Commonwealth of Massachusetts

Executive Office of Health and Human Services

Coordinating Care for MassHealth-enrolled Youth in Outpatient Therapy

Webinar Goals

- Review key elements of care coordination in Outpatient Therapy

- Review parameter and billing changes to Case Consultations, Family Consultations, and Collateral Contacts

- Solicit OP clinicians input for new online training resource

Outpatient Therapy is….

- the service most embedded in the community
- the first place for families when they need help
- a step down from a higher level of care for children and youth
- integral to care coordination for children and youth under 21

Levels of Care Coordination

Three Service "HUBS" (in order of decreasing intensity):

Intensive Care Coordination (Wraparound)
- Clinical Assessment with CANS
- SED determination for eligibility
- Medical Necessity determination
- Care coordination

In Home Therapy
- Clinical Assessment with CANS
- Medical Necessity determination
- Care coordination

Outpatient Therapy
- Clinical Assessment with CANS
- Medical Necessity determination
- Care coordination available

Time for a Check-In

What are Hub Dependent Services?

Care Coordination and Collaboration in Outpatient Therapy

When OP is Hub

- Conduct comprehensive assessment, including the CANS
- Evaluate the need for a higher level of care coordination or more intensive intervention
- Evaluate the need for other services and supports
- Identify treatment goals for hub-dependent services on the OP treatment plan
- Make referrals to other needed services and supports
- Maintain communication with other service providers and collaterals
- Facilitate discussions with providers and other collaterals about treatment planning and progress
- Anticipate and planning for care transitions and life transitions

When IHT or ICC is Hub

- Conduct comprehensive assessment, including the CANS
- Maintain communication with other service providers and collaterals
- Collaborate with other providers and collaterals about treatment needs and progress
- Participate in planning for care transitions and life transitions
- When appropriate prepare to become the hub

When Outpatient is the Hub

Activity	What does this mean for me?
Conduct comprehensive assessment, inclusive of CANS	• Use the Child and Adolescent Needs and Strengths tool at intake and ever 90 days thereafter • Enter the information into the CANS-VG
Evaluate the need for a higher level of care coordination or more intensive intervention.	• For **ICC**, fill out the *ICC Evaluation of Need Form* at intake and every 6 months • For **IHT**, discuss whether this hub would be a better fit for families in need of more intensive intervention
Evaluate the need for other services and supports	Based on assessment, consider whether client and family can benefit from other services and supports: • Formal supports, i.e. "hub dependent" services (Family Partners, In Home Behavioral Services, or Therapeutic Mentoring); psychiatry, etc • Informal supports, i.e. after school programs, sports and recreation, summer camps, health club memberships, faith/spirituality communities, other supports within the community.
Identify treatment goals for hub-dependent services on the OP treatment plan	Discuss with client and family how they could benefit from these services • e.g. how a Family Partner or Therapeutic Mentor can help operationalize other goals in a treatment plan while you focus on therapy.

When Outpatient is the Hub

Activity	What does this mean for me?
Make referrals to other needed services and supports	Warm hand-offs if necessary; following up with provider to ensure contact has been made
Maintain communication with other service providers and collaterals	Consulting with your client's family, school, doctor, or other important individuals, as appropriate, through meetings and phone calls
Facilitate discussions with providers and other collaterals about treatment planning and progress	Overseeing treatment team to ensure: • care is coordinated • goals from all collaterals align • convene meetings when necessary
Anticipate and plan for care transitions and life transitions	Helping client & family envision the future • Identifying steps to reach that future • Assisting families in describing success (ongoing process from start of treatment and throughout) • Reviewing progress toward goals • Making linkages and referrals to services and supports prior to discharge • Lining up necessary services and supports prior to discharge

Changes to Case Consultation, Family Consultation and Collateral Contacts Billing and Parameters

As of 10/1/16 the following codes can be billed in 15 minute units, according to the program specifications:

90882 Case Consultation

90887 Family Consultation

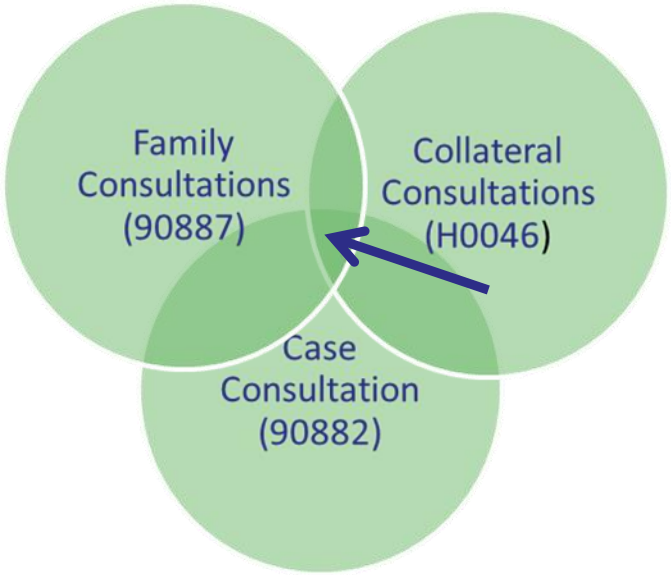
H0046 Collateral Contact

What do these changes mean?

- MassHealth and MCEs recognize that coordination and consultation are as important as the therapeutic encounter to helping children and youth improve.

- MCEs will now pay for consultation and coordination activities at the same rate as the outpatient face to face visit.

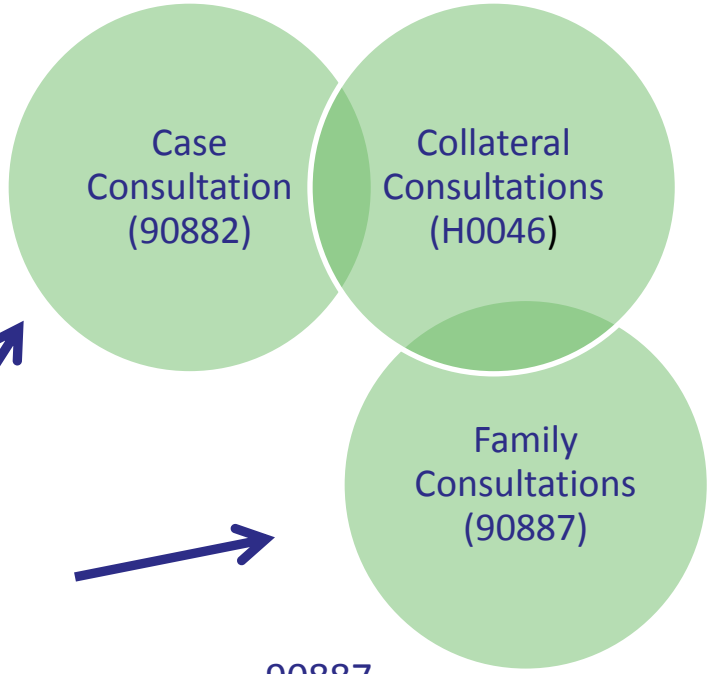
Overlaps between Case, Family, and Collateral Consultations



- Shared goals: clinically aid the client via coordination, assessment, planning (treatment, aftercare, termination), and implementation of the treatment plan
- Documented meetings (in person or telephone)
- At least 15 minutes (15 mins = 1 unit)
- Use the # of units to match medical necessity (there are no authorization requirements and no blanket maximum number of units)
- Providers need to be contracted with the MCE in order to be reimbursed for these services.

Differences between Case, Family, and Collateral Consultations

90882
- Consult with behavioral health clinicians
- Consult with medical professionals



H0046
- Only for Medicaid members under 21
- Individuals involved in the care or treatment of a member
- Includes voicemails and emails as modes of contact

90882 and 90887
- Can also be used for members aged 21 and over and commercial members, depending on the plan benefit
- **Does not** include voicemail and emails as modes of contact

90887
- Consult with family members or identified supports

How to do these changes benefit clients and me?

- Care coordination is simply good clinical practice.
- Good communication/collaboration→ better informed care plans and more effective treatment.
- New rates recognize the value of care coordination for overall care.
- Increased productivity!

Care Coordination when Outpatient is the Hub: Tim

Tim Clark is 14 years old and has just started seeing his OP therapist. He is currently taking medication for ADHD. Tim has missed many days of school and is in danger of repeating 9th grade. He has trouble getting along with his peers. He is not involved with any state agencies. After discussing ICC, Tim and his mom would rather keep OP as their hub. During the assessment process, the OP therapist learns that Tim loves manga and is working on his own comic book. He also starts identifying other current providers, relevant prior providers, and other systems (in this case, just Tim's school) that affect Tim and his family. With caregiver consent, the OP therapist reviews CANS records and other clinical documents and speaks with other stakeholders to pull together different perspectives.

Tim's therapist calls his PCP to talk about his ADHD treatment and medication. A phone call with a prior therapist gives a glimpse into the effect of past trauma on Tim's current behavior. The OP therapist has a phone call with Tim's mother where he learns about his parents' divorce and the resulting custody battle for Tim and his younger sister. He discusses with mom whether Tim could benefit from having a Therapeutic Mentor to help improve his social functioning in school and community. With her consent he makes the referral. He emails the school adjustment counselor and is able to set up a longer phone call to learn more about his functioning in school and to discuss options to get him back on track to completing 9th grade. Through this call he also learns there is a student run comic books club, which Tim later joins at the encouragement of his therapist and TM. Through the club Tim is able to befriend two other students who share his passion for Japanese comics. With mother's consent, the OP therapist convenes a meeting at school with the family, the adjustment counselor and Tim's teachers to get everyone on the same page with Tim's treatment goals and school goals.

Following the initial contacts and the school meeting, the OP therapist continues to coordinate services and consult with family and collaterals.

How would you bill for:

- Phone call with the PCP?
- Phone call with Tim's old therapist?
- Email and phone call with adjustment counselor?
- Phone call with Tim's mom?
- School meeting with school personnel, Tim's family and TM?

Care Coordination when ICC is the Hub: Sophie

Sophie is 13 years old and has been involved with her OP therapist for just over a year. When Sophie was 11 years old, her older brother committed suicide. Since that time, Sophie has experienced two episodes of severe depression. This past year she began cutting. Sophie has been refusing to go to school and is falling behind.

Initially, the family chose to keep OP as their hub but six months in it is very clear that Sophie requires more intensive intervention and her care coordination needs are more than the OP can manage alone. Sophie's parents wish for her to stay involved with the OP therapist but they agree that ICC is necessary to help them coordinate the many services and systems they are now involved with: IHT, primary care, psychiatry and special education (Sophie just got an IEP). With the family's blessing, her OP therapist does a warm hand-off to the nearby CSA where Sophie gets set up with an ICC.

Two weeks later, the new ICC calls Sophie's OP therapist and the two spend 30 minutes going over her case history and possible goals to include in the care plan. Later that month, the OP therapist attends the first care planning team (CPT) meeting convened by ICC with Sophie's family, IHT, psychiatrist, and Special Ed coordinator. Three weeks after the initial CPT meeting, Sophie is placed in an adolescent inpatient psychiatric unit. The inpatient unit convenes a discharge planning meeting with Sophie's ICC and all of her otherproviders, her parents, and the school in order to plan for her return to her home and school.

How would you bill for:

- Phone call with ICC?
- Attending the care planning team meeting?
- Attending the discharge planning meeting?

Outpatient Online Training Resource

CBHI and the CBH Knowledge center are teaming up to produce an online training resource for OP clinicians that will build on the information included in this webinar.

- Recognizing the time constraints you all face, what information do OP providers need most?
- What is the best way to convey this information?
- What barriers do we need to address to encourage as many OP providers as possible to use this resource?

Questions?

Where can I get more information?

For specific guidance on behavioral health billing, limitations and documentation requirements, consult your MCE:

Boston Medical Center (BMC) HealthNet Plan
1- 866-444-5155 | TTY:1-866-727-9441

Fallon Community Health Plan
1-800-341-4848 |TTY: 1-877-608-7677

Health New England (HNE)
1-800-495-0086 | TTY: 1-877-509-6981

Neighborhood Health Plan
1-800-414-2820 | TTY:1-800 655-1761

Tufts Health Public Plans
1-888-257-1985 | TTY: 1-888-391-5535

Massachusetts Behavioral Health Partnership
1-800-495-0086 | TTY: 1-877-509-6981