



COMMONWEALTH OF MASSACHUSETTS

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BULLETIN 2018-07

TO: Commercial Health Insurers, Blue Cross and Blue Shield of Massachusetts, Inc. and Health Maintenance Organizations

FROM: Gary D. Anderson, Commissioner of Insurance
Joan Mikula, Commissioner of Mental Health

DATE: December 14, 2018

RE: Access to Services to Treat Child-Adolescent Mental Health Disorders

The purpose of this Bulletin jointly issued by the Division of Insurance (Division) and the Department of Mental Health is to clarify certain mandated benefits for child-adolescent services as required by M.G.L. c. 175, §47B; M.G.L. c. 176A, §8A; M.G.L. c. 176B, §4A; and M.G.L. c. 176G, §4M. Please refer also to Division Bulletins 2000-06, 2000-10, 2002-07, 2003-11, 2009-04, 2009-11, and 2013-02.

Background

Mental health services required to be covered by health plans offered under M.G.L. chapters 175, 176A, 176B, and 176G (hereinafter referred to as insured health plans¹) are those that diagnose and/or treat an illness, disease, or health condition in order to reduce or alleviate symptoms and/or improve an individual’s emotional or behavioral functioning. All mental health benefits for biologically-based and for non-biologically-based disorders are required to be provided on a non-discriminatory basis.²

Required Benefits for Child-Adolescent Mental Health Disorders³

Insured health plans must include benefits on a non-discriminatory basis for the diagnosis and treatment of child-adolescent mental health disorders which substantially interfere with or substantially limit the functioning and social interactions of the child or adolescent; provided, that said interference or limitation is documented by, and the referral for said diagnosis and treatment is made by, the child’s primary care provider, primary pediatrician, or a licensed mental health

¹ An insured health plan is one that is offered by a licensed health Carrier through which the Carrier assumes the risk to pay the cost of specified medically necessary health treatment(s) in return for the receipt of premiums.
² See Bulletin 2013-02; Changes to Mental Health Benefit; Issued April 1, 2013.
³ For purposes of this Bulletin, all subsequent references to mental health disorders and services include substance use disorders and services and mental, behavioral, or emotional disorders, as described in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association.

professional, or is evidenced by conduct, including, but not limited to: (1) an inability to attend school as a result of such a disorder, (2) the need to hospitalize the child or adolescent as a result of the disorder, or (3) a pattern of conduct or behavior caused by such a disorder which poses a serious danger to self or others.⁴

Child-adolescent mental health services shall take place in the least restrictive clinically appropriate setting and shall consist of a range of inpatient, intermediate, and outpatient services that shall permit medically necessary, active care expected to lead to improvement of the condition in a reasonable period of time, as well as medically necessary noncustodial treatment for the mental health disorders. The covered services may be provided to the child, the child's parent(s), and/or other appropriate caregivers. Educational services to improve an individual's academic performance or developmental functioning are not required services under the benefit mandate for mental health services.

Intermediate Care and Outpatient Services

The Division expects that Carriers provide adequate access to intermediate care and outpatient services medically necessary to treat child-adolescent mental health disorders. In providing access to services in accordance with this Bulletin, Carriers shall ensure that if a provider is not independently licensed at the Masters/PhD/MD level, then the supervisor - who must be a Masters Level independently licensed provider - must sign off on the treatment plan whenever the child's or adolescent's condition changes. These intermediate care and outpatient services shall include, but are not limited to, the following services:

In-home behavioral services - a combination of medically necessary behavior management therapy and behavior management monitoring; provided, however, that such services shall be available, when indicated, where the child resides, including in the child's home, a foster home, a therapeutic foster home, or another community setting. In-home behavioral services include:

Behavior management monitoring - monitoring of a child's behavior, the implementation of a behavior plan and reinforcing implementation of a behavior plan by the child's parent or other caregiver.

Behavior management therapy - therapy that addresses challenging behaviors that interfere with a child's successful functioning; provided, however, that "behavior management therapy" shall include a functional behavioral assessment and observation of the youth in the home and/or community setting, development of a behavior plan, and supervision and coordination of interventions to address specific behavioral objectives or performance, including the development of a crisis-response strategy; and provided further, that "behavior management therapy" may include short-term counseling and assistance.

Family support and training - medically necessary services provided to a parent or other caregiver of a child to improve the capacity of the parent or caregiver to ameliorate or resolve the child's emotional or behavioral needs; provided, however, that such service shall be provided where the child resides, including in the child's home, a foster home, a therapeutic foster home, or another community setting. Family support and training addresses one or more goals on the youth's behavioral health treatment plan and may include educating parents/caregivers about the youth's behavioral health needs and resiliency factors, teaching parents/caregivers how to navigate

⁴ The examples of conduct listed in the statutes do not constitute a comprehensive list of conduct that indicates substantial limitation or interference for which diagnosis and treatment are required under the applicable statutes and bulletins. Insured health plans should not use these examples as the sole basis for determining medical necessity for services.

services on behalf of the child and how to identify formal and informal services and supports in their communities, including parent support and self-help groups.

In-home therapy – medically necessary therapeutic clinical intervention or ongoing training, as well as therapeutic support; provided however, that the intervention or support shall be provided where the child resides, including in the child’s home, a foster home, a therapeutic foster home, or another community setting. Where any Carrier’s Family Stabilization Treatment (FST) service is substantially similar to In-Home Therapy, it may be considered to meet the requirements of this Bulletin.

Therapeutic clinical intervention - intervention that shall include: (i) a structured and consistent therapeutic relationship between a licensed clinician and a child and the child’s family to treat the child’s mental health needs, including improvement of the family’s ability to provide effective support for the child and promotion of healthy functioning of the child within the family; (ii) the development of a treatment plan; and (iii) the use of established psychotherapeutic techniques, working with the family or a subset of the family to enhance problem solving, limit setting, communication, emotional support or other family or individual functions.

Ongoing therapeutic training and support - services that support implementation of a treatment plan pursuant to therapeutic clinical intervention that shall include, but not be limited to, teaching the child to understand, direct, interpret, manage and control feelings and emotional responses to situations and assisting the family in supporting the child and addressing the child’s emotional and mental health needs.

Therapeutic mentoring services – medically necessary services provided to a child, designed to support age-appropriate social functioning or to ameliorate deficits in the child’s age-appropriate social functioning resulting from a DSM diagnosis; provided, however, that such services may include supporting, coaching, and training the child in age-appropriate behaviors, interpersonal communication, problem solving, conflict resolution, and relating appropriately to other children and adolescents and to adults. Such services shall be provided, when indicated, where the child resides, including in the child’s home, a foster home, a therapeutic foster home, or another community setting. Therapeutic mentoring is a skill building service addressing one or more goals on the youth’s behavioral health treatment plan. It may also be delivered in the community, to allow the youth to practice desired skills in appropriate settings.

Mobile crisis intervention - a short-term, mobile, on-site, face-to-face therapeutic response service that is available 24 hours a day, 7 days a week to a child experiencing a behavioral health crisis. Mobile crisis intervention is used to identify, assess, treat and stabilize a situation, to reduce the immediate risk of danger to the child or others, and to make referrals and linkages to all medically necessary behavioral health services and supports and the appropriate level of care. The intervention shall be consistent with the child’s risk management or safety plan, if any. Mobile crisis intervention includes a crisis assessment and crisis planning, which may result in the development or update of a crisis safety plan.

Intensive care coordination - a collaborative service that provides targeted case management services to children and adolescents with a serious emotional disturbance, including individuals with co-occurring conditions, in order to meet the comprehensive medical, behavioral health, and psychosocial needs of an individual and the individual’s family, while promoting quality, cost-effective outcomes. This service includes an assessment, the development of an individualized care plan, referrals to appropriate levels of care, monitoring of goals, and coordinating with other services and social supports and with state agencies, as indicated. The service shall be based upon

a system of care philosophy and the individualized care plan shall be tailored to meet the needs of the individual. The service shall include both face-to-face and telephonic meetings, as indicated and as clinically appropriate. ICC is delivered in office, home or other settings, as clinically appropriate.

Community-based acute treatment for children and adolescents (CBAT) - mental health services provided in a staff-secure setting on a 24-hour basis, with sufficient clinical staffing to ensure safety for the child or adolescent, while providing intensive therapeutic services including, but not limited to: daily medication monitoring; psychiatric assessment; nursing availability; specializing (as needed); individual, group and family therapy; case management; family assessment and consultation; discharge planning; and psychological testing, as needed. This service may be used as an alternative to or transition from inpatient services. Whenever a Carrier's Acute Residential Treatment (ART) program is substantially similar to CBAT, it may be considered to meet the requirements of this Bulletin.

Intensive community-based treatment for children and adolescents (ICBAT) - provides the same services as CBAT for children and adolescents but of higher intensity, including more frequent psychiatric and psychopharmacological evaluation and treatment and more intensive staffing and service delivery. ICBAT programs have the capability to admit children and adolescents with more acute symptoms than those admitted to CBAT. ICBAT programs are able to treat children and adolescents with clinical presentations similar to those referred to inpatient mental health services but who are able to be cared for safely in an unlocked setting. Children and adolescents may be admitted to an ICBAT directly from the community as an alternative to inpatient hospitalization; ICBAT is not used as a step-down placement following discharge from a locked, 24-hour setting. Whenever a Carrier's ART program is substantially similar to ICBAT, it may be considered to meet the requirements of this Bulletin.

The following are not considered child-adolescent mental health intermediate care and outpatient services and are not required to be covered by an insured health plan:

- Programs in which the patient has a pre-defined duration of care without the health plan's ability to conduct concurrent determinations of continued medical necessity for an individual.
- Programs that only provide meetings or activities that are not based on individualized treatment planning.
- Programs that focus solely on improvement in interpersonal or other skills rather than services directed toward symptom reduction and functional recovery related to specific mental health disorders.
- Tuition-based programs that offer educational, vocational, recreational, or personal development activities, such as a therapeutic school, camp, or wilderness program. The health plan must provide coverage for medically necessary services provided while the individual is in the program, subject to the terms of the member's evidence of coverage including any network requirements or co-payments/coinsurance provisions.
- Programs that provide primarily custodial care services.⁵

⁵ See Bulletin 2009-11; Access to Intermediate and Outpatient Mental Health & Substance Use Disorder Services; Issued September 4, 2009.

Level of Benefits for Child-Adolescent Mental Health Services

The duration and types of child-adolescent mental health services for any particular individual will vary according to that person's individual needs. Because Chapter 80 of the Acts of 2000 and Chapter 256 of the Acts of 2008 do not specify a minimum benefit for child-adolescent mental health care, plan consideration of coverage for child-adolescent care should be based solely on medical necessity criteria rather than any arbitrary number of days or number of visits.

Medical Necessity

Pursuant to M.G.L. c. 176O, §16(b), insured health plans are required to cover health care services if (1) the services are a covered benefit under the insured's health benefit plan; and (2) the services are medically necessary under established criteria. Carriers that are accredited by the Division as managed care companies under M.G.L. c. 176O may employ utilization review, quality assurance and credentialing systems for insured health plans in making decisions about whether services are medically necessary. Utilization review is defined in M.G.L. c. 176O, §1 as "a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings."

An insured health plan must consider the individual health care needs of the insured in applying such guidelines. In accordance with M.G.L. c. 176O, an individual may appeal a decision by the health plan to reduce or modify a request for authorization of covered care based on the health plan's medical necessity criteria.

Clarifying Coverage within Health Plan Systems

The Division expects all Carriers offering insured health plans to amend existing Evidences of Coverage and other documents so that they present benefits for child-adolescent services in a manner that is consistent with the clarifications presented in this Bulletin.

All Services Except for Family Support and Training and Therapeutic Mentoring

The Division expects that Carriers will take all appropriate steps to ensure that any necessary changes to insured health plans, utilization criteria or other rating/claims systems are in place for plans issued or renewed on and after July 1, 2019 to provide access to all listed services except for family support and training and therapeutic mentoring. In order to ensure that all appropriate rate and form information may be processed by the Division for coverage becoming effective by July 1, 2019, Carriers are expected to file materials with the Division, and where appropriate with the Department of Mental Health (DMH), according to the following timeline:

January 15, 2019 Material is filed with the Division and DMH to identify criteria that is proposed to be used for each covered service to determine whether the service will be considered to be necessary and appropriate for a covered member. This criteria will be used as the basis for any adverse determination decisions and will be used when conducting internal and external appeals.

February 15, 2019 The Division and DMH will complete reviews of submitted criteria.

April 1, 2019 Form filing materials are submitted to the Division via the System for Electronic Rate and Form Filings (SERFF) that update existing Evidences of Coverage, provider directory information and other consumer materials to explain coverage for required mental health services for children and adolescents.

Rate filings are submitted to the Division for rates to be effective July 1, 2019 that incorporate required behavioral health services for children and

adolescents.

May 15, 2019 The Division completes its review of form and rate filing materials.

July 1, 2019 Coverage becoming effective on and after July 1, 2019 includes required mental health services for children and adolescents and Carriers have established systems that enable persons with such coverage to obtain such care through managed care systems.

Family Support and Training and Therapeutic Mentoring

The Division expects that Carriers will take all appropriate steps to ensure that any necessary changes to insured health plans, utilization criteria or other rating/claims systems are in place for plans issued or renewed on and after July 1, 2020, or such time as certification standards for these services are established as determined by the Division, to provide access to all family support and training and therapeutic mentoring. In order to ensure that all appropriate rate and form information may be processed by the Division for coverage becoming effective by July 1, 2020, Carriers are expected to file materials with the Division, and where appropriate with DMH, according to the following timeline:

January 15, 2020 Material is filed with the Division and DMH to identify criteria that is proposed to be used for each covered service to determine whether the service will be considered to be necessary and appropriate for a covered member. This criteria will be used as the basis for any adverse determination decisions and will be used when conducting internal and external appeals.

February 15, 2020 The Division and DMH will complete reviews of submitted criteria.

April 1, 2020 Form filing materials are submitted to the Division via the SERFF that update existing Evidences of Coverage, provider directory information and other consumer materials to explain coverage for required mental health services for children and adolescents.

Rate filings are submitted to the Division for rates to be effective July 1, 2020 that incorporate required behavioral health services for children and adolescents.

May 15, 2020 The Division completes its review of form and rate filing materials.

July 1, 2020 Coverage becoming effective on and after July 1, 2020 includes required mental health services for children and adolescents and Carriers have established systems that enable persons with such coverage to obtain such care through managed care systems.

If there are questions regarding this Bulletin, please contact Kevin Beagan, Deputy Commissioner at the Division of Insurance, at (617) 521-7323.