TUFTS Health Plan

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Community Behavioral Health Centers Performance Specifications

These performance specifications apply to the following Tufts Health Plan products:

- ☐ Tufts Health Plan Commercial[1]
- ☐ Tufts Medicare Preferred HMO (a Medicare Advantage product)[2]
- ☒ Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)[2]

These performance specifications apply to the following Tufts Health Public Plans products:

- ☐ Tufts Health Direct (a Massachusetts Qualified Health Plan (QHP) (a commercial product)
- ☒ Tufts Health Together (a MassHealth MCO Plan and Accountable Care Partnership Plan)
- ☐ Tufts Health RITogether (a Rhode Island Medicaid Plan)
- ☒ Tufts Health One Care (a dual-eligible product)

Providers contracted for this level of care or service will be expected to comply with applicable regulations set forth in the Code of Massachusetts Regulations and all requirements of these service-specific performance specifications. Additionally, **CBHCs are held accountable to Outpatient Performance Specifications and the General Behavioral Health Performance Specifications** found at www.masspartnership.com. The requirements outlined within these service-specific performance specifications take precedence over those in the General performance specifications.

DEFINITION

Community Behavioral Health Centers (CBHCs) are comprehensive community behavioral health providers that offer substance use disorder and mental health services, care coordination, peer supports, screening and coordination with primary careand the behavioral health care system. A CBHC (the provider) is required to maximize access to outpatient behavioral health care for Members by providingurgent access to same-day or next-day services, operating expanded hours with evening and weekend services providing evidence-based clinical stabilization, and connecting Members to the most appropriate ongoing care to meet their needs, including transitioning Members with stable, non-complex conditions to primary care or other community-based outpatient behavioral health providers, as is appropriate and available..

The core outpatient services provided by the CBHC will be paid as a bundled flat rate per encounter. An encounter is only billable when a covered clinical service is provided and may only be billed once per Member per day. There is one rate for Members under the age of 21 and another rate for Members age 21 and over. It is expected that services for children and youth will be provided by a specialized team for youth and families

CBHCs must provide Adult Community-Based Mobile Crisis Intervention (AMCI), services for adult Members and Youth Community-Based Mobile Crisis Intervention (YMCI), services for youth Members. AMCI and YMCI must be co-located at the CBHC site. CBHCs must also provide Adult Community Crisis Stabilization (Adult CCS) services and access to Youth Community Crisis Stabilization (YCCS) services. If the CBHC does not itself provide YCCS, it must have a formal agreement with a CBHC in its region that is providing YCCS services.

A CBHC shall be a legal entity with the capacity to contract and meet all provider enrollment qualifications. Multiple providers may partner to form a CBHC, or the CBHC may subcontract to other providers for the delivery of required services. However, the CBHC as the primary entity shall be solely accountable for ensuring all adult, child, AMCI, YMCI, Adult CCS, and YCCS services are delivered in compliance with these specifications and all other applicable laws, regulations, and standards.

The CBHC must be a licensed Massachusetts Department of Public Health (DPH) clinic with a mental health service designation, or a DPH-licensed hospital satellite that provides outpatient mental health and substance use disorder services and must be a Medicare-participating provider. The CBHC must either (1) be licensed by the DPH Bureau of

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1. Commercial products include HMO, POS, PPO, and CareLinkSM when Tufts Health Plan is the primary administrator.
2. Tufts Medicare Preferred and Tufts Health Plan SCO are collectively referred to in this payment policy as Senior Products.

Substance Addiction Services (BSAS) or (2) have a substance use disorder service designation on their DPH clinic license and a BSAS Certificate of Approval or be a DPH-licensed hospital that provides substance use disorder services. The CBHC must have a Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver and the appropriate state and federal controlled substance registrations. The following sections describe the services and requirements necessary for a CBHC to bill and be paid the CBHC encounter bundles for Members under the age of 21 and for Members 21 and older.

CORE SERVICES

The CBHC must offer a full range of services and interventions for mental health, substance use disorder, and co-occurring disorders, including clinically informed screenings, assessments, and evidence-based treatments. When clinically appropriate, the CBHC shall transition Members out of care at the CBHC and into care with a primary care provider or other community-based behavioral health care provider for ongoing support care. When serving youth, the CBHC must have expertise in working with youth under the age of 21 and their families, including infants and young children.

When serving youth, the CBHC must coordinate with Children's Behavioral Health Initiative (CBHI) providers, including Intensive Care Coordination (ICC), Family Support and Training (FS&T), In- Home Therapy (IHT), Therapeutic Mentoring (TM), In-Home Behavioral Services, and Family-based Intensive Treatment (FIT) when appropriate. When serving adults, the CBHC must coordinate with Behavioral Health Community Partners (BHCPs), when appropriate.

The following services must be delivered by the CBHC and are included in the payment bundle:

1. **Triage services** at initial contact with the Member or referral source to determine appropriate appointment.
2. **Same-day access (within 24 hours of initial contact)** to an intake and brief assessment for any new or existing Member contacting the organization for non-crisis services during business hours.
    a) Includes same-day evaluation for initiation and bridging with Medications for the treatment of Opioid Use Disorder (MOUD) and access to medication no later than 24 hours after evaluation.
    b) Includes timely referral to non CBHC-provided services such as partial hospital program or medical services, etc.
3. **Urgent appointment access (within 48 hours of initial contact)** to a comprehensive diagnostic assessment and urgent outpatient crisis counseling/psychotherapy, group therapy, and peer/support services. Urgency is determined at time of same day intake and triage and is additionally defined by the Member's statement of urgency.
4. **Urgent psychopharmacology access (within 72 hours of initial contact)** to urgent psychopharmacology appointments within 72 hours of the initial diagnostic evaluation and based on both assessment and Member's statement of urgency.
5. **Non-urgent (routine) and follow-up appointment access (within 14 calendar days of initial contact)** to the initial encounter, or sooner as clinically indicated, along with referral with a warm hand-off to specialty providers if needed (e.g., partial hospital programs, medical providers) or to other community-based outpatient providers who may be better suited to meet Member's needs based on Member's relative stability/complexity, provider's access, geography, specialization, and relative resource intensity required to adequately support Member's needs..
6. **Assessment** includes history of treatment episodes and efficacy of prior treatment.
    a) For <u>adult members</u>, this must include identification of current appropriate level of care needs and the use of standardized screening tools, such as Patient Health Questionnaire-9, Generalized Anxiety Disorder, and Drug Abuse Screening Test, among others. Assessment must also include history of overdose and risk of overdose, as well as determine the need for Behavioral Health Community Partner (BHCP) care coordination.
    b) For <u>youth members</u>, this must include the Child and Adolescent Needs and Strength (CANS) Tool inclusive of the comprehensive clinical assessment and the use of standardized screening tools, such as the CRAFFT, Mood and Feelings Questionnaire and/or Children's Depression Inventory, among others, to identify Members' needs. Assessment must also include history of overdoes and risk of overdose. Assessment must also determine the need for BHCP care coordination, if the Member is eligible for such supports.
7. **Pharmacotherapy with basic evidence-based medical monitoring and medication reconciliation**
    a) Note: Storage and administration of medications must be limited to the scope of the CBHC's DPH licensure and DEA registration if applicable.
8. **Individual and family therapy services** including the following treatment modalities:
    a) Required to offer in-house for all members:
        i. Solution-focused crisis counseling;
        ii. Motivational Interviewing;
        iii. Dialectical Behavior Therapy (DBT) - skills portion;
        iv. Cognitive Behavioral Therapy (CBT) for Depression, including Behavioral Activation; and

v. CBT for Anxiety, including Acceptance and Commitment Therapy

b) Required to offer in-house for adult members:
   i. Relapse Prevention for Substance Use Disorders

c) Required to offer in-house for child and youth members:
   i. Trauma-Focused Cognitive Behavioral Therapy (TF-CBT);
   ii. Attachment, Regulation, and Competency (ARC); and

9. **Specialty Services:** the CBHC must provide access to the following specialty services. If it does not have the capability, the CBHC must have a formal partnership with an entity that can deliver these services.
   a) For all members:
      i. Evidence-based practices for family therapy, such as Structural Family Therapy and Functional Family Therapy
   b) For adult members:
      i. Evidence-based practices for Post-Traumatic Stress Disorder, including Cognitive Processing Therapy (CPT), Prolonged Exposure (PE), or Eye Movement Desensitization and Reprocessing (EMDR); and
      ii. CBT for Psychosis, including First Episode Psychosis treatment such as NAVIGATE
   c) For child and youth members:
      i. Adolescent Community Reinforcement Approach (A-CRA); and
      ii. First Episode Psychosis Coordinated Specialty Care
10. **Group therapy services:**
   a) For adult members, group therapy services may include psychoeducation groups, groups focused on substance use disorder, evidence-based group interventions, and group support services; and
   b) For child and youth Members, group therapy services may include psychoeducation groups for children and caregivers, groups focused on social skills development, parenting groups, collaborative problem solving and CBT skills development.
11. **Prescribing and medication administration:**
   a) General psycho-pharmacotherapy prescribing;
   b) Buprenorphine, including for same-day induction, bridging, and maintenance for Members 16 and older, and treatment referral services for follow-up treatment;
   c) Oral Naltrexone and other MAT for the treatment of alcohol use disorders; and
   d) Clozapine for Members with psychotic disorders or related approved indications

   Note: Storage and administration of medications must be limited to the scope of the CBHC's DPH licensure, including ensuring that the necessary state and federal controlled registrations are obtained. Prior to prescribing MAT, the MassPAT must be checked.
12. **Providing access to Naloxone**

   Note: The CBHC must have a Massachusetts Controlled Substance Registration to store Naloxone on-site. The CBHC must have at least one staff member trained in the administration of Naloxone onsite 24/7.
13. **Medical screening:**
   a) The CBHC must have the capacity to conduct medical monitoring of pharmacotherapy for behavioral health conditions and must address requests such as prescription refills and/or medication questions related to behavioral health. These activities will include monthly documentation of:
      i. Vital signs;
      ii. Updated medication lists;
      iii. Reviewing side effects; and
      iv. Performing medication adjustment.
   b) The CBHC must offer on-site toxicology screenings including collection and testing of specimens using CLIA-waived testing procedures, including rapid or point-of-care testing, at all locations to support medication initiation, withdrawal management, and ongoing treatment for both mental health and substance use disorders.
   c) The CBHC must conduct screenings for health indicators based on Member presentation and refer Members to primary care and/or specialized providers for further assessment or treatment as clinically appropriate. Screenings may include:
      i. Body-Mass Index (BMI) screening;
      ii. Waist circumference screening;
      iii. Blood pressure screening;
      iv. Tobacco, alcohol, opioid, and other substance use disorder screening and medication treatment interventions;

v. Cognitive impairment/dementia screening, including referral for neuropsychiatric testing, as clinically appropriate;
vi. Chronic pain screening, including referral for alternative therapies, as clinically appropriate;
vii. Developmental screening, including referral for neuropsychological testing, as clinically appropriate; and
viii. Providing on-site lab work or ordering through a formal partnership as clinically indicated with referral to primary care as appropriate.
ix. Lab work includes:
- Basic chemistries, including Glucose, Hemoglobin A1c, and Lipid panel;
- Sexually transmitted infection screening, including HIV, syphilis, and gonorrhea;
- Serum medication levels, where indicated;
- Toxicology screening for Members using MOUD services including complete blood count, liver function, and Hepatitis B;
- Hepatitis C; and
- Pregnancy Testing

14. **Providing support for Members with Autism Spectrum Disorder and/or Intellectual and Developmental Disabilities (ASD/IDD),** including partnerships with specialty providers to enable rapid specialty consults for providers treating Members with co-occurring ASD/IDD.
15. **Coordination with primary care:** The CBHC must coordinate with the Member's primary care provider (PCP) and any specialty medical provider to ensure a team-based approach to jointly address the Member's behavioral and medical needs. The initial integrated care coordination outreach must occur within 72 hours of assessment for new Members, evidenced by documentation in the Member's medical record. Ongoing communication must be documented in the medical record at minimum every six months and/or upon new information such as medication changes or treatment plan updates.
16. **Discharge planning:** Discharge planning must begin at initial assessment and include plans to connect Members to the most appropriate ongoing care, with particular attention to geography, cultural and linguistic factors, and the resource intensity required to meet the Members' ongoing care needs. For many Members with relatively non-complex behavioral health needs, the most appropriate ongoing care may be outside of the CBHC, at less resource-intense settings, such as other community-based outpatient behavioral health providers or through the Member's primary care office. Member records must show evidence of discharge planning activities, including referrals for appropriate ongoing care and coordination with the member's health plan as needed. For ongoing care that occurs outside of the CBHC, all attempts must be made to facilitate a "warm hand-off"with an ongoing provider, including ensuring that the referral is accepted, an appointment is made and attended, and all appropriate records and clinical history are provided to the ongoing provider, in accordance with HIPAA.

The following services must be delivered by the CBHC but are not billable through the CBHC encounter bundle, although some services may be billed separately:

1. For <u>adult Members</u>, peer and other recovery supports, including:
   a. Certified Peer Specialists, Recovery Coaches, Recovery Support Navigators, and Family Support Services;
   b. Community Support Program (CSP) services; and
   c. Services by other peers and recovery supports as appropriate to meet the Member's needs.
2. For <u>child and youth Members</u>, peer and other supports, including:
   a. Young adult peer mentors; and
   b. Family support services, defined as services delivered by a family support navigator or community health worker to improve the capacity of the parent/caregiver to parent the youth, to improve the youth's functioning, and to address the youth's emotional and behavioral needs as identified by the treating provider. Such services may include assistance in navigating the child-serving systems (e.g., the Department of Children and Families (DCF), education, mental health, juvenile justice); 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); support, coaching, and training for the parent/caregiver.

ACCESS TO SERVICE

The CBHC must offer open access to assessment and treatment services for any individual seeking treatment for mental health, substance use disorders, or co-occurring disorders, as clinically appropriate and necessary. The CBHC must meet the following access requirements:

1. **Hours**
    a) CBHCs must be open:
        i. Monday-Friday: 8 a.m.- 8 p.m.
        ii. Saturday and Sunday: 9 a.m. - 5 p.m.
2. **Same-day Access**

Any new or existing Member contacting the organization, in person or by phone, during business hours must be given the opportunity to meet with qualified staff to complete an intake and brief assessment and to receive behavioral health urgent care services as clinically appropriate and/or necessary within 24 hours. This includes same-day evaluation for initiation and bridging with MOUD and access to medication no later than 24 hours after evaluation. This also includes timely referral to non CBHC-provided services such as partial hospitalization program or medical services, etc. Urgent Appointment Access (defined by the initial intake and Member's statement of urgency)

    a) The following must be available within 48 hours
        i. Comprehensive diagnostic assessment;
            a. Assessments for SUD and co-occurring disorders must incorporate an evaluation of ASAM dimensional criteria
        ii. Urgent outpatient crisis counseling/psychotherapy;
        iii. Group therapy, and
        iv. Peer/support services.

3. **Urgent Psychopharmacology Access**
    a) Assessment and treatment by a medication provider (e.g., pharmacotherapy, medication consultation) must be completed within 72 hours of the initial diagnostic evaluation and based on both assessment and Member's statement of urgency.
4. **Telehealth service delivery:** The CBHC must have the capacity to provide core services via telehealth and meet Executive Office of Health and Human Services requirements governing telehealth services. Services provided via telehealth must meet the cultural and linguistic needs of Members and be provided in agreement and/or at the request of the individual and not at the sole discretion of the CBHC.
    a) Arrangements to secure culturally and linguistically appropriate services must be documented and include when such services will be available.
5. **Flexible place of service delivery:** The CBHC must have the capacity and willingness to provide core services in homes and other community-based settings, such as schools and congregate care settings, when necessary and clinically appropriate.
6. **Transportation assistance:** The CBHC must help facilitate access to MassHealth's transportation benefit for Members and family members of all abilities, including readily available door-through-door, two-person assistance to appointments and other types of care.
7. **Language and cultural competencies:** The CBHC must offer services in Members' preferred languages, including American Sign Language, or provide access to a trained interpreter service when skilled staff are unavailable. Staff must adhere to the following cultural and linguistic competence principles:
    a) Capacity and competency to treat a variety of populations, including but not limited to:
        i. Persons with mental health condition
        ii. Persons with co-occurring mental health and substance use disorders
        iii. Persons with co-occurring behavioral health and medical conditions (utilizing assessment capabilities and referrals for medical conditions)
        iv. Persons with substance use disorder conditions
        v. Persons with opioid use disorder (OUD) requesting induction and bridging services for medication for opioid use disorder (MOUD) and referrals to ongoing care
        vi. Persons who are pregnant, postpartum, and lactating
        vii. Older adults (age 65+)
        viii. Persons with cognitive or decisional impairment (e.g., Alzheimer's , dementia, or brain injury)
        ix. Military service members, veterans, and families
        x. Culturally and linguistically diverse populations in their geographic area
        xi. Persons with Autism Spectrum Disorder (ASD) and/or intellectual and developmental disabilities (IDD)

xii. Persons who are deaf or hard of hearing
xiii. Persons who are blind, deaf-blind, and visually impaired
xiv. Persons with physical disabilities that limit mobility
xv. Persons who lack stable housing
xvi. Persons who are LGBTQIA+
xvii. Persons involved with the justice system
xviii. Youth in the care and/or custody of the Commonwealth

b) **Recovery-oriented:** CBHCs will support resiliency, rehabilitation, and recovery of all individuals to whom they provide behavioral health services, by integrating mental health, substance use disorder, and co-occurring disorder recovery and rehabilitation principles and practices throughout the service delivery model and implementing specific recovery-oriented services, including peer and family support services. Recovery-promoting treatment approaches instill hope; capitalize upon the strengths of the person and their family/support system; are aimed at enhancing problem-solving, coping, and other competencies; and are highly individualized and collaborative. Recovery-oriented processes recognize and respect that change occurs in non-linear stages, and effective providers assess the stage of readiness to change and pair effective interventions and techniques accordingly.

c) **Cultural and linguistic humility:** CBHCs commit to implementation of Culturally and Linguistically Appropriate Standards (CLAS) (Culturally and Linguistically Appropriate Services (CLAS) Initiative | Mass.gov) and ensure that the content and process of all services are informed by knowledge, respect for, and sensitivity to culture, and are provided in the individual's preferred language and mode of communication. Cultural and linguistic humility includes:
   i. Ability to provide services in a culturally and linguistically competent manner, including access to informal and formal supports reflecting the family's cultural and linguistic preferences, bilingual and American Sign Language professionals, materials, and interpreters;
   ii. Ability to hire, develop, and retain culturally and linguistically competent staff, including staff reflective of the racial, linguistic, gender, and sexual orientation diversity of the population in their geographic area;
   iii. Organizational commitment to continuous learning in the area of cultural competence, reflected in training curricula, supervision, and performance evaluation at all levels of the organization; and
   iv. Commitment to continuous evaluation of the service environment, written materials, communications, facilities, and approach of staff from a cross-cultural perspective to promote an open, welcoming, and accepting environment.

d) **Commitment to Member choice and Member-centered care**: CBHCs will deliver services in an individualized, respectful, flexible, and coordinated manner

e) **Broad knowledge of the community behavioral health system and commitment to community-based care:** Knowledge of behavioral health and social services provided in the community, how they are funded, and how Members access them; experience in developing professional relationships with colleagues in these organizations

8. **24-hour coverage**: The provider must have clinic coverage 24 hours per day, 7 days per week to respond to established Members with an urgent need or crisis situation.
   a) During business hours, clinic coverage must include, at minimum, an urgent outpatient session by a qualified professional and triage to appropriate services for the Member's presenting crisis.
   b) After hours, clinic coverage must include live telephonic access to qualified professionals and, if indicated, arrangements for further care and assistance in real-time to an appropriate provider (e.g., AMCI, YMCI, emergency departments (EDs)). Each CBHC must maintain a current roster of on-call clinicians available to speak with Members.
   c) A pre-recorded message will not fulfill the requirement for access to a qualified professional.
   d) The after-hours triage phone line must provide a direct connection to the CBHC's AMCI/YMCI.
9. **Access to Coordinated Specialty Care (CSC) for First Episode Psychosis**: CBHC providers must have the capacity to refer and coordinate with these specialty providers.
   a) Required competencies for CBHCs referring to CSC programs:
      i. Competency to detect/recognize signs and symptoms and ask/screen individuals experiencing early psychosis
      ii. Competency to skillfully obtain Member's consent to be referred (with warm hand-off) to specialized early psychosis service providers
      iii. Competency to support someone through hand-off/transition to specialized services.

CARE COORDINATION REQUIREMENTS

The CBHC is expected to coordinate care across the spectrum of services, including physical and behavioral healthcare, social services, housing, educational systems, and employment supports as appropriate to facilitate wellness and recovery of the whole person.

Based on need, the CBHC must assist Members and families of children and youth referred to external providers or resources in obtaining an appointment and confirm the appointment was completed. The CBHC will ensure timely access and bidirectional communication and referral pathways through a Memorandum of Understanding (MOU) or Affiliation Agreement with BHCPs, community service agencies (CSAs), and other care coordination entities.

The CBHC must ask the Member if they have an existing care coordinator or BHCP, conduct third- party confirmation of care coordinator participation if possible, assess for appropriateness of referral to care coordination or BHCP, and make the referral, preferably the same day, but no later than three calendar days, to the Member's MassHealth Managed Care Entity (MCE) (Accountable Care Organizations (ACOs), Managed Care Organizations, Senior Care Organizations, One Care plans, and the MassHealth behavioral health vendor) for care coordination where appropriate.

Members ages 21-64 who are enrolled in an MCO or ACO or are a part of the Adult Community Clinical Services (ACCS) program are most appropriate for referral to the BHCP program. However, where clinically appropriate, Members between 18-20 who do not have another source of care management may also be referred for BHCP supports.

If the Member is assessed to benefit from a BHCP, CBHI service, or other care coordination program, the CBHC must complete the appropriate referral preferably the same day, but no later than three calendar days, to the appropriate MCE or appropriate referral source. Specifically, for DMH ACCS Members, the CBHC must make the referral, preferably the same day, but no later than three calendar days, directly to DMH. DMH will determine further program eligibility. If the ACCS Member is deemed ineligible, the CBHC will be responsible, as described below, for providing care coordination to the Member. If referral to BHCP is indicated, and the Member has recently been discharged from an inpatient facility or ED and the MCE has not yet arranged for the Member to have a BHCP, the CBHC will request the MCE to expedite the referral.

For Members who have a BHCP, CBHI service, or care coordination entity (including payer, provider, or state agency resources), those services are expected to serve as the main point of contact and "first line" coordinator for the Member and the Member's family, where appropriate. The CBHC must communicate as clinically appropriate, but at minimum monthly, with the care coordinator and must engage in bidirectional communication of relevant information, including about transitions of care or change in clinical status. If the Member continues to receive services from the CBHC, the CBHC is expected to assign a staff to be a part of the Member's BHCP or CBHI care team.

For Members who do not have existing BHCP, care coordination services, ICC, do not meet the requirements, or refuse to receive those supports, it will be the CBHC's responsibility to provide a robust set of care coordination services, as appropriate, to ensure Member needs are met. Care coordination activities must include the following:

1. **Develop, document, and coordinate behavioral healthcare plan with the Member/family/caregiver upon completion of comprehensive assessment, no later than the third visit.**
    a. The CBHC must ensure that the comprehensive behavioral healthcare treatment plan is shared/included monthly in both the ongoing care and transition of care communication with relevant providers, state agencies, and members of treatment and care teams, in accordance with applicable privacy requirements.
    b. The CBHC must ensure that information is requested and received from all relevant treatment providers outside the CBHC and that all information is included in the Member's record, in accordance with applicable privacy requirements.
    c. The CBHC is responsible for ensuring crisis planning and coordination by guiding the Member and family through a crisis planning process. The CBHC must:
        i. Review the crisis planning tool with the Member to ensure understanding and consensus on plan components.
        ii. With Member consent, ensure the crisis plan is communicated with state agencies, members of the treatment team, care team, and family members, as appropriate.
        iii. For adult Members:
            1. In addition to detailed documentation of the behavioral healthcare treatment approach and results of any diagnostic evaluation, the comprehensive behavioral healthcare treatment plan should include information reported by the Member about their physical

health condition(s) and note impact on the Member's psychosocial functioning as clinically indicated, as well as social service needs and current providers as appropriate.
2. The CBHC, working with a team of support staff, must coordinate services with a Member's PCP or primary care clinician (PCC), other behavioral health providers, relevant state agencies, specialty medical providers such as neurologists and OB/GYNs, and the Member's MCE.
3. As appropriate, the treatment planning team should include individuals identified by the Member, including natural support and medical professionals, if appropriate, and other members of the Member's care team.
4. All components of the treatment plan must be documented, adherence to the treatment plan should be monitored, and outcomes should be monitored

iv. For child and youth Members:
1. Within seven days of first contact, the CBHC provider assesses the safety needs of the youth and family and creates an initial safety plan and an initial assessment, which clarifies the main need/focal problem, the contributing factors to the main need from multiple life domains, and matching interventions with an emphasis on youth/family interactions and skill building.
2. Designate a staff person to ensure that a comprehensive clinical assessment, inclusive of the CANS, is done within 21 days of the initial appointment and a comprehensive behavioral healthcare treatment plan and CANS is updated at least every 90 days in collaboration with the youth's family/caregiver(s) and treatment team. This designee should also ensure the treatment plan and CANS is shared/included in transition of care communication, in accordance with applicable confidentiality requirements, with relevant providers, state agencies, and members of the treatment team.
3. Ensure crisis planning and coordination, including a review and use of the set of Crisis Planning Tools (Safety Plan, Advance Communication to Treatment Providers, Supplements to Advance Communication and Safety Plan, Companion Guide for Providers on the Crisis Planning Tools for Families) where appropriate and in accordance with the Companion Guide for Providers, which should include strategies for accessing supports during a crisis; referral to an Emergency Department/calling 911 is not a sufficient crisis plan.

v. With parent/guardian consent, the appropriate CBHC staff members must communicate and collaborate with other individuals involved with the youth and their family and, to the extent permitted by law, provide entities with copies of the completed care plan, such as:
1. PCPs and PCCs;
2. Other behavioral health providers including outpatient and CBHI providers;
3. Schools, including special education system, as applicable;
4. State agencies, such as DCF, the Department of Mental Health (DMH), the Department of Youth Services (DYS), and the Department of Developmental Services (DDS), as applicable; and
5. For justice-involved youth, local police department jail diversion co-responders, probation officers, guardians ad litem, attorneys, and advocates.

vi. When requested by the family, CBHC staff member(s) may also accompany the family to meetings about the child's behavioral health treatment needs in schools, day care, foster homes, and other community-based locations. All meetings will be scheduled at a time and location that are convenient for the youth and family.

Support Transitions of Care

The CBHC must establish a standard process to support transitions of care, including follow-up appointments and development of transition plans in coordination with the Member, other providers, and/or state agencies serving the Member as appropriate. During the course of the comprehensive behavioral healthcare treatment plan development, identification of the primary responsible party to support transitions of care must be identified to avoid duplication and ensure coordination. Transition plans shall be coordinated with providers including but not limited to:

a. 24-hour facilities,
b. PCPs and PCCs,
c. Other outpatient behavioral health providers (including specialty care providers),
d. Existing care managers (including payer, provider, or state agency resources),

e. Community Partners,
f. CBHI services,
g. Schools,
h. Residential treatment centers, and
i. Congregate care settings.

2. For youth Members ages 16 - 20 who are approaching age of transition, establish and/or facilitate the development of an individualized transition plan. Transition-aged youth are defined as youth who are anticipated to change eligibility status within a single service system, are anticipated to move between two or more separate service systems, or are anticipated to exit a service system when the Member reaches a particular age. This transition plan must be developed directly with the Member and family/caregivers and any state agencies involved in the Member's case (involvement includes a pending eligibility application as well as any level of case management), and there must be effort to reach consensus, if possible, by all agencies. The plan will include at a minimum:
   a. A list of services and supports that a transitioning Member is expected to require over the next 12 months;
   b. A determination of whether there is the need for case management to ensure the plan is implemented, and if so, identification of the entity that is to provide case management services; and
   c. Information on how to access services that reasonably ensure health, safety, education/skill development, employment (where appropriate), civic engagement, housing, transportation, and connection to a caring adult.

Connections to Community-Based Social Services and Other Providers and Supports

1. The CBHC must:
   a. Conduct a social service needs assessment or review existing assessments based on the preferences of the Member for inclusion in overall care planning;
   b. Assist in connection to social services;
   c. Maintain relationships and coordinate with existing behavioral health providers, social services, Community Partners (CPs), ACOs, PCPs, Long-Term Services and Supports (LTSS) providers, Community Support Program (CSP) case managers, jail diversion co- responders, community clinical services providers, and MCEs;
   d. Ensure that a comprehensive social services plan is included in the transition of care communication with other providers, including social services providers and Member supports; and
   e. Ensure that Member's natural supports have been included in this process.

Coordination with State and Local Agencies

1. For Members enrolled with or receiving services from a state agency, the CBHC must communicate and coordinate services with the agency or agencies as appropriate.
2. For Members involved in the criminal justice system, the provider must communicate and coordinate services with the Department of Correction, houses of correction, DYS, parole, probation, and local police department jail diversion co-responders, as appropriate.
3. For Members who are older adults, communicate and coordinate services with local Aging Services Access Points and Councils on Aging, as appropriate, including connection to older adult behavioral health outreach teams.
4. For youth in the custody of DCF, communicate and coordinate with the agency directly, as well as with congregate care provider, foster family, and other DCF service providers.

Care Coordination Documentation

1. All care coordination activities must be documented in an easily accessed tracking log located in the Electronic Health Record (EHR).

STAFF COMPOSITION REQUIREMENTS

The CBHC is responsible for staffing locations such that the core services can be provided at each site, as required, and that access requirements are met. All licensure staffing requirements must also be met.

At a minimum, the CBHC must designate the following positions:

1. *Medical Director:* A board-certified or board-eligible psychiatrist who possesses a DEA controlled substance registration for prescribing of MOUD, who will be responsible for clinical and medical oversight and quality of care across all CBHC services. The Medical Director will be responsible for establishing all medical policies and protocols and supervising all medical services provided by staff.
2. *Board-certified or board-eligible psychiatrists* or other prescribers of MOUD who possesses a DEA registrations for prescribing of MOUD

3. *Board-certified or board eligible psychiatrist,* including a child and adolescent psychiatrist, or an Advanced Practice Registered Nurse (APRN): A board-certified or eligible for such certification psychiatrist, including a child and adolescent psychiatrist or an APRN, who shall provide psychiatric assessment, medication evaluations, and medical management and contribute to the comprehensive assessment and care planning.
4. *Clinical Program Director:* An independently licensed behavioral health clinician who will be responsible for the oversight and management of clinical staff hiring, scheduling, performance, and supervision; adequacy and appropriateness of Member care; program evaluation; development of in-service training for staff, and establishment of a quality management program
5. *Assistant Director:* An independently licensed behavioral health clinician who will support the clinical director with all leadership functions, including clinical and administrative oversight and quality of care across the CBHC
6. *Quality Director:* A dedicated CBHC quality director will provide this oversight managing quality across programs. A broader organization quality director may oversee CBHC quality by performing or designating quality staff who provide oversight of quality measurement requirements for all services provided as part of the CBHC system.
7. *Clinical Supervisor:* An independently licensed behavioral health clinician who will provide clinical supervision to all direct service staff across the CBHC service components. Clinical supervisors of clinicians providing CBHC services to children and adolescents must have at least two years' experience treating youth and/or families.
8. *Nurse Manager:* The Nurse Manager (RN) is a management position within the CBHC, responsible for providing supervision to nursing staff and oversight across CBHC service components as needed. The Nurse Manager will fill physician orders; administer medication; take vital signs; coordinate medical care; contribute to comprehensive assessment, inclusive of assessment of signs of substance withdrawal and completion of standardized assessment tools such as the Clinical Opioid Withdrawal Scale (COWS), Clinical Institute Withdrawal Assessment for Alcohol (CIWA), and Clinical Institute Withdrawal Assessment for Benzodiazepines (CIWA B); conduct brief crisis counseling and individualized risk management/safety planning; provide psycho-education; and assist with discharge planning and care coordination.
9. *Registered Nurse (RN):* The RN will perform the following core functions: fill physician orders; administer medication and engage in a medication reconciliation process, as outlined within the Components of Service section; take vital signs; coordinate medical care; contribute to comprehensive assessment, brief crisis counseling, individualized crisis prevention planning, and provider psychoeducation; and assist with discharge planning and care coordination.
10. A sufficient number of FTE of any of the following independently licensed clinicians to meet the needs of the population served by the CBHC, including those with a minimum of two years' experience treating youth and/or families:
    a) Master's- or doctoral-level Psychologist
    b) Licensed Independent Clinical Social Worker (LICSW)
    c) Psychiatric Advanced Practice Registered Nurse (APRN)
    d) Licensed Mental Health Counselor (LMHC)
    e) Licensed Marriage and Family Therapist (LMFT)
11. *Master's-level clinicians*
12. Additional clinical staff to meet regional need, such as:
    a) Licensed Alcohol And Drug counselor I (LADC I)
    b) Licensed Applied Behavior Analyst (LABA)
13. *Bachelor's-level or equivalently experienced staff:* Staff will provide care coordination, outreach and engagement, and discharge planning.
14. For adult services, at least one FTE of each of the following:
    a) Certified Peer Specialist
    b) Recovery Support Navigator or Recovery Coach
15. For child and youth services, at least one FTE of the each of the following:
    a) Peers or family support navigator staff who meet the following requirements:
        i. Preference for lived experience as the parent/caregiver of a youth with behavioral health needs and who comes from the same community as the population served;
        ii. A minimum of one year of experience in navigating any of the child- and family-serving systems and supporting family members who are involved with the child- and family-serving systems;
        iii. Demonstrated cultural humility, with an understanding of ethnic, cultural, and/or linguistic considerations for populations served; and
        iv. Experience providing services in a community setting.
16. *Medical assistants and/or phlebotomist:* Staff will identify Members via ID, medical record, or other means; draw blood using needles and other equipment; obtain toxicology samples, label samples correctly, and send them for testing as appropriate; medical assistants will also assist with vital signs, height/weight, and other relevant health data.

17. *Clerical staff:* will be responsible for maintaining records, ensuring release of information forms and other documentation is completed, and other administrative support.
18. *Security staff:* Security staff will provide enhanced safety and security. Staff will be trained with an approved behavioral support and management program, including skills in de-escalation, to maintain safety of all Members and staff at all hours of operation.
19. Other staff for CBHC administrative functions as needed: The CBHC is responsible for designating non-clinical staff to support the safety and quality of care for all Members who receive services within the program. Required staff within each CBHC include staff who provide oversight of quality measurement requirements for all services provided as part of the CBHC system. Additional staff must be identified for other essential functions for effective CBHC operations including training, practice transformation, quality improvement, utilization management, and electronic health record support.

Supervision Requirements

1. The CBHC must ensure that a clinician licensed at the independent practice level is available during all business hours for consultation.
2. The CBHC is required to comply with applicable DPH, Department of Mental Health, MassHealth, and MCEs' regulations and standards regarding clinical supervision.
3. Regular clinical supervision of unlicensed clinicians, including discussion of the cases in the unlicensed professional's caseload, must be delivered by an independently licensed staff member qualified to deliver supervision in the discipline of the supervisee and must occur with a frequency and duration commensurate with the caseload and in accordance with applicable licensure and programmatic requirements.
4. To ensure that supervision is appropriately documented, both the supervising clinician and the supervisee must maintain records of supervision meetings.
5. All paraprofessional staff must receive weekly individual, group, or dyadic supervision commensurate with their caseload. For paraprofessionals serving youth Members, supervision must be with a licensed behavioral health clinician who has specialized training in parent support, behavioral health needs of youth, family-centered treatment, and strengths-based interventions, and who is culturally and linguistically competent in working with youth and families with behavioral health needs.

Training Requirements

Each CBHC location must ensure licensed clinician(s) are certified and trained in the evidence based practice modalities offered. Providers must ensure adequate supervision and training for all employed or contracted workforce. Clinical leadership will be responsible for the oversight and ongoing training and coaching related to any evidence-based practices used by the provider. Employed or contracted workforce must be trained, certified, and/or licensed, and must maintain certification in designated modalities. All training must be documented in employee personnel records.

1. All staff must receive appropriate training in order to provide services based on the needs of the Member population. At minimum, all staff must receive training in:
    a) The clinical and psychosocial needs of the target population as defined by the CBHC;
    b) Upholding standards of trauma-informed care, including fostering trauma-informed environments;
    c) Crisis prevention and de-escalation, risk management and safety planning, and conflict resolution;
    d) Ethnic, cultural, and linguistic cultural competencies relevant to the community that the CBHC services;
    e) Available community resources and services, including the Community Partners program;
    f) Zero Suicide Evidence-Based Practice; and
    g) Overdose Prevention and Response (Narcan).
    h) All Member-facing staff must be trained in motivational interviewing and person-centered treatment planning. Clinical staff must be trained in CBT.
    i) All prescribing staff must be up to date on current psychotropic medications and possible side effects.
2. Staff providing adult services must receive annual training in:
    a) Safety and risk
    b) Treatment of substance use disorders, including:
        i. Confidentiality of treatment as specified under 42 CFR part 2;
        ii. Substance use disorders including tobacco and nicotine addiction, clinical assessment, and diagnosis; treatment planning; relapse prevention and aftercare planning;
        iii. Co-occurring disorders, including mental health disorders, gambling and other addictive behaviors, and mechanisms for ensuring coordination of care related to all co-occurring disorders

iv. Effects of substance use disorders on the family and related topics such as the role of the family in treatment and recovery, and the risks and benefits of all MAT/MOUD options, as well as the risks and benefits of not receiving treatment; and
v. Training on the American Society of Addiction Medicine (ASAM) Criteria and its application.

3. Staff providing youth services must receive annual training in:
   a) Child and adolescent systems;
   b) Role within a care planning team;
   c) Family-centered practice;
   d) Introduction to child-serving systems and processes (e.g., DCF, DYS, DMH, the Department of Elementary and Secondary Education);
   e) Basic Individualized Education Plan and special education information;
   f) Child and adolescent development, including sexuality;
   g) Behavior management coaching;
   h) Child Requiring Assistance/juvenile court issues;
   i) DC: 0-5: Evaluation and Diagnosis; and
   j) Clinical Assessment and Understanding training (UMass CANS) completion required for all clinical staff.

Documentation

All employed or contracted clinicians must comply with the provider's protocols for documentation, including use of an EHR that is accessible to other qualified members of the treatment team. All interventions, including support and treatment, must be documented in a shared EHR.

1.

ACCESS TO SERVICES OUTSIDE OF THE CBHC

The provider must facilitate access to needed services and supports that are not provided by the CBHC. These services and supports are not included in the CBHC encounter bundle. The provider must be able to facilitate access to at least the following services and supports through formal partnerships:

1. Laboratory services for necessary screening and testing;
2. Specialized services requiring special training or specific credentials including:
   a. Services for older adults, including geriatric psychiatry;
   b. Services for Members involved with the juvenile and adult justice system, including forensically-trained staff to conduct and review criminogenic risk assessments to inform appropriate treatment planning, and staff familiar with criminogenic risk/needs/responsivity models;
   c. Services for Members with ASD/IDD; and
   d. Services for Members with traumatic brain injury.
3. Warm hand-off to Opioid Treatment Programs or Office-Based Addiction Treatment Programs (OBATs) (if not available at the CBHC) when needed and preferred by the Member; and
4. Youth and family services such as ICC and other CBHI services.
5. Care coordination supports such as BHCP or other Care Management programs.

COMMUNICATION PROTOCOLS

Formal Communication Agreements:

To effectively coordinate and deliver care, the provider must hold formal communication agreements with other providers and develop documented processes for expected timelines, access to care, referral processes, and communication and escalation protocols. These may include Structured Business Associate Agreements/Clinical Associate Agreements, Memorandums of Understanding, or other formalized agreements, which must include the following elements:

1. Workflows and standard protocol for Member release of information;
2. Communication protocol/data exchange protocol with outside providers via EHR; and
3. Ability to utilize/plan to work with event notification services via EHR or another platform.

The provider must have these agreements with the following entities, which must be within the provider's catchment area whenever possible:

1. Inpatient psychiatric facilities (acute and freestanding);
2. Community-Based Acute Treatment (CBAT) providers;
3. 24-hour diversionary behavioral healthcare providers;

4. Opioid Treatment Programs;
5. Office-Based Addiction Treatment Programs (OBAT);
6. Residential services;
7. BHCP Programs;
8. Community service agencies and other CBHI service providers;
9. Early Intervention providers;
10. Older adult mental health services (e.g., Elder Mental Health Outreach Teams (EMHOTs), Aging Service Access Points (ASAPs), etc.)
11. 988 crisis call centers; and
12. State agency services and other relevant providers.

Outreach Plans:

The CBHC must develop an outreach plan that informs the entities in their catchment area listed below of the availability of the provider's services for any member of the community who may need urgent or ongoing behavioral health treatment. The outreach plan must include documented protocols for communication processes and plans for routine meetings.

1. Hospital emergency departments and inpatient psychiatric units/facilities
2. Organizations focused on recovery, such as:
    a. Recovery Learning Centers
    b. Recovery Support Centers
3. Organizations serving justice-involved Members, such as:
    a. Providers of behavioral health supports for justice-involved individuals
    b. Probation and parole
    c. Courts
    d. Houses of correction
    e. Local municipalities and police departments (including organizations that employ jail diversion clinicians)
    f. Department of Correction
    g. District attorney's offices
4. Case Management and Care Coordination Supports
    a. Providers of Community Support Programs (CSP), case management provided by state agencies, and other related case management supports
    b. CPs (behavioral health and LTSS)
5. Clinical providers
    a. PCPs and PCCs
    b. Community Health Centers
6. Autism resource centers
7. Homeless service providers
8. Agencies serving youth, families, and older adults, such as:
    a. Youth congregate care providers
    b. Schools
    c. Family resource centers
    d. Aging Services Access Points
    e. Councils on Aging
    f. Nursing facilities
9. Other community-based service organizations (e.g., providers of affordable and subsidized housing, child and adult protective services agencies).

The provider must also be able to accept referrals from primary care practices, MCEs, CPs, and state agencies.

The CBHC must engage in planning with local law enforcement and/or emergency medical services (EMS) providers, inclusive of jail diversion co-responders, to accept police drop-off.

QUALITY MEASURES AND REPORTING REQUIREMENTS

The provider is responsible for quality oversight of all adult and youth services delivered and/or subcontracted, including AMCI, Adult Community Crisis Stabilization, YMCI, and Youth Community Crisis Stabilization.

Reporting must be submitted to MassHealth or its designee on an annual basis for the following:

1. **General staffing report:** Reporting on all licensed and unlicensed staff, delineating staff capable of delivering services for special populations (e.g., ASD/IDD; justice-involved), trauma- informed care, and delivery of care in other languages; staff responsible for providing supervision; and staff who remain unlicensed for a longer timeframe than allowed by the respective professional licensure board
2. **Peer supervision report:** Staff trained to supervise peers with commensurate written supervision policy and procedures
3. **Workforce retention:** Reporting on the provider's plan for retaining staff, including professional development, training, salary adjustments, opportunities for growth, tuition reimbursement, and flexible schedule for school opportunities
4. **Outcomes and quality reporting:** Submission of data and quality measures using specified templates and processes, as outlined in provider's contract to serve as a CBHC
5. **Patient Satisfaction Survey** results
6. **Enterprise Invoice/Service Management** (EIM/ESM) data
7. **Written policies and procedures:**
    a. An intake policy;
    b. Admission procedures, including criteria and procedures for multidisciplinary review of each individual referral;
    c. Treatment procedures, including, but not limited to, development of the treatment plan, case assignment, case review, discharge planning, and follow-up on Members who leave the program, voluntarily or involuntarily;
    d. Medication policy that includes prescription, administration, and monitoring data;
    e. Policy and procedure for induction and bridging of MOUD;
    f. A referral policy, including procedures for ensuring uninterrupted and coordinated Member care upon transfer;
    g. Procedures for walk-in Members and clinical emergencies during operating and non- operating hours;
    h. Record-keeping policies, including what information must be included in each record, and procedures to ensure confidentiality;
    i. Personnel and management policies, including policies for hiring, training, evaluation, supervision, and termination for all staff; and
    j. A utilization review plan.

The provider must report within 10 days any deficiencies or citations indicated during a site visit performed by other agencies, including but not limited to the Department of Public Health, the Department of Mental Health, The Joint Commission, and the Commission on Accreditation of Rehabilitation Facilities.

The provider must report within 10 days any sanction or disciplinary action against any clinical staff by any agency or licensure board. In accordance with MassHealth and MCE requirements, the provider must report, to MassHealth or the applicable MCE, any adverse incident that occurs while the Member is in the provider's care on the business day or the next business day from when an adverse incident occurs.

Ongoing patient recorded outcomes measures must be collected on a regular schedule and utilized to inform Member progress in treatment. Results of outcomes measures must be one component of measuring clinical progress and included in the treatment plan.

EOHHS or THPP may require other ad hoc or ongoing provider-level quality measures.

MANAGEMENT FUNCTIONS

The CBHC will be responsible for conducting all clinical, medical, quality, administrative, and financial oversight functions across all the services provided by the CBHC system and all locations where these services are provided, including services provided by subcontractors. These functions include:

1. Staff recruitment, hiring, training, supervision, and evaluation
2. Triage
3. Clinical and medical oversight
4. Quality management/risk management
5. Information technology, data management, and reporting
6. Claims submission
7. Encounter form submission for AMCI/YMCI services
8. Data tracking related to Members' utilization of CBHC services
9. EIM/ESM data for BSAS
10. Oversight of subcontracts
11. Interface with payers including MassHealth, the MassHealth BH vendor, MCEs

CBHCs will be required to meet monthly with the MassHealth BH vendor and MCEs to review performance, including, but not limited to, the following:

1. For AMCI and YMCI services:
    a. Compliance with performance specifications
    b. Community-based evaluations
    c. Inpatient disposition
    d. Response time
    e. Family Partner utilization
    f. CPS utilization
    g. Chart audit
    h. Adult and YCCS utilization
    i. Staffing patterns
    j. Patient satisfaction surveys
2. For CBHC services:
    a. Compliance with performance specifications
    b. Urgent care utilization
    c. Chart audits
    d. Staffing patterns
    e. Healthcare Effectiveness Data and Information Set (HEDIS®)1 measures
    f. Patient Satisfaction Surveys

If the agency providing the adult component and the agency providing the youth component are different agencies, the lead agency will be responsible for all the functions described above.

DOCUMENT HISTORY

- November 2025: Updates
- January 2024: Tufts Health One Care (a dual-eligible product) name change.
- January 2023: Created