GENERAL PERFORMANCE SPECIFICATIONS

PURPOSE

Performance specifications are intended to enhance MassHealth Enrollee experience and outcomes by promoting transparency and consistency across Plans and providers. Performance specifications are expectations imposed on providers who contract for these specific and related services. Information contained in this document is based on publicly available information, Plan expectations, your contract, and MassHealth guidance. This information should be materially like any other MassHealth contracted Plan. Performance specifications, your provider manual, and other requirements can be found at providerexpress.com.

OVERVIEW

The Plan provider network supports Enrollees of all ages and their families living with severe and persistent mental illness, emotional or behavioral issues, substance use disorders, and co-occurring disorders to improve their level of functioning and live successfully in their communities. In doing so, the Plan provider network offers a broad continuum of care including emergency, inpatient, outpatient, and diversionary services, emphasizing the least restrictive, community-based services available whenever clinically appropriate. Recognizing that behavioral health and medical conditions co-exist, behavioral health providers incorporate both into the assessment and care planning processes and collaborate with medical providers to improve the outcome of the Enrollee's health. Providers of all levels of care must ensure that, in any setting in which behavioral health levels of care or both behavioral health and non-behavioral health levels of care are co-located, all performance specifications are met for the contracted levels of care.

All Plan network providers incorporate wellness, resiliency, and recovery principles and practices into their care approaches and offer recovery-oriented services. Providers are accepting of Enrollees, both initially as well as upon return after any disruption in services, regardless of resources. Providers engage Enrollees in services as they can participate. Care focuses on increasing Enrollees' ability to successfully manage their conditions, symptoms, and services; build recovery and resilience; and meet their personal goals. Programs are Enrollee and family driven, using a team approach with shared decision-making that facilitates the development of mutually agreed-upon care plans. With Enrollee consent, active family/guardian/natural support involvement is integral to treatment and discharge planning unless contraindicated.

Additionally, Plan network providers deliver behavioral health services in a manner which supports:

1. Clinical excellence and innovation in the provision of care;
2. Ethical care and professional integrity;
3. Enrollee accessibility;
4. Integration of behavioral health and physical health throughout all service delivery processes;

5. Coordination of care including integration with primary care clinicians (PCCs);
6. Data-driven practice, including evidence-based practices, outcomes measurement, and utilization management; and
7. Technical competence and innovation.

SERVICE COMPONENTS

Consent for Treatment

The provider identifies the Enrollee's custodial status and obtains all consent forms and releases of information in compliance with that status.

1. The provider obtains a consent-to-treatment form signed by the Enrollee or parent/guardian/caregiver.
2. The provider obtains appropriate consent for information sharing to coordinate care.
3. The provider follows current laws and standards regarding consent and release of information and conducts staff training as changes occur.
4. If the Enrollee or parent/guardian/caregiver of a minor declines or restricts the consent for coordination, the provider documents this as such in the Enrollee's health record. Attempts are continually made and documented to engage the Enrollee in giving consent, as appropriate to his/her treatment plan.

Cultural Competence

1. The program provides services that accommodate the Enrollee's individual needs, consider the Enrollee's family and community contexts, and build on the Enrollee's strengths to meet his or her behavioral health, social, and physical needs.
2. The program staff has the skills to recognize and respect the behaviors, ideas, thoughts, communications, attitudes, values, beliefs, customs, language, rituals, ceremonies, and practices characteristic of the population served. To ensure that effective care is provided, program staff, supervisors, and administrators seek consultation and additional services, when necessary, to overcome barriers obstructing the delivery of care and to further support cultural and linguistic competence.
3. The provider makes best efforts to ensure access to qualified clinicians able to meet the cultural, linguistic, ethnic, and other unique needs of all Enrollees served in their local community, directly or by referral, including Enrollees of minority groups, those who are homeless, Enrollees who are disabled, Enrollees who are deaf or hard of hearing, and other populations with special needs.
   a) Providers ask Enrollees' language of choice.
   b) Because clinical staff with linguistic capacity is preferable to interpreters/translators, providers offer the Enrollee a clinician who speaks his/her language of choice whenever possible or refers him/her to a provider who can do so.
   c) The provider has access to qualified interpreters/translators and translation services, experienced in behavioral health care, appropriate to the needs of the population served. If the program must seek interpreter/translation services outside of the agency, it

maintains a list of qualified interpreters/translators to provide this service, as well as relevant resources. Interpreter/translator services are provided at a level which enables an Enrollee to participate fully in the provider's clinical program.

4. Any written documentation is made available for Enrollees in a manner, format, and language that can be easily understood by those with limited English proficiency. Such materials, especially discharge documents, are translated into languages considered prevalent. It is considered best practice to have the capability to translate such materials into the Enrollee's preferred language when requested by the Enrollee.
5. Programs provide ongoing in-service training that includes cultural and linguistic competency issues pertaining directly to the population served, to ensure its staff demonstrate an understanding of and respect for Enrollees' diverse cultural, linguistic, and other unique needs.
6. Programs include cultural and linguistic competence in their ongoing quality assessment and improvement activities, including identifying and reducing the existence of health care disparities.

Recovery and Wellness

7. All program policies and procedures are designed to promote acceptance of Enrollees into their contracted services within an atmosphere of trust:
   a) At all levels of motivation and readiness; and
   b) With any reasonable personal preferences.

   Additionally, it is considered best practice to have the capability to accept and treat Enrollees presenting with various co-morbid conditions.
8. Programs promote Enrollees' recovery, empowerment, and use of their strengths and their families' strengths in achieving their clinical, recovery, and wellness goals and improving their health outcomes.
9. Programs integrate peer/family support services whenever possible, within their own programming and/or through active linkages with community resources.
10. Programs complement and integrate their services with the following formal and informal resources and programs:
    a) Recovery-oriented and peer-operated services and supports;
    b) Wellness programs that promote skill-building, vocational assistance, supported employment, and full competitive employment;
    c) Natural community supports for Enrollees and their families;
    d) Self-help including Anonymous recovery programs (e.g., 12- step programs) for Enrollees and their families; and
    e) Consumer/family/advocacy organizations that provide support, education, and/or advocacy services, such as Parent/Professional Advocacy League (PPAL), the Federation of Children with Special Needs, Recovery Learning Communities (RLCs), Clubhouses, the National Alliance on Mental Illness (NAMI), etc.
11. Programs provide ongoing, documented in-service training that includes principles of wellness, recovery, and resilience pertaining directly to the population served.
12. Programs incorporate recovery principles and practices in their ongoing service delivery as well

as in quality improvement activities.

STAFFING REQUIREMENTS

1. The provider complies with all provisions of the corresponding section in the service-specific performance specifications for each level of care for which they are contracted.
2. The provider complies with the staffing requirements of the applicable licensing body, the staffing requirements in the Plan service-specific performance specifications, and the credentialing criteria outlined in the Plan Provider Manual, Volume I, as referenced at providerexpress.com. If there are discrepancies between Plan performance specifications and any licensing body, the requirements of the licensing body take precedence.
3. Organizations that have staff who do not meet the credentialing criteria for a specific level of care may apply for a waiver for such staff persons through the Plan's waiver process as outlined in the Plan Provider Manual.
4. The provider ensures that program staff are qualified through education, experience, and/or training to provide support and treatment to the population served by the programs.
5. The provider follows documented internal policies and procedures for training and supervising staff, the components of which include:
    a) Orientation and ongoing information about the provider's policies and procedures.
    b) Orientation and ongoing information about the Plan's policies and procedures including but not limited to:
        I. Provider Manual;
        II. Medical Necessity criteria;
        III. Authorization parameters and procedures;
        IV. Performance Specifications for the levels of care provided;
        V. Per Diem/Per Services Definitions;
        VI. Adverse Incident Reporting; and
        VII. Alerts.
    c) At least annual staff training that promotes skill development in clinical and rehabilitation services appropriate to the level of care and the population served, including but not limited to training on recovery and wellness, the consumer/family perspective, and integration and care coordination with PCCs.
    d) Staff participation in supervision and consultation appropriate to their degree and licensure level, and in compliance with the Plan's credentialing criteria and service-specific performance specifications. The provider maintains documentation of staff supervision and consultation policies and procedures as well as provider compliance with those policies and procedures, and, upon request, provides this documentation to the Plan.
6. For all clinical reviews with Plan, the provider must utilize an appropriately Plan-credentialed clinician for that service (see Plan credentialing criteria at providerexpress.com). When requested by Plan, the provider will make an MD available for physician-to-physician reviews.

SERVICE, COMMUNITY AND OTHER LINKAGES

1. The provider complies with all provisions of the corresponding section in the service-specific performance specifications for each level of care for which they are contracted.
2. Programs actively engage in collaboration with Executive Office of Health and Human Services (EOHHS)-funded programs, including but not limited to:
   a) Department of Mental Health (DMH)-funded programs, such as Community-Based Flexible Supports;
   b) Department of Children and Families (DCF)-funded programs that support the safety, permanency and well- being of youth in the Care and Custody of the Commonwealth;
   c) Bureau of Substance Abuse Services (BSAS)-funded programs for Enrollees, such as recovery homes to promote continuity of services for substance use disorders from acute care to supportive and rehabilitative care and recovery supports;
   d) Department of Developmental Services (DDS) programs that involve rehabilitative and habilitative services for persons with developmental disabilities;
   e) Department of Youth Services (DYS) programs that help Enrollees stay in the community and avoid recidivism to DYS;
   f) Other programs and initiatives within EOHHS, MassHealth, and Department of Public Health (DPH) related to PCC coordination and pharmacy management, including federal and state grant programs; and
   g) Prevention and wellness programs at the state, regional, and local level.
3. The provider develops a working relationship with the Emergency Services Program (ESP)/ Mobile Crisis Intervention (MCI) provider that covers the catchment area in which the program is located. The provider:
   a) Responds to referrals from the ESP/MCI to their programs in a timely fashion.
   b) Trains staff on the appropriate use of the ESP/MCI services, including services available in the community as alternatives to hospital Emergency Department visits.
   c) Ensures that staff educate Enrollees about the availability of ESP/MCI services 24 hours per day, 7 days per week, 365 days per year, including how to access services from the local ESP/MCI in the community.
   d) Educates staff, Enrollees, and their families about engaging Enrollees in the development of crisis prevention plans, and/or safety plans as part of the Crisis Planning Tools for youth, and/or relapse prevention plans, as applicable, and, with Enrollee consent, sending a copy of these plans to the ESP/MCI Director at the Enrollee's local ESP/MCI.
4. The provider makes reasonable efforts to assist Enrollees with identifying transportation options, when needed, including public transportation, Prescription for Transportation (PT-1) forms, etc.

PROCESS SPECIFICATIONS

Assessment, Treatment Planning and Documentation

1. The provider complies with all provisions of the corresponding section in the service-specific performance specifications for each level of care for which they are contracted.
2. The provider offers hours of operation comparable to those offered to individuals with commercial insurance or to Medicaid Fee-for-Service if only MassHealth Enrollees are served.
3. The provider reports bed/service availability as required by the Plan on the Massachusetts Behavioral Health Access website (MABHAccess.com) for all levels of care included on the website.
4. The provider manages services to reduce and eliminate the necessity of maintaining waiting lists. Providers who are not able to offer access that complies with the Plan access standards as outlined in the Plan Provider Manual, Volume I, as referenced at providerexpress.com, must refer Enrollees to another Plan provider to ensure that Enrollees receive services in a timely manner. Providers contact Plan for assistance with making referrals as needed. If there are barriers to accessing covered services, the provider notifies Optum as soon as possible to obtain assistance. All such activities are documented.
5. With consent, the Enrollee and his/her parent/guardian/caregiver, family members, and other natural supports are active and integral participants throughout the service delivery process, including assessment, treatment planning, treatment services, discharge planning, and related meetings. All such activity is documented in the Enrollee's health record.
6. The provider makes best efforts to offer meetings, such as treatment planning meetings, and services, such as family therapy sessions, at times and locations convenient to the Enrollee and the family's schedule, including evening and weekend meeting times and the use of teleconferencing.
7. With consent, the Enrollee's PCC, other behavioral health providers, state agency staff, and other supports are engaged in treatment and discharge planning meetings.
8. The provider completes an initial written, comprehensive assessment for all Enrollees entering any level of care, which is documented in the Enrollee's health record.
9. The assessment includes, but is not limited to: history of presenting problem; chief complaints and symptoms; strengths; behavioral health, medical, developmental, family, and social history; linguistic and cultural background; for youth in the care/custody of the Commonwealth, history of out of home placements; mental status examination including assessment of suicide and violence risk; previous medication trials, current medications, and any allergies; DSM-5 diagnosis and clinical formulation that are supported by the clinical data gathered, rationale for treatment, and recommendations; level of functioning; current and past substance use; and name of PCC and other key providers.
10. For adults, the initial outcome measurement is administered prior to or on the date of the comprehensive assessment completion to document that the clinical data was integrated into the initial assessment process. Information in the assessment may be gathered from the Enrollee, family/guardian/caregiver, the referral source, past and current treaters, and/or other collateral contacts, with appropriate consent.
11. When requested and/or as indicated by the individual's clinical presentation, the provider

conducts and documents in the Enrollee's health record a substance use disorder assessment either directly or by linkage with a provider trained in substance use disorders.

12. The provider completes a comprehensive and individualized initial treatment plan built upon the assessment and developed with the Enrollee and/or parent/guardian/caregiver, and, with consent, family members, the PCC, other involved providers, and supports identified by the Enrollee.
    a) The treatment plan is signed, dated, and documented in the Enrollee's health record.
    b) The treatment plan includes but is not limited to objective and measurable goals, time frames, expected outcomes, the Enrollee's strengths, links to primary care especially for Enrollees with active co-occurring medical conditions, a plan to involve a state agency case manager, when appropriate, and treatment recommendations consistent with the service plan of the relevant state agency, if involved.
    c) The treatment plan is consistent with the Enrollee's diagnosis, describes all services needed during treatment, and reflects continuity and coordination of care.
    d) The time frames for the completion of the initial treatment plan are delineated in each of the service-specific performance specifications.
13. The provider assigns a multi-disciplinary treatment team to each Enrollee within the time frames delineated in each of the service-specific performance specifications. A multi-disciplinary treatment team meets to review the assessment and initial treatment plan and discharge plan within time frames delineated in each of the service-specific performance specifications.
14. The treatment plan is implemented, reviewed, and revised throughout the course of treatment, based on the provider's continual reassessment of the Enrollee and with the Enrollee's participation. The Enrollee's progress in achieving the treatment goals is documented in progress notes and treatment plan updates in the Enrollee's health record.
15. If the Enrollee terminates treatment without notice, every effort is made to contact the Enrollee to re-engage in treatment or to provide assistance to transfer the Enrollee to another appropriate source of care prior to discharging the Enrollee. Such activity is documented in the Enrollee's health record. When the Enrollee is identified as having state agency and/or other collateral involvement, and appropriate releases of information have been signed by the Enrollee/parent/guardian/caregiver, those collateral contacts, including the Enrollee's PCC, and/or the Plan's integrated care manager are informed of the Enrollee's treatment status.

Care Coordination

1. The provider seeks informed consent from the Enrollee to coordinate admissions, assessment, treatment/care planning, and discharge planning with the following collaterals, as appropriate to the level of care. The type and amount of information shared is appropriate to the purpose and the role of those to/from whom the information is being communicated/requested, including the following:
    a) Parents/guardians/caregivers/family/significant other/natural supports;
    b) PCC;
    c) ESP and MCI;
    d) 24-hour levels of care, including psychiatric hospitals, Community-Based Acute Treatment (CBAT) and Intensive Community-Based Acute Treatment (ICBAT) programs,

Community Crisis Stabilization (CCS), etc.;

e) State agency personnel (when providing services to Enrollees involved with a state agency), including DMH, DCF, DYS, DPH, DDS, and/or DTA;

f) Local education authority (LEA) (applies to all children, whether a regular education or special education student);

g) Police departments and local court systems;

h) Outpatient treaters and prescribers;

i) Other community-based providers, including CBHI services such as In-Home Therapy (IHT) and Intensive Care Coordination (ICC), Community Support Programs (CSPs), and substance use disorder programs; or

j) Other collaterals appropriate to the Enrollee and/or the level of care.

2. Care coordination efforts are documented in the Enrollee's health record.

Discharge Planning and Documentation

1. The provider complies with all provisions of the corresponding section in the service-specific performance specifications for each level of care for which they are contracted.
2. The provider ensures that staff who are responsible for discharge planning are knowledgeable about the continuum of behavioral health and medical services as well as other services and supports in the community, and discharge planning skills and strategies.
3. Staff involved in discharge planning are trained on the use of the MABHAccess.com website and are expected to utilize this resource to locate available step-down and other aftercare services for Enrollees.
4. The provider identifies barriers to discharge planning and aftercare and develops strategies to assist the Enrollee with arranging and utilizing aftercare services, making best efforts to ensure that the discharge plan (or other such documents that contain the required elements) is consistent with his/her benefit coverage.
5. As appropriate, the provider assists the Enrollee in scheduling a follow-up appointment for the Enrollee with his/her PCC.
6. With the Enrollee's consent, the provider, in collaboration with the Enrollee, his/her family, and/or his/her supports, develops a written, individualized, person-centered, strengths-based discharge plan (or other such documents that contain the required elements), prior to the Enrollee's discharge from any inpatient service or, if appropriate, any other behavioral health service, that is documented in the Enrollee's health record. Prior to the Enrollee's discharge, the provider provides the Enrollee with a copy of the discharge plan (or other such documents that contain the required elements). The plan includes, but is not limited to:

a) Identification of the Enrollee's needs, including but not limited to:

I. Housing;

II. Finances;

III. Medical care;

IV. Transportation;

V. Family, employment, and educational concerns;

VI. Natural community and social supports; and

VII. For Enrollees discharged from inpatient mental health services and for other Enrollees as clinically indicated, an updated crisis prevention plan for adults that follows the principles of recovery and resilience, or an updated safety plan for youth and their families, and/or a relapse prevention plan, as applicable. Such a plan is directed by the Enrollee and is designed to expedite a consumer- or family-focused clinical disposition in the event of a psychiatric crisis, based on the experience gained from past treatment. It identifies triggers that may lead to or escalate a psychiatric crisis and includes a preferred disposition as well as the Enrollee's preferences. With Enrollee consent, the plan may be implemented by an ESP/MCI provider, a medical or behavioral health provider, the PCC, or another individual as directed by the Enrollee.

b) A list of the services and supports that are recommended post-discharge, including identified providers, PCCs, and other community resources available to deliver each recommended service;

c) A list of prescribed medication, dosages, and potential side effects; and

d) Treatment recommendations consistent with the service plan of the relevant state agency for Enrollees who are state agency involved; and

e) For all ICC-involved youth, the discharge plan is consistent with the youth's Individual Care Plan (ICP).

7. For all youth under the age of 21, the provider makes best efforts to ensure a smooth transition for the return to home or discharge location, and to the next service, if any, by:
   a) Linking to necessary services and making appropriate referrals, including Children's Behavioral Health Initiative (CBHI) services and Community Support Program (CSP), if indicated;
   b) Documenting in the Enrollee's health record all efforts related to these activities, including the Enrollee's and family's/guardian's/caregiver's active participation in discharge planning;
   c) Reviewing and updating any of the Crisis Planning Tools (e.g., safety plan, Advance Communication to Treatment Providers, Supplements to Advance Communication and Safety Plan), in collaboration with the youth, family, ICC provider if enrolled in ICC, and, if indicated, with the youth's ESP/MCI provider, and sending a copy to those providers where consent is given; and
   d) Educating the youth and family regarding use of the ESP/MCI service if needed in the future including access to their mobile and other community-based services.
8. Additional discharge planning requirements for Enrollees who are homeless:
   a) The provider makes all reasonable efforts to discharge any homeless Enrollees to living situations other than emergency shelters.
   b) The provider provides comprehensive discharge planning for all homeless Enrollees, exhausts all potential avenues to secure placement or housing resources, and utilizes all community resources to assist with discharge planning.
   c) The provider completes and forwards to DMH within two business days of admission a DMH Service Authorization packet for Enrollees who are homeless, who appear to meet DMH clinical criteria for service eligibility, and who have not already been determined

eligible for DMH Continuing Care Services.

d) The provider documents in the Enrollee's health record all efforts related to these activities.

9. For Enrollees who are minors: if reasonable attempts have been unsuccessful to involve their parents/guardians/caregivers in treatment and discharge planning, and/or the parents/guardians/caregivers are unable to participate in planning meetings, the provider presents treatment findings and recommendations to parents/guardians/caregivers at the time of discharge. These findings and recommendations are documented in the Enrollee's health record.

PRIMARY CARE CLINICIAN INTEGRATION

1. Throughout the course of treatment, as applicable, and with appropriate consent, to ensure integration of care the provider assesses and makes inquiries about the Enrollee's medical/health status, utilization of medical visits, and compliance with medical treatment through self-report; communication with the Enrollee's PCC and/or other healthcare professionals identified by the Enrollee; and communication with the Plan.
2. The provider identifies the Enrollee's PCC. If there is none, the provider makes best efforts to assist the Enrollee in obtaining a PCC by: directing him/her to the telephone number for MassHealth's Customer Service Center located on the back of his/her MassHealth ID card; or directly providing him/her with the telephone number for MassHealth's Customer Service Center.
3. The provider obtains a release of information to contact the PCC. If the Enrollee declines, the provider documents this in the Enrollee's health record and continues to engage the Enrollee around this issue.
4. The provider communicates with the Enrollee's PCC via telephone or in writing with Enrollee/guardian consent, and such communication is documented in the Enrollee's health record. For inpatient and 24-hour diversionary services, this communication takes place within one business day. For all other services, this communication takes place within five (5) business days.
5. The provider contacts the PCC for the following purposes:
   a) To notify him/her regarding admission or enrollment in services and the reasons for such admission/enrollment;
   b) To obtain information regarding health status, including but not limited to medical and medication information;
   c) To coordinate assessment, treatment, and discharge planning;
   d) To share diagnostic and treatment/care plan information;
   e) To coordinate medication, if applicable; and
   f) To notify him/her of discharge and involve him/her in discharge and/or aftercare planning as indicated.
6. With appropriate consent, the provider maintains ongoing communication and collaboration with the PCC for these purposes, as well as to provide information to the PCC about the course of

the Enrollee's behavioral health treatment, including psychopharmacology and notable metabolic studies and/or other medical information. The provider utilizes information from the PCC to inform the Enrollee's assessment, treatment/care plan and discharge plan on an ongoing basis.

7. To facilitate communication between the behavioral health provider and the PCC, providers of all levels of care are encouraged to utilize the "Combined MCE Behavioral Health Provider/Primary Care Provider Communication Form." This form can be located at masspartnership.com in both the "For PCCs" and "For BH Providers" sections.

QUALITY MANAGEMENT

1. The provider will develop and maintain a quality management plan that is consistent with their contractual responsibilities to Optum, and which utilizes appropriate measures to monitor, measure, and improve the activities and services it provides.
2. A continuous quality improvement process is utilized and may include outcome measures and satisfaction surveys to measure and improve the quality of care and services delivered to Enrollees, including youth and their families.
3. Clinical outcomes data must be made available to Optum upon request and must be consistent with the performance specifications of this service.
4. Providers must report any adverse incidents and other reportable events that occur to the relevant authorities.