Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
www.mass.gov/masshealth

MassHealth
Nursing Facility Bulletin 180
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TO: Nursing Facilities Participating in MassHealth

FROM: Mike Levine, Assistant Secretary for MassHealth

RE: **Behavioral Health Community Partners Supports and DMH Case Transition Management Team for Nursing Facility Residents**

Introduction

Over the last several years, the needs of the nursing facility (NF) population have increased. NFs have reported an increase in the medical complexity of residents and an increase in need for behavioral health services. The Executive Office of Health and Human Services (EOHHS) will be using the Behavioral Health Community Partners (BH CP) Program and expanding support provided by a newly developed Department of Mental Health (DMH) Transition Case Management Team to work in a coordinated manner to provide additional support to a specific population within NFs. This bulletin describes the role of BH CPs and DMH transition case managers in serving NF residents with a positive Level 2 PASRR determination of Serious Mental Illness (SMI), and sets forth requirements for NFs related to the delivery of BH CP and DMH supports to their eligible residents.

BH CP Supports for NF Residents

MassHealth's BH CPs will support individuals 18 years or older residing in an NF who have received a positive Level 2 PASRR determination of SMI and have received a determination that NF services are appropriate for up to the next 12 months ("12-month determination"). Eligibility is not restricted to MassHealth members. The BH CPs are community-based organizations, contracted with MassHealth to provide enhanced care coordination for all eligible NF residents. BH CPs will provide care coordination services and supports that include, but are not limited to:

- outreach and engagement;
- comprehensive assessment, Health Related Social Needs (HRSN) screening, and ongoing person-centered treatment planning;
- care coordination across services including medical, behavioral health, long-term services and supports, and other state agency services; and as appropriate, referrals for DMH Clubhouse and Human Services Transportation (HST);
- support for transitions of care;
- connections to Options Counseling;
- medication review support;
- health and wellness coaching;
- connection to social services and community resources;
- coordinating with LTSS and/or other providers in the community to ensure that adequate supports are in place for the enrollee to transition home or into the community;
- coordinating behavioral health services (including, but not limited to, psychopharmacology, individual therapy, neuropsychological testing); and
- medication review to document current medication/regime.

DMH will enroll eligible NF residents in BH CPs and will notify the BH CP of the enrollment. Once the individual is enrolled in a BH CP, the BH CP will work to contact the enrollee either through phone calls, telehealth, or face-to-face visits. BH CP staff will be visiting enrollees in person and must have the ability to meet face-to-face with the enrollee in the NF.

Responsibilities of NFs in Working with BH CPs

Each NF may have at least one dedicated BH CP assigned to support eligible NF residents. BH CPs may contact the NF staff (including but not limited to social worker(s) and nurses) through email or phone calls or may ask to schedule time to meet with NF staff. NFs are required to respond to BH CPs in a timely manner.

NFs are required to support BH CPs by providing:

- assistance or feedback on the best times and ways to communicate with enrollees (e.g., an enrollee may prefer afternoon visits or may be hard to communicate with via phone);
- support in meeting with enrollees on the premises;
- information on any initial referrals the NF has initiated (e.g., referrals for neuropsychological testing, psychotherapy) to assist in follow-ups and coordinating care; and
- BH CPs with assistance in obtaining Releases of Information and requesting NF documentation that will assist the BH CPs in completing their Comprehensive Assessment, Care Planning, and Medication Review to document current medication/regime. This documentation may include, but is not limited to, the NF Care Plan; the list of medications, along with the regimen and dosage amounts; and psychosocial assessment.

NFs are required to comply with the requirements outlined in this bulletin or will otherwise be subject to sanctions. NFs continue to be subject to MassHealth regulations, including 130 CMR 456.000: *Long Term Care Services*; Department of Public Health regulations, including 105 CMR 150.00: *Standards for long-term care facilities*; and the federal PASRR regulations at 42 CFR 483.100. Pursuant to these regulations, NFs are required to create care plans and perform care coordination and discharge planning for all residents. BH CPs have specialized training and bring additional expertise in working with and supporting the needs of NF residents with serious mental illness. BH CPs will build upon the work of the NF for individuals enrolled in BH CPs.

If a MassHealth NF has questions about BH CP supports for NF residents, they may contact Community Partners at Community.Partners@mass.gov.

DMH Transition Case Management Supports for NF Residents

The DMH Transition Case Management Team is a team of case managers who work for DMH and are assigned to NF residents with a positive Level 2 PASRR determination of SMI who have received a determination that NF services are appropriate for up to the next 90 days ("90-day determination"). This team will support the resident's transition to the community.

The DMH case managers will:

- work with existing care-coordination services (BH CP, One Care plan, etc.);
- collaborate with the DMH Site Office in the community to facilitate referral and enrollment into DMH services;
- assist with referrals to other community services and supports (PCA, VNA, home modifications, etc.); and
- collaborate with the NF around discharge planning and help coordinate discharge.

DMH will assign a case manager to individuals with a PASRR 90-day determination. Case managers will use in-person and telehealth meetings to engage with the resident and care team. Communication will include email, phone, and in-person contact.

Responsibilities of NFs When Working with the DMH Transition Case Management Team

NFs are required to support the DMH Case Managers by providing:

- assistance or feedback on the best times and ways to communicate with residents;
- support in meeting with residents on the premises;
- information on any initial referrals the NF has initiated to assist in follow-ups and coordinating care; and
- information on any discharge or transfer of a resident, including emergency department visits and hospitalizations.

NFs are required to comply with the requirements outlined in this bulletin or will otherwise be subject to sanctions. NFs continue to be subject to MassHealth regulations, including 130 CMR 456.000: *Long Term Care Services*; Department of Public Health regulations, including 105 CMR 150.00: *Standards for long-term care facilities*; and the federal PASRR regulations at 42 CFR 483.100. Pursuant to these regulations, NFs are required to create care plans and perform care coordination and discharge planning for all residents. DMH Transition Case Managers have specialized training and bring additional expertise in working with and supporting the needs of NF residents with SMI. DMH Transition Case Managers will build upon the work of the NF for individuals assigned to them.

If an NF has questions about the DMH Transition Case Management Team for NF residents, they may send an email to kim.clougherty@mass.gov.

MassHealth Website

This bulletin is available on the MassHealth Provider Bulletins web page.

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Questions

If you have questions about the information in this bulletin, please email your inquiry to InstitutionalPrograms@mass.gov, with a copy to Community.Partners@mass.gov and kim.clougherty@mass.gov.