Medicaid Section 1115 Substance Use Disorder & Serious Mental Illness and Serious Emotional Disturbance Demonstrations
Monitoring Report Template

Note: PRA Disclosure Statement to be added here

1. Title page for the state's substance use disorder (SUD) and serious mental illness and serious emotional disturbance (SMI/SED) demonstrations or the SUD and SMI/SED components of the broader demonstration

This section collects information on the approval features of the state's section 1115 demonstration overall, followed by information for the SUD and SMI/SED components. The state completed this title page as part of its SUD and SMI/SED monitoring protocol(s). The state should complete this table using the corresponding information from its CMS-approved monitoring protocol(s) and submit this as the title page of all monitoring reports. The content of this table should stay consistent over time. Definitions for certain rows are below the table.

Overall section 1115 demonstration	
State	*Massachusetts*
Demonstration name	*MassHealth.*
Approval period for section 1115 demonstration	*10/01/2022-12/31/2027*
Reporting period	*10/01/2024-12/31/24*
SUD demonstration	
SUD component start date[a]	*10/01/2022.*
Implementation date of SUD component, if different from SUD component start date[b]	

SUD-related demonstration goals and objectives	**Access to Critical Levels of Care for OUD and other SUDs.** Coverage of OUD/SUD treatment services across a comprehensive continuum of care including: outpatient; intensive outpatient; medication assisted treatment (medication as well as counseling and other services with sufficient provider capacity to meet needs of Medicaid beneficiaries in the state); intensive levels of care in residential and inpatient settings; and medically supervised withdrawal management. **Use of Evidence-based SUD-specific Patient Placement Criteria.** Providers will assess treatment needs based on SUD-specific, multidimensional assessment tools, such as the ASAM Criteria or other assessment and placement tools that reflect evidence-based clinical treatment guidelines **Patient Placement.** The state will continue to employ a utilization management approach, in accordance with state law, such that beneficiaries have access to SUD services at the appropriate level of care and that the interventions are appropriate for the diagnosis and level of care, including an independent process for reviewing placement in residential treatment settings. **Use of Nationally Recognized SUD-specific Program Standards to set Provider Qualifications for Residential Treatment Facilities.** Residential treatment providers must align with the program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding in particular the types of services, hours of clinical care, and credentials of staff for residential treatment settings. Residential treatment providers must also be in compliance with state licensure requirements for substance use disorder treatment programs. **Standards of Care for Residential Treatment Settings.** The state will review residential treatment providers to ensure that providers deliver care consistent with the specifications in the ASAM Criteria or other comparable, nationally recognized SUD program standards based on evidence-based clinical treatment guidelines for types of services, hours of clinical care, and credentials of staff for residential treatment settings.

	Standards of Care for Medication Assisted Treatment. Residential treatment providers must offer Medication Assisted Treatment (MAT) on-site or facilitate access to MAT off-site. **Sufficient Provider Capacity at each Level of Care including Medication Assisted Treatment for SUD/OUD.** The state must ensure sufficient provider capacity in the critical levels of care throughout the state, including those that offer MAT. **Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and SUD/OUD.** The state has implemented opioid prescribing guidelines along with other interventions to prevent prescription drug abuse and expand coverage of and access to naloxone for overdose reversal as well as implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs. **Improved Care Coordination and Transitions between levels of care.** The state will continue to ensure residential and inpatient facilities link beneficiaries with community-based services and supports following stays in these facilities. **SUD Health IT Plan.** Implementation of the milestones and metrics for the SUD Health IT Plan.
SUD demonstration year and quarter	SUD DY8Q4

SMI/SED demonstration	
SMI/SED component demonstration start date[a]	*10/01/2022*
Implementation date of SMI/SED component, if different from SMI/SED component start date[b]	

SMI/SED-related demonstration goals and objectives	**Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings**. Hospitals that meet the definition of an IMD in which beneficiaries receiving demonstration services under the SMI and SED program are residing must be licensed or approved as meeting standards for licensing established by the agency of the state or locality responsible for licensing hospitals prior to the state claiming FFP for services provided to beneficiaries residing in a hospital that meets the definition of an IMD. In addition, hospitals must be in compliance with the conditions of participation set forth in 42 CFR Part 482 and either: a) be certified by the state agency as being in compliance with those conditions through a state agency survey, or b) have deemed status to participate in Medicare as a hospital through accreditation by a national accrediting organization whose psychiatric hospital accreditation program or acute hospital accreditation program has been approved by CMS. Residential treatment providers that meet the definition of an IMD in which beneficiaries receiving demonstration services under the SMI program are residing must be licensed, or otherwise authorized, by the state to primarily provide treatment for mental illnesses. They must also be accredited by a nationally recognized accreditation entity prior to the state claiming FFP for services provided to beneficiaries residing in a residential facility that meets the definition of an IMD. Facilities providing Youth Community Crisis Stabilization and Community Based Acute Treatment for Children and Adolescents (CBAT) services must meet these requirements.[1] A transition period to comply with rules is permitted and described in STC 7.9. Establishment of an oversight and auditing process that includes unannounced visits for ensuring participating psychiatric hospitals and residential treatment settings meet state licensure or certification requirements as well as a national accrediting entity's accreditation requirements. Use of a utilization review entity (for example, a MCO or administrative service organization) to ensure beneficiaries have access to the appropriate levels and types of care and, in accordance with state law, to provide oversight to ensure lengths of stay are limited to what is medically necessary and only those who have a clinical need to receive treatment in psychiatric hospitals and

	residential treatment settings are receiving treatment in those facilities. Establishment of a process for ensuring that participating psychiatric hospitals and residential treatment settings meet applicable federal program integrity requirements and establishment of a state process to conduct risk-based screening of all newly enrolling providers, as well as revalidation of existing providers (specifically, under existing regulations, the state must screen all newly enrolling providers and reevaluate existing providers pursuant to the rules in 42 CFR Part 455 Subparts B and E, ensure treatment providers have entered into Medicaid provider agreements pursuant to 42 CFR 431.107, and establish rigorous program integrity protocols to safeguard against fraudulent billing and other compliance issues). Implementation of a state requirement that participating psychiatric hospitals and residential treatment settings screen beneficiaries for co-morbid physical health conditions and substance use disorders (SUDs) and demonstrate the capacity to address co-morbid physical health conditions during short-term stays in residential or inpatient treatment settings (e.g., with on-site staff, telemedicine, and/or partnerships with local physical health providers). **Improving Care Coordination and Transitioning to Community-Based Care.** Implementation of a process to ensure that psychiatric hospitals and residential treatment settings provide intensive pre-discharge, care coordination services to help beneficiaries transition out of those settings into appropriate community-based outpatient services, including requirements that facilitate participation of community-based providers in transition efforts (e.g., by allowing beneficiaries to receive initial services from a community-based provider while the beneficiary is still residing in these settings and/or by engaging peer support specialists to help beneficiaries make connections with available community-based providers and, where applicable, make plans for employment). Implementation of a process to assess the housing situation of a beneficiary transitioning to the community from psychiatric hospitals and residential treatment settings and to connect beneficiaries who may experience homelessness upon discharge or

	who would be discharged to unsuitable or unstable housing with community providers that coordinate housing services, where available. Implementation of a requirement that psychiatric hospitals and residential treatment settings have protocols in place to ensure contact is made by the treatment setting with each discharged beneficiary within 72 hours of discharge and to help ensure follow-up care is accessed by individuals after leaving those facilities by contacting the individuals directly and, as appropriate, by contacting the community-based provider they were referred to. Implementation of strategies to prevent or decrease the length of stay in emergency departments among beneficiaries with SMI or SED (e.g., through the use of peer support specialists and psychiatric consultants in EDs to help with discharge and referral to treatment providers). Implementation of strategies to develop and/or enhance interoperability and data sharing between physical, SUD, and mental health providers, with the goal of enhancing coordination so that disparate providers may better share clinical information to improve health outcomes for beneficiaries with SMI or SED. **Increasing Access to Continuum of Care Including Crisis Stabilization Services.** Establishment of a process to annually assess the availability of mental health services throughout the Commonwealth, particularly crisis stabilization services, and updates on steps taken to increase availability. Commitment to implementation of the financing plan described in STC 7.2(d). Implementation of strategies to improve the state's capacity to track the availability of inpatient and crisis stabilization beds to help connect individuals in need with that level of care as soon as possible. Implementation of a requirement that providers, plans, and utilization review entities use an evidence-based, publicly available patient assessment tool, preferably endorsed by a mental health

	provider association (e.g., LOCUS or CASII) to determine appropriate level of care and length of stay. **Earlier Identification and Engagement in Treatment, Including Through Increased Integration.** Implementation of strategies for identifying and engaging individuals, particularly adolescents and young adults, with SMI/SED in treatment sooner, including through supported employment and supported education programs. Increasing integration of behavioral health care in non-specialty care settings, including schools and primary care practices, to improve identification of SMI/SED conditions sooner and improve awareness of and linkages to specialty treatment providers. Establishment of specialized settings and services, including crisis stabilization services, focused on the needs of young people experiencing SMI or SED. **Health IT Plan.** Implementation of the milestones and metrics for the SMI/SED Health IT Plan..
SMI/SED demonstration year and quarter	SMI/SED DY3Q4

[a] **SUD and SMI/SED demonstration components start dates:** For monitoring purposes, CMS defines the start date of the demonstration as the *effective date* listed in the state's STCs at time of SUD and SMI/SED demonstration component approvals. For example, if the state's STCs at the time of SUD demonstration approval note that the SUD demonstration is effective January 1, 2020 – December 31, 2025, the state should consider January 1, 2020 to be the start date of the SUD demonstration. Note that the effective date is considered to be the first day the state may begin its SUD or SMI/SED demonstration component. In many cases, the effective date is distinct from the approval date of a demonstration; that is, in certain cases, CMS may approve a section 1115 demonstration with an effective date that is in the future. For example, CMS may approve an extension request on December 15, 2020, with an effective date of January 1, 2021 for the new demonstration period. In many cases, the effective date also differs from the date a state begins implementing its demonstration.

[b] **Implementation date of SUD and SMI/SED demonstration components:** The date the state began claiming or will begin claiming federal financial participation for services provided to individuals in institutions for mental disease.

2. Executive summary

The executive summary for the SUD and SMI components of the demonstration should be reported below. It is intended for summary-level information only and may be combined for all policies included in the title page. The recommended word count is 500 words or less.

SUD

During this reporting period, the state observed a slight decrease in the number of beneficiaries who received any SUD treatment and a decrease in the number of those who used outpatient services. The state saw a significant decrease in the rate of inpatient stays for SUD per 1,000 MassHealth beneficiaries.

In the same reporting period, the state observed an increase in the number of beneficiaries who utilized intensive outpatient and/or partial hospitalization services for SUD, residential and inpatient services, withdrawal management services, and the Emergency Department.

During 2024, the state reviewed and evaluated various SUD services and criteria to develop future programmatic enhancements. These criteria and services include the 4th edition of the ASAM criteria, Recovery Coach and Recovery Support Navigator services, and the primary care sub-capitation program.

The state recently introduced a new tiered rate structure for Acute Treatment Services and Clinical Stabilization Services which has led to a significant increase in the number of public health insurance beds by the end of 2024.

SMI/SED

During this reporting period, the state saw a decrease in inpatient mental health service utilization, the number of beneficiaries who used intensive outpatient and/or partial hospitalization services related to mental health, and mental health service utilization for telehealth.

The state saw an increase in the number of beneficiaries who used emergency department services for mental health.

In October 2024, a new supplemental payment was added to the RY25 Inpatient Psychiatric Hospital Contract in addition to new requirements related to health information technology services. Additional further discharge planning requirements were added to the RY25 RFA for beneficiaries at risk of or experiencing homelessness.

In 2024, psychiatric hospitals were informed of an upcoming requirement to disclose ADT messages beginning in 2026 and were also reminded that they may utilize the Mass HIway

system to send and receive electronic care plans and medical records. In Q4 of 2024, additional hospitals joined the early adopter cohort for the Behavioral Health Treatment and Reform Platform.

During 2024, the state completed an 18-month process of stakeholder development and testing a new platform for the existing CANS tool, a patient assessment tool used with children and youth. The state has also continued to support a variety of behavioral health trainings focused on identifying and engaging beneficiaries in treatment sooner. The state contracted with the Technical Assistance Collaborative to hold stakeholder engagement sessions with CBHI providers and relevant state agencies to better understand the experience of beneficiaries utilizing or attempting to utilize CBHI services.

3. Narrative information on implementation, by milestone and reporting topic

A. SUD component

Prompt		State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
1.	**Assessment of need and qualification for SUD services**			
1.1	**Metric trends**			
1.1.1	The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to assessment of need and qualification for SUD services.		• #3 Any SUD Treatment	• For SUD Metric 3, between Q1 2024 and Q2 2024, we observed a 3.3% decrease in the number of beneficiaries who received any SUD treatment.
1.2	**Implementation update**			
1.2.1	Compared to the demonstration design and operational details, the state expects to make the following changes to: 1.2.1.a The target population(s) of the demonstration	X		*The state has no trends/updates to report*
	1.2.1.b The clinical criteria (e.g., SUD diagnoses) that qualify a beneficiary for the demonstration	X		*The state has no trends/updates to report*
1.2.2	The state expects to make other program changes that may affect metrics related to assessment of need and qualification for SUD services.	X		*The state has no trends/updates to report*

Prompt		State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
2.	**Access to Critical Levels of Care for OUD and other SUDs (Milestone 1)**			
2.1	**Metric trends**			
2.1.1	The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 1.		• #6 Any SUD treatment • #8 Outpatient Services • #9 Intensive Outpatient and Partial Hospitalization Services • #10 Residential and Inpatient Services • #11 Withdrawal Management • #12 MAT	• For SUD Metric 6, any SUD Treatment we used the 2023 HEDIS Medication List. Between Q1 2024 and Q2 2024, we observed no significant change in the number of beneficiaries who received any SUD treatment. • For SUD Metric 8, between Q1 2024 and Q2 2024, we observed a 3.6% decrease in metric 8, the number of beneficiaries who used outpatient services. • For SUD Metric 9, we observed a 7.4% increase in beneficiaries who used intensive outpatient and/or partial hospitalization services for SUD from Q1 2024 and Q2 2024. • For SUD Metric 10, between Q1 2024 and Q2 2024 we observed a 5.7% increase in residential and inpatient services. • Between Q1 2024 and Q2 2024, we observed a 4.2% increase in SUD Metric 11, the number of beneficiaries who use withdrawal management services (such as outpatient, inpatient, or residential). • For SUD Metric 12, Medication Assisted Treatment, we used the 2023 HEDIS Medication List. From Q1 2024 and Q2 2024, we observed no significant change in the number of beneficiaries who had a claim for MAT for SUD.

Prompt		State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
2.2	**Implementation update**			
2.2.1	Compared to the demonstration design and operational details, the state expects to make the following changes to: 2.2.1.a Planned activities to improve access to SUD treatment services across the continuum of care for Medicaid beneficiaries (e.g., outpatient services, intensive outpatient services, medication-assisted treatment, services in intensive residential and inpatient settings, medically supervised withdrawal management)			Beginning in 2023, the state introduced a tiered rate structure for Acute Treatment Services (ATS) and Clinical Stabilization Services (CSS) based on a provider's public payer mix. At implementation of the tiered rate structure, 19 ATS providers and 20 CSS providers were moved to the elevated tiers. At the end of 2024, revaluation of tiers rate structure identified that 4 new programs began to serve Members with public health insurance and 5 ATS providers and 3 CSS providers demonstrated increased access for members with public health insurance This increase in participating providers helped lead to a 45% increase in public health insurance beds by the end of 2024 compared to the start of the tiered rate structure program.
	2.2.1.b SUD benefit coverage under the Medicaid state plan or the Expenditure Authority, particularly for residential treatment, medically supervised withdrawal management, and medication-assisted treatment services provided to individual IMDs	X		*The state has no trends/updates to report*
2.2.2	The state expects to make other program changes that may affect metrics related to Milestone 1.	X		*The state has no trends/updates to report*

Prompt		State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
3.	**Use of Evidence-based, SUD-specific Patient Placement Criteria (Milestone 2)**			
3.1	**Metric trends**			
3.1.1	The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 2.			
3.2	**Implementation update**			
3.2.1	Compared to the demonstration design and operational details, the state expects to make the following changes to: 3.2.1.a Planned activities to improve providers' use of evidence-based, SUD-specific placement criteria			The state is reviewing the 4th edition of the ASAM criteria to determine feasibility of potential programmatic enhancements.
	3.2.1.b Implementation of a utilization management approach to ensure (a) beneficiaries have access to SUD services at the appropriate level of care, (b) interventions are appropriate for the diagnosis and level of care, or (c) use of independent process for reviewing placement in residential treatment settings			The state evaluated the utilization of Recovery Coach and Recovery Support Navigator services in 2024 to better understand the populations accessing these services, where services are currently operational, and how these services can be expanded throughout the state.
3.2.2	The state expects to make other program changes that may affect metrics related to Milestone 2.	X		

Prompt			State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
4.	**Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities (Milestone 3)**				
4.1	**Metric trends**				
4.1.1	The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 3. Note: There are no CMS-provided metrics related to Milestone 3. If the state did not identify any metrics for reporting this milestone, the state should indicate it has no update to report.		X		
4.2	**Implementation update**				
4.2.1	Compared to the demonstration design and operational details, the state expects to make the following changes to:				
	4.2.1.a	Implementation of residential treatment provider qualifications that meet the ASAM Criteria or other nationally recognized, SUD-specific program standards			The state is reviewing the 4th edition of the ASAM criteria to determine feasibility of potential programmatic enhancements
	4.2.1.b	Review process for residential treatment providers' compliance with qualifications.	X		*The state has no trends/updates to report*
	4.2.1.c	Availability of medication-assisted treatment at residential treatment facilities, either on-site or through facilitated access to services off site	X		*The state has no trends/updates to report*
4.2.2	The state expects to make other program changes that may affect metrics related to Milestone 3.		X		

Prompt		State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
5.	**Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment for OUD (Milestone 4)**			
5.1	**Metric trends**			
5.1.1	The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 4.			
5.2	**Implementation update**			
5.2.1	Compared to the demonstration design and operational details, the state expects to make the following changes to: Planned activities to assess the availability of providers enrolled in Medicaid and accepting new patients across the continuum of SUD care.			In 2024, the state introduced new perinatal Recovery Coach and Recovery Support Navigator provider types via the public hearing process. Program and rate regulations for these new provider types will be effective in 2025. The state is currently assessing new SUD requirements for the existing primary care sub-capitation program. The highest tier currently includes requirements for substance use disorder screening, BH referrals, BH medication management, as well as active buprenorphine availability.
5.2.2	The state expects to make other program changes that may affect metrics related to Milestone 4.	X		

Prompt		State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
6.	**Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD (Milestone 5)**			
6.1	**Metric trends**			
6.1.1	The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 5.		• #23 ED Utilization for SUD per 1,000 Medicaid Beneficiaries	• For SUD Metric 23, there was a 9.6% increase in ED utilization per 1,000 Medicaid beneficiaries between Q1 2024 and Q2 2024.
6.2	**Implementation update**			
6.2.1	Compared to the demonstration design and operational details, the state expects to make the following changes to: 6.2.1.a Implementation of opioid prescribing guidelines and other interventions related to prevention of OUD	X		*The state has no trends/updates to report*
	6.2.1.b Expansion of coverage for and access to naloxone	X		*The state has no trends/updates to report*
6.2.2	The state expects to make other program changes that may affect metrics related to Milestone 5.	X		*The state has no trends/updates to report*

Prompt		State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
7.	**Improved Care Coordination and Transitions between Levels of Care (Milestone 6)**			
7.1	**Metric trends**			
7.1.1	The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 6.	X		
7.2	**Implementation update**			
7.2.1	Compared to the demonstration design and operational details, the state expects to make the following changes to: Implementation of policies supporting beneficiaries' transition from residential and inpatient facilities to community-based services and supports.	X		*The state has no trends/updates to report*
7.2.2	The state expects to make other program changes that may affect metrics related to Milestone 6.	X		*The state has no trends/updates to report*

Prompt		State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
8.	**SUD health information technology (health IT)**			
8.1	**Metric trends**			
8.1.1	The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to its SUD health IT metrics.	X		
8.2	**Implementation update**			
8.2.1	Compared to the demonstration design and operational details, the state expects to make the following changes to:	X		*The state has no trends/updates to report*
	8.2.1.a How health IT is being used to slow down the rate of growth of individuals identified with SUD			
	8.2.1.b How health IT is being used to treat effectively individuals identified with SUD	X		*The state has no trends/updates to report*
	8.2.1.c How health IT is being used to effectively monitor "recovery" supports and services for individuals identified with SUD	X		*The state has no trends/updates to report*
	8.2.1.d Other aspects of the state's plan to develop the health IT infrastructure/capabilities at the state, delivery system, health plan/MCO, and individual provider levels	X		*The state has no trends/updates to report*
	8.2.1.e Other aspects of the state's health IT implementation milestones	X		*The state has no trends/updates to report*
	8.2.1.f The timeline for achieving health IT implementation milestones	X		*The state has no trends/updates to report*

Prompt		State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
8.2.1.g	Planned activities to increase use and functionality of the state's prescription drug monitoring program	X		*The state has no trends/updates to report*
8.2.2	The state expects to make other program changes that may affect SUD metrics related to health IT.	X		*The state has no trends/updates to report*
9.	**Other SUD-related metrics**			
9.1	**Metric trends**			
9.1.1	The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to other SUD-related metrics.		• #24 Inpatient Stays for SUD per 1,000 Medicaid Beneficiaries	• For SUD Metric 24, there was a 26.5% decrease between Q1 2024 and Q2 2024 in the rate of Inpatient Stays for SUD per 1,000 MassHealth beneficiaries.
9.2	**Implementation update**			
9.2.1	The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to other SUD-related metrics.	X		

B. SMI/SED component

Prompt			State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
1.	**Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings (Milestone 1)**				
1.1	**Metric trends**				
1.1.1	The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 1.		X		
1.2	**Implementation update**				
1.2.1	Compared to the demonstration design and operational details, the state expects to make the following changes to:		X		*The state has no trends/updates to report*
	1.2.1.a	The licensure or accreditation processes for participating hospitals and residential settings			
	1.2.1.b	The oversight process (including unannounced visits) to ensure participating hospital and residential settings meet state's licensing or certification and accreditation requirements	X		*The state has no trends/updates to report*
	1.2.1.c	The utilization review process to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight on lengths of stay	X		*The state has no trends/updates to report*
	1.2.1.d	The program integrity requirements and compliance assurance process	X		*The state has no trends/updates to report*

Prompt		State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
1.2.1.e	The state requirement that psychiatric hospitals and residential settings screen beneficiaries for co-morbid physical health conditions, SUDs, and suicidal ideation, and facilitate access to treatment for those conditions	X		*The state has no trends/updates to report*
1.2.1.f	Other state requirements/policies to ensure good quality of care in inpatient and residential treatment settings			A new inpatient psychiatric supplemental payment was added to the RY25 Psychiatric Hospital RFA and is based on the percentage of inpatient psychiatric admissions, percentages of claims with certain secondary diagnoses, and percentage of MassHealth Members admitted following EPIA protocol. The RY25 RFA additionally added requirements for hospitals to enhance interoperability and increase utilization of health information exchange services as well as additional discharge planning requirements for Members experiencing homelessness.
1.2.2	The state expects to make other program changes that may affect metrics related to Milestone 1.	X		

Prompt		State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
2.	**Improving Care Coordination and Transitions to Community-Based Care (Milestone 2)**			
2.1	**Metric trends**			
2.1.1	The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 2.	X		
2.2	**Implementation update**			
2.2.1	Compared to the demonstration design and operational details, the state expects to make the following changes to: 2.2.1.a Actions to ensure that psychiatric hospitals and residential treatment settings carry out intensive pre-discharge planning, and include community-based providers in care transitions			In late 2024, hospitals were informed of an upcoming requirement to disclose admissions, discharge, and transfer (ADT) messages to at least one certified ENS vendor beginning in 2026.
	2.2.1.b Actions to ensure psychiatric hospitals and residential settings assess beneficiaries' housing situations and coordinate with housing services providers			As stated in 1.2.1.f, additional discharge planning requirements for Members at risk of or experiencing homelessness were added to the RY25 Inpatient Psychiatric Hospital RFA.
	2.2.1.c State requirement to ensure psychiatric hospitals and residential settings contact beneficiaries and community-based providers within 72 hours post discharge	X		*The state has no trends/updates to report*

Prompt		State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
2.2.1.d	Strategies to prevent or decrease the lengths of stay in EDs among beneficiaries with SMI or SED (e.g., through the use of peers and psychiatric consultants in EDs to help with discharge and referral to treatment providers)			Additional hospitals joined the early adopter cohort for the Behavioral Health Treatment and Referral Platform (BH TRP) in Q4 of 2024.
2.2.1.e	Other state requirements/policies to improve care coordination and connections to community-based care)	X		*The state has no trends/updates to report*
2.2.2	The state expects to make other program changes that may affect metrics related to Milestone 2.	X		*The state has no trends/updates to report*

Prompt		State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
3.	**Access to Continuum of Care, Including Crisis Stabilization (Milestone 3)**			
3.1	**Metric trends**			
3.1.1	The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 3.		• #13 Mental Health Services Utilization - Inpatient • #14 Mental Health Services Utilization - Intensive Outpatient and Partial Hospitalization • #15 Mental Health Services Utilization - Outpatient • #16 Mental Health Services Utilization – ED • #17 Mental Health Services Utilization - Telehealth • #18 Mental Health Services Utilization - Any Services	• For SMI/SED Metric 13, there was a 13.7% decrease in inpatient mental health service utilization between Q1 2024 and Q2 2024. • For SMI/SED Metric 14, there was a 6.4% decrease in the number of beneficiaries in the demonstration population who used intensive outpatient and/or partial hospitalization services related to mental health between Q1 2024 and Q2 2024. • For SMI/SED Metric 15, there was no significant change in the number of beneficiaries in the demonstration population who used outpatient services for mental health between Q1 2024 and Q2 2024. • For SMI/SED Metric 16 there was a 4.7% increase in the number of beneficiaries in the demonstration population who used emergency department services for mental health between Q1 2024 and Q2 2024. • For SMI/SED Metric 17, there was 2.4% decrease in the MH service utilization for telehealth between Q1 2024 and Q2 2024. • For SMI/SED Metric 18 there was no significant change in the number of beneficiaries in the demonstration population who used any services for mental health between Q1 2024 and Q2 Q1 2024.

Prompt		State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
3.2	**Implementation update**			
3.2.1	Compared to the demonstration design and operational details, the state expects to make the following changes to: 3.2.1.a State requirement that providers use an evidenced-based, publicly available patient assessment tool to determine appropriate level of care and length of stay			The state underwent an 18-month process of stakeholder development and testing a new platform for the CANS. Over 250 clinicians helped to revise the CANS tool in the stakeholder development phase. This new platform is scheduled to launch in 2026.
	3.2.1.b Other state requirements/policies to improve access to a full continuum of care including crisis stabilization	X		*The state has no trends/updates to report*
3.2.2	The state expects to make other program changes that may affect metrics related to Milestone 3.	X		*The state has no trends/updates to report*

Prompt			State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
4.	**Earlier Identification and Engagement in Treatment, Including Through Increased Integration (Milestone 4)**				
4.1	**Metric trends**				
4.1.1	The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 4.			• #21 Count of Beneficiaries With SMI/SED (monthly)	• For SMI metric 21, there was no significant change in the count of beneficiaries in the demonstration population with SMI/SED between Q1 CY2024 and Q2 CY2024.
4.2	**Implementation update**				
4.2.1	Compared to the demonstration design and operational details, the state expects to make the following changes to:				In 2024, the state continued to support behavioral health training within early education and care spaces.
	4.2.1.a	Strategies for identifying and engaging beneficiaries in treatment sooner (e.g., with supported education and employment)			
	4.2.1.b	Plan for increasing integration of behavioral health care in non-specialty settings to improve early identification of SED/SMI and linkages to treatment	X		*The state has no trends/updates to report*
	4.2.1.c	Establishment of specialized settings and services, including crisis stabilization services, focused on the needs of young people experiencing SMI or SED			The state contracted with the Technical Assistance Collaborative in 2024 to conduct stakeholder engagement sessions with CBHI providers and relevant state agencies to better understand the experience of Members utilizing or attempting to utilize CBHI services
	4.2.1.d	Other state strategies to increase earlier identification/engagement, integration, and specialized programs for young people	X		*The state has no trends/updates to report*

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
4.2.2 The state expects to make other program changes that may affect metrics related to Milestone 4.	X		*The state has no trends/updates to report*

Prompt		State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
5.	**SMI/SED health information technology (health IT)**			
5.1	**Metric trends**			
5.1.1	The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to its SMI/SED health IT metrics.			
5.2	**Implementation update**			
5.2.1	Compared to the demonstration design and operational details, the state expects to make the following changes to: 5.2.1.a The three statements of assurance made in the state's health IT plan	X		*The state has no trends/updates to report*
	5.2.1.b Closed loop referrals and e-referrals from physician/mental health provider to physician/mental health provider and/or physician/mental health provider to community-based supports	X		*The state has no trends/updates to report*
	5.2.1.c Electronic care plans and medical records			In late 2024 as part of the BH TRP initiative, providers were reminded that they can utilize the Mass HIway system to send and receive electronic care plans and medical records.
	5.2.1.d Individual consent being electronically captured and made accessible to patients and all members of the care team	X		*The state has no trends/updates to report*
	5.2.1.e Intake, assessment and screening tools being part of a structured data capture process so that this information is interoperable with the rest of the health IT ecosystem	X		*The state has no trends/updates to report*

Prompt		State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
5.2.1.f	Telehealth technologies supporting collaborative care by facilitating broader availability of integrated mental health care and primary care	X		*The state has no trends/updates to report*
5.2.1.g	Alerting/analytics	X		*The state has no trends/updates to report*
5.2.1.h	Identity management	X		*The state has no trends/updates to report*
5.2.2	The state expects to make other program changes that may affect SMI/SED metrics related to health IT.			As referenced in 2.2.1.d, additional hospitals joined the early adopter cohort for the Behavioral Health Treatment and Referral Platform in Q4 of 2024. The RY25 Inpatient Psychiatric Hospital RFA added requirements for inpatient psychiatric hospitals to establish and implement policies and procedures to enhance the interoperability of their health information technology, increase utilization of health information services, and participate in the BH TRP initiative.

Prompt		State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
6.	**Other SMI/SED-related metrics**			
6.1	**Metric trends**			
6.2	**Implementation update**			
6.2.1	The state expects to make the following program changes that may affect other SMI/SED-related metrics.	X		*The state has no trends/updates to report*
7.	**Annual Assessment of Availability of Mental Health Services (Annual Availability Assessment)**			
7.1	**Description of changes to baseline conditions and practices**			

7.1.1	Describe and explain any changes in the mental health service needs of Medicaid beneficiaries with SMI/SED compared to those described in the Initial Assessment of the Availability of Mental Health Services (for example, prevalence and distribution of SMI/SED). Recommended word count is 500 words or less.			There was a change in the number of FQHCs that provide behavioral health services from 77 in CY2023 to 75 in CY2024. There was no change in the number of hospitals that qualify as IMDs between CY2023 and CY2024, or the number and location of PRTFs. MassHealth still has no QRTPs. Mobile crisis teams and CMHC numbers changed due to the implementation of the Behavioral Health Roadmap reform. The percentage of members with SMI increased from 9% to 11% between CY2023 and CY2024. In CY2023 there were 281 CMHCs and this number increased to 289 in CY2024. The number of intensive outpatient programs increased from 176 in CY2023 to 211 in CY2024. In terms of providers, the number of psychiatrists in CY2023 was 2,434 and in CY2024 that number remained the same. This does not represent the universe of licensed psychiatrists in MA because we were not able to include those that live in abutting states. The Medicaid-enrolled psychiatrists in CY2023 was 7,237 and was 7,134 in CY2024. As a reminder, psychiatrists living out of state that provide services in Massachusetts are included in the MassHealth enrolled provider counts. Some psychiatrists also work in multiple counties. The number of licensed therapists that treat mental illness in CY2023 was 31,956 and that number remains the same in CY2024. Again, this does not include people who live in abutting states. The number of Medicaid-enrolled licensed therapists in CY2023 was 35,734 and the number dropped to 27,411 in CY 2024. Data are based on MCE reports. For the therapists we chose one county for service provision if the provider worked in more than one county.

Prompt		State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
7.1.2	Describe and explain any changes to the organization of the state's Medicaid behavioral health service delivery system compared to those described in the Initial Assessment of the Availability of Mental Health Services. Recommended word count is 500 words or less.	X		
7.1.3	Describe and explain any changes in the availability of mental health services for Medicaid beneficiaries with SMI/SED in the state compared to those described in the Initial Assessment of the Availability of Mental Health Services. At minimum, explain any changes across the state in the availability of the following services: inpatient mental health services; outpatient and community-based services; crisis behavioral health services; and care coordination and care transition planning. Recommended word count is 500 words or less.	X		*The state has no trends/updates to report*
7.1.4	Describe and explain any changes in gaps the state identified in the availability of mental health services or service capacity while completing the Annual Availability Assessment compared to those described in the Initial Assessment of the Availability of Mental Health Services. Recommended word count is 500 words or less.	X		*The state has no trends/updates to report*

Prompt		State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
7.1.5	Describe and explain whether any changes in the availability of mental health services have impacted the state's maintenance of effort (MOE) on funding outpatient community-based mental health services. Recommended word count is 500 words or less.	X		*The state has no trends/updates to report*
7.2	**Implementation update**			
7.2.1	Compared to the demonstration design and operational details, the state expects to make the following changes to:	X		*The state has no trends/updates to report*
	7.2.1.a The state's strategy to conduct annual assessments of the availability of mental health services across the state and updates on steps taken to increase availability			
	7.2.1.b Strategies to improve state tracking of availability of inpatient and crisis stabilization beds	X		*The state has no trends/updates to report*

<table>
<tr><th colspan="2">Prompt</th><th>State has no trends/update to report (place an X)</th><th>Related metric(s) (if any)</th><th>State response</th></tr>
<tr><td colspan="5">8. Maintenance of effort (MOE) on funding outpatient community-based mental health services</td></tr>
<tr><td colspan="5">8.1 MOE dollar amount</td></tr>
<tr><td>8.1.1</td><td>Provide as a dollar amount the level of state appropriations and local funding for outpatient community-based mental health services for the most recently completed state fiscal year.</td><td></td><td></td><td>Massachusetts SFY2024 Expenditures on Community-Based Behavioral Health Services
<table>
<tr><th>Medicaid Population</th><th>Total Claim Dollars (M)</th><th>Federal Share (M)</th><th>State Share (M)</th></tr>
<tr><td>Managed Care</td><td>$1,358,402,759</td><td>$864,119,215</td><td>$494,283,544</td></tr>
<tr><td>FFS Services</td><td>$97,633,841</td><td>$52,722,274</td><td>$44,911,567</td></tr>
<tr><td>Total Community-Based Mental Health Spend</td><td>$1,456,036,600</td><td>$916,841,489</td><td>$539,195,111</td></tr>
</table></td></tr>
<tr><td colspan="5">8.2 Narrative information</td></tr>
<tr><td>8.2.1</td><td>Describe and explain any reductions in the MOE dollar amount below the amount provided in the state’s application materials. The state should confirm that it did not move resources to increase access to treatment in inpatient or residential settings at the expense of community-based services.</td><td></td><td></td><td>The state confirms that it did not move resources to increase access to treatment in inpatient or residential settings at the expense of community-based services.</td></tr>
</table>

Prompt			State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
9.	**SMI/SED financing plan**				
9.1	**Implementation update**				
9.1.1	Compared to the demonstration design and operational details, the state expects to make the following changes to:		X		*The state has no trends/updates to report*
	9.1.1.a	Increase availability of non-hospital, non-residential crisis stabilization services, including services made available through crisis call centers, mobile crisis units, and observation/assessment centers, with a coordinated community crisis response that involves law enforcement and other first responders			
	9.1.1.b	Increase availability of on-going community-based services, e.g., outpatient, community mental health centers, partial hospitalization/day treatment, assertive community treatment, and services in integrated care settings such as the Certified Community Behavioral Health Clinic model	X		*The state has no trends/updates to report*

4. Narrative information on other reporting topics applicable to both SUD and SMI/SED components

Prompts		State has no update to report (place an X)	State response
10.	**Budget neutrality**		
10.1	**Current status and analysis**		
10.1.1	Describe the current status of budget neutrality and an analysis of the budget neutrality to date. If the SUD and SMI/SED components are part of a broader demonstration, the state should provide an analysis of the SUD- and SMI/SED-related budget neutrality and an analysis of budget neutrality as a whole.	X	*The state has no trends/updates to report*
10.2	**Implementation update**		
10.2.1	The state expects to make other program changes that may affect budget neutrality.	X	*The state has no trends/updates to report*

Prompts		State has no update to report (place an X)	State response
11.	**SUD- and SMI/SED-related demonstration operations and policy**		
11.1	**Considerations**		
11.1.1	The state should highlight significant SUD and SMI/SED (or if broader demonstration, then SUD- and SMI/SED-related) demonstration components' operations or policy considerations that could positively or negatively affect beneficiary enrollment, access to services, timely provision of services, budget neutrality, or any other provision that has potential for beneficiary impacts. Also note any activity that may accelerate or create delays or impediments in achieving the SUD and SMI/SED demonstration components approved goals or objectives, if not already reported elsewhere in this document. See Monitoring Report Instructions for more detail.	X	*The state has no trends/updates to report*
11.2	**Implementation update**		
11.2.1	The state experienced challenges in partnering with entities contracted to help implement the demonstration (e.g., health plans, credentialing vendors, private sector providers) and/or noted any performance issues with contracted entities.	X	*The state has no trends/updates to report*
11.2.2	The state is working on other initiatives related to SUD, OUD and/or SMI/SED.	X	*The state has no trends/updates to report*
11.2.3	The initiatives described above are related to the SUD and/or SMI/SED demonstration components. (The state should note similarities and differences from the SUD and SMI/SED demonstration components).	X	*The state has no trends/updates to report*

Prompts	State has no update to report (place an X)	State response
11.2.4 Compared to the demonstration design and operational details, the state expects to make the following changes to: 11.2.4.a How the delivery system operates under the demonstration (e.g., through the managed care system or fee for service)	X	*The state has no trends/updates to report*
11.2.4.b Delivery models affecting demonstration participants (e.g., Accountable Care Organizations, Patient Centered Medical Homes)	X	*The state has no trends/updates to report*
11.2.4.c Partners involved in service delivery	X	*The state has no trends/updates to report*
11.2.4.d ***SMI/SED-specific:*** The state Medicaid agency's Memorandum of Understanding (MOU) or other agreement with its mental health services agency	X	*The state has no trends/updates to report*

Prompts		State has no update to report (place an X)	State response
12.	**SUD and SMI/SED demonstration evaluation update**		
12.1	**Narrative information**		
12.1.1	Provide updates on SUD and SMI/SED evaluation work and timeline. The appropriate content will depend on when this monitoring report is due to CMS and the timing for the demonstration. There are specific requirements per 42 Code of Federal Regulations (CFR) § 431.428a(10) for annual reports. See Monitoring Report Instructions for more details.		The SUD and SMI/SED evaluation team met weekly to prepare for data collection and analysis.
12.1.2	Provide status updates on deliverables related to the demonstration evaluation and indicate whether the expected timelines are being met and/or if there are any real or anticipated barriers in achieving the goals and timeframes agreed to in the STCs.	X	*The state has no trends/updates to report and has no real or anticipated barriers in achieving the goals and timeframes agreed to in the STCs.*
12.1.3	List anticipated evaluation-related deliverables related to this demonstration and their due dates.	X	*The state has no trends/updates to report*

Prompts		State has no update to report (place an X)	State response
13.	**Other demonstration reporting**		
13.1	**General reporting requirements**		
13.1.1	The state reports changes in its implementation of the demonstration that might necessitate a change to approved STCs, implementation plan, or monitoring protocol.	X	*The state has no trends/updates to report*
13.1.2	The state anticipates the need to make future changes to the STCs, implementation plan, or monitoring protocol, based on expected or upcoming implementation changes.	X	*The state has no trends/updates to report*
13.1.3	Compared to the demonstration design and operational details, the state expects to make the following changes to: 13.1.3.a The schedule for completing and submitting monitoring reports	X	*The state has no trends/updates to report*
	13.1.3.b The content or completeness of submitted monitoring reports and/or future monitoring reports	X	*The state has no trends/updates to report*
13.1.4	The state identified current or anticipated issues submitting timely post-approval demonstration deliverables, including a plan for remediation.	X	*The state has no trends/updates to report*

Prompts		State has no update to report (place an X)	State response
13.1.5	Provide updates on the results of beneficiary satisfaction surveys, if conducted during the reporting year, including updates on grievances and appeals from beneficiaries, per 42 CFR § 431.428(a)5.		• #36: From 1/1/2024-12/31/2024, there were 226 grievances filed related to services for SMI/SED. As a reminder, due to MCO/ACO contractual obligations, SMI/SED are not broken out. • #37: From 1/1/2024-12/31/2024, there were 103 appeals filed related to services for SMI/SED. As a reminder, due to MCO/ACO contractual obligations, SMI/SED are not broken out. Appeals include those that were resolved and those still active at the end of the calendar year. Appeals are not available for FFS for CY24 • #38: From 1/1/2024-12/31/2024, there were 1044 adverse incidents filed related to services for SMI/SED. As a reminder, adverse incidents are not available for FFS members by payer type. In addition, per MCO/ACO contractual obligations, SMI/SED are not broken out. Data are reported on adverse incidents and therefore, there is no uniform way to break out minor vs critical incidents.
13.2	**Post-award public forum**		
13.2.2	If applicable within the timing of the demonstration, provide a summary of the annual post-award public forum held pursuant to 42 CFR § 431.420(c) indicating any resulting action items or issues. A summary of the post-award public forum must be included here for the period during which the forum was held and in the annual monitoring report.	X	*The state has no trends/updates to report*

Prompts		State has no update to report (place an X)	State response
14.	**Notable state achievements and/or innovations**		
14.1	**Narrative information**		
14.1.1	Provide any relevant summary of achievements and/or innovations in demonstration enrollment, benefits, operations, and policies pursuant to the hypotheses of the SUD and SMI/SED (or if broader demonstration, then SUD- or SMI/SED-related) demonstration components or that served to provide better care for individuals, better health for populations, and/or reduce per capita cost. Achievements should focus on significant impacts to beneficiary outcomes. Whenever possible, the summary should describe the achievement or innovation in quantifiable terms (e.g., number of impacted beneficiaries).		Between January and September 2024, CBHCs provided 447,961 outpatient clinic visits to 44,472 members. CBHC MCI teams provided 18,545 crisis evaluations to 12,836 members in the community during this same period. In addition, there were 3,388 admissions to a community crisis stabilization program. Their average length of stay was 6.19 days. In CY 2024, 754 individuals were dropped off by police at a CBHC and 258 individuals were admitted directly from a CBHC to an inpatient psychiatric facility, circumventing the ED. The state saw EPIA referrals (alerts of patients waiting for an inpatient psychiatric bed for longer than 48 hours for youth and 60 hours for adults) for all plans decrease by 59% from Q1-Q3 of 2022 compared to the same period in 2024.

*The state should remove all example text from the table prior to submission.

Note: Licensee and states must prominently display the following notice on any display of Measure rates:

SUD measures IET-AD, FUA-AD, FUM-AD, and AAP [Metrics #15, 17(1), 17(2), and 32] and SMI/SED measures MPT, FUH-CH, FUH-AD, FUA-AD, FUM-AD, AAP, and APM measures (#13, 14, 15, 16, 17, 18, 7, 8, 9, 10, 26, 29) *are Healthcare Effectiveness Data and Information Set (HEDIS®) measures that are owned and copyrighted by the National Committee for Quality Assurance (NCQA). HEDIS measures and specifications are not clinical guidelines, do not establish a standard of medical care and have not been tested for all potential applications. The measures and specifications are provided "as is" without warranty of any kind. NCQA makes no representations, warranties or endorsements about the quality of any product, test or protocol identified as numerator compliant or otherwise identified as meeting the requirements of a HEDIS measure or specification. NCQA makes no representations, warranties, or endorsement about the quality of any organization or clinician who uses or reports performance measures and NCQA has no liability to anyone who relies on HEDIS measures or specifications or data reflective of performance under such measures and specifications.*

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