Behavioral Health Outpatient Services Performance Specifications

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

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

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

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

Providers contracted for this level of care or service are expected to comply with applicable regulations set forth in the Code of Massachusetts Regulations and all requirements of these service-specific performance specifications in addition to the General Behavioral Health Performance specifications. All performance specifications are located in the Provider Resource Center.

DEFINITION

Outpatient services are behavioral health services provided in an ambulatory care setting (e.g. mental health clinic, hospital outpatient department, community health center, group or private practice, etc.), or may be provided in a home or school setting. The treatment modalities, and frequency and length of treatment will vary according to the Member's individualized treatment needs. Outpatient is the least intensive level-of-care available to Members.

The goal of outpatient services is the improvement and/or maintenance of a Member's level of functioning and the alleviation of symptoms that interfere with functioning. These services provide the Member with the opportunity to achieve stability and/or wellness in the community in the least intensive level of care without leaving their own living situation.

COMPONENETS OF SERVICE

1. The provider maintains all required state licenses and may be accredited by JCAHO or another nationally recognized accreditation organization as a facility that provides psychiatric services.
2. Outpatient Service providers will provide the following, or ensure referral for same:
    - Diagnostic evaluation
    - Short-term solution-focused outpatient therapy
    - Individual, couples, group and family therapies
    - Access to psychopharmacological services (including assessment, crisis intervention and on-going monitoring)
    - Emergency therapy session appointments
    - Case and family consultation
    - After-hours telephone crisis coverage
3. Outpatient providers will adhere to their own internal written protocols for treating special populations (e.g., children, elders, developmentally disabled, cultural and linguistic minorities, homeless, etc.) and/or offering appropriate referrals. Providers will build and maintain the capacity to serve Members with such special needs. The model includes procedures and information to provide access to emergency mental health services for Members with special needs.

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[1] Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLink℠ when Tufts Health Plan is the primary administrator.

[2] Tufts Medicare Preferred and Tufts Health Plan SCO are collectively referred to in this payment policy as Senior Products.

4. Clinicians, including psychiatrists, psychiatric residents, psychiatric nurse mental-health clinical specialists, psychologists, Licensed Independent Clinical Social Workers (LICSWs), Licensed Mental Health Counselors (LMHCs), Licensed Marriage and Family Therapists (LMFTs), Licensed Clinical Social Workers (LCSWs), and unlicensed Master's level clinicians working under the supervision of an independently licensed clinician, who provide Behavioral Health Services to Members under the age of 21 who are part of Tufts Health Together, will become certified in the use of the CANS Tool and recertified every two years.
5. The CANS Tool will be used whenever a Behavioral Health Clinical Assessment is completed for a Tufts Health Together Member under the age of 21, including the initial Behavioral Health Clinical Assessment and, at a minimum, every 90 days thereafter during ongoing treatment.
6. With the consent by the Member, parent, guardian, custodian or other authorized individual as applicable, the provider will input into the CANS IT system the information gathered using the CANS Tool and the determination of whether or not the assessed Member is suffering from a Serious Emotional Disturbance (SED).
7. Outpatient providers must ensure that, for referrals for psychotherapy appointments from an inpatient unit, Members will be scheduled for an outpatient therapy appointment within 7 days from the date of discharge from the inpatient unit.
8. Outpatient providers must ensure that, for referrals for medication appointments from an inpatient unit, Members will be scheduled for a psychopharmacological appointment as soon as clinically indicated, but in no case longer than 14 business days post-discharge.
9. If the Member is unable or unwilling to keep an appointment, the clinician will attempt to contact the Member within 24 hours and document the attempt, including unsuccessful attempts, within the Member's record.
10. The provider is responsible for checking Member eligibility via the Eligibility Verification System (EVS) on the day of each appointment.
11. When consent is given, providers will identify and refer Members to the appropriate Tufts Health Public Plans Care Management program, as appropriate. Members who are pregnant and use substances, homeless individuals with a psychiatric and/or substance use or addiction history, etc., should be referred to the appropriate services as well.
12. Providers of services for children and youth will be familiar with the range of community-based services available to children and youth.
13. Outpatient providers will have established relationships with the providers of Emergency Services and Youth Mobile Crisis.

STAFFING REQUIREMENTS

1. Provider staff must meet the credentialing standards of Tufts Health Public Plans as outlined in the Provider Manual and are qualified by virtue of credentials, experience and training to provide treatment to the particular target population of the program.
2. The provider's training program for staff will include, at a minimum, a review of multi-treatment modalities, outpatient specialty services, and Tufts Health Public Plans' performance specifications.
3. The provider will ensure that all clinical work is supported by regularly scheduled and ongoing clinical supervision and consultation as appropriate or required by law.
4. Any staff member diagnosing, treating and billing for services who is not an independently licensed behavioral health clinician must meet the criteria for a "counselor" set forth in 130 CMR 429.424, and be directly and continuously supervised by a fully qualified and licensed professional staff member as set forth in 130 CMR 429.424. Supervisors must maintain supervision notes. Tufts Health Public Plans reserves the right to review records to confirm adequate levels of supervision.
5. Senior clinical staff must be available for consultation (including a psychiatrist if appropriate) during all hours of operation regarding emergent and urgent situations.
6. Staffing should reflect the cultural, gender and linguistic needs of the community it serves.

SERVICE, COMMUNITY AND COLLATERAL LINKAGES

1. The provider coordinates treatment, treatment planning and transitional care/discharge with the Member's primary care clinician, other behavioral health providers and other community-based providers, involved state agencies, educational system, community supports and family, guardian, and/or significant others when applicable. If consent for such coordination is withheld or refused by the parent or guardian of a minor, then this is documented in the Member's record.
2. The provider obtains written informed consent at the onset of treatment to actively include family/guardian/significant others, relevant state agencies, schools, and other organizations in

treatment and continuing care planning. If serving DDS, DCF, DMH or DYS involved Members, providers maintain collaborative relationships with the local area offices of these agencies. All attempts to involve state agency staff will be documented in the Member's record.

3. Unless clinically contraindicated and when consent is given (for adults and emancipated minors), the provider supports and encourages the involvement of the guardian, family members, caretakers, and/or significant others of the Member in conferences, joint treatment sessions, and all aspects of aftercare planning and follow-up to the maximum extent that family participation is possible and appropriate. If involving other people in the Member's care, the contraindications will be documented in the Member's record. The provider meets with the parent/guardian to review aftercare and follow-up instructions. The Member's stated rationale, if the Member has offered one, for his/her willingness to provide consent should be noted in the Member's record.
4. When working with Tufts Health Together Members under the age of 21, the provider will recognize its role as a "hub provider" for those Members receiving "hub dependent" services, such as Therapeutic Mentoring, In Home Behavioral Therapy, and Family Support and Training Services. Collaboration with the hub-dependent service must be evident in the Member's record.
5. The provider has wellness, self-help, and recovery information and resources including, but not limited to: written consumer/survivor accounts of recovery experiences, a listing of other self-help groups and a listing of advocacy and wellness organizations statewide (examples are listed on tuftshealthplan.com, including National Alliance for the Mentally Ill (NAMI), PAL, Independent Living Centers, etc.).

QUALITY MANAGEMENT (QM)

1. The provider will develop and maintain a quality management plan that is consistent with that of Tufts Health Public Plans 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 will include outcome measures and satisfaction surveys to measure and improve the quality of care and service delivered to Members, including youth and their families.
3. Clinical outcomes data must be made available to Tufts Health Public Plans upon request and must be consistent with Tufts Health Public Plans' performance standard for acute inpatient services.
4. All Reportable Adverse Incidents will be reported to Tufts Health Public Plans within 1 business day of their occurrence per Tufts Health Public Plans policy and DMH licensing requirements. A Reportable Adverse Incident is an occurrence that represents actual or potential harm to the well-being of a Member, or to others by action of a Member, who is receiving services managed by Tufts Health Public Plans or has recently been discharged from services managed by Tufts Health Public Plans.
5. The program will adhere to all reporting requirements of DPH and/or DMH regarding Serious Incidents and all related matters.

PROCESS SPECIFICATIONS

Treatment Planning and Documentation

The provider will ensure that an individualized, comprehensive bio-psychosocial written assessment is completed within the first week for any Member entering treatment.

1. The assessment will include, but is not limited to, review and assessment of:
    - History of presenting problem
    - Chief complaints and symptoms
    - Mental health and substance use history
    - Comprehensive medical history
    - Family, social history and linguistic cultural background
    - For children in the care and/or custody of the Commonwealth, history of placements outside the home
    - Current substance use
    - Mental status exam
    - Previous medication trials, current medications and any allergies
    - Diagnoses and clinical formulation
    - Level of functioning
    - The individual's strengths, and for children and adolescents, family strengths
    - Name of primary care clinician
    - Individual Educational Plans (IEP)

2. If the Member is on medication, medication reconciliation will be initiated within the first visit. If the Member is not on medication a referral for a psychiatric/medication assessment will be initiated as needed.
3. For youth under age 21 who are Members of Tufts Health Together, a CANS must be completed during the initial assessment (up to 2 visits) and every 90 days thereafter.
4. The provider shall ensure that assessments are completed and that the treatment team has met to review the assessment and initial treatment plan before the third outpatient visit.
5. With consent and unless clinically contraindicated, providers actively involve Members, their families and relevant others in treatment planning to the fullest extent possible. When the court has appointed a guardian, the provider must involve the guardian in treatment planning and other decision making. The Member's stated rationale, if the Member has offered one, for his/her willingness to provide consent should be noted in the Member's record.
6. The provider will utilize the individualized written assessment, including the clinical formulation, to develop a treatment plan.
7. The provider will develop initial treatment plans that are in writing and include, at a minimum:
    - A description of all services needed during the course of treatment
    - Measurable goals (short and long term), specific steps needed to achieve the goals, expected outcomes and time frames for achieving the goals
    - Indication of the strengths of the individual and his/her family as identified in the assessment
    - When appropriate, indication of the need for involvement of a state agency, such as DCF, DMH, DYS or DDS
    - Treatment recommendations consistent with the service plan of the relevant state agency for Members who are also DMH clients or children in the care and/or custody of the Commonwealth, and for DDS and DYS clients
8. The provider will periodically review initial treatment plans and modify them at a minimum of every 90 days.
9. The provider will ensure that Members with co-occurring disorders have a treatment plan through which they receive simultaneous care for both diagnoses.
10. The provider will invite and encourage the following persons to participate in the development and modification of the Member's treatment plan and the treatment itself and to attend all treatment plan meetings:
    - In the case of an individual over the age of 16 or an emancipated minor, the Member, the Member's family, Member's Guardian, providers of other outpatient services and other identified supports, but only when the consent of the Member to such involvement(s) has been obtained, unless the individual has a legal guardian, in which case the consent of the legal guardian is required
    - In the case of an individual under the age of 16 who is not an emancipated minor, with the consent of a parent or guardian, the Member, if appropriate, Member's family, other providers of outpatient services and other identified supports
    - For Members who are also DMH clients or children in the care and/or custody of the Commonwealth, the designated staff from the relevant state agencies
    - For Members in Care Management, the Care Management clinician
11. Components of the provider's treatment planning incorporate Member identified concerns, including but not limited to, the following: housing, finances, health care, transportation, familial, occupational, educational and social supports.
12. Any service frequency or modality modification will be a planned and inclusive process with the Member. Rationale for such modification will be documented in the Member's record.
13. Providers will use a Tufts Health Public Plans approved outcome tool and use outcome measures to gauge attainment of treatment goals.

Discharge Planning and Documentation

1. Discharge is a planned process beginning upon initiation of services and continues throughout treatment. Discharge plans must include the necessary community supports, including community agencies, Member's family, and Member's significant others, when Member consent is given.
2. If the Member terminates without notice, every effort is made to contact the Member to obtain the Member's participation in the treatment and to provide assistance for appropriate follow-up plans (i.e., schedule another appointment or provide appropriate referrals). Such activity is documented

in the Member's record. When the Member is a DMH identified consumer, DMH is informed of the termination.

3. The provider shall create a written discharge plan for each Member prior to the individual's discharge from care, and the discharge plan will be contained in the Member's medical record.
4. The provider will include in the discharge plan, at a minimum, identification of the individual's needs, including but not limited to:
    - Housing
    - Finances
    - Medical care
    - Transportation
    - Family, employment and educational concerns
    - Social supports
    - A Crisis Prevention Plan
    - Services recommended and available post-discharge
    - List of prescribed medications, dosages and possible side effects
5. The provider will furnish a written discharge summary to the Member, parents, guardians, residential provider and relevant state agencies at the time of the individual's discharge, to include without limitation, descriptions of behavior management techniques and any potential medication side effects.

PERFORMANCE SPECIFICATIONS FOR CASE CONSULTATION, FAMILY CONSULTATION, COLLATERAL CONTACT FOR MEDICAID MEMBERS UNDER THE AGE OF 21

Case Consultation (90882) is a documented meeting of at least 15 minutes duration, either in person or by telephone, between the treating provider and other behavioral health/medical clinicians or physicians, concerning a Member who is a client of the BH provider.

Goals of case consultation are to identify and plan for additional services, coordinate a treatment plan, review the individual's progress and revise the treatment plan, as required.

The scope of required service components provided, includes but is not limited to, the following:

- Treatment coordination
- Treatment planning
- Assessment of the appropriateness of additional or alternative treatment
- Clinical consultation (which does not include supervision)
- Second clinical opinion
- Aftercare planning
- Termination planning

Case Consultation shall not include clinical supervision or consultation with other clinicians who provide the same service at the same agency. The meeting could take place between two outpatient providers who work for different agencies, between the treating outpatient provider and any behavioral health provider offering services at a different level of care, or between the treating outpatient provider and a representative from a school, state, medical office, CBHI agency or residential provider.

Family Consultation (90887) is a documented meeting of at least 15 minutes duration, either in person or by telephone, between the treating provider, and with family members or others who are significant to the Member and clinically relevant to a Member's treatment.

Goals of family consultation are to educate, identify and plan for additional services or resources, coordinate a treatment plan, review the individual's progress or revise the treatment plan, as required.

The scope of required service components provided, includes but is not limited to, the following:

- Treatment coordination
- Treatment planning with the Member's family or identified supports
- Assessment of the appropriateness of additional or alternative treatment
- Aftercare planning
- Termination planning
- Support or reinforcement of treatment objectives for the Member's care

The meeting is between the treating outpatient provider and Member-identified family or supports.

Collateral Contact (H0046) is a documented communication of at least 15 minutes duration, either in-person, by telephone (including voice mails) or by email. These contacts are between a provider and individuals who are involved in the care or treatment of a Member under 21 years of age. This would

include but is not limited to: school and day care personnel, state agency staff, human services agency staff, court appointed personnel, religious or spiritual advisers, and/or other community resources.
The scope of required service components provided, includes but is not limited to, the following:

- Treatment coordination
- Treatment planning with the Member's family or identified supports
- Implementation of additional or alternative treatment
- Aftercare planning
- Termination planning
- Supporting or reinforcing treatment objectives for the Member's care

The contact is between the outpatient provider and identified individuals involved in the Member's behavioral health or medical care or Member-identified family or supports.

DOCUMENT HISTORY

- December 2020: Template updates