carelon
Behavioral Health

Massachusetts
Medical Necessity Criteria

Carelon Behavioral Health Strategies,
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Medical Necessity Criteria

Carelon Behavioral Health medical necessity criteria (MNC), also known as clinical criteria, are reviewed and updated at least annually to ensure that they reflect the latest developments in serving individuals with behavioral health diagnoses. Beacon's Corporate Medical Management Committee (CMMC) adopts, reviews, revises, and approves Medical Necessity Criteria per client and regulatory requirements.

Medical necessity criteria varies according to state and/or contractual requirements and member benefit coverage. To determine the proper medical necessity criteria, use the following as a guide:

1. For all Medicare members, first identify relevant Centers for Medicare and Medicaid (CMS) National Coverage Determinations (NCD) or Local Coverage Determinations (LCD) Criteria.
2. If no CMS criteria exists for Medicare members and for all non-Medicare members, identify relevant custom MNC.
3. If no custom criteria exists for the applicable level of care and the treatment is substance use disorder-related, the American Society of Addiction Medicine (ASAM) criteria would be appropriate.
   ** Exception: Substance Use Lab Testing Criteria is in InterQual® Behavioral Health Criteria.*
4. If the level of care is not substance use disorder-related, Change Healthcare's Interqual® Behavioral Health Criteria would be appropriate.
5. If 1-4 above are not met, Beacon's national MNC would be appropriate.

*Please note as of 9/21/19, Carelon Behavioral Health began utilizing Change Healthcare's Interqual® Behavioral Health Criteria that can be accessed through the Carelon Behavioral Health website.

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Overview of the MNC

(Note: Hyperlinks are enabled on this page and throughout each section.)

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E. Acute Treatment Services (ATS) for Substance Use Disorders – Medically Monitored (Level 3.7)

F. Adolescent Acute Inpatient Detoxification and Rehabilitation for Substance Use Disorders

G. Transitional Care Unit (TCU)

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   2. Partial Hospitalization Program

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   5. Medicare: CMS LCD L33632 Psychiatry and Psychology Services
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   1. Applied Behavioral Analysis (ABA)
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G. Psych Consultation on an Inpatient Medical Unit or ED

H. Community Support Program for Individuals with Justice Involvement (CSP JI)

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E. Therapeutic Mentoring Services 1. MassHealth Standard and Commonhealth 2. Commercial only F. Family Stabilization Team (FST)/In-Home Therapy Commercial (IHT) G. Family Partner (Commercial Only) H. Intensive Hospital Diversion Program (Masshealth Only)	

Section I: Inpatient Services

Overview

This chapter contains information on MNC and service descriptions for inpatient behavioral health (BH) treatment including:

A. Inpatient Psychiatric Services
   1. Medicare: CMS LCD L33624 Inpatient Psychiatric Hospitalization
   2. Inpatient Psychiatric Services
      a. Acute Inpatient Mental Health Services – High-Intensity
B. Inpatient Substance Use Disorder Services
   1. Medicare: CMS NCD 130.1 Inpatient Hospital Stay for Alcohol Detoxification
   2. Level 4 Detoxification (Detox) – Medically Managed
C. Transfer from Medical to Acute Inpatient Psychiatric Services
D. Observation Beds

A.1. CMS LCD L33624 Inpatient Psychiatric Hospitalization (Medicare Only)

A.2. Inpatient Psychiatric Services

A.2.a. Acute Inpatient Mental Health Services – High-Intensity

Acute, High-Intensity Inpatient Services include psychiatric services of a higher level of intensity than can be provided by a general psychiatric inpatient psychiatric unit. This service provides a level of security beyond the capacity of a general psychiatric inpatient unit to assure the safety of the member, other patients, and staff. In addition to the usual 24-hour skilled nursing care, daily medical care, structured treatment milieu, multidisciplinary assessments, and multimodal interventions, this service provides single rooms, limited census, enhanced staffing, and increased capacity for observation and intervention by staff specifically trained to treat and contain atypical aggressive, assaultive, and dangerous behavior occurring in the context of an acute psychiatric presentation. The goal of this specialized service is acute stabilization and treatment of the member's presenting condition, including dangerous behavior, so that the member can transition to a general inpatient psychiatric unit or another less-intensive level of care.

Acute, High-Intensity Inpatient Services would not be authorized exclusively in response to general psychiatric inpatient bed availability.

Admission Criteria	Continued Stay Criteria	Discharge Criteria
*In addition to the criteria for general Inpatient Psychiatric Services, the **following criterion** is necessary for admission:* 1. The member presents a current threat of harm to self or others which is not likely to be safely managed on a general inpatient psychiatric unit as evidenced by: a. The Member consistently requires a level of close monitoring or intervention by staff beyond 1:1 observation and the usual capacity of a general inpatient psychiatric unit to maintain safety; b. The member's treatment requires staff with specific training and skills to treat and contain atypical aggressive, assaultive behavior beyond the abilities of typical general inpatient psychiatric unit staff; and c. The member's treatment and maintenance of safety require a highly structured clinical program and environment including single rooms, limited census, enhanced staffing, and increased observation. ***At least one** of the following criteria (2-5) must be met as evidence of danger to self or others requiring more-intensive observation and intervention:* 2. The member has an established history of significant treatment-resistant assaultive behavior to self and/or others; 3. The member has recent history of behaviors that were	*Must meet **ALL** continued stay criteria for Inpatient Psychiatric Services as well as the **following criterion**:* 1. The member's condition continues to meet admission criteria for Acute, High-Intensity Inpatient Mental Health Services requiring specialized milieu and increased observation and staffing levels and acute treatment interventions have not been exhausted, and no other less-intensive level of care would be adequate.	***ANY** of the following criteria (1-3) is sufficient for discharge from Acute Inpatient Mental Health – High-Intensity:* 1. The member no longer meets continuing stay criteria for Acute, High-Intensity Inpatient Mental Health Services requiring specialized milieu and increased observation and staffing levels but does meet admission criteria for general Acute Inpatient Psychiatric Services or another level of care, either more- or less-intensive, where the member can be safely treated; 2. Treatment plan goals and objectives have been substantially met and/or a safe, continuing care program can be arranged and deployed at a less intensive level of care; or 3. The member is not making progress toward treatment goals, and there is no reasonable expectation of progress at this level of care. The need for high-intensity of services is the result of a chronic condition, and the member requires transfer to a long-term care setting for ongoing treatment.

not successfully or safely managed on a general inpatient psychiatric unit; 4. The member is actively engaged in significant dangerous behavior which has not responded to usual interventions at a less-intensive level of care; or 5. The member has a significant history of dangerous sexualized behavior including being a registered Level III sex offender or person designated as a Sexually Dangerous Person.		
Exclusion Criteria: *In addition to the exclusion criteria for general inpatient admissions* ***any*** *of the following criteria is sufficient for exclusion from this level of care:* 1. The member can be safely maintained and effectively treated at a less-intensive level of care; 2. The primary problem is not psychiatric. It is social, legal, or medical problem without a concurrent major psychiatric episode meeting criteria for this level of care, or admission is being used as an alternative to incarceration, the juvenile justice system, or for respite or housing; 3. Medical condition that requires a medical/surgical setting for treatment, regardless of the psychiatric presentation; 4. Medical co-morbidities unable to be safely managed in this specialty setting; 5. Behavioral dyscontrol in the context of traumatic brain injury, intellectual disability, pervasive developmental disorder, dementia, or other medical condition without		

indication of acute DSM-5-TR diagnosis; or 6. Current legal charges including murder, aggravated assault, and rape, and eligibility for treatment in a specialized forensic program.		
Psychosocial, Occupational, and Cultural and Linguistic Factors These factors may change the risk assessment and should be considered when making level-of-care decisions.		

B.1. CMS National Coverage Determination (NCD) Guideline NCD Inpatient Hospital Stay for Alcohol Detoxification 130.1 (Medicare Only)

B.2. Level 4 Detoxification (Detox) – Medically Managed - See ASAM Criteria

C. Observation Behavioral Health Service

Section II: Diversionary Treatment Services (24-Hour Diversionary Services)

Overview

Diversionary services are those mental health and substance use disorder services that are provided as clinically appropriate alternatives to inpatient behavioral health services; to support a member in returning to the community following a 24-hour acute placement; or to provide intensive support to maintain functioning in the community. There are two categories of diversionary services, those provided in a 24-hour facility, and those which are provided in a non-24-hour setting or facility.

This chapter contains service descriptions and MNC for the following 24-hour diversionary services:

A. Community-Based Acute Treatment (CBAT)
   A.1. Intensive Community-Based Acute Treatment (ICBAT)
B. Residential Recovery Services (RSS) for Substance Use Disorders (Level 3.1)
C. Co-occurring Enhanced Residential Recovery Services (RRS) for Substance Use Disorders (Level 3.1)
D. Clinical Stabilization Services (CSS) for Substance Use Disorders (Level 3.5)

E. Acute Treatment Services (ATS) for Substance Use Disorders – Medically Monitored (Level 3.7)
F. Adolescent Acute Inpatient Detoxification and Rehabilitation for Substance Use Disorders
G. Transitional Care Unit (TCU)
H. Dual Diagnosis Acute Treatment (DDAT)
I. Individualized Treatment and Recovery (ITS)

A. Community-Based Acute Treatment (CBAT)

Community-Based Acute Treatment (CBAT) is provided to children/adolescents who require a 24-hour-a-day, seven-day-a-week staff-secure (unlocked) acute treatment setting. For children and adolescents with serious behavioral health disorders, CBAT provides therapeutic intervention and specialized programming in a controlled environment with a high degree of supervision and structure. CBAT services are provided in the context of a comprehensive, multidisciplinary, and individualized treatment plan that is frequently reviewed and updated based on the member's clinical status and response to treatment. Intensive therapeutic services include, but are not limited to, daily medication monitoring; psychiatric assessment; nursing availability; specialing (as needed); individual, group and family therapy; case management; family assessment and consultation; discharge planning; and psychological testing as needed. Active family/caregiver involvement through family therapy, a key element of treatment, is expected. Discharge planning should begin at admission, including plans for reintegration into the home, school, and community. If discharge to home/family is not an option, alternative placement must be rapidly identified with regular documentation of active efforts to secure such placement.

Admission Criteria	Continued Stay Criteria	Discharge Criteria
All of the following criteria are necessary for admission; For Eating Disorders, all criteria must also be met, with the exclusion of the age requirement: 1. The child/adolescent demonstrates symptomology consistent with a DSM-5-TR diagnosis, which requires and can reasonably be expected to respond to therapeutic intervention; 2. The child/adolescent is experiencing emotional or behavioral problems in the home, school, community, and/or treatment setting and is not sufficiently stable, either emotionally or behaviorally, to be treated outside of a highly structured, 24-hour therapeutic environment;	***All of the following criteria are necessary for continuing treatment at this level of care. For Eating Disorders criteria all criteria must be met:*** 1. The child/adolescent's condition continues to meet admission criteria at this level of care; 2. The child/adolescent's treatment does not require a more-intensive level of care, an no less-intensive level of care would be appropriate; 3. Treatment planning is individualized and appropriate to the child/adolescent's age and changing condition, with realistic, specific, and attainable goals and objectives stated; 4. All services and treatment are carefully structured to achieve	***Criteria 1 and 2 are necessary for discharge:*** 1. The child/adolescent can be safely treated at an alternative level of care; and 2. An individualized discharge plan can with appropriate, realistic, and timely follow-up care is in place. ***One of the following criteria is also necessary for discharge from this level of care:*** 1. The child/adolescent's documented treatment plan goals and objectives have been substantially met, and/or a safe, continuing care program can be arranged and deployed at an alternate level of care;

Admission Criteria	Continued Stay Criteria	Discharge Criteria
3. The member has only poor to fair motivation, and/or insight and community supports are inadequate to support recovery; 4. The family situation and functioning levels are such that the child/adolescent cannot currently remain in the home environment and receive outpatient treatment; and *5.* The member has sufficient cognitive capacity to respond to active acute and time limited psychological treatment and interventions. **Psychosocial, Occupational, and Cultural and Linguistic Factors** These factors may change the risk assessment and should be considered when making level-of-care decisions.	optimum results in the most time-efficient manner possible consistent with sound clinical practice; 5. If treatment progress is not evident, then there is documentation of treatment plan adjustments to address the lack of progress; 6. Care is rendered in a clinically appropriate manner and focused on the child/adolescent's behavioral and functional outcomes; 7. An individualized discharge plan has been developed that includes specific realistic, objective, and measureable discharge criteria and plans for appropriate follow-up care. A timeline for expected implementation and completion is in place, but discharge criteria have not yet been met; 8. The child/adolescent is actively participating in treatment to the extent possible consistent with their condition, or there are active effort being made that can reasonably be expected to lead the child/adolescent's engagement in treatment, improve functionality, and reduce acute psychiatric/behavioral symptoms; 9. Unless contraindicated, family, guardian, and/or natural supports are actively involved in the treatment as required by the treatment plan, or there are active efforts being made and documented to involve them; 10. When medically necessary, appropriate psychopharmacological intervention has been	2. The child/adolescent, parent, and/or legal guardian is competent but not engaged in treatment or is not following the program rules and regulations. The lack of engagement is of such a degree that treatment at this level of care becomes ineffective or unsafe, despite multiple, documented attempts to address engagement issues. In addition, it has been determined that the child/adolescent does not meet criteria for inpatient level of care; 3. Consent for treatment is withdrawn, and it is determined that the child/adolescent or parent/guardian has the capacity to make informed decisions and does not meet criteria for inpatient level of care; 4. The child/adolescent is not making progress toward treatment goals, despite persistent efforts to engage them, and there is no reasonable expectation of progress at this level of care, nor is it required to maintain the current function; or 5. The child/adolescent's physical condition necessitates transfer to a medical facility.

Admission Criteria	Continued Stay Criteria	Discharge Criteria
	prescribed and/or evaluated; and 11. There is documented active coordination of care with other behavioral health providers, the primary care clinician (PCC), and other services and state agencies. If coordination is not successful, the reasons are documented and efforts to coordinate care continue.	
Exclusion Criteria: ***Any*** *of the following criteria is sufficient for exclusion from this level of care:* 1. The child/adolescent exhibits severe suicidal, homicidal, or acute mood symptoms/thought disorder, which require a more-intensive level of care; 2. The parent/guardian does not voluntarily consent to admission or treatment; 3. After initial evaluation and stabilization, it is determined that the presenting symptomatology is indicative of a DSM-5-TR diagnosis, which is amenable to continued treatment at this level of care. Conditions that would not be appropriate for continued treatment are; a. permanent cognitive dysfunction without an acute psychiatric disorder; b. primary substance use disorder requiring treatment in a specialized level of care; c. medical illness requiring treatment in a medical setting; or d. impairments indicate no reasonable expectation of progress toward treatment goals at this level of care; 4. Chronic condition with no indication of need for ongoing		

Admission Criteria	Continued Stay Criteria	Discharge Criteria
treatment at this level of care to maintain stability and functioning; 5. The child adolescent can be safely maintained and effectively treated in a less-intensive level of care; 6. The primary problem is not psychiatric. It is social, legal, or medical problem, without a concurrent major psychiatric episode meeting criteria for this level of care; or 7. The admission is being used as an alternative to placement within the juvenile justice or protective services system, or as an alternative to specialized schooling (which should be provided by the local school system) or as respite or housing.		

A.2. Intensive Community-Based Acute Treatment (ICBAT)

ICBAT provides the same services as Community-Based Acute Treatment (CBAT) but of higher intensity, including more frequent psychiatric evaluation, medication management, and a higher staff-to-patient ratio.

This is an addendum to Community-Based Acute treatment (CBAT). All CBAT criteria for this admission, exclusion, continued stay, and discharge apply to this level of care as well as the specific criteria listed below.

Admission Criteria	Continued Stay Criteria	Discharge Criteria
In addition to the criteria for Community-Based Acute Treatment as noted above in A1, one of the following criteria is necessary for ICBAT level of care, and the member must be able to be safely contained in a staff-secure setting. **There is need for either daily psychiatry or a higher staff ratio due to:** 1. Suicidal or homicidal ideation with plan; 2. Command hallucinations; 3. Persecutory delusions;	***Must meet ALL continued stay criteria for CBAT as noted above in A, and continue to meet admission criteria for ICBAT***	***Must meet discharge criteria for CBAT as noted above in A***

4. Fire-setting or sexually reactive behavior; or 5. Impairment to the degree that the member manifests severe psychiatric symptoms which impact social and interpersonal functioning and is not responsive to less-intensive treatment and/or management efforts.		

B. Residential Recovery Services (RSS) for Substance Use Disorders (Level 3.1) – See ASAM Criteria

C. Co-Occurring Enhanced Residential Rehabilitation Services (RRS) for Substance Use Disorders (Level 3.1)

Co-Occurring Enhanced Residential Rehabilitation Services (RRS) meet the American Society for Addiction Medicine (ASAM) definition for Level 3.1 Co-Occurring Enhanced. This shall mean a 24-hour, safe, structured environment, located in the community, which supports members' recovery from substance use disorders and moderate to severe mental health issues while reintegrating into the community and returning to social, vocation/employment, and/or educational roles. Scheduled, goal-oriented clinical services are provided in conjunction with psychiatry and medication management to support stabilization and development of skills necessary to achieve recovery. Clinical services are provided a minimum of five hours a week and additional outpatient levels of care may be accessed concurrently as appropriate.

Criteria	
For admission, exclusion, continued stay, and discharge criteria, refer to the current edition of *ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions.*	
Additional Criteria	
Admission Criteria	*Members eligible for a* Co-Occurring Enhanced RRS *level of care* ***must meet each of the following criteria:*** 1. Following a clinical assessment based on the six dimensions of the American Society for Addiction Medicine (ASAM) Criteria, the member is deemed appropriate for a Co-Occurring Enhanced RRS level of care. The member is sufficiently stabilized to participate in the assessment process. 2. The member is diagnosed as having both a substance use disorder and moderate to severe mental health condition, consistent with relevant DSM-5-TR diagnosis.

	3. Mental health symptomology and presentation, inclusive of social, emotional, cognitive, and behavioral presentations, must be sufficiently acute that a small milieu and high staff to member ratios are necessary for the member to be successful in the program. Behavioral health presentation must be such that 24-hour clinical supervision may be required, and frequent individualized attention is necessary for the member to be successful in the milieu and with treatment goals. Based on symptom presentation, the member can be appropriately and safely treated in a community environment but would not likely be successful in a Co-Occurring Capable RRS program. 4. The member is in immediate need of medication evaluation and reconciliation and requires support from a structured program environment in accessing community prescribers and achieving stability on a medication regimen. 5. The member has a recent history of service utilization that highlights the need for co-occurring enhanced services. Within the past three months, a member must have experienced at least one of the following events: a. An inpatient psychiatric hospitalization; b. At least two emergency department and/or ESP visits; or c. Unsuccessful engagement and/or inability to succeed in other community-based services based on psychosocial or clinical complexity related to substance use and/or mental health disorders. ***Note:*** *Members who do not meet the Admission Criteria and do not meet the Exclusion Criteria are still eligible for 3.1 co-occurring enhanced services if they meet either of the following criteria:* 1. The member has been discharged from an inpatient psychiatric program and is able to participate in the treatment activities in a community-based setting. Members discharged to Co-Occurring Enhanced RRS programs from an acute psychiatric setting may benefit from additional services that offer psychiatric and clinical supports in conjunction with the Co-Occurring Enhanced RRS program. In such cases, treatment planning and service delivery must be coordinated and aligned. 2. Members who have gone through withdrawal management and/or are inducted on MAT are eligible for direct admission to Co-Occurring Enhanced RRS services provided that any symptoms of post-acute withdrawal are manageable in a community setting with access to low-intensity nurse monitoring and/or management with medication-assisted treatment. This includes members discharged from the emergency department after receiving withdrawal management services.
Exclusion Criteria	*Members are <u>not</u> eligible for a Co-Occurring Enhanced RRS Program if they meet any of the following criteria:*

	1. The member does not have a mental health diagnosis or has a substance use disorder as a primary diagnoses and can be treated effectively in a Co-Occurring Capable RRS program. 2. The member has substance use disorder and mental health diagnoses and can be effectively treated in a Co-Occurring Capable RRS program with access to outpatient mental health counseling. 3. The member does not require overnight clinical supervision, does not require substantial individualized staff attention, and could be effectively treated in a Co-Occurring Capable RRS program. 4. The member is experiencing symptoms of severe withdrawal that require the resources of a hospital, emergency department, and/or medically monitored withdrawal management facility, such as an acute treatment services program. 5. The member cannot be appropriately treated and/or is not safe in a community-based setting based on acute psychiatric symptoms.

D. Clinical Stabilization Services (CSS) for Substance Use Disorders (Level 3.5) – See ASAM Criteria

E. Acute Treatment Services (ATS) for Substance Use Disorders – Medically Monitored (Level 3.7 Detoxification) – See ASAM Criteria

F. Adolescent Acute Inpatient Detoxification and Rehabilitation for Substance Use Disorders – See ASAM Criteria

G. Transitional Care Unit (TCU)

Transitional Care Units (TCU) are designed for youth whose placement is the responsibility of a state supported agency such as the Department of Children and Families (DCF), Department of Mental Health (DMH), Early Education and Care (EEC), the Department of Youth Services (DYS), or at Beacon's discretion for youth with no state agency involvement. TCUs are solely intended to meet the needs of youth who no longer meet medical necessity criteria for continued inpatient behavioral health, Intensive Community-Based Acute Treatment (ICBAT), or Community-Based Acute Treatment (CBAT) level of care, and they require additional community exposure/therapeutic/milieu to support community tenure when discharged. The expected placement setting for these youth will be home with parent(s)/caregiver(s), foster care, community-based group home, or a residential treatment program. These services are designed to facilitate the youth's transition in 30 days or less to the next placement setting through comprehensive transition planning and medically necessary behavioral health services.

Admission Criteria	Continued Stay Criteria	Discharge Criteria

***All** of the following criteria are necessary for participation in this level of care:*	***All** of the following criteria are required for continuing treatment at this level of care:*	***Any** of the following criteria is sufficient for discharge from this level of care:*
1. The youth is under the age of 19 years old; 2. The member has a DSM-5-TR or corresponding ICD diagnosis; 3. The youth no longer meets the medical necessity criteria for continued stay at an acute inpatient behavioral health level of care, however is still experiencing emotional or behavioral symptoms in the home, school, community, and/or treatment setting. The youth requires ongoiong monitoring and intervention to support transtition work to identified disposition; 4. The expected placement setting for the youth is not yet secured, and/or continued transition work is needed to ready the Member for placement; and 5. The member has improved motivation, and/or insight and community supports are adequate to support recovery and engage in transition planning. **Psychosocial, Occupational, and Cultural and Linguistic Factors** These factors may change the risk assessment and should be considered when making level-of-care decisions.	1. The member continues to meet admission criteria and have medically necessary therapeutic needs. Another less-restricted level of care would not be adequate; 2. Care is rendered in a clinically appropriate manner and focused on the member's behavioral and functional outcomes as described in the treatment and discharge plans; 3. The member remains without an identified or specific placement resource; 4. Treatment planning is individualized and appropriate to the member's age and changing condition, with realistic, specific, attainable goals and objectives stated; 5. Treatment is monitored regularly, and the treatment plan is modified with consideration of all applicable and appropriate treatment modalities which can include: family, support systems, social, educational, occupational, and interpersonal assessments. This process should actively involve family, guardian and/or other support systems unless contraindicated; and 6. All services and treatment are carefully structured to achieve optimum results in transitioning the member to the next placement. 7. The youth and parent/guardian continues to engage with support system which can include school system, state agency, community based providers, natural supports etc.	1. The goals and objectives for TCU have been substantially met; 2. An appropriate placement setting has been located, and transitional services are in place; 3. The youth's therapeutic needs can be met in a less-restrictive level of care; 4. The lack of engagement is such a degree that treatment at this level of care becomes ineffective, despite multiple, documented attempts to address engagement issues**;** 5. Consent for treatment is withdrawn, and parent/guardian have identified alternative disposition; or 6. The youth is at imminent risk to harm self or others, or sufficient impairment is present that they required a more-intensive level of care.

Exclusion Criteria: ***Any** one of the following is sufficient for exclusion for this level of care:* 1. The youth is at imminent risk to harm self or others, or sufficient		
impairment is present that they required a more-intensive level of care; 2. The parent/guardian does not voluntarily consent to admission or treatment; 3. The youth has complex medical or developmental conditions that would preclude beneficial utilization of services; or 4. The expected placement setting for the youth is a more-intensive, long-term placement setting such as Intensive Residential Treatment Program (IRTP), Clinically Intensive Residential Treatment (CIRT), or Continuing Care Unit (CCU).		

H. Dual Diagnosis Acute Treatment (DDAT)

Dual Diagnosis Acute Treatment for individuals with co-occurring mental health disorders provides diversionary and/or step-down opportunities for members who require substance detoxification services through a planned program of 24-hour, medically monitored evaluation, care, and treatment, and whose co-occurring mental health disorder requires a 24-hour, medically monitored evaluation, care, and treatment program, including the prescribing and dosing of medications typically used for the treatment of mental health disorders. DDAT services for individuals with co-occurring addiction and mental health disorders are typically rendered in a licensed acute care or community-based setting (e.g., licensed freestanding or hospital-based programs, or a licensed detoxification program) with 24-hour physician and psychiatrist consultation availability, 24-hour nursing care and observation, counseling staff trained in addiction and mental health treatment, and overall monitoring of medical care. Services are typically provided under a defined set of physician-approved policies, procedures, or clinical protocols.

Unless contraindicated, the family, guardian, and/or natural supports are actively involved in the treatment as required by the treatment plan, or there are active efforts being made, and documented, to involve them.

Admission Criteria	Continued Stay Criteria	Discharge Criteria

***All** of the following criteria must be met:* 1. DSM-5-TR or corresponding ICD substance use disorder diagnosis, which require, and are expected to respond to, intensive, structured treatment intervention; 2. The member agrees to voluntary admission and is able to appropriately participate in safety planning; 3. The member's psychiatric condition does not require 24-hour medical/psychiatric and nursing services; 4. The member may require medically monitored ATS detoxification (detox) services; and 5. The member requires 24-hour supervision in a high-intensity milieu to address the following: a. Access to nursing and medical monitoring; b. Environmental interference with recovery efforts; c. Severity of addiction; and d. Need for relapse prevention skills.	***All** of the following criteria must be met:* 1. The member continues to meet admission criteria of this level of care; 2. Another less-restrictive level of care would not be adequate to provide needed containment and administer care; 3. The member is experiencing symptoms of such intensity that if discharged, they would likely be readmitted; 4. Treatment is still necessary to reduce symptoms and improve functioning so the Member may be treated in a less-restrictive level of care; 5. There is evidence of progress towards resolution of the symptoms causing a barrier to treatment continuing in a less-restrictive level of care; 6. Medication assessment has been completed, when appropriate, and medication trials have been initiated or ruled out; 7. The family/guardian is participating in treatment as clinically indicated and appropriate; and 8. Coordination of care and active discharge planning are ongoing, with the goal of transitioning the member to a less-intensive level of care.	***Criteria # 1, 2, 3 or 4 are suitable; criteria # 5 and 6 are recommended, but optional:*** 1. The member no longer meets admission criteria and/or meets criteria for another level of care, either more- or less-intensive; 2. The member withdraws consent for treatment and does not meet criteria for involuntary/mandated treatment; 3. The member does not appear to be participating in a treatment plan; 4. The member is not making progress towards goals, nor is there any expectation of any progress; 5. The member's individual treatment plan and goals have been met; or 6. The member's support system is in agreement with the aftercare treatment plan.

I. Individualized Treatment and Recovery (ITS) - see ASAM criteria

J. Eating Disorder Residential (Commercial)

Section III: Structured Day Treatment Services (Non-24-Hour Diversionary Services)

Overview

Diversionary services are those mental health and substance use disorder treatment services that are provided as clinically appropriate alternatives to behavioral health inpatient services; to support a member in returning to the community following a 24-hour acute placement; or to provide intensive support to maintain functioning in the community. There are two categories of diversionary services, those provided in a 24-hour facility, and those which are provided in a non-24-hour setting or facility.

This chapter contains service descriptions and MNC for the following non-24-hour diversionary services specifically designed to provide a continuum between inpatient and outpatient levels of care, including:

A. Partial Hospitalization Program
    1. Medicare: CMS LCD L33626 Psychiatric Partial Hospitalization Programs
    2. Partial Hospitalization Program
B. Day Treatment
C. Structured Outpatient Addictions Programs (SOAP)
D. Intensive Outpatient Treatment

A.1. CMS LCD L33626 Psychiatric Partial Hospitalization Programs (Medicare Only)

A.2. Partial Hospitalization Program

B. Day Treatment

C. Structured Outpatient Addictions Programs (SOAP) – See ASAM Criteria

D. Intensive Outpatient Treatment

Section IV: Intensive Home- and Community-Based Services for Youth

Overview

Intensive treatment services for mental health and substance use disorders are provided to enrollees in community-based settings such as home, school, or community service agency. These services are more intensive than standard outpatient services.

This chapter contains service descriptions and MNC for the following Intensive Home- or Community-Based Services for Youth:

A. Family Support and Training (FS&T)*
B. Intensive Care Coordination (ICC)*
    1. MassHealth*
    2. Commercial
C. In-Home Therapy (IHT) – MassHealth only with the exception of MassHealth Limited
D. In-Home Behavioral Services (IHBS)

1. MassHealth*
2. Commercial

E. Therapeutic Mentoring (TM) Services*
F. Family Stabilization Team (FST)/In-Home Therapy Commercial (IHT)

*These services are available to MassHealth Standard and Commonhealth members under the age of 21 only.

A. Family Support and Training (FS&T)*

**Available only to MassHealth Standard and Commonhealth members under the age of 21.*

Family Support and Training (FS&T) is a service provided to the parent/caregiver of a youth (under the age of 21) in any setting where the youth resides, such as the home (including foster homes and therapeutic foster homes) and other community settings. FS&T is a service that provides a structured, one-to-one, strength-based relationship between a Family Support and Training Partner and a parent/caregiver. The purpose of this service is for resolving or ameliorating the youth's emotional and behavioral needs by improving the capacity of the parent/caregiver to parent the youth so as to improve the youth's functioning as identified inthe outpatient or In-Home Therapy treatment plan or Individual Care Plan (ICP), for youth enrolled in Intensive Care Coordination (ICC), and to support the youth in the community or to assist the youth in returning to the community. Services may include education, assistance in navigating the child serving systems (DCF, education, mental health, juvenile justice, etc.); fostering empowerment, including linkages to peer/parent support and self-help groups; assistance in identifying formal and community resources (e.g., after-school programs, food assistance, summer camps, etc.); and support, coaching, and training for the parent/caregiver.

FS&T is delivered by strength-based, culturally, and linguistically appropriate qualified paraprofessionals under the supervision of a licensed clinician. FS&T services must achieve a goal(s) established in an existing behavioral health treatment plan/care plan for outpatient or IHT or an Individual Care Plan for youth enrolled in ICC. Services are designed to improve the parent/caregiver's capacity to ameliorate or resolve the youth's emotional or behavioral needs and strengthen their capacity to parent.

Delivery of ICC may require care coordinators to team with FS&T partners. In ICC, the care coordinator and FS&T partner work together with youth with SED and their families while maintaining their discrete functions. The FS&T partner works one-on-one and maintains regular frequent contact with the parent(s)/caregiver(s) in order to provide education and support throughout the care planning process, attends CPT meetings, and may assist the parent(s)/caregiver(s) in articulating the youth's strengths, needs, and goals for ICC to the care coordinator and CPT. The FS&T partner educates parents/caregivers about how to effectively navigate the child-serving systems for themselves, about the existence of informal/community resources available to them, and facilitates the parent's/caregiver's access to these resources.

Criteria	
Admission Criteria	***All*** *of the following criteria are necessary for participation in this level of care*: 1. A comprehensive behavioral health assessment inclusive of the MA Child and Adolescent Needs and Strengths (CANS) indicates that the youth's clinical condition warrants this service in order to improve the capacity of the parent/caregiver in ameliorating or resolving the youth's emotional or behavioral needs and strengthen the parent/caregiver's capacity to parent so as to successfully support the youth in the home or community setting. If the member has MassHealth as a secondary insurance and is being referred to services by a provider who is paid through the member's primary insurance, the provider must conduct a comprehensive behavioral health assessment. A CANS is not required. 2. The parent/caregiver requires education, support, coaching, and guidance to improve their capacity to parent in order to ameliorate or resolve the youth's emotional or behavioral needs so as to improve the youth's functioning as identified in the outpatient or IHT treatment plan/ICP, for those youth enrolled in ICC, and to support the youth in the community. 3. Outpatient services alone are not sufficient to meet the parent/caregiver's needs for coaching, support, and education. 4. The parent/caregiver gives consent and agrees to participate. 5. A goal identified in the youth's outpatient or In-Home Therapy treatment plan or ICP, for those enrolled in ICC, with objective outcome measures pertains to the development of the parent/caregiver capacity to parent the youth in the home or community. 6. The youth resides with or has current plan to return to the identified parent/caregiver.
Psychosocial, Occupational, and Cultural and Linguistic Factors	*These factors may change the risk assessment and should be considered when making level-of-care decisions.*
Exclusion Criteria	***Any one*** *of the following is sufficient for exclusion for this level of care:* 1. There is impairment with no reasonable expectation of progress toward identified treatment goals for this service. 2. There is no indication of need for this service to ameliorate or resolve the youth's emotional needs or to support the youth in the community. 3. The environment in which the service takes place presents a serious safety risk to the FS&T partner making visits; alternative community settings are not likely to ameliorate the risk, and no other safe venue is available or appropriate for this service. 4. The youth is placed in a residential treatment setting with no current plans to return to the home setting. 5. The youth is in an independent living situation and is not in the family's home or returning to a family setting. 6. The service needs identified in the treatment plan/ICP are being fully met by similar services from the same or any other agency.
Continued Stay Criteria	***All*** *of the following criteria are required for continuing treatment at this level of care*: 1. The parent/caregiver continues to need support to improve their capacity

	to parent in order to ameliorate or resolve the youth's emotional or behavioral needs as identified in the outpatient or IHT treatment plan/ICP, for those youth enrolled in ICC, and to support the youth in the community. 2. Care is rendered in a clinically appropriate manner and focused on the parent/caregiver's need for support, guidance, and coaching. 3. All services and supports are structured to achieve goals in the most time-efficient manner possible. 4. For youth in ICC, with required consent, informal and formal supports of the parent/caregiver are actively involved on the youth's team. 5. With required consent, there is evidence of active coordination of care with the youth's care coordinator (if involved in ICC) and/or other services and state agencies. 6. Progress in relation to specific behavior, symptoms, or impairments is evident and can be described in objective terms, but goals have not yet been achieved, or adjustments in the treatment plan/ICP to address lack of progress are evident.
Discharge Criteria	***Any one*** *of the following criteria is sufficient for discharge from this level of care*: 1. The parent/caregiver no longer needs this level of one-to-one support and is actively utilizing other formal and/or informal support networks. 2. The youth's treatment plan/ICP indicate the goals and objectives for FS&T have been substantially met. 3. The parent/caregiver is not engaged in the service. The lack of engagement is of such a degree that this type of support becomes ineffective or unsafe, despite multiple, documented attempts to address engagement issues. 4. The parent/guardian/caregiver withdraws consent for treatment.

B1. Intensive Care Coordination (ICC)*

**Available only to MassHealth Standard and Commonhealth members under the age of 21.*

Intensive Care Coordination (ICC) is a service that facilitates care planning and coordination of services for MassHealth youth with serious emotional disturbance (SED), under the age of 21, and enrolled in MassHealth Standard or CommonHealth. Care planning is driven by the needs of the youth and developed through a *Wraparound* planning process consistent with *Systems of Care* philosophy.

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

The care coordinator facilitates the development of a Care Planning Team (CPT) comprised of both formal and natural support persons who assist the family in identifying goals and developing an

Individual Care Plan (ICP) and risk management/safety plan; convenes CPT meetings; coordinates and communicates with the members of the CPT to ensure the implementation of the ICP; works directly with the youth and family to implement elements of the ICP; coordinates the delivery of available services; and monitors and reviews progress toward ICP goals and updates the ICP in concert with the CPT. The provision of ICC services reflects the individualized needs of youth and their families. Changes in the intensity of a youth's needs over time should not result in a change in care coordinator.

Delivery of ICC may require care coordinators to team with Family Partners. In ICC, the care coordinator and Family Partner work together with youth with SED and their families while maintaining their discrete functions. The Family Partner works one-on-one and maintains regular frequent contact with the parent(s)/caregiver(s) in order to provide education and support throughout the care planning process, attends CPT meetings, and may assist the parent(s)/caregiver(s) in articulating the youth's strengths, needs, and goals for ICC to the care coordinator and CPT. The Family Partner educates parents/caregivers about how to effectively navigate the child-serving systems for themselves and about the existence of informal/community resources available to them and facilitates the caregiver's access to these resources.

ICC is defined as follows:
Assessment: The care coordinator facilitates the development of the Care Planning Team (CPT), who utilize multiple tools, including a strength-based assessment inclusive of the Child and Adolescent Needs and Strengths (MA CANS version), in conjunction with a comprehensive assessment and other clinical information to organize and guide the development of an Individual Care Plan (ICP) and a risk management/safety plan. The CPT is a source for information needed to form a complete assessment of the youth and family.

The CPT includes, as appropriate, both formal supports, such as the care coordinator, providers, case managers from child-serving state agencies, and natural supports, such as family members, neighbors, friends, and clergy. Care coordinator assessment activities include without limitation:

- assisting the family to identify appropriate members of the CPT;
- facilitating the CPT to identify strengths and needs of the youth and family in meeting their needs; and
- collecting background information and plans from other agencies.

The assessment process determines the needs of the youth for any medical, educational, social, therapeutic, or other services. Further assessments will be provided as medically necessary.

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

Referral and related activities: Using the ICP, the care coordinator:

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

Monitoring and follow-up activities: The care coordinator will facilitate reviews of the ICP, convening the CPT as needed to update the plan of care to reflect the changing needs of the youth and family. The care coordinator working with the CPT perform such reviews and include:

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

Criteria	
Admission Criteria	***All** of the following are necessary for admission to this level of care:* 1. The youth meets the criteria for serious emotional disturbance (SED) as defined by either Part I or II of the criteria below. **Part I:** The youth currently has, or at any time during the past year, has had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet the diagnostic criteria specified within ICD-10 or DSM-5-TR of the American Psychiatric Association, with the exception of other V codes, substance use disorders, and developmental disorders, unless these disorders co-occur with another diagnosable disturbance. All of these disorders have episodic, recurrent, or persistent features; however, they vary in terms of severity and disabling effects. The diagnosable disorder identified above has resulted in functional impairment that substantially interferes with or limits the youth's role or functioning in family, school, or community activities. Functional impairment is defined as difficulties that substantially interfere with or limit the youth in achieving or maintaining developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills. Functional impairments of episodic, recurrent, and continuous duration are included unless they are temporary and expected responses to stressful events in the environment. Youth who would have met functional impairment criteria during the referenced year without the benefit of treatment or other support services are included in this definition. OR **Part II:**

	The youth exhibits one or more of the following characteristics over a long period of time and to a marked degree that adversely affects educational performance: an inability to learn that cannot be explained by intellectual, sensory, or health factors; an inability to build or maintain satisfactory interpersonal relationships with peers and teachers; inappropriate types of behavior or feelings under normal circumstances; a general pervasive mood of unhappiness or depression; or a tendency to develop physical symptoms or fears associated with personal or school problems. The emotional impairment is not solely the result of autism, developmental delay, intellectual impairment, hearing impairment, vision impairment, deaf-blind impairment, specific learning disability, traumatic brain injury, speech or language impairment, health impairment, or a combination thereof. 2. The youth: a. needs or receives multiple services other than ICC from the same or multiple provider(s); OR b. needs or receives services from, state agencies, special education, or a combination thereof; AND c. needs a care planning team to coordinate services the youth needs from multiple providers or state agencies, special education, or a combination thereof. 3. The person(s) with authority to consent to medical treatment for the youth voluntarily agrees to participate in ICC. The assent of a youth who is not authorized under applicable law to consent to medical treatment is desirable but not required. 4. For youth in a hospital, skilled nursing facility, psychiatric residential treatment facility or other residential treatment setting who meet the above criteria, the admission to ICC may occur no more than 180 days prior to discharge from the above settings.
Psychosocial, Occupational, Cultural, and Linguistic Factors	*These factors may change the risk assessment and should be considered when making level-of-care decisions.*
Exclusion Criteria	***Any** of the following criteria is sufficient for exclusion from this level of care:* 1. The person(s) with authority to consent to medical treatment for the youth does not voluntarily consent to participate in ICC. 2. The youth is in a hospital, skilled nursing facility, psychiatric residential treatment facility, or other residential treatment setting at the time of referral and is unable to return to a family home environment or community setting with community-based supports.
Continued Stay Criteria	***All** of the following criteria must be met for continued treatment at this level of care*: 1. The youth's clinical condition(s) continues to warrant ICC services in order to coordinate the youth's involvement with state agencies and special education or multiple service providers. 2. Progress toward Individualized Care Plan (ICP)-identified goals is evident and has been documented based upon the objectives defined

	for each goal, but the goals have not yet been substantially achieved despite sound clinical practice consistent with *Wraparound* and *Systems of Care* principles; OR 3. Progress has not been made, and the Care Plan Team (CPT) has identified and implemented changes and revisions to the ICP to support the goals of the youth and family.
Discharge Criteria	***Any** of the following criteria is sufficient for discharge from this level of care:* 1. The youth no longer meets the criteria for SED. 2. The CPT determines that the youth's documented ICP goals and objectives have been substantially met, and continued services are not necessary to prevent worsening of the youth's behavioral health condition. 3. Consent for treatment is withdrawn. 4. The youth and parent/care giver are not engaged in treatment. Despite multiple, documented attempts to address engagement, the lack of engagement is of such a degree that it implies withdrawn consent or treatment at this level of care becomes ineffective or unsafe. 5. The youth is placed in a hospital, skilled nursing facility, psychiatric residential treatment facility, or other residential treatment setting and is unable to return to a family home environment or a community setting with community-based supports or ICC. 6. The youth turns 21.

B2. Intensive Care Coordination (ICC)

Available to Commercial members

Intensive Care Coordination (ICC) is a service that facilitates care planning and coordination of services and supports, driven by the needs of the youth and family. ICC is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote patient safety, and quality of care developed through a "wraparound" planning process, consistent with the *Systems of Care* philosophy. Services include a comprehensive assessment, a risk/safety plan, family education, advocacy, support, referrals, and linkages to the continuum of care. An individual care plan (ICP) is developed in collaboration with the family and collaterals, such as a PCP or school personnel, through a care planning team (CPT).

The individuals' impairment is not solely the result of autism, developmental delay, intellectual impairment, hearing impairment, vision impairment, deaf-blind impairment, specific learning disability, traumatic brain injury, speech or language impairment, health impairment or a combination thereof. Psychosocial, occupational, cultural, and linguistic factors may change the risk assessment and should be considered when making level of care (LOC)/medical necessity decisions. (See below for continuation of level of care/medical necessity criteria.)

Admission Criteria	Continued Stay Criteria	Discharge Criteria
Criteria #1 - 6 must all be met: 1. The member is a youth, younger than 19 years of age; 2. The member meets the criteria for a DSM-5-TR or corresponding ICD diagnosis; 3. The member receives multiple services across different provider disciplines and/or state agencies, whose treatment goals are not consistently aligned *and* needs a care planning team to coordinate the necessary services from all providers, state agencies, and/or special education; 4. The parent/guardian consents and voluntarily agrees to participate in ICC; 5. If the member is in a hospital, skilled nursing facility, psychiatric residential treatment facility, or other residential treatment setting, discharge is expected within 180 days or less; and **6.** The member is not receiving ICC or similar services, including care coordination through a state agency.	***All*** *of the following criteria must be met:* 1. The member's clinical condition(s) continues to warrant ICC services in order to coordinate involvement with state agencies, special education, and/or multiple service providers; and 2. Progress toward ICP identified goals: a. has been made and documented (based on defined objectives for each goal), but goals have not yet been substantially achieved; *or* b. has not been made, and the CPT has identified and implemented changes and revisions to the ICP to better support the goals.	***Any*** *one of the following criteria must be met:* 1. The member no longer meets admission criteria; 2. CPT determines that the member's documented ICP goals and objectives have been substantially met, and continued services are not necessary; 3. The parent/guardian withdraws consent for treatment; 4. The parent/caregiver is not engaged in the service to such a degree that this service is ineffective or unsafe, despite multiple, documented attempts to address engagement issues; 5. The member is placed in a hospital, skilled nursing facility, psychiatric residential treatment facility, or other residential treatment setting and is unable to return to a family home environment or a community setting; or 6. The member becomes 19 years of age.

C. In-Home Therapy – MassHealth Only with the exception of MassHealth Limited

Available to all MassHealth members under the age of 21 (with the exception of MassHealth Limited)

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

In-Home Therapy is situational, working with the youth and family in their home environment, fostering understanding of the family dynamics, and teaching strategies to address stressors as they arise. IHT fosters a structured, consistent, strength-based therapeutic relationship between a licensed clinician and the youth and family for the purpose of treating the youth's behavioral health needs, including improving the family's ability to provide effective support for the youth to promote their healthy functioning within the family.

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

The IHT team (comprised of the qualified practitioner(s), family, and youth), develops a treatment plan and, using established psychotherapeutic techniques and intensive family therapy, works with the entire family, or a subset of the family, to implement focused, structural, or strategic interventions and behavioral techniques to: enhance problem-solving, limit-setting, risk management/safety planning, and communication; build skills to strengthen the family, advance therapeutic goals, or improve ineffective patterns of interaction; identify and utilize community resources; and develop and maintain natural supports for the youth and parent/caregiver(s) in order to promote sustainability of treatment gains. Phone contact and consultation are provided as part of the intervention.

IHT is provided by a qualified clinician who may work in a team that includes one or more qualified paraprofessionals.

Therapeutic Training and Support is a service provided by a qualified paraprofessional working under the supervision of a clinician to support implementation of the licensed clinician's treatment plan to assist the youth and family in achieving the goals of that plan. The paraprofessional assists the clinician in implementing the therapeutic objectives of the treatment plan designed to address the youth's mental health, behavioral, and emotional needs. This service includes teaching the youth to understand, direct, interpret, manage, and control feelings and emotional responses to situations and to assist the family to address the youth's emotional and mental health needs. Phone contact and consultation are provided as part of the intervention.

IHT services may be provided in any setting where the youth is naturally located, including, but not limited to, the home (including foster homes and therapeutic foster homes), schools, child care centers, respite settings, and other community settings.

Criteria	
Admission Criteria	***All** of the following criteria are necessary for participation in this level of care*: 1. A comprehensive behavioral health assessment inclusive of the MA Child and Adolescent Needs and Strengths (MA CANS) indicates that the youth's clinical condition warrants this service in order to enhance problem-solving, limit-setting, and risk management/safety planning and communication; to advance therapeutic goals or improve ineffective patterns of interaction; and to build skills to strengthen the parent/caregiver's ability to sustain the youth in their home setting or to prevent the need for more-intensive levels of service such as inpatient hospitalization or other out-of-home behavioral health treatment services. 2. The youth resides in a family home environment (e.g., foster, adoptive, birth, kinship) and has a parent/guardian/caregiver who voluntarily agrees to participate in IHT. 3. Outpatient services alone are not or would not likely be sufficient to meet the youth and family's needs for clinical intervention/treatment. 4. Required consent is obtained.
Psychosocial, Occupational, and Cultural and Linguistic Factors	*These factors may change the risk assessment and should be considered when making level-of-care decisions.*
Exclusion Criteria	***Any one** of the following is sufficient for exclusion for this level of care:* 1. Required consent is not obtained. 2. The youth is in a hospital, skilled nursing facility, psychiatric residential treatment facility, or other residential treatment setting at the time of referral and is not ready for discharge to a family home environment or community setting with community-based supports. 3. The needs identified in the treatment plan that would be addressed by IHT services are being fully met by other services. 4. The environment in which the service takes place presents a serious safety risk to the IHT service provider; alternative community settings are not likely to ameliorate the risk, and no other safe venue is available or appropriate for this service. 5. The youth is in an independent living situation and is not in the family's home or returning to a family setting. 6. The youth has medical conditions or impairments that would prevent beneficial utilization of services.
Continued Stay Criteria	***All** of the following criteria are required for continuing treatment at this level of care*: 1. The youth's clinical condition continues to warrant IHT, and the youth is continuing to progress toward identified, documented treatment plan goal(s). 2. Progress toward identified treatment plan goal(s) is evident and has been documented based upon the objectives defined for each goal, but the goal(s) has not been substantially achieved. OR 3. Progress has not been made, and the IHT team has identified and implemented changes and revisions to the treatment plan to support the goals.

	4. The youth is actively participating in the treatment as required by the treatment plan/ICP to the extent possible consistent with their condition. 5. The parent/guardian/caregiver is actively participating in the treatment as required by the treatment plan/ICP.
Discharge Criteria	***Any one** of the following criteria is sufficient for discharge from this level of care*: 1. The youth no longer meets admission criteria for this level of care or meets criteria for a less- or more-intensive level of care. 2. The treatment plan goals and objectives have been substantially met, and continued services are not necessary to prevent worsening of the youth's behavioral health condition. 3. The youth and parent/guardian/caregiver are not engaged in treatment. Despite multiple, documented attempts to address engagement, the lack of engagement is of such a degree that it implies withdrawn consent or treatment at this level of care becomes ineffective or unsafe. 4. The youth is placed in a hospital, skilled nursing facility, psychiatric residential treatment facility, or other residential treatment setting and is not ready for discharge to a family home environment or a community setting with community-based supports. 5. Required consent for treatment is withdrawn. 6. The youth is not making progress toward treatment goals, and there is no reasonable expectation of progress at this level of care, nor is this level of care required to prevent worsening of the youth's condition.

D1. In-Home Behavioral Services

Available only to MassHealth Standard and Commonhealth members under the age of 21
In-Home Behavioral Services (IBHS) are delivered by one or more members of a team consisting of professional and paraprofessional staff, offering a combination of medically necessary Behavior Management Therapy and Behavior Management Monitoring.

Behavior Management Therapy: This service includes a behavioral assessment (including observing the youth's behavior, antecedents of behaviors, and identification of motivators), development of a highly specific behavior plan; supervision and coordination of interventions; and training other interveners to address specific behavioral objectives or performance goals. This service is designed to treat challenging behaviors that interfere with the youth's successful functioning. The behavior management therapist develops specific behavioral objectives and interventions that are designed to diminish, extinguish, or improve specific behaviors related to the youth's behavioral health condition(s) and which are incorporated into the behavior plan and the risk management/safety plan.

Behavior Management Monitoring: This service includes implementation of the behavior plan, monitoring the youth's behavior, reinforcing implementation of the behavior plan by the parent(s)/guardian(s)/caregiver(s), and reporting to the behavior management therapist on implementation of the behavior plan and progress toward behavioral objectives or performance goals. Phone contact and consultation may be provided as part of the intervention.

For youth engaged in Intensive Care Coordination (ICC), the behavior plan is designed to achieve a goal(s) identified in the youth's Individual Care Plan (ICP). The Care Planning Team (CPT) works closely with the youth, parent/guardian/caregiver, and/or other individual(s) identified by the family to support adherence to the behavior plan and to sustain the gains made.

Criteria	
Admission Criteria	***All** of the following criteria are necessary for participation in this level of care*: 1. A comprehensive behavioral health assessment inclusive of a Functional Behavioral Assessment indicates that the youth's clinical condition warrants this service in order to diminish, extinguish, or improve specific behaviors related to the youth's behavioral health condition(s). If the member has MassHealth as a secondary insurance and is being referred to services by a provider who is paid through the member's primary insurance, the provider must conduct a comprehensive behavioral health assessment. 2. Less-intensive behavioral interventions have not been successful in reducing or eliminating the problem behavior(s) or increasing or maintaining desirable behavior(s). 3. Clinical evaluation suggest that the youth's clinical condition, level of functioning, and intensity of need require the establishment of a specific structure, and the establishment of positive behavioral supports to be applied consistently across home and school settings; and warrant this level of care to successfully support him/her/their in the home and community. **4.** Required consent is obtained.
Psychosocial, Occupational, and Cultural and Linguistic Factors	*These factors may change the risk assessment and should be considered when making level-of-care decisions*
Exclusion Criteria	***Any one** of the following criteria is sufficient for exclusion from this level of care*: 1. The environment in which the service takes place presents a serious safety risk to the behavior management therapist or monitor, alternative community settings are not likely to ameliorate the risk, and no other safe venue is available or appropriate for this service. 2. The youth is at imminent risk to harm self or others, or sufficient impairment exists that requires a more-intensive level of care beyond a community-based intervention. 3. The youth has medical conditions or impairments that would prevent beneficial utilization of services. 4. Introduction of this service would be duplicative of services that are already in place. 5. The youth is in a hospital, skilled nursing facility, psychiatric residential treatment facility, or other residential setting at the time of referral and is not ready for discharge to a family home environment or community setting with community-based supports.
Continued Stay Criteria	***All** of the following criteria are required for continuing treatment at this level of care*: 1. The youth's clinical condition(s) continues to warrant IHBS in order to maintain him/her/them in the community and continue progress toward goals established in the behavior plan.

	2. The youth is actively participating in the plan of care and treatment to the extent possible consistent with their condition. 3. With consent, the parent/guardian/caregiver, and/or natural supports are actively involved in the treatment as required by the behavior plan, or there are active efforts being made and documented to involve them.
Discharge Criteria	***Any one*** *of the following criteria is sufficient for discharge from this level of care*: 1. The youth no longer meets admission criteria for this level of care or meets criteria for a less- or more-intensive level of care. 2. The youth's behavior plan goals and objectives have been substantially met, and continued services are not necessary to prevent the worsening of the youth's behavior. 3. The youth and/or parent/guardian/caregiver are not engaged in treatment. The lack of engagement is of such a degree that treatment at this level of care becomes ineffective or unsafe, despite multiple, documented attempts to address engagement issues. 4. The youth is not making progress toward goals and objectives in the behavior plan, and there is no reasonable expectation of progress at this level of care, nor is it required to maintain the current level of functioning. 5. Consent for treatment is withdrawn.

D2. In-Home Behavioral Services

Available to Commercial members only

Behavior Management Therapy: This service includes a behavioral assessment (including observing the youth's behavior, antecedents of behaviors, and identification of motivators), development of a highly specific behavior plan; supervision and coordination of interventions; and training other interveners to address specific behavioral objectives or performance goals. This service is designed to treat challenging behaviors that interfere with the youth's successful functioning. The behavior management therapist develops specific behavioral objectives and interventions that are designed to diminish, extinguish, or improve specific behaviors related to the youth's behavioral health condition(s) and which are incorporated into the behavior plan and the risk management/safety plan.

Behavior Management Monitoring: This service includes implementation of the behavior plan, monitoring the youth's behavior, reinforcing implementation of the behavior plan by the parent(s)/guardian(s)/caregiver(s), and reporting to the behavior management therapist on implementation of the behavior plan and progress toward behavioral objectives or performance goals. Phone contact and consultation may be provided as part of the intervention.

This service is not hub-dependent, however, for youth engaged in Intensive Care Coordination (ICC), the behavior plan is designed to achieve a goal(s) identified in the youth's Individual Care Plan (ICP). The Care Planning Team (CPT) works closely with the youth, parent/guardian/caregiver, and/or other individual(s) identified by the family to support adherence to the behavior plan and to sustain the gains made.

Admission Criteria	Continued Stay Criteria	Discharge Criteria
***All** of the following criteria must be met:* 1. The member is a youth, younger than 19 years of age, living with a parent/guardian/caregiver; 2. The member has a DSM-5-TR or corresponding ICD diagnosis; 3. A comprehensive behavioral health assessment, inclusive of a Functional Behavioral Assessment and Observations, indicates that the youth's clinical condition warrants this service in order to diminish, extinguish, or improve specific behaviors related to the youth's behavioral health condition(s); and 4. Clinical evaluation suggests the member's condition, level of functioning, and intensity of need require the establishment of a specific, structured, positive behavioral plan to be applied consistently to successfully support the member in the home and community. The member does not meet acute inpatient or CBAT levels of care. **AND** at least one (1) of the following from items 5-7: 5. The member's symptoms are so severe that the member is putting the family unit at risk/threatens the routine functioning or the family (e.g., aggression, self-harming behavior, refusing to leave the house, etc.); **OR** 6. The member exhibits a potential for repeat admissions to inpatient, partial hospital program, or CBAT, either by a history or by the length and intensity of the current treatment episode; **OR** 7. The member is being discharged from an inpatient or partial hospital program or CBAT facility to a safe and stable home environment (as determined by	***All** of the following criteria must be met:* 1. The member continues to meet admission criteria; 2. Another less-intensive level of care would not be adequate to administer care; 3. The member is making progress but has not improved to the degree that service is no longer required and if services end, the member could be at risk for higher levels of care; 4. Treatment is still necessary to reduce symptoms and improve functioning so the member may be treated in a less-intensive level of care; 5. There is evidence of progress towards resolution of the symptoms causing a barrier to continuation of treatment in a less-intensive level of care; 6. The parent/guardian/caregiver is participating in treatment; and 7. Coordination of care and active discharge planning are ongoing, with the goal of transitioning the member to a less-intensive level of care.	***Any** one of the following criteria must be met:* 1. The member no longer meets admission criteria and/or meets criteria for another level of care, either more- or less-intensive; 2. The member's behavior plan goals and objectives have been substantially met, and continuation of this service is not necessary to prevent the member's behavior from worsening; 3. The member and/or parent/guardian/caregiver are not engaged in treatment to such a degree that this treatment becomes ineffective or unsafe, despite multiple, documented attempts to address engagement issues; 4. The member is not making progress toward goals and objectives in the behavior plan, and there is no reasonable expectation of progress at this level of care, nor is it required to maintain the current level of functioning; or 5. The parent/guardian withdraws consent for treatment.

Admission Criteria	Continued Stay Criteria	Discharge Criteria
referral source or IHBS provider) with parent/guardian/care giver. **Exclusion Criteria** 1. The member may not receive IHBS and ABA treatment concurrently. 2. The member has medical conditions or impairments that would prevent beneficial utilization of services. 3. Introduction of this service would be duplicative of services that are already in place. 4. The parent/guardian/caregiver does not consent for treatment and does not agree to work with the IHBS provider. 5. The member is at imminent risk to harm self or others, or sufficiently impaired that a more-intensive level of care (LOC) is appropriate.		

E1. Therapeutic Mentoring

Available only to MassHealth Standard and Commonhealth members under age of 21

Therapeutic Mentoring (TM) Services are provided to youth (under the age of 21) in any setting where the youth resides, such as the home (including foster homes and therapeutic foster homes) and other community setting such as a school, child care centers, respite settings, and other culturally and linguistically appropriate community settings.
Therapeutic Mentoring offers structured, one-to-one, strength-based support services between a therapeutic mentor and a youth for the purpose of addressing daily living, social, and communication needs.

Therapeutic Mentoring services include supporting, coaching, and training the youth in age-appropriate behaviors, interpersonal communication, functional skill-building, problem-solving and conflict resolution, and relating appropriately to other youth, as well as adults, in recreational and social activities pursuant to a behavioral health treatment plan developed by an outpatient or IHT provider in concert with the family and youth whenever possible or Individual Care Plan (ICP) for youth in ICC. These services help to ensure the youth's success in navigating various social contexts, learning new skills, and making functional progress, while the Therapeutic Mentor offers supervision of these interactions and engages the youth in discussions about strategies for effective handling of peer interactions.

Therapeutic Mentoring services must be necessary to achieve a goal(s) established in an existing behavioral health treatment plan for outpatient or IHT or in an ICP for youth in ICC, and progress

toward meeting the identified goal(s) must be documented and reported regularly to the youth's current treater(s). Services are designed to support age-appropriate social functioning or ameliorate deficits in the youth's age-appropriate social functioning.

Criteria	
Admission Criteria	***All** of the following criteria are necessary for admission to this level of care*: 1. A comprehensive behavioral health assessment inclusive of the MA Child and Adolescent Needs and Strengths (MA CANS) indicates that the youth's clinical condition warrants this service in order to support age-appropriate social functioning or ameliorate deficits in the youth's age-appropriate social functioning. If the member has MassHealth as a secondary insurance and is being referred to services by a provider who is paid through the member's primary insurance, the provider must conduct a comprehensive behavioral health assessment. A CANS is not required. 2. The youth requires education, support, coaching, and guidance image-appropriate behaviors, interpersonal communication, problem-solving and conflict resolution, and relating appropriately to others to address daily living, social, and communication needs and to support the youth in a home, foster home, or community setting, OR the youth may be at risk for out-of-home placement as a result of the youth's mental health condition OR requires support in transitioning back to the home, foster home, or community from a congregate care setting. 3. Outpatient services alone are not sufficient to meet the youth's needs for coaching, support, and education. 4. Required consent is obtained. 5. The youth is currently engaged in outpatient services, IHT, or ICC and the provider or ICC CPT determine that Therapeutic Mentoring Services can facilitate the attainment of a goal or objective identified in the treatment plan or ICP that pertains to the development of communication skills, social skills, and peer relationships.
Psychosocial, Occupational, and Cultural and Linguistic Factors	*These factors may change the risk assessment and should be considered when making level-of-care decisions*
Exclusion Criteria	***Any one of the following is sufficient for exclusion for this level of care:*** 1. The youth displays a pattern of behavior that may pose an imminent risk to harm self or others, or sufficient impairment exists that requires a more-intensive service beyond community-based intervention. 2. The youth has medical conditions or impairments that would prevent beneficial utilization of services. 3. Therapeutic Mentoring services are not needed to achieve an identified treatment goal. 4. The youth's primary need is only for observation or for management during sport/physical activity, school, after-school activities, or recreation, or for parental respite. 5. The service needs identified in the treatment plan/ICP are being fully met by similar services. 6. The youth is placed in a residential treatment setting with no plans for return to the home setting.
Continued Stay Criteria	***All** of the following criteria are required for continuing treatment at this level of care*: 1. The youth's clinical condition continues to warrant Therapeutic Mentoring Services in order to continue progress toward treatment plan goals.

	2. The youth's treatment does not require a more-intensive level of care. 3. No less-intensive level of care would be appropriate. 4. Care is rendered in a clinically appropriate manner and focused on the youth's behavioral and functional outcomes as described in the treatment plan/ICP. 5. Progress in relation to specific behavior, symptoms, or impairments is evident and can be described in objective terms, but goals have not yet been achieved, or adjustments in the treatment plan/ICP to address lack of progress are evident. 6. The youth is actively participating in the plan of care to the extent possible consistent with their condition. 7. Where applicable, the parent/guardian/caregiver and/or natural supports are actively involved as required by the treatment plan/ICP.
Discharge Criteria	***Any one** of the following criteria is sufficient for discharge from this level of care*: 1. The youth no longer meets admission criteria for this level of care or meets criteria for a less- or more-intensive level of care. 2. The treatment plan/ICP goals and objectives have been substantially met, and continued services are not necessary to prevent worsening of the youth's behavioral health condition. 3. The youth and parent/guardian/caregiver are not engaged in treatment. Despite multiple, documented attempts to address engagement, the lack of engagement is of such a degree that it implies withdrawn consent or treatment at this level of care becomes ineffective or unsafe. 4. Required consent for treatment is withdrawn. 5. The youth is not making progress toward treatment goals, and there is no reasonable expectation of progress at this level of care, nor is it required to maintain the current level of functioning. 6. The youth is placed in a hospital, skilled nursing facility, psychiatric residential treatment facility, or other residential treatment setting and is not ready for discharge to a family home environment or a community setting with community-based supports.

E2 Therapeutic Mentoring *Commercial Only*

Therapeutic Mentoring (TM) Services are provided to youth (under the age of 19) in any setting where the youth resides, such as the home (including foster homes and therapeutic foster homes), and in other community settings, such as, child care centers, respite settings, and other culturally and linguistically appropriate community settings. TM offers structured, one-to-one, strength-based support services between a therapeutic mentor and a youth for the purpose of addressing daily living, social, and communication needs. TM services include supporting, coaching, and training the youth in age-appropriate behaviors, interpersonal communication, functional skill-building, problem-solving and conflict resolution, and relating appropriately to other youth, and adults in recreational and social activities. TM services must be pursuant to a behavioral health treatment plan, indicating a behavioral health diagnosis, developed by an outpatient, or FST/IHT provider, in concert with the family and youth whenever possible, or Individual Care Plan (ICP) for youth in ICC. These services help to ensure the youth's success in navigating various social contexts, learning new skills, and making functional progress. The Therapeutic Mentor offers supervision of these interactions, and engages the youth in discussions about strategies for effective handling of community interactions. TM is delivered by strength-based, culturally and linguistically appropriate qualified paraprofessionals under the supervision of a licensed clinician.

TM services must be necessary to achieve a goal(s) established in an existing behavioral health treatment plan for outpatient or IHT or in an ICP for youth in ICC. Progress toward meeting the identified goal(s) must be documented and reported weekly to the youth's current treater(s). If there is no significant progress, appropriate changes to the treatment plan must be documented. Services are designed to support age- appropriate social functioning or ameliorate deficits in the youth's age-appropriate social functioning.

Admission Criteria	Continued Stay Criteria	Discharge Criteria
All of the following are necessary for admission to this level of care: 1. A comprehensive behavioral health assessment indicates that the youth's clinical condition warrants this service in order to support age-appropriate social functioning, or to ameliorate deficits in the youth's age-appropriate social functioning; 2. The member is a youth, younger than 19 years of age, living with a parent/guardian/caregiver in the community; 3. The youth requires education, support, coaching, and guidance in age-appropriate behaviors, interpersonal communication, problem-solving and conflict resolution, and relating appropriately to others. These services are needed to address daily living, social, and communication needs, and to support the youth in a home, foster home, or community setting; 4. The member displays such risk behaviors as to warrant a level of care beyond the formal outpatient suite of services, or naturally occurring services in the youth's family or available social network. These behaviors have caused impairments in functioning at home, in school or in the community; 5. Required consent is obtained; and	**All the following criteria must be met:** 1. The youth's clinical condition continues to warrant TM Services in order to continue progress toward treatment plan goals; 2. The youth's treatment does not require a more-intensive level of care; 3. No less-intensive level of care would be appropriate; 4. Care is rendered in a clinically appropriate manner and focused on the youth's behavioral and functional outcomes as described in the treatment plan/ICP; 5. Progress in relation to specific behavior, symptoms, or impairments is evident and can be described in objective terms. If goals have not yet been achieved, adjustments in the treatment plan/ICP to address lack of progress are evident. 6. The youth is actively participating in the plan of care to the extent possible consistent with their condition; and 7. Where applicable, the parent/guardian/caregiver and/or natural supports are actively involved, as required by the treatment plan/ICP. Treatment does not require a more-intensive level of care.	**Any one of the following criteria is sufficient for discharge from this level of care:** 1. The youth no longer meets admission criteria for this level of care, or meets criteria for a less- or more-intensive level of care; 2. The treatment plan/ICP goals and objectives have been substantially met, and continued services are not necessary to prevent worsening of the youth's behavioral health condition; 3. The youth and parent/guardian/caregiver are not engaged in treatment. Despite multiple, documented attempts to address engagement, the lack of engagement is of such a degree that it implies withdrawn consent, or treatment at this level of care becomes ineffective or unsafe; 4. Required consent for treatment is withdrawn; 5. The youth is not making progress toward treatment goals, and there is no reasonable expectation of progress at this level of care. Also, this service is not required in order to maintain the current level of functioning; 6. The youth is placed in a hospital, skilled nursing facility, psychiatric residential

6. The youth is currently engaged in outpatient services, IHT, or ICC, and the provider treatment plan or ICC CPT determines that TM Services can facilitate the attainment of a specific, measureable goal or objective identified in the treatment plan or ICP. The goal or objective pertains to the development of communication skills, social skills and peer relationships. This goal is specified at the time of initial referral and is updated throughout treatment.		treatment facility, or other residential treatment setting, and is not ready for discharge to a family home environment or to a community setting with community-based supports; 7. The youth displays a pattern of behavior that may pose an imminent risk to harm self or others, or sufficient impairment exists that requires a more intensive service beyond community-based intervention; 8. The youth has medical conditions or impairments that would prevent beneficial utilization of services; 9. TM services are not needed to achieve an identified treatment goal, or the treatment goal is not age-appropriate, or the treatment goal is inappropriate for the youth's baseline level of functioning; 10. The youth's primary need is only for observation or for management during sport/physical activity, school, after-school activities, or recreation, or for parental respite; 11. The service needs identified in the treatment plan/ICP are being fully met by similar services; or 12. The youth is placed in a residential treatment setting with no plans for return to the home setting within approximately three weeks.

F. Family Stabilization Teams (FST)/In-Home Therapy Commercial IHT

Available only to Commercial members only

Family Stabilization Teams (FSTs) provide an intensive, flexible stabilization service for children, adolescents, parents, guardians, or foster parents following an acute psychiatric episode. This service is generally provided as an alternative to, or step-down from, inpatient or Community-Based Acute Treatment (CBAT). The goal of an FST is to assist children and adolescents and their families to address multiple life stressors through the provision of intensive, short-term, transitional services. FST services are expected to complement other services already in place for the member. The FST worker does not replace the role of the member's outpatient therapist.

Admission Criteria	Continued Stay Criteria	Discharge Criteria
***All** of the following criteria must be met* 1. The member is a youth, younger than 19 years of age, living with a parent/guardian/caregiver; 2. The member displays such risk behaviors such as to warrant a level of care beyond the formal Outpatient suite of services, or naturally occurring services in the youth's family, community or available social network. These risk behaviors have caused impairments in functioning at home, school or in the community; 3. Intensive outpatient services, Family Therapy or other available natural or formal supports, together with appropriate Department of Children and Families (DCF) and/or Department of Mental Health (DMH), as applicable, services are not sufficient to meet the family's needs for support and psycho-education during the member's transition into the home; 4. The family is not receiving similar in-home services from DMH or DCF or another IHT team; and 5. The parent/guardian/caregiver agrees to work with the FST.	***All** of the following criteria must be met:* 1. The member continues to meet admission criteria; 2. Another less-intensive level of care would not be adequate to administer care; 3. The member is making progress but has not improved to the degree that services is no longer required and if services end, the member could be at risk for higher levels of care; 4. Treatment is still necessary to reduce symptoms and improve functioning so the member may be treated in a less-intensive level of care; 5. There is evidence of progress towards resolution of the symptoms causing a barrier to treatment continuing in a less-intensive level of care; 6. The parent/guardian/caregiver is participating in treatment, as appropriate; and 7. Coordination of care and active discharge planning are ongoing, with goal of transitioning the member to a less-intensive level of care.	***Criteria # 1, 2, 3, or 4 are suitable; criteria #5 and #6 are recommended but optional:*** 1. The member no longer meets admission criteria and/or meets criteria for another level of care, either more- or less-intensive; 2. The member or parent/guardian withdraws consent for treatment; 3. The member or parent/guardian are not engaged in treatment to such a degree that treatment at this level of care becomes ineffective or unsafe, despite multiple, documented attempts to address engagement issues; 4. The member is not making progress toward goals, nor is there expectation of any progress; 5. The member's individual treatment plan and goals have been met; or 6. The member's support system is in agreement with the aftercare treatment plan.

G. Family Partner (FP)

Available to commercial members only

Family Partner (FP) is a service provided to the parent/caregiver of a youth (under the age of 19) in any setting where the youth resides, such as the home (including foster homes and therapeutic foster homes), and in other community settings. FP is a service that aims to create a structured, one-to-one, strength-based relationship between a Family Partner and a parent/caregiver. The purpose of this service is to resolve or ameliorate the youth's emotional and behavioral needs by improving the capacity of the parent/caregiver to parent the youth. The intent of this service is to improve the youth's functioning, as identified in the outpatient or IHT treatment plan, or Individual Care Plan (ICP) for youth enrolled in ICC, and to support the youth in the community, or to assist the youth in returning to the community. Services may include education, assistance in navigating the child serving systems (DCF, education, mental health, juvenile justice, etc.); fostering empowerment, including linkages to peer/parent support and self-help groups; assistance in identifying formal and community resources (e.g., after-school programs, food assistance, summer camps, etc.); and support, coaching, and training for the parent/caregiver.

FP is delivered by strength-based, culturally and linguistically appropriate qualified paraprofessionals under the supervision of a licensed clinician. FP services must work towards a goal(s) established in an existing behavioral health treatment plan/care plan for outpatient or IHT, or an Individual Care Plan, for youth enrolled in ICC. Services are designed to improve the parent/caregiver's capacity to ameliorate or resolve the youth's emotional or behavioral needs, and to strengthen their own capacity to parent.

Delivery of appropriate ICC services may require care coordinators to collaborate with Family Partners. In ICC, the care coordinator and Family Partner work together with youth with SED, and their families while maintaining their discrete functions. The Family Partner works one-on-one and maintains regular frequent contact with the parent(s)/caregiver(s), in order to provide education and support throughout the care planning process. The Family Partner attends CPT meetings, and may assist the parent(s)/caregiver(s) in articulating the youth's strengths, needs, and goals for ICC to the care coordinator and CPT. The Family Partner educates parents/caregivers about how to effectively navigate the child-serving systems for themselves, about the existence of informal/community resources available to them, and facilitates the parent's/caregiver's access to these resources.

Admission Criteria	Continued Stay Criteria	Discharge Criteria
All criteria must be met: 1. A comprehensive behavioral health assessment, showing a diagnosed behavioral health condition, indicates that the youth's clinical condition warrants this service in order to improve the abilities of the parent/caregiver to alleviate youth functional impairment; 2. The parent/caregiver requires education, support, coaching, and guidance to improve their capacity to parent, in order to ameliorate or resolve the youth's emotional or behavioral needs. The intent of these services is to support the youth in the community, and to improve the youth's functioning, as identified specifically in the outpatient or IHT treatment plan/ICP, for those youth enrolled in ICC; 3. Outpatient services, and available community-based natural and formal supports, - alone are not sufficient to meet the parent/caregiver's needs for coaching, support, and education; 4. The parent/caregiver gives consent and agrees to participate; 5. A specific, measureable goal is identified in the youth's outpatient or IHT treatment plan, or ICP for those enrolled in ICC, that pertains to the development of the parent/caregiver capacity to parent the youth in the home or community; 6. The youth resides with or has a current plan to return to the identified parent/caregiver; 7. The member displays such risk behavioral as to warrant a level of care beyond the	**All the following criteria must be met:** 1. The parent/caregiver continues to need support to improve his/her capacity to support the youth in the community, and to ameliorate or resolve the youth's emotional or behavioral needs, as identified in the outpatient or IHT treatment plan/ICP, for those youth enrolled in ICC; 2. Care is rendered in a clinically appropriate manner, and is focused on the parent/caregiver's need for support, guidance, and coaching; 3. All services and supports are structured to achieve goals in the most time-efficient manner possible; 4. For youth in ICC, with required consent, informal and formal supports of the parent/caregiver are actively involved on the youth's team; 5. With required consent, there is evidence of active coordination of care with the youth's care coordinator (if involved in ICC) and/or other services and state agencies; and 6. Progress in relation to specific behavior, symptoms, or impairments is evident and can be described in objective terms, but goals have not yet been achieved, or adjustments in the	**Any one of the following criteria is sufficient for discharge from this level of care:** 1. The parent/caregiver no longer needs this level of one-to-one support and is actively utilizing other formal and/or informal support networks; 2. The youth's treatment plan/ICP indicates the goals and objectives for Family Partner have been substantially met; 3. The parent/caregiver is not engaged in the service. The lack of engagement is of such a degree that this type of support becomes ineffective or unsafe, despite multiple documented attempts to address engagement issues; 4. The parent/guardian/caregiver withdraws consent for treatment; 5. There is impairment with no reasonable expectation of progress toward identified treatment goals for this service; 6. There is no indication of need for this service to ameliorate or resolve the youth's emotional needs, or to support the youth in the community; 7. The environment in which the service takes place presents a serious safety risk to the Family Partner making visits. Alternative community settings are not likely to ameliorate the risk, and no other safe venue is available or appropriate for this service; 8. The youth is placed in a residential treatment setting with no current plans to return to the home setting; or 9. The youth is in an independent living situation, and is not in the family's home or returning to a family setting. The service

formal Outpatient suite of services, or naturally occurring services in the youth's family or available social network. These behaviors have caused impairments in functioning at home, school or in the community; and 8. While the youth may be a parent themselves, only the identified member's parent is receiving the interventions. This is not a service for young parents to gain parenting skills.	treatment plan/ICP to address lack of progress are evident.	needs identified in the treatment plan/ICP are being fully met by similar services from the same or any other agency.

H. Intensive Hospital Diversion Program

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

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

Admission Criteria	Exclusion Criteria	Discharge Criteria
***All** of the following criteria are necessary for admission to this level of care:* 1. The member must meet current Medical Necessity Criteria for IHT and have additional acute needs that cannot be met by IHT, as defined by the following: a. The member is in acute crisis and at imminent risk of 24-hour level of care and	***Any one** of the following is sufficient for exclusion for this level of care:* 1. The member is concurrently receiving IHT or other intensive home-based service, including those provided by other state agencies. 2. The member has reached 21 year of age.	***Any one** of the following criteria is sufficient for discharge from this level of care:* 1. The youth no longer meets admission criteria for this level of care, or meets criteria for a less- or more-intensive level of care; 2. The treatment plan goals and objectives have been substantially met and continued services are not necessary to prevent worsening of the

has been evaluated by a MCI team or ED clinician b. MCI or other crisis evaluation indicates the need for more intensive treatment then IHT and Mobile Crisis Intervention together, and the member can be safely maintained in the community with IHD in place as agreed upon by family and crisis clinician.		youth's behavioral health condition. 3. The youth is no longer living in a home setting.

Section V: Emergency/Crisis Services

Overview

This section outlines services provided to members who are experiencing a mental health crisis and require an emergency service. Emergency services may include one or more of the following:

A. Emergency Services Program (ESP)
B. NMNC 4.401.04 Mobile Crisis
C. Community Crisis Stabilization (CCS)

Consistent with the Massachusetts Managed Care Act, Carelon Behavioral Health promotes access to emergency care without requiring prior authorization or notification from the member. Carelon Behavioral Health however, requires a face-to-face evaluation for all members requiring acute services; this process allows members access to emergency services as quickly as possible and at the closest facility or by the closest crisis team.

- **MassHealth and Commonwealth Care members**
  MassHealth and the Connector *mandate* that Emergency Services Providers (ESPs) perform an emergency screening for *all* MassHealth and Commonwealth Care enrollees, respectively.
- **Commercial members**
  Commercial members must be screened by a qualified behavioral health professional from the hospital emergency room or by an ESP.

If there are extenuating circumstances, and the ESP cannot evaluate the member within one (1) hour after the member's arrival to the site, Carelon Behavioral Health will allow a qualified behavioral health clinician from a hospital emergency room to provide the emergency evaluation. When an emergency admission is necessary, Carelon Behavioral Health-contracted facilities must take all reasonable steps to contact Carelon Behavioral Health with relevant clinical information as close to the time of admission as possible, but not to exceed 24 hours. If an emergency room physician and a Carelon Behavioral Health physician do not agree on what constitutes medically necessary treatment, the opinion of the emergency room physician shall prevail.

A. Emergency Services Program (ESP)

The **Emergency Services Program (ESP)** provides on-site and Mobile Crisis Intervention (MCI) assessment and treatment 24 hours per day, seven days per week to individuals in an active state of crisis. The purpose of the ESP is to respond rapidly, assess effectively, and provide early intervention to help individuals and their families who are in crisis, ensuring their safety and entry into the continuum of care at the appropriate level. This would include, as clinically indicated, direct provision of crisis assessment, including collateral contacts, coordination of care with other behavioral health providers, short-term crisis counseling, and medication evaluation and prescription. The ESP facilitates all necessary acute medical evaluation and uses this information to inform the crisis assessment and planning. The ESP also identifies services and alternatives that will minimize distress and aid in crisis stabilization. Referrals and coordination of services are provided to link individuals and their families with other service providers and community supports that can assist with maintaining maximum functioning in the least-restrictive environment. This service may be provided on-site in an ESP, in medical emergency departments, or in community settings in response to requests by police, providers, community-based agencies, family members, guardians, protective service workers, or the individual in crisis.

Crisis intervention requires flexibility in the duration of the initial intervention, the person's participation in the treatment, and the number and type of follow-up services. It is crucial that the individual and their family or other primary caretakers/guardians and natural support systems participate in the crisis intervention process whenever possible.

Criteria

Admission Criteria

Both *of the following criteria (1-2) are necessary for admission to this level of care*:

1. The individual must be in an active state of crisis; and
2. The intervention must be reasonably expected to improve/stabilize the individual's condition and resolve the crisis safely in the community or to determine that a more-intense treatment is immediately necessary and arrange for such treatment disposition at the appropriate level of care.

In addition to the above, ***at least one*** *of the following (3-4) must be present:*

3. The individual demonstrates and/or collateral contact(s) report suicidal/assaultive/destructive ideas, threats, plans, or attempts that represent risk to self or others as evidenced by degree of intent, lethality of plan, means, hopelessness, or impulsivity; or
4. The individual demonstrates and/or collateral contact(s) report an incapacitating or debilitating disturbance in mood/thought/behavior that is disruptive to interpersonal, familial, occupational, and/or educational functioning to the extent that immediate intervention is required.

Psychosocial, Occupational, and Cultural and Linguistic Factors

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

Exclusion Criteria

Does not apply

Continued Stay Criteria

Does not apply

Discharge Criteria

***Any** of the following criteria (1-3) is sufficient for discharge from this level of care:*

1. The individual is released or transferred to an appropriate treatment setting based on crisis intervention, evaluation, and resolution;
2. A plan of aftercare follow-up is in place and is expected to reasonably continue to provide services and prevent exacerbation of the crisis; or
3. Consent for treatment is withdrawn, and it has been determined that the individual, parents, and/or guardian has the capacity to make an informed decision. In addition, the individual does not meet the criteria for a more-intensive level of care; involuntary inpatient treatment is inappropriate; or the court has denied involuntary inpatient treatment.

B. Mobile Crisis Intevention (MCI)

Mobile Crisis Intervention (MCI) is the youth (under the age of 21)-serving component of an ESP provider. MCI will provide a short-term service that is a mobile, on-site, face-to-face, and/or telehealth, if deemed appropriate, therapeutic response to a youth experiencing a behavioral health crisis for the purpose of identifying, assessing, treating, and stabilizing the situation and reducing immediate risk of danger to the youth or others consistent with the youth's risk management/safety plan, if any. This service is provided 24 hours a day, 7 days a week.

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

For youth who are receiving Intensive Care Coordination (ICC), MCI staff will coordinate with the youth's ICC care coordinator throughout the delivery of the service. MCI also will coordinate with the youth's primary care physician, any other care management program or other behavioral health providers providing services to the youth throughout the delivery of the service.

Criteria

Admission Criteria

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

1. The youth must be in a behavioral health crisis that was unable to be resolved to the caller's satisfaction by phone triage. For youth in ICC, efforts by the care coordinator and Care Plan Team (CPT) to triage and stabilize the crisis have been insufficient to stabilize the crisis, and ESP/MCI has been contacted.

2. Immediate intervention is needed to attempt to stabilize the youth's condition safely in situations that do not require an immediate public safety response.
3. The youth demonstrates impairment in mood, thought, and/or behavior that substantially interferes with functioning at school, home, and/or in the community.

*In addition to the above, **at least one** of the following must be present:*

1. The youth demonstrates suicidal/assaultive/destructive ideas, threats, plans, or actions that represent a risk to self or others.
2. The youth is experiencing escalating behavior(s) and, without immediate intervention, they are likely to require a higher intensity of services.

*In addition to the above, **at least one** of the following must be present:*

1. The youth is in need of clinical intervention in order to resolve the crisis and/or to remain stable in the community.
2. The demands of the situation exceed the parent's/guardian's/caregiver's strengths and capacity to maintain the youth in their present living environment, and external supports are required.

Psychosocial, Occupational, and Cultural and Linguistic Factors

These factors may change the risk assessment and should be considered when making level-of-care decisions.

Exclusion Criteria

Consent for an evaluation and mobile crisis intervention services is refused.

Continued Stay Criteria

Does not apply

Discharge Criteria

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

1. The crisis assessment and other relevant information indicate that the youth needs a more- or less-intensive level of care, and the MCI has facilitated transfer to the next treatment setting and ensured that the risk management/safety plan has been communicated to the treatment team at that setting.
2. The youth's physical condition necessitates transfer to an inpatient medical facility, and the MCI provider has communicated the youth risk management/safety plan to the receiving provider.
3. Consent for treatment is withdrawn, and there is no court order requiring such treatment.

C. Community Crisis Stabilization

This level of care is a facility- or community-based program where individuals with an urgent/emergent need can receive crisis stabilization services in a staff-secure, safe, structured setting that is an alternative to hospitalization. It provides continuous 24-hour observation and supervision for individuals who do not require intensive clinical treatment in an inpatient psychiatric setting and would benefit from a short-term, structured stabilization setting.

Services at this level of care include crisis stabilization, initial and continuing bio-psychosocial assessment, care management, medication management, and mobilization of family/guardian/natural supports and community resources. Some of the functions, such as medication management, administration, and physical care, will require access to medical services while other services can be provided by mental health professionals. The primary objective of the crisis stabilization service is to promptly conduct a comprehensive assessment of the individual and to develop a treatment plan with emphasis on crisis intervention services necessary to stabilize and restore the individual to a level of functioning that requires a less-restrictive level of care. Active family/guardian/significant other/natural supports involvement is necessary unless contraindicated; frequency should occur based on individual needs.

Admission Criteria	Continued Stay Criteria	Discharge Criteria
All *of the following criteria are necessary for admission to this level of care:* 1. The individual demonstrates active symptomatology consistent with a DSM-5-TR diagnosis, which requires and can reasonably be expected to respond to intensive, structured intervention within a brief period of time; 2. An adult demonstrates a significant incapacitating disturbance in mood/thought/behavior, interfering with activities of daily living so that immediate stabilization is required; OR A child/adolescent is experiencing emotional or behavioral problems in the home, school, community, and/or treatment setting and is not sufficiently stable, either emotionally or behaviorally, to be treated outside of a 24-hour therapeutic environment; 3. Clinical evaluation of the individual's condition indicates recent significant	***All*** *of the following criteria are necessary for continuing treatment at this level of care:* 1. The individual's condition continues to meet admission criteria at this level of care; 2. The individual's treatment does not require a more-intensive level of care, and no less-intensive level of care would be appropriate or is available; 3. After initial evaluation and stabilization, it is determined that the presenting symptomatology is indicative of a DSM-5-TR diagnosis, which is amenable to continued treatment at this level of care; 4. Care is rendered in a clinically appropriate manner and is focused on the individual's behavioral and functional outcomes as described in the treatment and discharge plan; and 5. Treatment planning is individualized and appropriate to the individual's age and changing condition, with realistic, specific, and	***Any*** *of the following criteria is sufficient for discharge from this level of care:* 1. The individual no longer meets admission criteria or meets criteria for a less- or more-intensive level of care; 2. Treatment plan goals and objectives have been substantially met and/or a safe, continuing care program can be arranged and deployed at a less intensive level of care. Follow-up aftercare appointment is arranged for a time frame consistent with the individual's condition and applicable Carelon Behavioral Health standards; 3. The individual, parent, and/or legal guardian is not engaged in treatment or is not following program rules and regulations. The lack of engagement is of such a degree that treatment at this level of care becomes ineffective or unsafe, despite multiple, documented attempts to address engagement issues. In addition, either it has been

decompensation with a strong potential for danger to self or others, and the individual cannot be safely maintained in a less-restrictive level of care; 4. The individual requires 24-hour observation and supervision but not the constant observation of an inpatient psychiatric setting except when being used as an alternative to an inpatient level of care; 5. Clinical evaluation indicates that the individual can be effectively treated with short-term intensive crisis intervention services and returned to a less-intensive level of care within a brief time frame; and 6. It is reasonably expected that a short-term crisis stabilization period in a safe and supportive environment will ameliorate the individual's symptoms. **Psychosocial, Occupational, and Cultural and Linguistic Factors:** *These factors may change the risk assessment and should be considered when making level-of-care decisions*	attainable goals and objectives stated. Treatment planning should include active family or other support systems social, occupational and interpersonal assessment with involvement unless contraindicated. Expected benefit from all relevant treatment modalities, including family and group treatment, is documented. 6. The treatment plan has been implemented and updated with consideration of all applicable and appropriate treatment modalities; 7. All services and treatment are carefully structured to achieve optimum results in the most time efficient manner possible consistent with sound clinical practice; 8. Progress in relation to specific symptoms or impairments is clearly evident and can be described in objective terms, but goals of treatment have not yet been achieved, or adjustments in the treatment plan to address lack of progress are evident; 9. The individual is actively participating in treatment to the extent possible consistent with the individual's condition; 10. When medically necessary, appropriate psychopharmacological intervention has been prescribed and/or evaluated; 11. There is documented active discharge planning starting with admission; and 12. There is documented active coordination of care with behavioral health providers, the primary care physician (PCP), and other services and state agencies. If	determined that involuntary inpatient treatment is inappropriate, or a court has denied a request to issue an order for involuntary inpatient treatment; 4. Consent for treatment is withdrawn, and either it has been determined that involuntary inpatient treatment is inappropriate, or the court has denied involuntary inpatient treatment; 5. Support systems that allow the individual to be maintained in a less-restrictive treatment environment have been secured; 6. The individual is not making progress toward treatment goals, and there is no reasonable expectation of progress at this level of care, nor is it required to maintain the current level of functioning; or 7. The individual's physical condition necessitates transfer to a medical facility.

	coordination is not successful, the reasons are documented and efforts to coordinate care continue.	

Exclusion Criteria

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

1. The individual's psychiatric condition is of such severity that it can only be safely ntreated in an inpatient setting;
2. The individual's medical condition is such that it requires treatment in a medical setting;
3. The individual/parent/guardian does not voluntarily consent to admission or treatment;
4. The individual can be safely maintained and effectively treated in a less-intensive level of care;
5. The primary problem is not psychiatric. It is a social, legal, or medical problem without a concurrent major psychiatric episode meeting criteria for this level of care;
6. Admission is being used as an alternative to incarceration, the juvenile justice system, protective services, specialized schooling, or as an alternative to medical respite or housing; or
7. Conditions that would not be appropriate for treatment at this level of care are:
   a. permanent cognitive dysfunction without acute DSM-5-TR diagnosis;
   b. primary substance use disorder requiring treatment in a specialized level of care;
   c. medical illness requiring treatment in a medical setting;
   d. impairment with no reasonable expectation of progress toward treatment goals at this level of care; or
   e. chronic condition with no indication of need for ongoing treatment at this level of care to maintain stability and functioning.

Section VI: Outpatient Services

Overview

This chapter contains service descriptions and medical necessity criteria for the following outpatient behavioral health services:

A. Outpatient Services
   1. Medicare: CMS NCD 130.2 Outpatient Hospital Services for Treatment of Alcoholism
   2. Medicare: CMS NCD 130.5 Alcohol and Drug Abuse Treatment Services in a Freestanding Clinic
   3. Medicare: CMS NCD 130.6 Outpatient Treatment of Drug Abuse (Chemical Dependency)
   4. Medicare: CMS NCD 130.7 Outpatient Hospital Withdrawal Treatments for Narcotic Addictions
   5. Medicare: CMS LCD L33632 Psychiatry and Psychology Services
   6. Outpatient Professional Services

B. Dialectical Behavioral Therapy (DBT)
C. Fire Setters and Sexual Offending Evaluations
D. Psychological and Neuropsychological Testing
E. NMNC 5.504.03 Outpatient Psychiatric Home-Based Therapy
F. Applied Behavior Analysis
   1. Applied Behavior Analysis (ABA)

2. Medicaid: Applied Behavior Analysis (ABA)
3. Early Intensive Behavioral Intervention (EIBI)

G. Opioid Replacement Therapy
1. Methadone Maintenance Treatment
2. Buprenorphine Maintenance Treatment

H. Ambulatory Detoxification (Level 2.d)
I. Acupuncture Treatment for Substance Use Disorders

Beacon's utilization management of outpatient behavioral health services is based on the following principles:

1. Outpatient treatment should result in positive outcomes within a reasonable time frame for specific disorders, symptoms, and/or problems. The evaluation of goals and treatment should be based on the member's diagnosis, symptoms, and level of functioning;
2. Treatment should be targeted to specific goals that have been mutually negotiated between the provider and the member. Goals of initial and extended outpatient therapy may include crisis resolution, symptom reduction, stabilization, improvement in adaptation, and/or recovery from addiction;
3. Treatment modality, frequency, and length of treatment should be individualized for each member. Most clinical situations can be effectively managed using a short-term and/or intermittent model of treatment with varying modalities and frequency of contact, as needed;
4. Individuals with chronic or recurring behavioral health disorders may require a longer term approach with intermittent visits over extended periods, or sustained contacts with increased intensity of services around periods of relapse or decompensation; and
5. Members must have flexibility in accessing outpatient treatment, including transferring.

Please note that visits for psychopharmacology evaluation and management (E/M) and group therapy visits are not subject to this preauthorization process.

Definitions:

- **Diagnostic Evaluation** is an assessment of a member's level of functioning, including physical, psychological, social, educational, and environmental strengths and challenges for the purpose of diagnosis and treatment planning.
- **Inpatient-Outpatient Bridge Visit** is a single-session consultation conducted by an outpatient BH provider while a member remains on an inpatient psychiatric unit. The 'Inpatient-Outpatient Bridge Visit' involves the outpatient provider meeting with a member and the inpatient treatment team or designated team clinician.
- **Medication Visit** is an individual visit specifically for psychopharmacological evaluation, prescription, review, and/or monitoring by a psychiatrist or registered nurse clinical specialist for efficacy and side effects.
- **Psychiatric Consultation on an Inpatient Medical Unit** is an in-person meeting of at least 15 minutes' duration between a psychiatrist or advanced practice registered nurse clinical specialist and a member, at the request of the medical unit or attending physician, to assess the member's mental status, provide greater diagnostic clarity and/or assist the unit medical and nursing staff with a BH or psychopharmacological treatment plan for the member.

A.1. CMS National Coverage Determination (NCD) Guideline Outpatient Hospital Services for Treatment of Alcoholism 130.2 (Medicare Only)

A.2. CMS National Coverage Determination (NCD) of Alcohol and Drug Abuse in a Freestanding Clinic 130.5 (Medicare Only)

A.3. CMS National Coverage Determination (NCD) for Hospital-Based Outpatient Treatment of Drug Abuse (Chemical Dependency) 130.6 (Medicare Only)

A.4. CMS National Coverage Determination (NCD) for Outpatient Hospital Withdrawal Treatments for Narcotic Addictions 130.7 (Medicare Only)

A.5. CMS Local Coverage Determination (LCD) of Psychiatry and Psychology Services L33632 (Medicare Only)

A.6. Outpatient Professional Services

B. Dialectical Behavioral Therapy (DBT)

Dialectical Behavioral Therapy (DBT) is a manual-directed outpatient treatment, developed by Marsha Linehan, PhD, and her colleagues, that combines strategies from behavioral, cognitive, and supportive psychotherapies for members with borderline personality disorder and chronic, para suicidal behaviors. This level of care (LOC) may be used for other disorders for which there is evidence of efficacy, based on medical necessity criteria.

Standard and Comprehensive DBT consists of an initial treatment readiness evaluation, weekly two-hour group skills training provided by a skills group leader, and a minimum of one (1) hour individual therapy session every other week provided by the primary individual therapist. Twenty-four-hour telephone coaching by a DBT team provider is designed to provide practice in changing maladaptive behaviors and assistance in the application of DBT behavioral skills outside of therapy sessions.

There is also weekly, or minimum twice monthly, treatment team consultation group for DBT team providers. In general, the member and primary therapist will establish a DBT treatment agreement for a 6-month to one-year period.

Admission Criteria	Continued Stay Criteria	Discharge Criteria
***All** of the following criteria must be met:* 1. An initial assessment completed by a DBT provider shows the member is in the contemplative or action phase of readiness to	***All** of the following criteria must be met:* 1. The member continues to meet admission criteria, and another level of care (LOC) is not appropriate;	***Any** one of the following is suitable:* 1. The member no longer meets admission criteria and/or meets criteria for another level of care, either more- or less-

change and can commit to the DBT treatment plan; 2. The member is at least 13 years of age; 3. The member meets at least one of the following: a. The member has a diagnosis of Borderline Personality Disorder or other DSM-5-TR personality disorder diagnosis with evidence of maladaptive personality traits and/or evidence documented by mental health treatment provider(s) in the preceding two years; b. The member presents with complex, co-existing diagnoses; and 4. The member meets at least two of the following: a. Repeated, unsuccessful attempts in routine outpatient mental health treatment, or symptoms that are unlikely to respond with regular outpatient treatment; b. Maladaptive behaviors and symptoms (e.g., self-injury, chronic suicidal ideation, suicide attempts, serial problematic relationships, over-spending, substance use); or c. At least one inpatient or partial hospitalization for psychiatric symptoms in the preceding two years. **Psychosocial, Occupational, and Cultural and Linguistic Factors:** These factors may change the risk assessment and should be considered when making level of care decisions. **Exclusion Criteria** ***Any*** *of the following criteria are sufficient for exclusion from this level of care:* 1. The member is such a serious	2. DBT treatment contract is likely to result in progress toward identified goals; 3. The member's progress is monitored regularly, and the DBT treatment plan and contract are modified if the member is not making progress toward a set of clearly defined goals and skill acquisition; 4. Goals for treatment are measurable, specific, and targeted to the member's clinical issues, including self-harm behaviors, emotional lability, poor self-esteem, and unstable personal relationships; 5. Treatment contract planning is individualized and appropriate to the member's clinical status and skill development level and includes a 24-hour crisis plan; 6. Assessment of readiness to change every six months performed and the member continues to progress through cycle; 7. Frequency (intensity) of contact and treatment modality matches the severity of current symptoms (intermittent treatment allowing the member to function with maximal independence is the goal); or 8. Treatment planning includes family or other support systems as appropriate, and tolerated and permitted by the member.	intensive; 2. The member is able to function adequately without significant impairment in overall psychosocial functioning; indicating that continued DBT is no longer required; 3. The member has substantially met the specific goals outlined in the DBT treatment plan (there is resolution or acceptable reduction in targeted symptoms that necessitated treatment); 4. The member has attained a level of functioning that can be supported by routine outpatient services and/or self-help and other community supports; 5. The defined problems are not likely to respond to continued DBT services; 6. The member does not appear to be participating in a treatment plan and is not making progress toward treatment goals; 7. The member is not making progress toward the goals, and there is no reasonable expectation of progress; or 8. Assessment of readiness to change shows the member has fallen back to and remained in the pre-contemplation stage for greater than six months, and there is no reasonable expectation that the member will progress through these stages despite treatment interventions at this level of care.

risk to self or others, or sufficient impairment exists, that a more-intensive level of structure and supervision beyond the scope of this program is required; or 2. The member can be safely maintained and effectively treated in a less-intensive level of care.		

C. Assessment for Safe and Appropriate Placement (ASAP)

Fire Setters and Sexual Offending Evaluation and Assessment for Safe and Appropriate Placement (ASAP) is required by MGL 119 Sec. 33B.

ASAP is an assessment conducted by an ASAP-qualified diagnostician who has specialized training and experience in the evaluation and treatment of youth who engage in sexual-offending or fire-setting behaviors. ASAPs are only for youth in the care and custody of the Department of Children and Families (DCF) who meet the admission criteria.

Admission Criteria	Discharge Criteria
ASAP is exclusively reserved for youth in the care and custody of DCF who are being initially placed into foster care, a family home-care setting, or a community group home setting. ***One of the following criteria must be met:*** 1. Youth have been adjudicated delinquent for a sexual offense or the commission of arson and have admitted to such behavior; 2. Youth are the subject of documented or substantiated report of a sexual offense or the commission of arson; or 3. Youth are currently in a foster home, group home, or independent living program and exhibit sexual offending and/or fire-setting behaviors that were not previously known to DCF. **Exclusion Criteria** ***Any*** *one of the following is sufficient for exclusion for this level of care:* 1. Youth are currently placed in a residential facility or who are transitioning from a residential facility to a less-restrictive setting; or 2. Youth is being discharged from an acute, 24 hour inpatient psychiatric facility or a Community-Based Acute Treatment/Intensive Community-Based Acute Treatment (CBAT/ICBAT) program to a restrictive setting such as a residential treatment facility. A written safety plan is	***Any*** *one of the following is suitable:* 1. The ASAP evaluation is completed. 2. The member is placed in a long-term residential treatment setting or has been incarcerated.

developed by the youth's treatment team is required prior to the youth's discharge.	

D. Psychological and Neuropsychological Testing

E.1. Applied Behavioral Analysis (ABA) (Commerical)

E.2. Medicaid: Applied Behavior Analysis (ABA) Therapy (Medicaid Only)

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

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

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

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

The individual ABA treatment plan is developed by a licensed behavior analyst. The actual one-on-one sessions are typically provided by behavior technicians or paraprofessionals, with services ranging in hours of member contact per week based on the severity of symptoms and intensity of treatment. The technician is supervised by the licensed behavior analyst.

Treatment may be provided in a variety of settings, such as at home and in the community. ABA services covered under a health benefit plan are typically delivered by a contracted and credentialed provider in a home or community setting. Services provided in a school setting are distinct and separate from those covered by the health plan and are typically covered by the educational system's special education resources as part of the Individual Education Plan (IEP) pursuant to Public Law 94-142.

ABA is typically an extremely intensive treatment program designed to address challenging behavior as defined in our admission criteria. It can occur in any number of settings, including, home, agencies, and hospitals.

Admission Criteria	Continued Stay Criteria	Discharge Criteria
***All** of the following criteria are necessary for admission.* 1. The member has a definitive diagnosis of an Autism Spectrum Disorder (DSM-5-TR) or an Autistic Disorder/Asperger's Disorder/PDD, NOS diagnosis (DSM V) and is under the age of 21; 2. The diagnosis in (1) above is made by a licensed physician or psychologist experienced in the diagnosis and treatment of autism with developmental or child/adolescent expertise; 3. The child or adolescent has received a comprehensive diagnostic and/or functional assessment (e.g., ABLLS-R, Vineland-II, ADI-R, ADOS-G, CARS2, VB-MAPP, or Autism Behavior Checklist), which include the following: a. complete medical history to include pre- and perinatal, medical, developmental, family, and social elements; b. physical examination, which may include items such as growth parameters, head circumference, and a neurologic examination; c. detailed behavioral and functional evaluation outlining the behaviors consistent with the diagnosis of ASD and its associated comorbidities. A diagnostic evaluation must include the scores from the use of formal diagnostic tests and scales as well as observation and history of behaviors. Screening scales such as the MCHAT-R are not sufficient to make a diagnosis	***All** of the following criteria are necessary for continuing treatment at this level of care.* 1. The individual's condition continues to meet admission criteria for ABA, either due to continuation of presenting problems, or appearance of new problems or symptoms; 2. There is reasonable expectation that the individual will benefit from the continuation of ABA services. Treatment planning is individualized and appropriate to the individual's changing condition with realistic and specific goals and objectives stated. The treatment plan is updated based on treatment progress including the addition of new target behaviors; 3. Initial assessment from a licensed behavior analyst supports the request for ABA services; 4. A member's progress is monitored regularly evidenced by behavioral graphs, progress notes, and daily session notes. The treatment plan is to be modified, if there is no measurable progress toward decreasing the frequency, intensity and/or duration of the targeted behaviors and/or increase in skills for skill acquisition to achieve targeted goals and objectives; 5. There is documented skills transfer to the individual and treatment transition planning from the beginning of treatment;	***Any** of the following criteria are sufficient for discharge from this level of care.* 1. A member's individual treatment plan and goals have been met; 2. The individual has achieved adequate stabilization of the challenging behavior, and less-intensive modes of treatment are appropriate and indicated; 3. The individual no longer meets admission criteria, or meets criteria for a less- or more-intensive services; 4. Treatment is making the symptoms persistently worse; or 5. The individual is not making progress toward treatment goals, as demonstrated by the absence of any documented meaningful (i.e., durable and generalized) measurable improvement or stabilization of challenging behavior, and there is no reasonable expectation of progress.

and will not be accepted as the only formal scale; and d. medical screening and testing has been completed to identify the etiology of the disorder, rule out treatable causes, and identify associated comorbidities as indicated; 4. The member exhibits atypical or disruptive behavior that significantly interferes with daily functioning and activities or that poses a risk to the member or others related to aggression, self-injury, property destruction, etc.; 5. Initial evaluation from a licensed behavior analyst supports the request for the ABA services; and 6. The diagnostic report clearly states the diagnosis and the evidence used to make that diagnosis.	6. There is a documented active attempt at coordination of care with relevant providers/caretakers, etc., when appropriate. If coordination is not successful, the reasons are documented; 7. Parent(s) and/or guardian(s) involvement in the training of behavioral techniques must be documented in the member's medical record and is critical to the generalization of treatment goals to the member's environment; and 8. Services are not duplicative of services that are part of an Individual Educational Plan (IEP) or Individual Service Plan (ISP) when applicable.	
Exclusion Criteria: ***Any*** *of the following criteria are sufficient for exclusion from this level of care.* 1. The individual has medical conditions or impairments that would prevent beneficial utilization of services; 2. The individual requires the 24-hour medical/nursing monitoring or procedures provided in a hospital setting; 3. The individual is receiving ongoing In-Home Behavioral Services or services similar to ABA; 4. The following services are not included within the ABA treatment process and will not be certified: a. vocational rehabilitation; b. supportive respite care; c. recreational therapy; and d. respite care; 5. The services are primarily for school or educational purposes; or 6. The treatment is investigational or unproven, including, but not		

limited to facilitated communication, Auditory Integration Therapy (AIT), Holding Therapy, and Higashi (Daily Life Therapy).		

E.3. Early Intensive Behavioral Intervention (EIBI)

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

Early Intensive Behavioral Intervention (EIBI)
"A well-developed scientific discipline among the helping professions that focuses on the analysis, design, implementation, and evaluation of social and other environmental modifications to produce meaningful changes in human behavior. ABA includes the use of direct observation, measurement, and functional analysis of the relations between environment and behavior. ABA uses changes in environmental events, including antecedent stimuli and consequences, to produce practical and significant changes in behavior."

Types of behavioral interventions include, but are not limited to: direct services from a team of specialists providing home-based Early Intensive Behavioral Intervention; assessments and treatment planning; parent training; consultation and training for early intervention staff; co-visits with EI professionals; parental and caregiver involvement in the process; and continued use of the strategies outside of the formal sessions. All are important for the success of the treatment in the long term.

EIBI is typically an intensive treatment program for children 0-3 years of age, designed to address challenging behaviors as defined in the admission criteria. It is not a center-based program. It can only occur in settings that are natural or typical for a same-age infant or toddler without a disability. Natural settings may include home or community settings. Community settings include, but are not limited to, childcare centers, childcare homes, libraries, and parks.

Criteria

Admission Criteria

All *of the following criteria are necessary for admission.*
1. The member, who is under the age of three, has a referral from an EIP (Early Intervention provider);
2. If required, the EIBIs obtain Prior Authorization to conduct an assessment. (In most cases, EIBIs do not need to wait until the family has selected a specific provider to obtain the Prior Authorization for assessment.); and
3. The child must have a confirmed diagnosis of Autism Spectrum Disorder (ASD), conferred by a physician or licensed psychologist, allowing the child to get started with services as soon as

possible. It is preferred that the diagnosis be made using an evidence based diagnostic tool and that the DSM-5-TR criteria are referenced in the diagnostic evaluation summary.

Exclusion Criteria

Any *of the following criteria are sufficient for exclusion from this level of care.*

1. The individual has medical conditions or impairments that would prevent beneficial utilization of services;
2. The individual requires 24-hour medical/nursing monitoring or procedures provided in a hospital setting;
3. The individual is receiving ongoing In-Home Behavioral Services or services similar to ABA;
4. The following services are not included within the ABA treatment process and will not be certified:
    a. vocational rehabilitation;
    b. supportive respite care;
    c. recreational therapy; and
    d. respite care;
5. The services are primarily for school or educational purposes; or
6. The treatment is investigational or unproven, including, but not limited to facilitated communication, Auditory Integration Therapy (AIT), Holding Therapy, and Higashi (Daily Life Therapy).

Continuing Stay Criteria

All *of the following criteria are necessary for continuing treatment at this level of care.*

1. The individual's condition continues to meet admission criteria for EIBI, either due to continuation of presenting problems, or appearance of new problems or symptoms;
2. There is reasonable expectation that the individual will benefit from the continuation of ABA services. Treatment planning is individualized and appropriate to the individual's changing condition with realistic and specific goals and objectives stated. The treatment plan is updated based on treatment progress including the addition of new target behaviors;
3. The initial assessment was from a BCBA or LABA with request for EIBI services;
4. A member's progress is monitored regularly evidenced by behavioral graphs, progress notes, and daily session notes. The treatment plan is to be modified if there is no measurable progress toward decreasing the frequency, intensity, and/or duration of the targeted behaviors and/or increase in skills for skill acquisition to achieve targeted goals and objectives;
5. There is documented skills transfer to the individual and treatment transition planning from the beginning of treatment;
6. Services must be written on the IFSP and consented to by the family; and
7. Services are consented to by the parent/guardian and not duplicative of services that are part of an Individual Educational Plan (IEP) or Individual Service Plan (ISP).

Discharge Criteria

Any *of the following criteria are sufficient for discharge from this level of care.*

1. A member's individual treatment plan and goals have been met;
2. The individual has achieved adequate stabilization of the challenging behavior, and less-intensive modes of treatment are appropriate and indicated;
3. The individual no longer meets admission criteria, or meets criteria for less- or more-intensive services;

4. The child turns 3 years of age and/or has been transitioned to the Local Education Agency (LEA) for services;
5. Treatment is making the symptoms persistently worse; or
6. The individual is not making progress toward treatment goals, as demonstrated by the absence of any documented meaningful (i.e., durable and generalized), measurable improvement or stabilization of challenging behavior, and there is no reasonable expectation of progress.

F. Opioid Replacement Therapy

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

F.1. Methadone Maintenance Treatment – See ASAM Criteria

F.2. Buprenorphine Maintenance Treatment (BMT) – See ASAM Criteria

G. Ambulatory Detoxification (Level 2.d) – See ASAM Criteria

H. Acupuncture Treatment for Substance Use Disorders – See ASAM Criteria

Section VII: Other Behavioral Health Services

Overview

This chapter contains other behavioral health service descriptions and level of care criteria for the following:

A. Electro-Convulsive Therapy (ECT)
B. Transcranial Magnetic Stimulation
    1. Medicare: CMS LCD L33398 Transcranial Magnetic Stimulation
    2. Transcranial Magnetic Stimulation
C. Recovery Support Navigator (RSN)
D. Recovery Coach (RC)
E. Community Support Programs (CSP)
F. Program of Assertive Community Treatment (PACT) Medicaid Only
G. Psych Consultation on an Inpatient Medical Unit or ED
H. Community Support Programs for Justice Involved (CSP-JI)

A. Electro-Convulsive Therapy

B. 1. CMS Local Coverage Determination (LCD) of Transcranial Magnetic Stimulation L33398 (Medicare Only)

B. 2. Transcranial Magnetic Stimulation (TMS)

C. Recovery Support Navigators

Recovery support navigator (RSN) services are staffed by paraprofessionals who provide care management and system navigation supports to members with a diagnosis of substance use disorder and/or co-occurring disorders. The purpose of RSN services is to engage members as they present in the treatment system and support them in accessing needed services that allow them to access treatment and community resources.

Members can access RSN services based on medical necessity and a referral by a medical or behavioral health provider, community partner (CP), or other care manager who has contact with the member and is able to identify the need for RSN services.

RSN services are appropriate for members with substance use disorder and/or co-occurring disorders who are in need of additional support in remaining engaged in treatment, identifying and accessing treatment and recovery resources in the community, including prescriber for addiction and psychiatric medications, and/or developing and implementing personal goals and objectives around treatment and recovery from substance use and co-occurring disorders.

The RSN explores treatment recovery options with the member, helps clarify goals and strategies, provides education and resources, and provides assistance to members in accessing treatment and community supports. RSN is not responsible for a member's comprehensive care plan or medical or clinical service delivery, but supports the member in accessing those services and participates as part of overall care team when appropriate.

The RSN service is based within a Licensed Behavioral Health Outpatient Clinic or Opioid Treatment Center, and RSNs can be deployed to any setting.

Admission Criteria	Continued Stay Criteria	Discharge Criteria
All *of the following criteria are necessary for admission to this level of care*:* 1. The member demonstrates symptomatology consistent with a DSM-5-TR diagnosis for a substance use disorder, which requires and can reasonably be expected to respond to therapeutic intervention;	***All*** *of the following criteria are necessary for continuing in treatment for this level of care:* 1. Severity of illness and resulting impairment continue to warrant this level of care in order to maintain the member in the community and continue progress toward RSN service plan goals and clinical treatment plan goals;	***Any*** *of the following criteria is sufficient for discharge from this level of care:* 1. The member no longer meets admission criteria or meets criteria for a less- or more-intensive level of care; 2. RSN service plan goals and objectives have been substantially met, and/or a safe, continuing care

AND at least one (1) of the following: 2. The member is at a transition point in their treatment and/or recovery and/or at risk for admission to 24-hour behavioral health inpatient/diversionary services, as evidenced by one or more of the following: a. Discharge from a 24-hour behavioral health inpatient/diversionary level of care within the past 180 days; b. Multiple ESP and/or emergency department (ED) encounters within the past 90 days; c. Documented barriers to accessing and/or consistently utilizing essential medical and behavioral health services; d. Initiating or changing an addiction pharmacotherapy or medication assisted treatment (MAT) regimen and/or changing MAT provider; e. Release from incarceration within 90 days; f. Loss of housing stability within 90 days; g. Loss of employment within 90 days; h. Loss of family support and connection within 90 days; or i. Currently pregnant or up to 12 months postpartum, with or without custody. **OR** 3. The member is referred by a primary care practitioner for assistance with necessary medical follow-up. *Exceptions may be made on a member-by-member basis.	2. The member's treatment does not require a more-intensive level of care, and no less-intensive level of care would be appropriate or is available; 3. After initial evaluation and stabilization, it is determined that the presenting symptomatology is indicative of a DSM-5-TR diagnosis (inclusive of psychosocial and contextual factors and disability, as applicable), which is amenable to continued services at this level of care. Conditions that would not be appropriate for continued RSN services are: a. Permanent cognitive dysfunction without acute DSM-5-TR diagnosis; b. Medical illness requiring treatment in a medical setting; c. Impairment with no reasonable expectation of progress toward RSN service plan goals at this level of care; or d. Chronic condition with no indication of need for ongoing services at this level of care to maintain stability and functioning; 4. RSN services are rendered in a clinically appropriate manner and focused on the member's behavioral and functional outcomes as described in the RSN service and discharge plans; 5. RSN service planning is individualized and appropriate to the member's age and changing condition, with realistic, specific, and attainable goals and objectives stated. RSN service planning includes family, support systems, social, educational, occupational, medical, and	program can be arranged and deployed at a less-intensive level of care; 3. Consent for the RSN service is withdrawn. In addition, it has been determined that the member, parent, and/or guardian has the capacity to make an informed decision, and the member does not meet the criteria for a more-intensive level of care; 4. Support systems that allow the member to be maintained in a less-restrictive treatment environment have been secured; or 5. The member is not making progress toward RSN service plan goals, and there is no reasonable expectation of progress at this level of care, nor is it required to maintain the current level of functioning.

Psychosocial, Occupational, and Cultural and Linguistic Factors: *These factors may change the risk assessment and should be considered when making level of care decisions.*	interpersonal assessments. This process should actively involve family, guardian, and/or other support systems unless contraindicated. Expected benefit from all planned services is documented. The RSN service plan is updated and implemented with consideration of all applicable and appropriate services and treatment modalities; 6. All services and treatment are carefully structured to achieve optimum results in the most time-efficient manner possible consistent with sound clinical practice; 7. Progress in relation to specific symptoms or impairments is clearly evident and can be described in objective terms, but goals of RSN services and clinical treatment services have not yet been achieved, or adjustments in the RSN service plan to address lack of progress are documented; 8. The member is actively participating in the RSN service plan and related treatment services, to the extent possible consistent with the member's condition; 9. Unless contraindicated, the family, guardian, and/or natural supports are actively involved in RSN services; and 10. When medically necessary, the member has been referred to appropriate psychopharmacological services.	
Exclusion Criteria: ***Any*** *of the following criteria may be sufficient for exclusion from this level of care:* 1. The member is at acute risk to harm self or others, or sufficient impairment exists to require a		

more-intensive level of service beyond community-based intervention; 2. The member has severe medical conditions or impairments that would prevent beneficial utilization of services; 3. The member is receiving similar supportive services and does not require this level of care; or 4. The member, and their parent/guardian/caregiver when applicable, does not consent to Recovery Support Navigator services.		

D. Recovery Coach

Recovery coaches (RCs) are individuals currently in recovery who have lived experience with substance use disorders and/or co-occurring mental health disorders and have been trained to help their peers with a similar experience to gain hope, explore recovery, and achieve life goals. RCs are actively engaged in their own personal and family recovery and share real-world knowledge and experience with others who are on their own recovery path. RCs share their recovery story and personal experiences in an effort to establish an equitable relationship and support members in obtaining and maintaining recovery.

The primary responsibility of RCs is to support the voices and choices of the members they support, minimizing the power differentials as much as possible. The focus of the RC role is to create a relationship between equals that is non-clinical and focused on removing obstacles to recovery; linking members to the recovery community; and serving as a personal guide and mentor. The RC will work with the member to develop a Wellness Plan that orients the activities of the RC service.

Members can access RC services based on medical necessity and a referral by a medical or behavioral health provider, community partner (CP), or other care manager who has contact with the member and is able to identify the need for RC services.

RCs are employed by an organization that is able to provide supervision, an organizational culture that supports fidelity to the model, and an environment that is conducive to the needs of RCs and the members they serve.

Any provider organization can provide peer recovery coach services if they also provide behavioral health services and meet credentialing requirements.

Admission Criteria	Continued Stay Criteria	Discharge Criteria
All *of the following criteria are necessary for admission to this level of care*:*	***All*** *of the following criteria are necessary for continuing in treatment for this level of care:*	***Any*** *of the following criteria is sufficient for discharge from this level of care:*

1. The member demonstrates symptomatology consistent with a DSM-5-TR diagnosis for a substance use disorder; **AND** at least one (1) of the following: a. is attempting to achieve and/or maintain recovery from substance use and/or co-occurring disorders; b. could benefit from education about harm reduction and/or education about recovery and community resources; c. could benefit from support in increasing motivation and readiness to change; d. could benefit from peer support in establishing connections with the recovery community; e. could benefit from the structure of a Wellness Plan; or f. is pregnant or up to 12-months postpartum, with or without custody. **OR** 2. The member is referred by a primary care provider for assistance with necessary medical follow-up. **Psychosocial, Occupational, and Cultural and Linguistic Factors:** *These factors may change the risk assessment and should be considered when making level of care decisions.*	1. The member is actively involved with the recovery coach and is making connection at a minimum of one contact every 21 days; 2. The member is actively addressing components of the Wellness Plan and making adjustments as needed; 3. There is documented, active coordination of services with other behavioral health providers, the primary care provider, and other services and state agencies. If coordination is not successful the reasons are documented, and efforts to coordinate services continue; 4. There is documented, active discharge planning starting with admission to the recovery coach service; and 5. When medically necessary, the member is supported in accessing appropriate psychopharmacological services.	1. The member no longer meets admission criteria; 2. Recovery coach Wellness Plan goals and objectives have been met; 3. The member and parent and/or legal guardian is/are not utilizing or engaged in the RC services as demonstrated by fewer than one contact every 21 days (see performance specifications); 4. Consent for the recovery coach service is withdrawn; or 5. Support systems that allow the member to be maintained in the community have been established.

Exclusion Criteria: ***Any*** *of the following criteria may be sufficient for exclusion from this level of care:* 1. The member is at acute risk to harm self or others, or sufficient impairment exists to require a more-intensive level of service beyond community-based intervention; 2. The member has severe medical conditions or		
impairments that would prevent beneficial utilization of services; 3. The member is receiving similar supportive services and does not require this level of care; or 4. The member, and their parent/guardian/caregiver when applicable, does not consent to recovery coach services.		

E. Community Support Programs (CSP)

Community Support Programs (CSPs) provide an array of services delivered by community-based, mobile, paraprofessional staff, supported by a clinical supervisor, to members with psychiatric or substance use disorder diagnoses and/or to members for whom their psychiatric or substance use disorder diagnoses interfere with their ability to access essential medical services. These programs provide support services that are necessary to ensure members access and utilize behavioral health services. 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. The CSP service plan assists the member with attaining their goals in their clinical treatment plan in outpatient services and/or other levels of care, and works to mitigate barriers to doing so.

In general, a member who can benefit from CSP services has a mental health, substance use disorder, and/or co-occurring disorder that has required psychiatric hospitalization or the use of another 24-hour level of care, or has resulted in serious impairment with a risk of admission. CSP services are used to prevent hospitalization. Usually in combination with outpatient and other clinical services, they are designed to respond to the needs of individuals whose pattern of service utilization or clinical profile indicates high risk of readmission into any 24-hour behavioral health inpatient/diversionary treatment setting.

These services are designed to be maximally flexible in supporting individuals to implement their clinical treatment plans in outpatient and/or other levels of care and attain the skills and resources needed to maintain community tenure. Such services may include:

- Assisting members in improving their daily living skills so they are able to perform them independently or access services to support them in doing so;
- Providing service coordination and linkage;

- Providing temporary assistance with transportation to essential medical and behavioral health appointments while transitioning to community-based transportation resources (e.g., public transportation resources, PT-1 forms, etc.);
- Assisting with obtaining benefits, housing, and health care;
- Collaborating with Emergency Services Programs/Mobile Crisis Intervention (ESPs/MCIs) and/or outpatient providers; including working with ESPs/MCIs to develop, revise, and/or utilize member crisis prevention plans and/or safety plans as part of the Crisis Planning Tools for youth; and
- Fostering empowerment, recovery, and wellness, including linkages to recovery-oriented peer support and/or self-help supports and services.

These outreach and supportive services are directed primarily toward adults and vary according to duration, type, and intensity of services, depending on the changing needs of each individual. Children and adolescents are eligible for CSP services; however, their needs may be better served by services within the Children's Behavioral Health Initiative (CBHI).

Community Support Program services are expected to complement other clinical services that are being utilized by the individual and support the member's attainment of their clinical treatment plan goals.

Admission Criteria	Continued Stay Criteria	Discharge Criteria
***All** of the following criteria must be met*:* 1. The member demonstrates symptomatology consistent with a DSM diagnosis, which requires and can reasonably be expected to respond to therapeutic intervention; **AND** at least one (1) of the following: 2. The member is at risk for admission to 24-hour behavioral health inpatient/diversionary services, as evidenced by one or more of the following: a. Discharge from a 24-hour behavioral health inpatient/diversionary level of care within the past 180 days; b. Multiple ESP and/or emergency department (ED) encounters within the past 90 days; or c. Documented barriers to accessing and/or	***All** of the following criteria are necessary for continuing treatment at this level of care:* 1. Severity of illness and resulting impairment continue to warrant this level of care in order to maintain the member in the community and continue progress toward CSP service plan goals and clinical treatment plan goals; 2. The member's treatment does not require a more-intensive level of care, and no less-intensive level of care would be appropriate or is available; 3. After initial evaluation and stabilization, it is determined that the presenting symptomatology is indicative of a DSM-5-TR diagnosis (inclusive of psychosocial and contextual factors and disability, as applicable), which is amenable to continued services at this level of care. Conditions that would	***Any of the following criteria is sufficient for discharge from this level of care:*** 1. The member no longer meets admission criteria or meets criteria for a less- or more-intensive level of care; 2. CSP service plan goals and objectives have been substantially met, and/or a safe, continuing care program can be arranged and deployed at a less-intensive level of care; 3. The member or parent and/or legal guardian is/are not utilizing or engaged in the CSP service. The lack of engagement is of such a degree that treatment at this level of care becomes ineffective or unsafe, despite multiple, documented attempts to address engagement issues. In addition, it has been determined that the member, parent, and/or guardian has the capacity to make an informed

consistently utilizing essential medical and behavioral health services; 3. The member is referred by a primary care physician (PCP) for assistance with necessary medical follow-up. *Exceptions may be made on a member-by-member basis. **Psychosocial, Occupational, and Cultural and Linguistic Factors:** *These factors may change the risk assessment and should be considered when making level of care decisions.* **Exclusion Criteria:** ***Any*** *of the following criteria may be sufficient for exclusion from this level of care:* 1. The member is at acute risk to harm self or others, or sufficient impairment exists to require a more-intensive level of service beyond community-based intervention; 2. The member has severe medical conditions or impairments that would prevent beneficial utilization of services; 3. The member is receiving similar supportive services and does not require this level of care; or 4. The member, and their parent/guardian/caregiver when applicable, does not consent to the Community Support Program.	not be appropriate for continued CSP services are: a. Permanent cognitive dysfunction without acute DSM-5-TR diagnosis; b. Primary substance use disorder requiring treatment in a specialized level of care; c. Medical illness requiring treatment in a medical setting; d. Impairment with no reasonable expectation of progress toward CSP service plan goals at this level of care; e. Chronic condition with no indication of need for ongoing services at this level of care to maintain stability and functioning; 4. CSP services are rendered in a clinically appropriate manner and focused on the member's behavioral and functional outcomes as described in the CSP service and discharge plans; 5. CSP service planning is individualized and appropriate to the member's age and changing condition, with realistic, specific, and attainable goals and objectives stated. CSP service planning includes family, support systems, social, educational, occupational, medical, and interpersonal assessments. This process should actively involve family, guardian, and/or other support systems unless contraindicated. Expected benefit from all planned service is documented. The CSP service plan is updated and implemented with consideration of all applicable	decision, and the member does not meet the criteria for a more-intensive level of care; 4. Consent for the CSP service is withdrawn. In addition, it has been determined that the member, parent, and/or guardian has the capacity to make an informed decision, and the member does not meet the criteria for a more-intensive level of care; 5. Support systems that allow the member to be maintained in a less-restrictive treatment environment have been secured; 6. The member is not making progress toward CSP service plan goals, and there is no reasonable expectation of progress at this level of care, nor is it required to maintain the current level of functioning; or 7. The member is no longer at risk for admission to a 24-hour behavioral health inpatient/diversionary level of care as defined in Admission Criterion 2.

	and appropriate services and treatment modalities; 6. All services and treatment are carefully structured to achieve optimum results in the most time-efficient manner possible consistent with sound clinical practice; 7. Progress in relation to specific symptoms or impairments is clearly evident and can be described in objective terms, but goals of CSP services and clinical treatment services have not yet been achieved, or adjustments in the CSP service plan to address lack of progress are documented; 8. The member is actively participating in the CSP service plan and related treatment services, to the extent possible, consistent with the member's condition; 9. Unless contraindicated, the family, guardian, and/or natural supports are actively involved in CSP services as required by the CSP service plan, or there are active efforts being made and documented to involve them; 10. When medically necessary, the member has been referred to appropriate psychopharmacological services; 11. There is documented, active discharge planning starting with admission to the CSP program; and 12. There is documented, active coordination of services with other behavioral health providers, and other services and state agencies. If coordination is not successful, the reasons are documented, and efforts to coordinate services continue.	

F. Program of Assertive Community Treatment (PACT) (Adult Only)

WellSense Medicaid, Fallon Medicaid and Fallon SCO Only

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

PACT services follow national program guidelines.*

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

Criteria

Admission Criteria

***All** of the following criteria (1-5) are necessary for admission to this level of care*:

1. The individual must be an adult, age 19 or older, who is either Medicaid eligible and/or a DMH client on the date of service;
2. The individual must have a psychiatric diagnosis as defined in the DSM-5-TR;
3. As a result of the psychiatric diagnosis, the individual has significant functional impairments as demonstrated by at least one of the following conditions:
    a. Inability to consistently perform practical daily living tasks (e.g., maintaining personal hygiene; meeting nutritional needs; caring for personal financial affairs; obtaining medical, legal, and housing services; recognizing and avoiding common dangers or hazards to self and possessions; budgeting; employment or carrying out child-care responsibilities) or persistent or recurrent failure to perform daily living tasks except with significant support or assistance from others (such as friends, family, or relatives);
    b. Inability to maintain a safe living situation (e.g., repeated evictions or loss of housing); or
    c. High risk or recent history of criminal justice involvement (e.g., arrest and incarceration).
4. One or more of the following indicators of continuous, high-service need is present:

a. The member has a history of psychiatric hospital admissions or psychiatric Emergency Services visits in the last 365 days;
b. Active, co-existing substance use disorder greater than six months' duration;
c. Currently admitted to an acute level of care or supervised community residence but able to be discharged if intensive community support services are provided; or
d. In danger of requiring acute level of care if more intensive services are not available; or
e. Inability to keep office-based appointments.

5. The individual and legal guardian, if appropriate, are willing to accept and cooperate with the PACT team.

Psychosocial, Occupational, and Cultural and Linguistic Factors

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

Exclusion Criteria

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

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

Continued Stay Criteria

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

1. Severity of illness and resulting impairment continue to require this level of service;
2. Treatment planning is individualized and appropriate to the individual's changing condition, with realistic and specific goals and objectives stated;
3. The mode, intensity, and frequency of treatment are appropriate;
4. Active treatment is occurring, and continued progress toward goals is evident; or adjustments to the treatment plan have been made to address lack of progress; and
5. The individual and family (when appropriate and with consent) are participating to the extent capable with a program that is considered adequate to alleviate the signs and symptoms justifying treatment.

Discharge Criteria

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

1. The individual's treatment plan and discharge goals have been substantially met;
2. Consent for treatment is withdrawn;
3. The individual no longer meets the admission criteria or meets criteria for a less- or more-intensive level of care;
4. The member is in an institution (state hospital or prison) for an extended period of time which precludes the PACT team's ability to maintain a relationship with the member, or there is no planned return to the community set to occur within a reasonable time frame; or
5. The member and/or legal guardian is not engaged in or utilizing the service to such a degree

that treatment at this level of care becomes ineffective or unsafe despite use of motivational techniques and multiple, documented attempts to address engagement issues. In addition, it has been determined that the Member and/or guardian has the capacity to make an informed decision, and the Member does not meet criteria for a more-intensive level of care.

G. Psychiatric Consultation on an Inpatient Medical Unit or ED

Consultation-liaison (C-L) psychiatry is the subspecialty of psychiatry concerned with medically and surgically ill patients. Consults may be obtained on Members hospitalized on medical/surgical units or those presenting to emergency departments (EDs).

In general, the aims of psychiatric consultation are:

1. to ensure the safety and stability of Members within the medical/emergency environment;
2. to collect sufficient history and medical data from appropriate sources to assess the Member and formulate the problem;
3. to conduct a mental status examination; and,
4. to initiate an active treatment plan that could include medication, as deemed appropriate.

Criteria

Admission Criteria

The following criterion *is necessary for admission to this level of care:*

1. The member is an inpatient on a medical/surgical unit or in the emergency department (ED).

One *of the following criteria (2-7) is also necessary for admission to this level of care:*

1. The member has a suspected psychiatric or behavioral disorder, a significant psychiatric history, or current or recent use of psychotropic medications;
2. The member has a high risk for psychiatric problems by virtue of serious medical illness (e.g., organ transplantation);
3. The member displays acute agitation as a result of psychosis, intoxication, withdrawal, dementia, delirium, or other etiologies (e.g., toxic metabolic disturbances, cardiopulmonary, endocrine, neurologic disorders);
4. The member expresses suicidal or homicidal ideation or a wish to die, including a request for hastened death, physician-assisted suicide, or euthanasia; or
5. The member's care involves a medico-legal situation (e.g., where there is a question of a patient's capacity to consent to or refuse medical or surgical treatment).

Psychosocial, Occupational, and Cultural and Linguistic Factors

These factors may change the risk assessment and should be considered when making level-of-care decisions.

Exclusion Criteria

The following criterion *is sufficient for exclusion from this level of care:*

1. The Member can be safely maintained and effectively treated without psychiatric consultation.

Continued Stay Criteria

One *of the following criteria (1-2) is necessary for continuing consultation:*

1. There is a need for ongoing data collection, systems interventions, psychopharmacological monitoring, prevention of behavioral or psychiatric relapse, or increased compliance with treatment recommendations; or
2. The member needs restraints or is on constant observation, remains psychotic, agitated, potentially violent, psychiatrically unstable or suicidal, or a delirium has not resolved.

Discharge Criteria

The Member no longer requires psychiatric consultation services.

H. Community Support Program for Individuals with Justice Involvement (CSP-JI)

The following Community Support Program for Individuals with Justice Involvement (CSP-JI) medical necessity criteria supersedes CSP medical necessity criteria for the CSP-JI support Program.

Criteria

Admission Criteria

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

1. The Member demonstrates symptomatology consistent with a DSM-5-TR diagnosis, which requires and can reasonably be expected to respond to therapeutic intervention;
   AND
2. The Member is at risk for admission or commitment to a 24-hour facility, as evidenced by one or more of the following:
   a. Discharge from a 24-hour behavioral health inpatient or diversionary level of care (including state hospitals) within the past year;
   b. Discharge from a correctional institution infirmary, a crisis stabilization unit for detoxification, or close mental health observation in the past year within a correctional institution;
   c. Discharge from a residential treatment unit in a correctional institution in the past year;
   d. Multiple encounters with an Emergency Services Program (ESP) or emergency department (ED), urgent behavioral healthcare, or restoration centers within the past year; OR
   e. History of underutilization of essential medical and behavioral health services;
   AND
3. The individual's risk profile constitutes a barrier to accessing or consistently utilizing essential medical and behavioral health services as evidenced by one or more of the following:
   a. The individual demonstrates antisocial behavior symptomology, which may be consistent with an Antisocial Personality Disorder, as evidenced by criminal activity that has led or could lead to criminal justice problems, lack of concern for others, antisocial cognition, and/or disregard for authority (expressed through distrust, conflict or opposition), and which prevents positive change;
   b. The individual's danger of relapse to addiction and/or mental disorder is accompanied by an uninterrupted cycle of relapse-reoffending-incarceration-release-relapse without the

opportunity for treatment;
   c. The individual continues to engage repetitively and compulsively in behaviors that pose a risk of relapse to addiction and/or mental disorder (such as antisocial behavior or criminal activity, or spending time in places where antisocial behavior is the focus) because of a lack of understanding of the relationship between those behaviors and relapse to substance use, mental disorders, or criminal activity;
   d. The individual lacks social contacts or has unsupportive contacts that jeopardize recovery (i.e. family, school, home, work and/or leisure/social environments inhibit opportunity for treatment for or recovery of addiction and/or mental disorder); or
   e. The individual is identified as high or very high risk of recidivism on validated risk assessments due, at least in part, to a substance use, mental health, or co-occurring disorder.

AND

4. Justice Involvement Eligibility - The individual is:
   a. A former inmate or detainee of a correctional institution who has been released from a correctional institution within the past year at the time of enrollment in CSP-JI; OR
   b. An individual under the risk/need supervision of the Massachusetts Probation Service, Massachusetts Parole Board, or both, as determined by Massachusetts Probation Service or the Massachusetts Parole Board.

Psychosocial, Occupational, and Cultural and Linguistic Factors

These factors may change the risk assessment and should be considered when making level of care decisions.

Exclusion Criteria

Any of the following criteria may be sufficient for exclusion from this level of care
1. The member is receiving similar supportive services and does not require this level of care; or
2. The member does not consent to Community Support Program services.

Continued Stay Criteria

Any of the following criteria are necessary for continuing in treatment at this level of care:
1. The Member is actively participating in the CSP-JI service plan and related treatment services, to the extent possible, consistent with the member's condition;
2. The individual is in regular communication with CSP-JI staff;
3. There is documented, active coordination of services with other behavioral health providers, the PCC, and other services and state agencies. If coordination is not successful, the reasons are documented, and efforts to coordinate services continue;
4. No less-targeted intervention would be appropriate or is available;
5. Progress in relation to implementing the individual's service plan is evident and can be described in objective terms, but goals of the service plan and engagement in clinical treatment services have not yet been achieved; and
6. Any adjustments in the service plan to address lack of progress are documented.

Discharge Criteria

Any of the following criteria is sufficient for discharge from this level of care:
1. CSP-JI service plan goals and objectives have been substantially met, and/or a safe, continuing

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

I. Non-24-Hour Diversionary Services Community Support Program Chronically Homeless Individuals (CSP-CHI)

Definitions:

Chronic Homelessness: a definition established by the U.S. Department of Housing and Urban Development (HUD)
A disabled individual who has been continuously homeless on the streets or in an emergency shelter or safe haven for 12 months or longer, or has had four or more episodes of homelessness (on the streets, or in an emergency shelter or safe haven) over a three-year period where the combined occasions must total at least 12 months. Occasions must be separated by a break of at least seven nights; stays in institution of fewer than 90 days do not constitute a break. To meet the disabled part of the definition, the individual must have a diagnosable substance use disorder, serious mental illness, developmental disability, post-traumatic stress disorder, cognitive impairment resulting from a brain injury, or chronic physical illness or disability, including the co-occurrence of two or more of those conditions.

Permanent Supportive Housing (PSH): a model of housing that combines ongoing subsidized housing matched with flexible health, behavioral health, social, and other support service. PSH has been proven to be an effective intervention for persons experiencing chronic homelessness
"Housing First" is a specific PSH approach that prioritizes supporting people experiencing homelessness to enter low-threshold housing as quickly as possible and then providing supportive services necessary to keep them housed.

Community Support Program for Chronically Homeless Individuals (CSP-CHI)
CSP-CHI is a more-intensive form of CSP for chronically homeless individuals who have identified a PSH housing opportunity. Once housing is imminent with members moving within 120 days, members receiving CSP may receive CSP-CHI services. CSP-CHI includes assistance from specialized professionals who – based on their unique skills, education, or lived experience – have the ability to engage and support individuals experiencing chronic homelessness in searching for PSH, by preparing for and transitioning to an available housing unit, and, once housed, coordinating access to physical health, behavioral health, and other needed services geared towards helping them sustain tenancy and meet their health needs. The types of CSP-CHI services available may be categorized as:

- **Pre-Tenancy:** engaging the member and assisting in the search for an appropriate and affordable housing unit;
- **Transition into Housing:** assistance arranging for and helping the member move into

housing; and
- **Tenancy Sustaining Supports:** assistance focused on helping the member remain in housing and connect with other community benefits and resources.

Services should be flexible with the goal of helping eligible members attain the skills and resources needed to maintain housing stability. CSP-CHI services may be delivered within housing, at provider sites, or in the community.

CSP-CHI cannot be used to cover the costs of any housing-related "goods," including, but not limited to: housing applications fees, criminal record checks, fees related to securing identification documents, transportation, security deposits, first month's rent, rent/utility arrearages, utility hookups, furnishings, moving expenses, or home modifications.

These services are designed to be maximally flexible in supporting individuals to implement their clinical treatment plans in outpatient and/or other levels of care and attain the skills and resources needed to maintain housing retention. Such services may include:
- Assisting members with housing resources and dynamics of searching for housing including, but not limited to:
  - Obtaining and completing housing applications;
  - Requesting reasonable accommodations;
  - Dealing with poor housing history or lack of housing history, poor or lack of credit history, or criminal record mitigation;
  - Gathering supporting documentation;
  - Negotiating and completing lease agreements;
  - Identifying resources for move-in costs (first and last month's rent, security deposits), furniture, and household goods; and
  - Coordination with landlords to establish relationships with the member regarding housing rules and requirements to maintain tenancy.
- Assisting members in improving their daily living skills so they are able to perform them independently or access services to support them in doing so;
- Providing service coordination and linkage;
- Assist with referral and coordination to necessary healthcare providers;
- Providing assistance with transportation to essential medical and behavioral health appointments while transitioning to community-based transportation resources (e.g., public transportation resources, PT-1 forms, etc.);
- Assisting with obtaining and maintaining financial benefits;
- Collaborating with Emergency Services Programs (ESPs) and/or outpatient providers; working to develop, revise, and/or utilize Member crisis prevention plans and/or safety plans; and
- Fostering empowerment, recovery, and wellness, including linkages to recovery-oriented peer support and/or self-help supports and services.

Community Support Program services are expected to complement other clinical services that are being utilized by the individual and support the Member's attainment of their clinical treatment plan goals.

Criteria

Admission Criteria

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

1. The member demonstrates Chronic Homelessness and symptomatology consistent with a DSM-5-TR diagnosis, which requires and can reasonably be expected to respond to therapeutic intervention;
2. Providers may begin billing for the delivery of CSP-CHI as early as 120 days before a member moves into housing. Once the member has obtained housing, CSP-CHI providers may bill continuously until such a time as the Plan determines that CSP-CHI is no longer medically necessary.

Exclusion Criteria

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

1. The member is not chronically homeless as defined by the U.S. Department of Housing and Urban Development (HUD);
2. The member is receiving similar supportive services and does not require this level of care; or
3. The member, and their parent/guardian/caregiver when applicable, does not consent to CSP-CHI services.

Continued Stay Criteria

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

1. Ongoing need for assistance with maintaining living skills to ensure long-term housing tenancy;
2. The member's treatment does not require a more-intensive level of care, and no less-intensive level of care would be appropriate or is available;
3. CSP services are rendered in a clinically appropriate manner and focused on the member's behavioral and functional outcomes as described in the CSP-CHI service and discharge plans;
4. CSP-CHI service planning is individualized and appropriate to the member's age and changing condition, with realistic, specific, and attainable goals and objectives stated. CSP-CHI service planning includes family, support systems, social, educational, occupational, medical, and interpersonal assessments. This process should actively involve family, guardian, and/or other support systems unless contraindicated. Expected benefit from all planned services is documented. The CSP-CHI service plan is updated and implemented with consideration of all applicable and appropriate services and treatment modalities;
5. All services and treatment are carefully structured to achieve optimum results in the most time-efficient manner possible consistent with sound clinical practice;
6. Progress in relation to specific symptoms or impairments is clearly evident and can be described in objective terms, but goals of CSP-CHI services and clinical treatment services have not yet been achieved, or adjustments in the CSP-CHI service plan to address lack of progress are documented;
7. The member is actively participating in the CSP-CHI service plan and related treatment services, to the extent possible consistent with the member's condition;
8. Unless contraindicated, the family, guardian, and/or natural supports are actively involved in CSP-CHI services as required by the CSP-CHI service plan, or there are active efforts being made and documented to involve them;
9. When medically necessary, the Member has been referred to appropriate psychopharmacological services; and
10. There is documented, active coordination of services with other behavioral health providers, the PCP, and other services and state agencies. If coordination is not successful, the reasons are documented, and efforts to coordinate services continue.

Discharge Criteria

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

1. The member no longer meets admission criteria, has been housed, and is able to maintain tenancy independently.
2. CSP-CHI service plan goals and objectives have been substantially met, and/or a safe, continuing care program has been arranged and the member is utilizing other community resources;
3. The member is not utilizing or engaged in CSP-CHI service;
4. The lack of engagement is of such a degree that treatment at this level of care becomes ineffective or unsafe, despite multiple, documented attempts to address engagement issues. In addition, it has been determined that the member has the capacity to make an informed decision, and the member does not meet the criteria for a more-intensive level of care;
5. Support systems have been identified and are being utilized that assist the member to maintain housing; or
6. The member is not making progress toward CSP-CHI service plan goals, and there is no reasonable expectation of progress at this level of care.