHP) for Eating Disorders

Major revisions made:
1. In the description of the service (first page) and throughout the specs, modification of language relative to this specialty PHP service
2. In the Components of Service section, addition of language specifying that medical services are provided by “a physician who is” an internist with a specialty in eating disorders
3. In the Staffing Requirements section, addition of “experience” relative to the qualifications of the attending psychiatrist and psychiatric nurse mental health clinical specialist (PNMHCS)
4. In the Staffing Requirements section, addition of language specifying that the program ensures a pediatrician is available for medical issues for children and adolescents up to age 17
5. In the Staffing Requirements section, addition of language relative to the provider ensuring that mandatory trainings related to the clinical needs of this specialty population are available for all staff directly responsible for providing any treatment component during a Member’s stay, and modification of language relative to what the trainings include
6. In the Assessment section, addition of language specifying that if the PHP is open on weekends and holidays, the medical director ensures that a pediatrician or internist is available for phone consultation, as needed
7. In the Assessment section, addition of language specifying that: 1) the attending psychiatrist is available to meet with the Member and provide consultation to medical and other PHP staff throughout the Member’s length of stay; 2) that the PHP is staffed with an attending psychiatrist who, in consultation with a pediatrician or internist, consistently provides, and is responsible for, the day to day and overall care of the Member when the Member is attending the PHP; and 3) the pediatrician or internist provides consultation to the attending psychiatrist, he/she does not serve as the Member’s primary physician, but remains an active participant on the Member’s treatment team
8. In the Assessment section, addition of language specifying that the attending psychiatrist, and other staff he/she may designate (e.g., pediatrician, internist, PNMHCS, certified nurse specialist (CNS), nurse practitioner (NP)), participates in daily rounds and treatment team meetings and is available to consult with the Member’s treatment team throughout the Member’s length of stay, and that the treatment team for each Member, at a minimum, consists of a psychiatrist, a pediatrician or internist, a nurse, and a social worker
9. In the Assessment section, addition of language specifying that all required assessments include the assessment of the Member’s eating disorder, co-occurring psychiatric and eating disorders, and potential medical complications, and that all treatment plans and treatment plan reviews and updates include goals and interventions specific to the Member’s eating disorder, co-occurring psychiatric and eating disorders, and potential medical complications
10. In the Assessment section, addition of language relative to arrangements made to obtain appropriate laboratory tests, “when indicated, and that physicians are available for consultation relative to medical complications, if any”
11. In the Assessment section, modification of language relative to the assignment to each Member of a primary clinician and/or treatment team that develops a treatment and a rehabilitation and recovery program, and coordinates ongoing treatment interventions for his or her eating disorder(s)
12. In the Assessment section, addition of language specifying that the pediatrician or internist: 1) documents in the Member’s health record that the Member is medically safe for discharge; and 2) does
not conduct the discharge without the face-to-face psychiatric evaluation conducted by an attending psychiatrist or medical director prior to the Member’s discharge from the PHP

13. In the Discharge section, modification of language clarifying that discharge and/or aftercare plan includes “aftercare services” (rather than “referrals”) that address eating disorder recovery

14. In the Discharge section, addition of language that the provider specifically ensures that the Member’s primary care clinician (PCC) is involved in discharge planning and is provided with a copy of the discharge plan within required timeframes

**Corresponding rationales for these major revisions:**

1. Reinforcement of intent of this specialty service, and consistency with language in PHP specs
2. Clarification, reinforcement of requirements, consistency with language in Inpatient Eating Disorders Services specs
3. Correction of missing language, consistency with language in other specialty specs, reinforcement of requirements
4. Reinforcement of requirements and quality of care, and consistent with best practices within the greater behavioral health field
5. Relevance, consistency with revisions made in other specs (and supported by provider feedback), and reinforcement of quality of care
6. Reinforcement of requirements and quality of care, and consistent with best practices within the greater behavioral health field
7. Reinforcement of: requirements, the need for collaboration and integrated care, quality of care, and oversight, and consistent with best practices within the greater behavioral health field
8. Reinforcement of: requirements, the need for collaboration and integrated care, quality of care, and oversight, and consistent with best practices within the greater behavioral health field
9. Clarification, reinforcement of requirements and quality of care
10. Consistency with language in other specialty specs, reinforcement of: requirements, the need for collaboration and integrated care, quality of care, and oversight
11. Clarification, reinforcement of requirements and quality of care
12. Reinforcement of: requirements, the need for collaboration and integrated care, quality of care, and oversight, and consistent with best practices within the greater behavioral health field
13. Reinforcement of: requirements, quality of care, continuity of care for the Member
14. Reinforcement of: requirements, the need for collaboration and integrated care, quality of care, continuity of care for the Member

**Input sought:**

*MBHP/HNE BH Internal Review*  
1. First level review: Gina Battaglia  
2. Second level review: Hisla Bates, MD, Anne Pelletier Parker  
3. Final review/approval: Stephanie Brown, Mike Curry, Erin Donohue, Alex Forster, Andrea Gewirtz, Janice Harrington, Terri Hubbard, Carol Kress, Tamara Lange, Evan Morse, Moira Muir, Nancy Norman, MD, Elisabeth Okrant, Joe Passeneau, Anne Pelletier Parker, Garland Russell, George Smart, John Straus, MD, Scott Taberner, Kenneth Talbot, James Thatcher, MD
External Review

1. MBHP/HNE BH obtained extensive provider input into the original drafting of the performance specifications when they were developed for most levels of care at the start of the MBHP/HNE BH PCC Plan contract. During this revision, as MBHP/HNE BH informed MassHealth, we sought provider input into the specifications only for major levels of care in which we were drafting significant changes. The performance specifications for this level of care did not contain substantive changes to warrant vetting with the provider network or other stakeholders.

2. MBHP/HNE BH engaged in a cross-walk of these specs with: the DMH inpatient mental health regulations, the Centers for Medicare & Medicaid Services (CMS) regulations, and with our contract.
Covered Service: Psychiatric Day Treatment

Major revisions made:
1. Addition of service component - development and/or updating of crisis prevention plans, or safety plans, as part of the Crisis Planning Tools for youth
2. Modification to the delivery of the service (during and outside business hours) specifying phone coverage outside business hours and actions the provider may take if a Member experiencing a behavioral health crisis contacts him/her during or outside business hours (e.g., refer to his/her OP provider; refer him/her to an ESP/MCI for emergency behavioral health crisis assessment, intervention, and stabilization; and/or implement other interventions to support and enable him/her to remain in the community, when clinically appropriate)
3. Replacement of “Psychiatric Nurse (RN)” with “Registered Nurse (RN)” and replacement of “Certified Alcohol and Drug Counselor” with “Certified Alcoholism and Drug Abuse Counselor”
4. Within the Assessment section, replacement of “case coordinator” with “primary counselor”
5. With regard to the multi-disciplinary treatment team: inclusion of reference to an initial discharge plan, modification of the timeframe for review of assessment and initial treatment and discharge plans (from “by the fifth day of attendance” to “within 48 hours of admission”), and modification of the qualifying events after which review of the treatment plan is required (omission of “after the fifth day of attendance”) including clarification of “psychiatric admission”
6. Requirement of an MOU with the local ESP/MCI program to collaborate around crisis prevention/safety plans and to facilitate the Member’s access of ESP/MCI services

Corresponding rationales for these major revisions:
1. Development/updating of crisis prevention/safety plan is a reasonable expectation for most LOCs; reinforcement of continuity of care for the Member
2. Provider clarification/reinforcement of requirements and procedures
3. Corrections of language to ensure consistency with the corresponding acronyms
4. Correction of language to ensure consistency with the per diem definition
5. Reinforcement of the need for discharge planning to begin upon admission; to comply with the timeframe for our contract deliverable; and provider clarification to reinforce requirements and procedures
6. Reinforcement of the importance of collaboration and continuity of care for the Member

Input sought:

MBHP/HNE BH Internal Review
1. First level review: George Smart, Carol Kress
2. Second level review: Anne Pelletier Parker, James Thatcher, MD, Carol Kress
3. Final review/approval: Stephanie Brown, Mike Curry, Erin Donohue, Alex Forster, Andrea Gewirtz, Janice Harrington, Terri Hubbard, Carol Kress, Tamara Lange, Janet Leopold, Evan Morse, Moira Muir, Nancy Norman, MD, Elisabeth Okrant, Joe Passeneau, Anne Pelletier Parker, Garland Russell, George Smart, John Straus, MD, Scott Taberner, Kenneth Talbot, James Thatcher, MD
External Review

1. MBHP/HNE BH obtained extensive provider input into the original drafting of the performance specifications when they were developed for most levels of care at the start of the MBHP/HNE BH PCC Plan contract. During this revision, as MBHP/HNE BH informed MassHealth, we sought provider input into the specifications only for major levels of care in which we were drafting significant changes. The performance specifications for this level of care did not contain substantive changes to warrant vetting with the provider network or other stakeholders.
Covered Service: Structured Outpatient Addiction Program (SOAP)

Major revisions made:
1. In the description of the service on the first page, modification of language clarifying the service, including the addition of Members who may benefit from the service, e.g., those being stepped down from Clinical Stabilization Services (CSS)
2. In the Components of Service section, addition of clarifying language relative to full therapeutic programming being provided at least five days per week
3. In the Components of Service section, modification of the list of required service components: addition of some (substance use disorder assessment and treatment services, nursing assessment and services, and assignment of a primary counselor, all of which are in the per diem definition); addition of relapse prevention education, including structuring of time outside the program (taken from the Enhanced SOAP for Members who are Homeless specs); modification of access to medical services for pregnant women; and omission of some components that are not in the per diem definition (individual therapy, family intervention/education, psycho-educational groups, life skills training)
4. In the Components of Service section, modification of language relative to the provision of a minimum of “half a day of service (one 3.5 hour unit)”
5. In the Staffing section, addition of language referencing the provision of staff orientation and at least annual training that includes but is not limited to the treatment of substance use disorders and co-occurring disorders and motivational interviewing
6. In the Assessment section, addition of language relative to the review and updating of the Member’s treatment/recovery plan, as needed, once per week
7. In the Service, Community, and Collateral Linkages section, addition of language relative to the provider’s collaboration with the Member’s primary care clinician (PCC) as delineated in the Primary Care Clinician Integration section in the General performance specifications

Corresponding rationales for these major revisions:
1. Clarification of target population for this service
2. Reflection of those SOAPs that offer weekend programming, e.g., programs offering more than five days per week
3. Consistency with the per diem definition
4. Consistency with language elsewhere in the specs, in the MBHP/HNE BH Benefits Grid, and in the provider file
5. Reinforcement that staff orientation and training is provided, in particular, to facilitate skill development related to co-occurring disorders and motivational interviewing
6. Provider clarification, introduction of required timeframes for the completion of treatment/recovery plan updates
7. Provider clarification, reinforcement of: requirements, integrated care, collaboration, and continuity of care for the Member

Input sought:

MBHP/HNE BH Internal Review
1. First level review: Gina Battaglia, Anne Pelletier Parker, Jonna Hopwood, Steve Zessis, Elizabeth O'Brien, Kevin Weir, Moira Muir, James Thatcher, MD
2. Second level review: Anne Pelletier Parker
3. Final review/approval: Stephanie Brown, Mike Curry, Erin Donohue, Alex Forster, Andrea Gewirtz, Janice Harrington, Terri Hubbard, Carol Kress, Tamara Lange, Evan Morse, Moira Muir, Nancy Norman, MD, Elisabeth Okrant, Joe Passeneau, Anne Pelletier Parker, Garland Russell, George Smart, John Straus, MD, Scott Taberner, Kenneth Talbot, James Thatcher, MD

External Review

1. MBHP/HNE BH obtained extensive provider input into the original drafting of the performance specifications when they were developed for most levels of care at the start of the MBHP/HNE BH PCC Plan contract. During this revision, as MBHP/HNE BH informed MassHealth, we sought provider input into the specifications only for major levels of care in which we were drafting significant changes. The performance specifications for this level of care did not contain substantive changes to warrant vetting with the provider network or other stakeholders.
2. MBHP/HNE BH engaged in a cross-walk of these specs with our contract.
Covered Service: Structured Outpatient Addiction Program (SOAP) with Motivational Interviewing (MI)

Major revisions made:
1. In the description of the service on the first page, modification of language clarifying the service, including the addition of Members who may benefit from the service, e.g., those being stepped down from Clinical Stabilization Services (CSS)
2. In the Components of Service section, omission of language contained in the SOAP performance specs
3. In the Components of Service section, addition of language emphasizing that the SOAP with MI incorporates motivational interviewing techniques and strategies into all of the program’s interventions and services.
4. In the Staffing section, addition of language emphasizing that the SOAP with MI documents, for all program staff, staff orientation and at least annual training on motivational interviewing skills and strategies

Corresponding rationales for these major revisions:
1. Clarification of target population for this service
2. Elimination of redundancy and clarification relative to the unique requirements for SOAP with MI
3. Reinforcement of motivational interviewing as the core service component and key differentiator in this covered service
4. Reinforcement that staff orientation and training is provided, in particular, to facilitate skill development related to motivational interviewing

Input sought:

MBHP/HNE BH Internal Review
1. First level review: Gina Battaglia, Anne Pelletier Parker, Jonna Hopwood, Steve Zessis, Elizabeth O’Brien, Kevin Weir, Moira Muir, James Thatcher, MD
2. Second level review: Anne Pelletier Parker
3. Final review/approval: Stephanie Brown, Mike Curry, Erin Donohue, Alex Forster, Andrea Gewirtz, Janice Harrington, Terri Hubbard, Carol Kress, Tamara Lange, Evan Morse, Moira Muir, Nancy Norman, MD, Elisabeth Okrant, Joe Passeneau, Anne Pelletier Parker, Garland Russell, George Smart, John Straus, MD, Scott Taberner, Kenneth Talbot, James Thatcher, MD

External Review
1. MBHP/HNE BH obtained extensive provider input into the original drafting of the performance specifications when they were developed for most levels of care at the start of the MBHP/HNE BH PCC Plan contract. During this revision, as MBHP/HNE BH informed MassHealth, we sought provider input into the specifications only for major levels of care in which we were drafting significant changes. The performance specifications for this level of care did not contain substantive changes to warrant vetting with the provider network or other stakeholders.
Outpatient Services
Covered Service: Acupuncture Treatment

Major revisions made:
1. In the service description on the first page, addition of language specifying that these specs govern the detoxification period and that aftercare services are subject to the Outpatient Services specs
2. In Components of Service section, addition of language specifying that the provider is licensed by the Department of Public Health (DPH) as an Acupuncture program and complies with those regulations
3. In Components of Service section, the following modifications to the list of service components: addition of bio-psychosocial evaluation, medical history/screening and physical examination, and substance use disorder assessment and treatment services (contained within the existing per diem definition but missing from these specs); addition of development of a treatment/recovery plan, and development and/or updating of crisis prevention plans, and/or safety plans, and/or relapse prevention plans, as applicable
4. In Components of Service section, omission of language relative to crisis coverage and after-hours coverage availability, and addition of language specifying actions the provider may take if a Member experiencing a behavioral health crisis contacts him/her during or outside business hours (e.g., refer to his/her OP provider; refer him/her to an ESP/MCI for emergency behavioral health crisis assessment, intervention, and stabilization; and/or implement other interventions to support and enable him/her to remain in the community, when clinically appropriate)
5. In Staffing section, addition of a physician, psychiatrist, nurse practitioner, physician assistant, registered nurse or licensed practical nurse (either on-site or through an Affiliation Agreement) for the purpose of consultation to staff (in addition to existing language referencing a clinician certified in addiction treatment)
6. In Staffing section, omission of registered nurse from the list of staff on-site during the hours of operation for the purpose of conducting the medical history/screening to determine that acupuncture is not contraindicated
7. In the Staffing section, addition of language requiring that supervision of nursing staff is overseen by a registered nurse
8. In Assessment section, addition of clarifying language relative to the completion by the assigned clinician of a bio-psychosocial evaluation, initial treatment/recovery plan, and initial discharge plan upon admission (this was implicitly assumed in the original language)
9. In the Assessment section, addition of language requiring a physical examination which conforms to the principles established by the American Society of Addiction Medicine to be completed for all Members within 24 hours of admission
10. In Assessment section, addition of language relative to the assignment of a multi-disciplinary treatment team to each Member within 24 hours of admission, that the multi-disciplinary treatment team meets to review the evaluation, the initial treatment/recovery plan, and the initial discharge plan within 48 hours of admission, and that on weekends and holidays the treatment/recovery plan may be developed by an abbreviated treatment team with a review by the full treatment team on the next business day
11. In Assessment section, modification of language differentiating the requirements for treatment/recovery plan review frequencies by the multi-disciplinary treatment team: a) during intensive acupuncture administration for detoxification purposes (at least every 48 hours, with updates when major clinical changes occur), and b) during less intensive treatment for relapse prevention (at
the intervals identified within the original Acupuncture specs, with the addition of “after any 24-hour behavioral health inpatient admission that necessitates a change in the treatment/recovery plan”)

12. In Assessment section, addition of PNMHCS to the list of authorized prescribers who may request drug screening services

13. In Service, Community, and Collateral Linkages section, addition of language relative to the provider’s collaboration with the Member’s primary care clinician (PCC) as delineated in the PCC Integration section of the General performance specifications

**Corresponding rationales for these major revisions:**

1. Provider clarification; reinforcement of requirements
2. Provider clarification; reinforcement of requirements
3. Provider clarification; reinforcement of requirements and continuity of care for the Member; consistency with changes within the greater behavioral health/substance use disorder field; consistency with the relevant per diem definition; consistency with BSAS regs (“screening”)
4. Provider clarification; consistency with expectations for other non-24-hour diversionary levels of care (e.g., CSP, Psychiatric Day Treatment, IOP); reinforcement of requirements and continuity of care
5. Provider clarification; consistency with BSAS regs which do not specify the kind of consultation
6. Provider clarification; lack of qualifications and per recommendation of MassHealth
7. Provider clarification; compliance with licensing bodies (BSAS regulations); reinforcement of requirements
8. Compliance with licensing bodies (BSAS regulations); provider clarification; reinforcement of requirements
9. Provider clarification; compliance with licensing bodies (BSAS regulations); reinforcement of requirements
10. Compliance with contract language and licensing bodies (BSAS regulations); provider clarification; reinforcement of requirements; appropriateness given the service requirements; consistency with the timeframes and language within Acute Treatment Services (ATS) for Substance Use Disorders
11. Provider clarification; reinforcement of requirements; appropriateness given the service requirements; consistency with the timeframes for ATS for Substance Use Disorders
12. Provider clarification; acknowledgement of the role of the PNMHCS
13. Provider clarification; reinforcement of requirements, integrated care, collaboration, and quality of care for the Member

**Input sought:**

**MBHP/HNE BH Internal Review**

1. First level review: Gina Battaglia, James Thatcher, MD
2. Second level review: Jonna Hopwood, Anne Pelletier Parker
3. Final review/approval: Stephanie Brown, Mike Curry, Erin Donohue, Alex Forster, Andrea Gewirtz, Janice Harrington, Terri Hubbard, Carol Kress, Tamara Lange, Evan Morse, Moira Muir, Nancy Norman, MD, Elisabeth Okrant, Joe Passeneau, Anne Pelletier Parker, Garland Russell, George Smart, John Straus, MD, Scott Taberner, Kenneth Talbot, James Thatcher, MD

**External Review**

2014 MBHP/HNE BH Performance Specifications Revisions: Summaries of Changes
Effective July 1, 2014
1. MBHP/HNE BH obtained extensive provider input into the original drafting of the performance specifications when they were developed for most levels of care at the start of the MBHP/HNE BH PCC Plan contract. During this revision, as MBHP/HNE BH informed MassHealth, we sought provider input into the specifications only for major levels of care in which we were drafting significant changes. The performance specifications for this level of care did not contain substantive changes to warrant vetting with the provider network or other stakeholders.
2. MBHP/HNE BH engaged in a cross-walk of these specs with the DPH BSAS regulations, and with our contract.
Covered Service: Ambulatory Detoxification

Major revisions made:

1. In the service description on the first page, addition of language specifying that these specs govern the detoxification period and that aftercare services are subject to the Outpatient Services specs
2. In Components of Service section, addition of language specifying that the provider is licensed by the Department of Public Health (DPH) as an Ambulatory Detoxification program and complies with those regulations
3. In Components of Service section, addition of two service components: development of a treatment/recovery plan; and development and/or updating of crisis prevention plan, and/or safety plan, and/or relapse prevention plan, as applicable
4. In Components of Service section, addition of language requiring the program to provide a minimum of nine hours of service programming per week
5. In Components of Service section, omission of language relative to crisis coverage and after-hours coverage, and addition of language specifying actions the provider may take if a Member experiencing a behavioral health crisis contacts him/her during or outside business hours (e.g., refer to his/her OP provider; refer him/her to an ESP/MCI for emergency behavioral health crisis assessment, intervention, and stabilization; and/or implement other interventions to support and enable him/her to remain in the community, when clinically appropriate)
6. In Staffing Requirements section, addition of language requiring that supervision of nursing staff be overseen by a registered nurse
7. In Staffing Requirements section, addition of language requiring that supervision of nursing staff be overseen by a registered nurse
8. In Assessment section, addition of clarifying language relative to the completion by the assigned clinician/counselor of a bio-psychosocial evaluation, initial treatment/recovery plan, and initial discharge plan upon admission (this was implicitly assumed in the original language)
9. In Assessment section, addition of language requiring that a physical examination which conforms to the principles established by the American Society of Addiction Medicine be completed for all Members within 24 hours of admission, that if the examination is conducted by a qualified health care professional who is not a physician, the results and any recommendations arising from the examination are reviewed by the nursing supervisor prior to implementation, and that ambulatory detoxification services are provided after the provider determines through physical examination that such services are required
10. In Assessment section, addition of language relative to the assignment of a multi-disciplinary treatment team to each Member within 24 hours of admission, that the multi-disciplinary treatment team meets to review the bio-psychosocial evaluation, the initial treatment/recovery plan, and the initial discharge plan within 48 hours of admission, and that on weekends and holidays the treatment/recovery plan may be developed by an abbreviated treatment team, with a review by the full treatment team on the next business day
11. In Assessment section, modification of the requirement for treatment/recovery plan reviews by the multi-disciplinary treatment team (from the intervals outlined within the original specs to “at least every 48 hours, and updated when major clinical changes occur”)
12. In Assessment section, addition of psychiatric nurse mental health clinical specialist (PNMHCS) to the list of authorized prescribers who may request drug screening services
13. In Service, Community, and Collateral Linkages section, addition of language relative to the provider’s collaboration with the Member’s primary care clinician (PCC) as delineated in the PCC Integration section of the General performance specifications

**Corresponding rationales for these major revisions:**
1. Provider clarification; reinforcement of requirements
2. Provider clarification; reinforcement of requirements
3. Provider clarification; reinforcement of requirements and continuity of care for the Member; consistency with changes within the greater behavioral health/substance use disorder field
4. Provider clarification; compliance with licensing bodies (BSAS regulations); reinforcement of requirements
5. Provider clarification; consistency with expectations for other non-24-hour diversionary levels of care (e.g., CSP, Psychiatric Day Treatment, IOP); reinforcement of requirements and continuity of care
6. Provider clarification; compliance with licensing bodies (BSAS regulations); reinforcement of requirements
7. Provider clarification; compliance with licensing bodies (BSAS regulations); reinforcement of requirements
8. Compliance with licensing bodies (BSAS regulations); provider clarification; reinforcement of requirements
9. Provider clarification; compliance with licensing bodies (BSAS regulations); reinforcement of requirements
10. Compliance with contract language and licensing bodies (BSAS regulations); provider clarification; reinforcement of requirements; appropriateness given the service requirements; consistency with the timeframes and language within Acute Treatment Services (ATS) for Substance Use Disorders
11. Provider clarification; reinforcement of requirements; appropriateness given the service requirements; consistency with the timeframes for ATS for Substance Use Disorders
12. Provider clarification; reinforcement of requirements; acknowledgement of the role of the PNMHCS
13. Provider clarification; reinforcement of requirements, integrated care, collaboration, and quality of care for the Member

**Input sought:**

**MBHP/HNE BH Internal Review**
1. First level review: Gina Battaglia, Jonna Hopwood, James Thatcher, MD, Kevin Weir, Steve Zessis, Moira Muir, Elizabeth O’Brien
2. Second level review: Anne Pelletier Parker
3. Final review/approval: Stephanie Brown, Mike Curry, Erin Donohue, Alex Forster, Andrea Gewirtz, Janice Harrington, Terri Hubbard, Carol Kress, Tamara Lange, Evan Morse, Moira Muir, Nancy Norman, MD, Elisabeth Okrant, Joe Passeeneau, Anne Pelletier Parker, Garland Russell, George Smart, John Straus, MD, Scott Taberner, Kenneth Talbot, James Thatcher, MD

**External Review**
1. MBHP/HNE BH obtained extensive provider input into the original drafting of the performance specifications when they were developed for most levels of care at the start of the MBHP/HNE BH

2014 MBHP/HNE BH Performance Specifications Revisions: Summaries of Changes
Effective July 1, 2014
PCC Plan contract. During this revision, as MBHP/HNE BH informed MassHealth, we sought provider input into the specifications only for major levels of care in which we were drafting significant changes. The performance specifications for this level of care did not contain substantive changes to warrant vetting with the provider network or other stakeholders.

2. MBHP/HNE BH engaged in a cross-walk of these specs with the DPH BSAS regulations, and with our contract.
Covered Service: Assessment for Safe and Appropriate Placement (ASAP)

Major revisions made:

1. In the description of the service (first page) and throughout the specs, modification of language: “sexually abusive behaviors” to “sexual offending behaviors”; addition of another category of youth who are appropriate for an ASAP (those currently in a foster home, group home, or independent living program, and who exhibit sexual offending and/or fire-setting behaviors that were not previously known to the Department of Children and Families (DCF)); addition of three categories of youth who are not appropriate for an ASAP and the reasons (youth who are currently placed in a residential facility for whom MBHP/HNE BH has not granted Member-specific approval; youth who are transitioning from a residential facility to a less restrictive setting, either on- or off-site from the residential facility; and youth being discharged from a Community-Based Acute Treatment (CBAT) program to a restrictive setting such as a residential treatment facility)

2. In the Staffing Requirements section, omission of licensed registered nurse (RN) and addition of psychiatric nurse mental health clinical specialist (PNMHCS) to the list of professionals whom MBHP/HNE BH credentials as ASAP Qualified Diagnosticians, as well as master’s-level clinicians, who meet MBHP/HNE BH’s credentialing criteria, as ASAP Qualified Diagnosticians in an MBHP/HNE BH-contracted clinic or facility

3. In the Staffing Requirements section, modification of additional credentialing criteria for providers assessing fire-setting behaviors: addition of knowledge of DCF’s mission, population served, levels of care and their services; modification of hours per year of documented juvenile fire-setter-specific assessment experience (from 40 to 120); modification of hours per year of documented juvenile fire-setter-specific training experience (from 15 to 45); and addition of the clarifier “continuing medical education/continuing education units (CME/CEUs)” relative to the training experience

4. In the Staffing Requirements section, modification of additional credentialing criteria for providers assessing sexual offending behaviors: addition of knowledge of DCF’s mission, population served, levels of care and their services; addition of “documented” relative to juvenile sexual-offender-specific assessment experience and juvenile sexual-offender-specific assessment and treatment training experience; and addition of the clarifier “(CME/CEUs)” relative to the training experience

5. In the Staffing Requirements section, modification of language clarifying that ASAP interns must meet MBHP/HNE BH-defined requirements of master’s-level interns, supervised by a licensed, contracted/credentialed ASAP provider

6. In the Referral and Assessment Process section, addition of language clarifying the steps relative to the referral process, including modification of assignment of the youth to an MBHP/HNE BH ASAP Qualified Diagnostician (“within 24 hours” to “within one business day”)

7. In the Referral and Assessment Process section, addition of language clarifying the steps relative to the completion of the ASAP report, including addition of “as part of the Crisis Planning Tools for youth” to “post-assessment safety plan”, and addition of a timeframe (within three business days) in which the MBHP/HNE BH ASAP Qualified Diagnostician forwards the ASAP report to the DCF Area Office and Lead Agency

8. In the Subsequent Clinical Assessments section, utilization of the term “initial ASAP” for “first ASAP” or “previously completed ASAP”, and the term “subsequent ASAP” for “subsequent clinical assessment” or “ASAP update” or “second ASAP” or “clinical assessment update”
9. In the Subsequent Clinical Assessments section, addition of the following note relative to identification of how the behaviors adversely impact the youth’s current community setting or pending community setting: “If a one-year time period has not elapsed and a subsequent ASAP is needed and/or indicated, on a Member-specific basis the DCF Regional Clinical Team makes such a recommendation to MBHP/HNE BH.”

Corresponding rationales for these major revisions:
1. Provider clarification; reinforcement of requirements; consistency with current language within the greater behavioral health field; incorporation of DCF suggested edits
2. Provider clarification; reinforcement of requirements; consistency with MBHP/HNE BH credentialing criteria
3. Provider clarification; reinforcement of requirements; consistency with MBHP/HNE BH credentialing criteria
4. Provider clarification; reinforcement of requirements; consistency with MBHP/HNE BH credentialing criteria
5. Provider clarification; reinforcement of requirements; consistency with MBHP/HNE BH credentialing criteria
6. Provider clarification; reinforcement of requirements and quality of care
7. Provider clarification; reinforcement of requirements and quality of care; supported by DCF feedback
8. Provider clarification; reinforcement of requirements and consistency; supported by DCF feedback
9. Provider clarification; reinforcement of procedures; per recommendation of MassHealth

Input sought:

MBHP/HNE BH Internal Review
1. First level review: Gina Battaglia, Tara Fischer
2. Second level review before stakeholder input was obtained: Anne Pelletier Parker, Nanette Campo, Ronna Sanchez, Garland Russell
3. Third level review after stakeholder input was obtained: Anne Pelletier Parker, Tara Fischer
4. Final review/approval: Stephanie Brown, Mike Curry, Jaclyn Devine, Erin Donohue, Alex Forster, Andrea Gewirtz, Janice Harrington, Jonna Hopwood, Terri Hubbard, Carol Kress, Tamara Lange, Evan Morse, Moira Muir, Nancy Norman, MD, Elisabeth Okrant, Joe Passeneau, Anne Pelletier Parker, Garland Russell, George Smart, John Straus, MD, Scott Taberner, Kenneth Talbot, James Thatcher, MD

External Review
1. MBHP/HNE BH engaged in a cross-walk of these specs with our contract.
2. MBHP/HNE BH disseminated the draft revised ASAP performance specifications to DCF and incorporated several areas of their feedback, i.e., after the second level of internal review, as noted above.

Notable feedback received from the provider network and other stakeholders:
Areas where MBHP/HNE BH incorporated provider and stakeholder feedback, specifically from DCF
1. Substitution of “placement” with “community setting” or “disposition”, emphasizing the youth’s return to a community setting
2. Inclusion of “a community group home setting”, and “initial placement into a residential school based on individual needs, with MBHP/HNE BH Member-specific approval” relative to where youth are being placed

3. Omission of proposed language specifying that residential facilities are responsible for treatment, safety and supervision, given not all are equipped to provide treatment for sexual offending or fire-setting behaviors

Areas where MBHP/HNE BH did not incorporate provider and stakeholder feedback
1. Not applicable
Covered Service: Dialectical Behavioral Therapy (DBT)

Major revisions made:
1. Replacement of DSM-IV with DSM-5 throughout
2. Replacement of “clinician” with “therapist” throughout
3. Language relative to the administration of outcome measurement “by the DBT program” and to the provision of a summary of findings to MBHP/HNE BH “upon request”

Corresponding rationales for these major revisions:
1. Consistency with changes within the greater behavioral health field
2. Language consistency
3. Clarification of expectations related to outcomes management

Input sought:

MBHP/HNE BH Internal Review
1. First level review: George Smart, Nanette Campo, Alex Forster, Janet Leopold
2. Second level review: Anne Pelletier Parker
3. Final review/approval: Stephanie Brown, Mike Curry, Erin Donohue, Alex Forster, Andrea Gewirtz, Janice Harrington, Terri Hubbard, Carol Kress, Tamara Lange, Janet Leopold, Evan Morse, Moira Muir, Nancy Norman, MD, Elisabeth Okrant, Joe Passeneau, Anne Pelletier Parker, Garland Russell, George Smart, John Straus, MD, Scott Taberner, Kenneth Talbot, James Thatcher, MD

External Review
1. MBHP/HNE BH obtained extensive provider input into the original drafting of the performance specifications when they were developed for most levels of care at the start of the MBHP/HNE BH PCC Plan contract. During this revision, as MBHP/HNE BH informed MassHealth, we sought provider input into the specifications only for major levels of care in which we were drafting significant changes. The performance specifications for this level of care did not contain substantive changes to warrant vetting with the provider network or other stakeholders.
Covered Service: Outpatient Services

Major revisions made:
1. In description of the service (first page), omission of the proposed language “Medication Management” from the list of services to which these specs apply
2. In Components of Service section, addition of the following to the list of required service components: “bio-psychosocial evaluation;” and “care coordination as required for a primary behavioral health hub in the provision of CBHI services for youth;”
3. In Components of Service section, addition of language regarding the provider’s responsibilities as a primary behavioral health hub for youth under the age of 21 relative to the CBHI
4. In Staffing section, addition of language relative to availability of a multi-disciplinary team appropriate to Members’ needs and inclusive of licensed professionals as set forth in the DPH outpatient mental health regulations
5. In Staffing section, modification of language relative to the availability of “supervisory” (versus “senior”) clinical staff for consultation to staff, and the addition of a psychiatric nurse mental health clinical specialist (PNMHCS) to be available for consultation to staff as needed
6. In Assessment section, addition of language clarifying that Members referred from an inpatient unit are offered an outpatient therapy appointment “(which may be an intake appointment for therapy services)” within 7 calendar days from the date of discharge from the inpatient unit
7. In Assessment section, addition of language clarifying, with appropriate Member consent, the responsibilities of the provider when a Member is evaluated by an ESP/MCI, admitted to a 24-hour level of care, or discharged from a 24-hour level of care, including inclusion of the most recent Child and Adolescent Needs and Strengths (CANS) assessment as part of the information provided to the ESP/MCI or 24-hour level of care
8. In Assessment section, addition of language clarifying the completion of assessments and treatment plans, according to the requirements delineated in the MBHP/HNE BH General performance specifications
9. In Discharge section, addition of language relative to the development/implementation of an aftercare plan when the Member meets the outpatient discharge criteria established in his/her treatment plan, that the provider provides the Member with a copy of the plan upon his/her discharge, and documents these activities in his/her health record
10. In Discharge section, addition of language clarifying the provider’s responsibilities relative to Members under age 21 who are also engaged in Therapeutic Mentoring (TM) or Family Support and Training (FS&T) services
11. In Service, Community, and Collateral Linkages section, addition of language clarifying the working relationships and linkages providers must develop with other providers, as well as how these relationships and linkages may be documented, including the addition of active participation in local Systems of Care meetings
12. In Service, Community, and Collateral Linkages section, addition of language referencing utilization of: 1) case consultation, family consultation, and collateral contact when involving parents/guardians/caregivers in the planning, assessment, and treatment for Members, and 2) with Member consent and as applicable, case consultation and collateral contacts to involve the collaterals identified within the Care Coordination section of the General performance specs in the planning, assessment, and treatment for Members
Corresponding rationales for these major revisions:

1. Requirements specific to medication management are included in these specs; there are no specs for medication management
2. Provider clarification; reinforcement of existing service component requirement in per diem (“bio-psychosocial evaluation”); reinforcement of: requirements and procedures as primary behavioral health hub in the provision of CBHI services for youth (“care coordination”), and importance of collaboration and continuity of care for the Member
3. Provider clarification; reinforcement of: requirements and procedures as primary behavioral health hub in the provision of CBHI services for youth, and quality and continuity of care for the Member
4. Consistency with licensing bodies; reinforcement of quality of care
5. Provider clarification; reinforcement of oversight; acknowledgement of the role of the PNMHCS
6. Provider clarification; compliance with contract deliverable, NCQA, and HEDIS® measures
7. Provider clarification; reinforcement of quality and continuity of care for the Member; supported by provider and stakeholder feedback
8. Provider clarification; reinforcement of requirements, procedures, and quality of care
9. Provider clarification; reinforcement of requirements; per recommendation of MassHealth
10. Provider clarification; reinforcement of: requirements and procedures as primary behavioral health hub in the provision of CBHI services for youth, and quality and continuity of care for the Member; supported by provider and stakeholder feedback
11. Provider clarification; reinforcement of: quality of care, collaboration, continuity of care for the Member, and CBHI vision and mission
12. Provider clarification; reinforcement of: quality of care, collaboration, continuity of care for the Member; supported by provider and stakeholder feedback

Input sought:

**MBHP/HNE BH Internal Review**

1. First level review: Gina Battaglia, Tara Fischer, Nanette Campo, Barbara Wilson, George Smart
2. Second level review: Anne Pelletier Parker, Steve Feldman
3. Third level review before written provider and stakeholder input was obtained: Anne Pelletier Parker
4. Fourth level review: Stephanie Brown, Mike Curry, Erin Donohue, Alex Forster, Andrea Gewirtz, Janice Harrington, Terri Hubbard, Carol Kress, Tamara Lange, Janet Leopold, Evan Morse, Moira Muir, Nancy Norman, MD, Elisabeth Okrant, Joe Passeneau, Anne Pelletier Parker, Garland Russell, George Smart, John Straus, MD, Scott Taberner, Kenneth Talbot, James Thatcher, MD
5. Fifth level review after written provider and stakeholder input was incorporated: Anne Pelletier Parker, James Thatcher, MD, Moira Muir
6. Final review/approval: Stephanie Brown, Mike Curry, Erin Donohue, Alex Forster, Andrea Gewirtz, Janice Harrington, Terri Hubbard, Carol Kress, Tamara Lange, Evan Morse, Moira Muir, Nancy Norman, MD, Elisabeth Okrant, Anne Pelletier Parker, Garland Russell, John Straus, MD, Scott Taberner, Kenneth Talbot, James Thatcher, MD

**External Review**

1. MBHP/HNE BH engaged in a cross-walk of these specs with the DPH Outpatient Mental Health regulations, as well as with our contract.
2. MBHP/HNE BH disseminated the revised Outpatient Services performance specs to outpatient providers to gather their input, after the revised specs were initially submitted to MassHealth. Along with outpatient providers, MBHP/HNE BH also included Vic DiGravio, President/CEO of the Association for Behavioral Healthcare (ABH). MBHP/HNE BH incorporated several areas of their feedback.

Notable feedback received from the provider network and other stakeholders:
Areas where MBHP/HNE BH incorporated provider and stakeholder feedback, specifically from outpatient providers and representatives from ABH
1. Clarification that the development and/or updating of crisis prevention plans and/or safety plans are done “as clinically indicated” to reflect this is not a requirement for all Members
2. Addition of clarifying language “Provision of the following covered services” relative to diagnostic evaluation; individual, couples, group and family therapy; case and family consultation; and collateral contact, to differentiate diagnostic evaluation from bio-psychosocial evaluation
3. Slight modification of language that providers “make best efforts to” develop and maintain the capacity to serve Members with special needs in their communities and adhere to their “organizations’” written protocols for treating such populations and/or offer appropriate referrals “if they are unable to serve these Members directly”
4. Modification of language relative to medication reconciliation to reflect that it is done “with the Member, and, with the Member’s consent, other treatment providers”
5. Addition of language clarifying that providers are proactive and “make best efforts to” facilitate Member attendance at initial and ongoing appointments
6. Addition of language clarifying that providers “make best efforts to” offer operating hours that are responsive to the needs of Members and their families
7. Modification of language relative to the termination process, including that the provider “makes best efforts to” initiate a thoughtful process
8. Slight modification of language, in the Discharge section, relative to crisis prevention plans and/or safety plans and/or relapse prevention plans, i.e., emphasizing that they are developed with Member consent and as clinically indicated

Areas where MBHP/HNE BH did not incorporate provider and stakeholder feedback, specifically from outpatient providers and representatives from ABH
1. Elimination of the requirement for Memoranda of Understanding (MOU) or Affiliation Agreements with others if providers are unable to provide a service directly, such as psychopharmacology, especially to children (Note: MBHP/HNE BH Regional Directors have expected this in practice for years)
2. Lack of compensation/reimbursement for the provision of care coordination functions, as required for a primary behavioral health hub in the provision of CBHI services for youth
Covered Service: Outpatient Services Home-Based and Non-Facility-Based

Major revisions made:
1. Throughout the specs, omission of language contained in either the General specs or the Outpatient Services specs
2. In the service description on the first page, addition of language, “Relative to outpatient services provided in a school setting, please see the MBHP/HNE BH Outpatient School-Based performance specifications”
3. In the Components of Service section, addition of language clarifying to whom home-based and non-facility-based services are available

Corresponding rationales for these major revisions:
1. Elimination of duplicative information and reinforcement of intent of the service
2. Provider clarification; reinforcement of requirements and procedures
3. Provider clarification; reinforcement of requirements and procedures

Input sought:

MBHP/HNE BH Internal Review
1. First level review: Gina Battaglia, Tara Fischer, Nanette Campo, Barbara Wilson, George Smart
2. Second level review: Anne Pelletier Parker, Steve Feldman
3. Final review/approval: Stephanie Brown, Mike Curry, Erin Donohue, Alex Forster, Andrea Gewirtz, Janice Harrington, Terri Hubbard, Carol Kress, Tamara Lange, Janet Leopold, Evan Morse, Moira Muir, Nancy Norman, MD, Elisabeth Okrant, Joe Passeneau, Anne Pelletier Parker, Garland Russell, George Smart, John Straus, MD, Scott Taberner, Kenneth Talbot, James Thatcher, MD

External Review
1. MBHP/HNE BH obtained extensive provider input into the original drafting of the performance specifications when they were developed for most levels of care at the start of the MBHP/HNE BH PCC Plan contract. During this revision, as MBHP/HNE BH informed MassHealth, we sought provider input into the specifications only for major levels of care in which we were drafting significant changes. The performance specifications for this level of care did not contain substantive changes to warrant vetting with the provider network or other stakeholders.
2. MBHP/HNE BH engaged in a cross-walk of these specs with the Department of Public Health (DPH) Outpatient Mental Health regulations.
Covered Service: Outpatient Services School-Based

Major revisions made:
1. Throughout the specs, omission of language contained in either the General specs or the Outpatient Services specs
2. In the Components of Service section, addition of language clarifying to whom school-based services are available
3. In the Staffing section, modification of language relative to the training provided to staff
4. In the Assessment section, modification of language clarifying the need for re-evaluation of the appropriateness of school-based services for Members in an ongoing manner
5. In the Assessment section, modification of language relative to ensuring continuity of care for Members, including during summer months
6. In the Service, Community, and Collateral Linkages section, modification of language clarifying utilization of case consultation, family consultation, and collateral contacts when involving parents/guardians/caregivers and school personnel in the planning, assessment, and treatment for Members
7. In the Service, Community, and Collateral Linkages section, addition of language relative to the development and maintenance of Memoranda of Understanding (MOU) with each school in which the provider delivers school-based outpatient services

Corresponding rationales for these major revisions:
1. Elimination of duplicative information; reinforcement of intent of the service
2. Provider clarification; reinforcement of requirements and procedures
3. Provider clarification; reinforcement of requirements and procedures; consistency with best practices within the greater behavioral health field
4. Provider clarification; reinforcement of requirements and procedures; consistency with medical necessity criteria
5. Provider clarification; reinforcement of: requirements and procedures, and continuity of care for the Member
6. Provider clarification; reinforcement of: quality of care, collaboration, and continuity of care for the Member
7. Provider clarification; reinforcement of: requirements and procedures, collaboration, and quality of care

Input sought:

MBHP/HNE BH Internal Review
1. First level review: Gina Battaglia, Tara Fischer, Nanette Campo, Barbara Wilson, George Smart
2. Second level review: Anne Pelletier Parker, Steve Feldman
3. Final review/approval: Stephanie Brown, Mike Curry, Erin Donohue, Alex Forster, Andrea Gewirtz, Janice Harrington, Terri Hubbard, Carol Kress, Tamara Lange, Janet Leopold, Evan Morse, Moira Muir, Nancy Norman, MD, Elisabeth Okrant, Joe Passeneau, Anne Pelletier Parker, Garland Russell, George Smart, John Straus, MD, Scott Taberner, Kenneth Talbot, James Thatcher, MD
External Review

1. MBHP/HNE BH obtained extensive provider input into the original drafting of the performance specifications when they were developed for most levels of care at the start of the MBHP/HNE BH PCC Plan contract. During this revision, as MBHP/HNE BH informed MassHealth, we sought provider input into the specifications only for major levels of care in which we were drafting significant changes. The performance specifications for this level of care did not contain substantive changes to warrant vetting with the provider network or other stakeholders.

2. MBHP/HNE BH engaged in a cross-walk of these specs with the Department of Public Health (DPH) Outpatient Mental Health regulations
Covered Service: Opioid Replacement Therapy

Major revisions made:

1. In Components of Service section, the following modifications to the list of service components: addition of buprenorphine dosing; addition of other components contained within the existing per diem definition but missing from these specs; addition of “directly or by referral” to “psychiatric consultation” and “urine and/or serum drug screening”; addition of development and/or updating of crisis prevention plan, and/or safety plan, and/or relapse prevention plan, as applicable; omission of “crisis intervention” and “annual blood work”

2. In Components of Service section, omission of language relative to crisis coverage and after-hours coverage availability and addition of language specifying actions the provider may take if a Member experiencing a behavioral health crisis contacts him/her during or outside business hours (e.g., refer to his/her OP provider; refer him/her to an ESP/MCI for emergency behavioral health crisis assessment, intervention, and stabilization; and/or implement other interventions to support and enable him/her to remain in the community, when clinically appropriate)

3. In the Staffing section, addition of “Registered pharmacist” to the list of multi-disciplinary staff

4. In Assessment section, addition of language relative to the completion by the assigned counselor of a bio-psychosocial evaluation, initial treatment/recovery plan, and initial discharge plan upon admission and prior to dosing

5. In the Assessment section, addition of language relative to the requirement for a physical examination which conforms to the principles established by the American Society of Addiction Medicine (ASAM) for all Members within 24 hours of admission

6. In Assessment section, addition of language relative to the multi-disciplinary treatment team’s review of the evaluation, the initial treatment/recovery plan, and the initial discharge plan within 48 hours of admission

7. In Assessment section, addition of clarifying language relative to intervals at which the treatment/recovery plan and discharge plan are reviewed by the multi-disciplinary treatment team in collaboration with the Member, with the addition of “after any 24-hour behavioral health inpatient admission that necessitates a change in the treatment/recovery plan”

8. In Assessment section, addition of language requiring the initial dosage of an opioid agonist treatment medication to be ordered by a physician, not exceeding the federal dosage guidelines for the specified opioid

9. In Service, Community, and Collateral Linkages section, addition of language relative to the provider’s collaboration with the Member’s primary care clinician (PCC) as delineated in the PCC Integration section of the General performance specifications

Corresponding rationales for these major revisions:

1. Provider clarification; reinforcement of requirements and continuity of care for the Member; consistency with changes within the greater behavioral health/substance use disorder field; consistency with the relevant per diem definition

2. Provider clarification; consistency with expectations for other non-24-hour diversionary levels of care (e.g., CSP, Psychiatric Day Treatment, IOP); reinforcement of requirements and continuity of care

3. Consistency with language in the Assessment section of the specs and per recommendation of MassHealth
4. Compliance with licensing bodies (BSAS regulations); provider clarification; reinforcement of requirements
5. Compliance with licensing bodies (BSAS regulations); provider clarification; reinforcement of requirements
6. Compliance with contract language and licensing bodies (BSAS regulations); provider clarification; reinforcement of requirements; appropriateness given the service requirements; consistency with the timeframes for Acute Treatment Services (ATS) for Individuals with Substance Use Disorders
7. Provider clarification; reinforcement of requirements; appropriateness given the service requirements; consistency with the timeframes for ATS for Individuals with Substance Use Disorders
8. Compliance with licensing bodies (BSAS regulations); provider clarification; reinforcement of requirements and oversight
9. Provider clarification; reinforcement of requirements, integrated care, collaboration, and quality of care for the Member

Input sought:

**MBHP/HNE BH Internal Review**
1. First level review: Gina Battaglia, Jonna Hopwood, James Thatcher, MD, Kevin Weir, Steve Zessis, Moira Muir, Elizabeth O'Brien
2. Second level review: Anne Pelletier Parker
3. Final review/approval: Stephanie Brown, Mike Curry, Erin Donohue, Alex Forster, Andrea Gewirtz, Janice Harrington, Terri Hubbard, Carol Kress, Tamara Lange, Evan Morse, Moira Muir, Nancy Norman, MD, Elisabeth Okrant, Joe Passeneau, Anne Pelletier Parker, Garland Russell, George Smart, John Straus, MD, Scott Taberner, Kenneth Talbot, James Thatcher, MD

**External Review**
1. MBHP/HNE BH obtained extensive provider input into the original drafting of the performance specifications when they were developed for most levels of care at the start of the MBHP/HNE BH PCC Plan contract. During this revision, as MBHP/HNE BH informed MassHealth, we sought provider input into the specifications only for major levels of care in which we were drafting significant changes. The performance specifications for this level of care did not contain substantive changes to warrant vetting with the provider network or other stakeholders.
2. MBHP/HNE BH engaged in a cross-walk of these specs with the DPH BSAS regulations, and with our contract.
Covered Service: Psychological Testing

Major revisions made:
1. Designation of the clinician who is providing direct services to the Member as “treating clinician”
2. Clarification of the process when the referral is from a source other than a treating clinician - psychologists request authorization for testing, as opposed to submitting a Psychological Evaluation Request (PER) form
3. Instruction for psychologists to utilize the Interactive Voice Registration (IVR) system to obtain authorization for testing that is allowable within the IVR parameters and directing them to the location of the IVR Manual

Corresponding rationales for these major revisions:
1. Provider clarification of requirements
2. Provider clarification of requirements and procedures
3. Provider clarification of requirements, and reference to a valuable provider resource

Input sought:

MBHP/HNE BH Internal Review
1. First level review: Pedro Garrido-Castillo, Nanette Campo
2. Second level review: Anne Pelletier Parker
3. Final review/approval: Stephanie Brown, Mike Curry, Erin Donohue, Alex Forster, Andrea Gewirtz, Janice Harrington, Terri Hubbard, Carol Kress, Tamara Lange, Janet Leopold, Evan Morse, Moira Muir, Nancy Norman, MD, Elisabeth Okrant, Joe Passeneau, Anne Pelletier Parker, Garland Russell, George Smart, John Straus, MD, Scott Taberner, Kenneth Talbot, James Thatcher, MD

External Review
1. MBHP/HNE BH obtained extensive provider input into the original drafting of the performance specifications when they were developed for most levels of care at the start of the MBHP/HNE BH PCC Plan contract. During this revision, as MBHP/HNE BH informed MassHealth, we sought provider input into the specifications only for major levels of care in which we were drafting significant changes. The performance specifications for this level of care did not contain substantive changes to warrant vetting with the provider network or other stakeholders.
Covered Service: Urgent Outpatient Services (UOS)

Major revisions made:
1. In the service description on the first page, addition of clarifying language describing UOS, including the timeframe in which this service is provided, to whom it is provided, its focus and goal, and reference to its role in meeting access standards
2. In Components of Service section, addition of language clarifying the responsibilities of UOS providers, relative to: the availability and scheduling of appointments, development and/or updating of a crisis prevention plan and/or safety plan, access to routine outpatient services, and the scheduling of follow-up appointments
3. In Components of Service section, modification of language relative to connecting Members with the local ESP/MCI if they are assessed to be in need of “emergent crisis services” (rather than the previous language: “more extensive crisis services”)
4. In Components of Service section, addition of language relative to the number of sessions the UOS provider typically provides to a given Member (e.g., one) and what may be considered an exception
5. In Staffing section, addition of language relative to the provision of initial and at least annual training to UOS clinicians
6. In Assessment section, addition of clarifying language relative to the clinical assessment, sharing it with the Member’s current outpatient providers, connecting Members with referrals and linkages, and the UOS provider’s knowledge base of resources
7. In Assessment section, addition of language relative to discharge information given to the Member and, with consent, to his/her outpatient provider and other providers as indicated
8. In Assessment section, addition of language relative to expectations if transportation is a barrier for the Member to utilize outpatient and/or other aftercare services

Corresponding rationales for these major revisions:
1. Provider clarification; reinforcement of: requirements, procedures, and intent of the service
2. Provider clarification; reinforcement of: requirements and procedures, continuity of care, and intent of the service
3. Provider clarification; reinforcement of: requirements and procedures, continuity of care, and intent of the service
4. Provider clarification; reinforcement of: requirements and procedures, continuity of care, and intent of the service
5. Provider clarification; reinforcement of requirements and procedures; consistency with best practices within the greater behavioral health field relative to crisis assessment and intervention skills and strategies
6. Provider clarification; reinforcement of: requirements and procedures, continuity of care, and intent of the service
7. Provider clarification; compliance with MBHP/HNE BH record review record keeping standards; reinforcement of: requirements and procedures, continuity of care, and intent of the service
8. Provider clarification; reinforcement of: requirements, procedures, and continuity of care

Input sought:
**MBHP/HNE BH Internal Review**

1. First level review: Gina Battaglia, Barbara Wilson, Moira Muir, Chris Mink, Anne Pelletier Parker
2. Second level review: Anne Pelletier Parker
3. Final review/approval: Stephanie Brown, Mike Curry, Erin Donohue, Alex Forster, Andrea Gewirtz, Janice Harrington, Terri Hubbard, Carol Kress, Tamara Lange, Evan Morse, Moira Muir, Nancy Norman, MD, Elisabeth Okrant, Joe Passeneau, Anne Pelletier Parker, Garland Russell, George Smart, John Straus, MD, Scott Taberner, Kenneth Talbot, James Thatcher, MD

**External Review**

1. MBHP/HNE BH obtained extensive provider input into the original drafting of the performance specifications when they were developed for most levels of care at the start of the MBHP/HNE BH PCC Plan contract. During this revision, as MBHP/HNE BH informed MassHealth, we sought provider input into the specifications only for major levels of care in which we were drafting significant changes. The performance specifications for this level of care did not contain substantive changes to warrant vetting with the provider network or other stakeholders.
Other Outpatient Services
Covered Service: Electroconvulsive Therapy (ECT)

Major revisions made:
1. In the Pre-ECT Evaluation subsection, addition of language clarifying that the facility ensures it has “documented” a minimal set of procedures to be undertaken for all individuals
2. In the Pre-ECT Evaluation section, modification of language ensuring an evaluation of concurrent medications the individual is taking “to determine their impact on” ECT
3. In the Administering ECT subsection, modification of language relative to electrode placement, i.e., that the ECT psychiatrist should determine the choice of electrode placement and should be skilled in both unilateral and bilateral ECT, and that the utilization of either procedure should be based on an ongoing assessment of risk versus benefit to the individual (as opposed to unilateral electrode placement to the non-dominant hemisphere being the preferred method)
4. In the Administering ECT subsection, addition of clarifying language relative to monitoring during treatment, i.e., that additionally, any onset of new risk factors, or significant worsening of those present at pre-ECT, should be evaluated prior to the next treatment
5. In the Administering ECT subsection, addition of clarifying language differentiating between ECT administered in an acute setting and that in an outpatient setting, i.e., that, for ECT administered in an acute setting, individuals are monitored for at least 24 hours “to assess for cognitive side effects, or prolonged” or late seizures “(tardive seizures)” that may occur after the ECT session, and that for ECT administered in an outpatient setting, individuals are clinically assessed prior to each ECT session and after each ECT session for any adverse effects that may occur during the postictal recovery period.; also reference is made to the American Psychiatric Association’s (APA) guidelines for ECT
6. In the Administering ECT subsection, modification of language relative to the frequency of ECT, i.e., that ECT treatment is “usually done in 6-12 sessions at a frequency of 2-3 times per week”, and that “ECT frequency may change when a positive” response is “obtained, with the ECT psychiatrist and the attending psychiatrist working in consultation”

Corresponding rationales for these major revisions:
1. Reinforcement of the need for documentation of policies and procedures
2. Reinforcement of the need for determining the impact of existing medications on ECT
3. Clarification, reinforcement of requirements and quality of care, and consistency with best practice in the greater behavioral health field
4. Clarification, reinforcement of requirements and quality of care, and consistency with best practice in the greater behavioral health field
5. Clarification, reinforcement of requirements and quality of care, per recommendation of MassHealth, and consistency with best practice in the greater behavioral health field
6. Clarification, reinforcement of requirements and quality of care, per recommendation of MassHealth, and consistency with best practice in the greater behavioral health field

Input sought:

MBHP/HNE BH Internal Review
1. First level review: James Thatcher, MD
2. Second level review: Anne Pelletier Parker
3. Final review/approval: Stephanie Brown, Mike Curry, Erin Donohue, Alex Forster, Andrea Gewirtz, Janice Harrington, Terri Hubbard, Carol Kress, Tamara Lange, Janet Leopold, Evan Morse, Moira Muir, Nancy Norman, MD, Elisabeth Okrant, Joe Passeneau, Anne Pelletier Parker, Garland Russell, George Smart, John Straus, MD, Scott Taberner, Kenneth Talbot, James Thatcher, MD

External Review

1. MBHP/HNE BH obtained extensive provider input into the original drafting of the performance specifications when they were developed for most levels of care at the start of the MBHP/HNE BH PCC Plan contract. During this revision, as MBHP/HNE BH informed MassHealth, we sought provider input into the specifications only for major levels of care in which we were drafting significant changes. The performance specifications for this level of care did not contain substantive changes to warrant vetting with the provider network or other stakeholders.

2. MBHP/HNE BH referenced The APA Task Force on ECT, as well as the ValueOptions criteria for ECT, for additional guidelines around the administration of ECT.
Covered Service: Psychiatric Consultation on an Inpatient Medical Unit

Major revisions made:
1. In the Components of Service and Related Staffing requirements section, addition of clarifying language that the service is available “365 days per year”
2. In the Components of Service and Related Staffing requirements section, addition of language clarifying the credentials required for the staff providing the psychiatric consultation, e.g., “a psychiatrist or child psychiatrist who is board-certified and/or who meets MBHP/HNE BH’s credentialing criteria for a psychiatrist or child psychiatrist; a clinical psychologist; a child-trained psychiatric nurse mental health clinical specialist (PNMHCs) who is board-certified; or a nurse practitioner/board-certified registered nurse clinical specialist (RNCS)”
3. In the Assessment section, modification of language relative to the timeliness of the service, e.g., addition of “provided and” to the following statement: “All psychiatric consultations on a medical/surgical unit are provided and documented in a progress note in the Member’s health record as soon as possible and no later than within 24 hours of the consultation.”
4. In the Service, Community, and Collateral Linkages section, addition of clarifying language that the consultant is familiar with “how to access” other professionals when additional expertise is needed

Corresponding rationales for these major revisions:
1. Provider clarification of requirements
2. Provider clarification, reinforcement of credentialing requirements, and recommended by MassHealth
3. Provider clarification and reinforcement of timeliness of the service provision
4. Provider clarification of requirements

Input sought:

MBHP/HNE BH Internal Review
1. First level review: James Thatcher, MD
2. Second level review: Anne Pelletier Parker
3. Final review/approval: Stephanie Brown, Mike Curry, Erin Donohue, Alex Forster, Andrea Gewirtz, Janice Harrington, Terri Hubbard, Carol Kress, Tamara Lange, Janet Leopold, Evan Morse, Moira Muir, Nancy Norman, MD, Elisabeth Okrant, Joe Passeneau, Anne Pelletier Parker, Garland Russell, George Smart, John Straus, MD, Scott Taberner, Kenneth Talbot, James Thatcher, MD

External Review
1. MBHP/HNE BH obtained extensive provider input into the original drafting of the performance specifications when they were developed for most levels of care at the start of the MBHP/HNE BH PCC Plan contract. During this revision, as MBHP/HNE BH informed MassHealth, we sought provider input into the specifications only for major levels of care in which we were drafting significant changes. The performance specifications for this level of care did not contain substantive changes to warrant vetting with the provider network or other stakeholders.
Emergency Services
Covered Service: Emergency Services Program (ESP)

Major revisions made:
1. Throughout the specs, replacement of “MCI” or “Adult MCI” with “mobile crisis intervention” and/or “adult mobile crisis intervention”, as applicable
2. On the first page, addition of language specifying that providers contracted for this service are held accountable to the Mobile Crisis Intervention performance specifications as well as the Community Crisis Stabilization performance specifications
3. In the Components of Service section, omission of language referencing the administrative review required within ESP programs at the time a triage decision is made to provide ESP services in the community-based location or an ED setting, and incorporation, elsewhere in the specifications, of an additional strategy for mitigating risk relative to obtaining supervisory consultation around these triage decisions (see #11 below)
4. In the Components of Service section, language clarifying that ESPs provide transportation “arrangement” for Members and their families to and from the ESP, home setting, or appropriate outpatient and/or medication service following an ESP intervention
5. In the Components of Service section, modification of language clarifying that the ESP provides adult and child psychiatric consultation 24/7/365 “to ESP/MCI clinicians and supervisors” and that the ESP provides access to “routine, urgent or emergent face-to-face” psychiatric and medication evaluations
6. In the Components of Service section, addition of “Persons with co-occurring behavioral health and medical conditions” to the list of populations for which the ESP ensures the integration of service delivery
7. In the Staffing Requirements section, addition of language clarifying that “bachelor’s-level staff may answer triage calls with master’s-level clinicians and supervisors available to consult with and take calls when indicated”
8. In the Staffing Requirements section, addition of language clarifying that the psychiatric clinician is available for phone consultation “to the ESP clinician or supervisor” within 15 minutes of request
9. In the Staffing Requirements section, modification of language clarifying that the ESP ensures access to “routine, urgent or emergent” (instead of “timely”) face-to-face psychiatric and medication evaluations for Members assessed during an ESP intervention “who” (instead of “to”) require “such” (instead of “urgent”) access to these services
10. In the Staffing Requirements section, addition of “Persons with co-occurring behavioral health and medical conditions” to the list of special populations for which the ESP ensures that all ESP clinicians and other ESP staff receive training and meet core clinical competencies
11. In the Triage section, addition of language clarifying the requirement of “written triage protocols, including procedures for obtaining supervisory review of triage decisions in potentially high-risk situations”
12. In the Triage section, addition of language requiring “the utilization of the adult and MCI standardized documentation forms”
13. In the Triage section, addition of language clarifying “where there is a subcontract, the ESP ensures there is a similar process in place for the ESP or the subcontractor to review the subcontracted vendor’s assessments and dispositions”
14. In the Triage section, addition of language requiring: “the completion and electronic submission of an encounter form for every ESP/MCI intervention provided;” “for each subsequent day in an
intervention, the ESP is responsible for the completion and electronic submission of an abbreviated subsequent ESP/MCI follow-up encounter;” “that these subsequent encounters are connected to the full encounter by a unique encounter ID;” and “that the ESP ensures that encounter forms are electronically submitted to MBHP/HNE BH within the timeframe established by MBHP/HNE BH”

15. In the Service, Community, and Collateral Linkages section, addition of language clarifying that with Member consent, the ESP collaborates with the Member’s PCC as delineated in the Primary Care Clinician Integration section of the General performance specifications

16. In the Service, Community, and Collateral Linkages section, addition of language requiring ESPs/MCIs “to collaborate with the Emergency Department (ED) to ensure that proper documentation of any intervention within the ED is appropriately shared with that facility”

Corresponding rationales for these major revisions:

1. Clarification, differentiation between MCI services for youth and mobile crisis intervention services in general and/or for adults
2. Provider clarification, reinforcement of requirements
3. Language consolidation, and reinforcement of oversight
4. Correction of language to ensure the specifications are consistent with the per diem definition (ESPs do not directly provide transportation)
5. Provider clarification, consistency with language used elsewhere in the specs, reinforcement of requirements and quality of care
6. Provider clarification, reinforcement of: requirements, quality of care, integrated care, and per recommendation of MassHealth
7. Provider clarification, consistency with language used elsewhere in the specs, and per recommendation of MassHealth
8. Provider clarification, and per recommendation of MassHealth
9. Provider clarification, consistency with language used elsewhere in the specs
10. Provider clarification, reinforcement of: requirements, staff competence, and quality of care, and per recommendation of MassHealth
11. Provider clarification to reinforce requirements and procedures, reinforcement of oversight, and reinforcement of quality of care
12. Provider clarification, reinforcement of requirements, procedures, and standardization
13. Provider clarification to reinforce requirements and procedures, reinforcement of oversight, and reinforcement of quality of care
14. Provider clarification, reinforcement of requirements, procedures, and standardization
15. Provider clarification, reinforcement of: requirements, quality of care, continuity of care, integrated care, and per recommendation of MassHealth
16. Provider clarification, reinforcement of: requirements and procedures, standardization, collaboration, and continuity of care for the Member

Input sought:

MBHP/HNE BH Internal Review
1. First level review: Moira Muir, Shelley Baer, Doug Kozlowski,
2. Second level review: Anne Pelletier Parker

2014 MBHP/HNE BH Performance Specifications Revisions: Summaries of Changes
Effective July 1, 2014
3. Final review/approval after vetting with providers: Stephanie Brown, Mike Curry, Erin Donohue, Alex Forster, Andrea Gewirtz, Janice Harrington, Terri Hubbard, Carol Kress, Tamara Lange, Janet Leopold, Evan Morse, Moira Muir, Nancy Norman, MD, Elisabeth Okrant, Joe Passeneau, Anne Pelletier Parker, Garland Russell, George Smart, John Straus, MD, Scott Taberner, Kenneth Talbot, James Thatcher, MD

External Review

1. In 2009, during the redesign of the ESP system, MBHP/HNE BH obtained extensive input from providers and other stakeholders, as well as input from the Department of Mental Health (DMH) and MassHealth.

2. In 2012, MBHP/HNE BH obtained input and approval from MassHealth.