REQUEST FOR PROPOSAL

Extended Acute Care Hospital Based

Issued By:

Magellan Behavioral Health of Pennsylvania, Inc.
In collaboration with
Community Care Behavioral Health Organization, Chester, Bucks, Delaware, and Montgomery Counties

Issue Date:

April 7, 2021

PROJECT OFFICER

Jeanne Ewing
Senior Account Executive
Magellan Behavioral Health
of Pennsylvania, Inc.
215-504-3972
ewingj@magellanhealth.com

TABLE OF CONTENTS

I. OBJECTIVE

INTRODUCTION

Magellan Behavioral Health of Pennsylvania, Inc. (Magellan), in collaboration with Community Care Behavioral Health Organization (CCBHO), Bucks, Chester, Delaware and Montgomery Counties is releasing a Request for Proposal for an Extended Acute Care Program.

OBJECTIVE

Magellan, CCBHO and Bucks, Chester, Delaware, and Montgomery Counties are interested in receiving proposals that describe extended acute care inpatient delivery systems and services for persons with mental health challenges in need of long-term inpatient care. The Extended Acute Care (EAC) inpatient level of care is intended to serve as diversion from placement at Wernersville State Hospital, or resource for discharge from acute care hospitals. This request is being made to increase inpatient psychiatric community alternatives as a result of the State closure of civil inpatient admissions at Norristown State Hospital in 2018. The subsequent allocation of six (6) civil beds at Wernersville State Hospital per each of the four (4) Southeast Region Suburban Counties has resulted in a significant reduction in long-term care access. In order to offset this reduction, the counties are seeking to increase community-based treatment options that will effectively meet the needs of individuals with complex psychiatric needs. In light of this, counties are trying to create best practice, recovery-oriented levels of care. Specifically, all proposals must be for a 20-bed hospital-based program affiliated with a medical institution. EAC should be part of the hospital and within the overall plan of the hospital's service delivery such that its primary function is not the delivery of mental health services. Respondents must ensure that no component part of their proposed program will meet the definition of an Institution for Mental Diseases (IMD), as IMDs are specifically excluded from eligibility. All proposals must be geographically relevant to Bucks, Chester, Delaware, and Montgomery Counties, but not necessarily located in these counties.

POPULATION TO BE SERVED

The individuals who are eligible for this program are 18 years of age and older, have a physician certified primary DSM5 mental health diagnosis, and qualify for voluntary admission under Section 201 of the Mental Health Procedures Act (MHPA) (50 P.S. S7201) or involuntary under Section 303 or 304 of the MHPA (50 P.S. S7303-&304). Diagnosis will include a severe, mental illness as their primary diagnosis. This may consist of, but is not limited to, Schizophrenia, Schizoaffective Disorder, Bipolar Disorder, Major Depressive Disorder, or Borderline Personality Disorder and as reflected in the Adult Priority Population Bulletin OHMSAS-19-03.

The individuals served in this program will require a structured, safe and secure therapeutic environment to serve people with serious and persistent mental illness and functional impairments who may have been institutionalized, and who are currently receiving inpatient or are recommended as needing extended acute level of care through psychiatric evaluation. Individuals needing the support of an EAC will likely have extensive trauma histories and any program development should take this into consideration.

They may experience the following problems:

- Co-occurring medical conditions and medication complications
- Problematic social/peer relationships
- Basic hygiene and daily activity needs
- Co-occurring developmental/intellectual disability/traumatic brain injury
- Referral from an acute psychiatric inpatient setting that recommends transfer to an EAC or have a psychiatric evaluation that specifically recommends admission to an EAC with medical clearance for admission.
- Lack of adherence to recommended clinical treatments and/or medication regimens
- History of issues inclusive of:
    - impulsive acting out to self and/or to others,
    - self-injurious behaviors,
    - emotional, sexual, physical abuse,
    - co-occurring drug and/or alcohol abuse

II. PROPOSAL TIMEFRAMES

ACTION	DATE
RFP released	April 7, 2021
Letter of intent submitted by	April 16, 2021
Questions regarding RFP submitted by	April 16, 2021
Responses to RFP questions distributed by	April 30, 2021
RFP submissions due	All responses must be received by the close of business on June 1, 2021
Proposal Review dates	June 2, 2021 – July 9, 2021
Proposal interview dates (if needed)	July 19, 2021 – July 23, 2021
Provider selection dates	August 2, 2021

III. INSTRUCTIONS

1. Applicants must submit a letter of intent by 4/16/21 indicating desire to submit a proposal. The letter of intent is a non-binding document and will provide an overview of the proposal. In order to be eligible for submission, this letter of intent must be sent by the date provided. This document will be evaluated based on the minimum qualifications which includes attestation that the provider 1) Is a PA Medical Assistance provider, 2) Is a facility associated with a medical institution, 3) Qualifies under Medicare to provide inpatient as a billable service, and 4) Can guarantee that no component part of the organization can be classified as an IMD.
2. Applicants must respond to all components of this RFP and work within the page limits where indicated. Failure to comply may result in disqualification. A proposal must address everything outlined in the Appendices.
3. All responses to the RFP are due by close of business on **June 1, 2021.** Respondents will provide their proposals in all three formats:

   - One email containing the "Technical Proposal", the "Financial Proposal", and the "Transmittal Letter". Proposals should be sent to **Jeanne Ewing, ewingj@magellanhealth.com.**

     The Counties, Magellan, and Community Care Behavioral Health Organization reserve the right to disqualify any and all proposals received after the identified date and time.

     The submission must contain the following and be in 3 separate documents:

   - A document entitled "**Technical Proposal**" which will not contain any references to pricing or cost. This will be the detailed response or description of service being proposed.
   - A document entitled "**Financial Proposal**" which will contain the detailed business plan of financing the technical proposal, staffing, operations, general and administrative expenses, and all related capital expenses. Included in the financial proposal, respondents will address their plan's financial sustainability.
   - A document entitled "**Transmittal Letter**" which shall be signed by an official who has the legal authority to bind the company to the terms of the proposal.

4. Proposals shall be submitted with the following expressed understanding:

   - This Request for Proposal is not subject to the competitive bidding process and any contract entered into as a result of any proposal will not be based on the concept of the "lowest responsible applicant."
   - The Primary Contractors Magellan, or Community Care Behavioral Health Organization, may procure any service by any other means.
   - While the population to be served will include individuals that may be covered by both Medicare and Medicaid, and in those circumstances would be paid by the Medicare rate only, in this RFP, we are requesting that you identify the average rate, to be paid by all providers, for the program to remain fiscally sustainable (See Financial Proposal Section).

- The Counties, Magellan, or Community Care Behavioral Health may modify the selection process or the scope of the project or the required responses.
- Any Reinvestment start-up funds requested will be negotiated and contracted with each County separately. Reinvestment funds are retained earnings from prior years of HealthChoices operations that may be available to assist with start-up, through the County Primary Contractors (Bucks, Montgomery, Delaware, and Chester).

5. Best and final negotiations may occur.
6. Magellan, Community Care Behavioral Health Organization, and the Primary Contractors will select finalists with which they will begin the interview and selection process prior to contract negotiations.
7. Consideration will be given to those proposals that identify training initiatives and development as part of the technical proposal.

IV. ADDITIONAL INFORMATION FOR APPLICANTS

A. ISSUING OFFICE

The Project Officer listed below is the sole point of contact for this RFP. **Contact with any other state officials or officials from Counties concerning this RFP, unless authorized by the Project Officer, is grounds for disqualification.** Note that, following the release of this RFP, all questions should be submitted to the Project Officer in writing, via e- mail.

Written questions shall be forwarded via e-mail with the subject heading "Extended Acute RFP" to the following: Jeanne Ewing, ewingj@magellanhealth.com

B. CONTRACT

If Reinvestment start-up funds are requested and approved, successful bidders will be expected to enter into an agreement with each managed care entity and any willing county. County contracts are subject to approval by the Board of Commissioners, County Council, or other duly authorized entity.

C. REJECTION OF PROPOSALS

The Counties may reject any and all proposals received as a result of this RFP and may negotiate separately with competing applicants. If all proposals are unacceptable, the counties reserve the right to reject the proposals and to issue a new RFP, if indicated. The counties reserve the right to reject a proposal at any time during the process.

D. INCURRING COSTS

All costs of developing proposals and any subsequent expenses relating to contract negotiation are entirely the responsibility of the applicant.

E. AMENDMENTS TO RFP

If it becomes necessary to revise any part of this RFP, Magellan will issue an amendment to all applicants who responded to the original RFP.

V. INFORMATION REQUIRED FROM APPLICANTS

GENERAL INFORMATION

This section includes instructions for preparing the Technical as well as the Financial Proposals. Applicants should review the instructions carefully. Failure to comply with these instructions in full may result in disqualification. To be considered, the proposals must include responses to all requirements in each respective part of the proposal(s). Any other information thought to be relevant, but not applicable to the enumerated categories, should be provided as appendices to the proposals. If an applicant supplies or quotes publications in response to a requirement, there must be a reference to the document number and page number. This will afford a quick reference for the evaluators. Proposals not furnishing this reference will be considered to have not utilized supplemental material.

The proposal must consist of:

- Transmittal letter, one for each proposal,
- Technical Proposal, so identified; and
- Financial Proposal, so identified,
- and separate from the Technical Proposal.

APPLICANTS MUST STRICTLY ADHERE TO THE PAGE LIMITS INDICATED FOR EACH SECTION.

TRANSMITTAL LETTER

The transmittal letter must be on official letterhead and signed by an individual with legal authority to bind the applicant. The transmittal letter must include the name and title of the Chief Executive Officer or other individual authorized to legally bind the applicant. The transmittal letter must also include the identification of a primary contact and that person's title, address, telephone and telefax numbers and e-mail address. The letter must state that the applicant accepts the terms, conditions, criteria, and requirements set forth in the RFP.

VI. TECHNICAL PROPOSAL

REQUIREMENTS

General Requirements:

- Provide a secure, fully staffed, and monitored extended acute inpatient unit.
- Meet staffing requirements as further outlined in this RFP and as required by applicable regulations.
- Provide an integrated treatment approach that includes designated community treatment providers.
- Provide an integrated treatment approach that includes behavioral health, physical health, and addresses social determinants of health in discharge planning factors.

- Provide highly individualized assessment, treatment planning, and intervention to address the recovery needs of each person in a structured, safe, secure, and trauma-informed environment.
- Provide evidence-based practice therapeutic approaches.
- Provide individualized and adaptive programming schedules to meet the changing treatment needs of each individual.
- Support and/or provide activities that promote and demonstrate community inclusion.
- Seek external clinical consultation as needed (with prior BHO authorization), providing documented evidence of clinical rationale.
- Update risk assessment and risk management strategies regularly as part of each individual's clinical record.
- Provide psychological testing as needed.
- Provide functional behavioral assessments as needed.
- Describe approach in working with individuals with co-occurring needs, e.g. MH/D&A, MH/ID and/or Autism, MH/Physical Health complications.
- Provide a coordinated discharge planning process demonstrating engagement with members, identified natural supports and community support provider(s). Discharge plan is based on a whole person approach with focus on transitioning to community.
- Allow individual access to community legal services, advocacy groups, mental health, consumer, and family organizations and authorized federal, state, or local governments in accordance with HIPAA and DHS requirements.

Staffing Requirements:

- Staffing ratios will, at a minimum, be in accordance with psychiatric inpatient regulations: http://www.pacodeandbulletin.gov/secure/pacode/data/055/chapter1151/055_1151.pdf.
- Staffing will include full time Certified Peer Specialist(s) as part of the treatment team.
- At least one supervisor will be certified to supervise Certified Peer Specialists.
- Individual psychotherapy will be provided by licensed staff having a minimum of a master's degree in Psychology, Social Work, or a related social services discipline; CCDP.
- Part-time or full-time behavioral management therapist will be part of the treatment team. Clinical supervision will be provided by a licensed psychologist, licensed clinical social worker, or a psychiatrist.
- Attending psychiatrist (s) must approve any recommended treatment and treatment plans.

- Staffing will be sufficient in number to allow for individualized community integration activities and adhere to Joint Commission Standards, as outlined in the DRAFT Bulletin in EAC Revised Draft Bulletin on Hospital Based EACs.
- Specialized staff training will be made available to provide appropriate behavior management assistance, psycho- educational groups, individual and group therapy.
- Staffing should include a Nurse to provide connections to primary and specialty care, coordination with MCO's, natural supports and community based behavioral health supports. Members should receive medication education, self-management strategies and wellness goals to apply in a community-based setting.
- Describe any additional specialized positions that you plan to provide to promote your vision of individual recovery and community inclusion.
- Provide a complete staffing pattern, including the qualifications required for each staff position. Identify specific individuals where possible, including all degrees and certifications. An organizational chart, résumés and/or job descriptions may be attached as exhibits.
- Staffing will have demonstrated competencies in evidence-based practice approaches, cultural competency and trauma informed care approaches.
- Describe staff orientation and ongoing training. If available, please provide an orientation schedule or curriculum.
- Provide procedures for supervision of staff.

Reporting Requirements:

- Per Magellan and Community Care Behavioral Health policies and procedures, reporting requirements will be established based on implementation oversight process.

PROPOSAL REQUIREMENTS AND FORMAT

Identifying Information: Cover sheet to include legal name of the organization submitting the proposal, address, phone number, fax number, web site, contact person and email address.

Section 1.01

A. *Program Philosophy*: no more than two (2) pages

- Describe the general approach, values, and beliefs that form the foundation for the Program.
- Illustrate how key concepts of Recovery, understanding of trauma, and person-centered treatment are addressed and integrated into the program philosophy.

B. *Agency Experience:* no more than two (2) pages

- Describe your agency's experience in working with adults, with serious and persistent mental illness and their families, including individuals who: are transition-age (18-25); have co- occurring disorders; represent cultural minorities; and/or, are recovering from trauma.
- Describe your experience in other human service areas.

Attach the following information:

- A current table of organization of the Agency
- Resumes of key personnel and job descriptions
- A list of board members, which includes name, board title, term of office, address and phone number, occupation and relationship to the organization. Names and relationship to the respondent of any other individuals who are in key roles
- Letters of support from at least three types of references: one individual who has received your behavioral health services in the past 12 months, one family member, and one funding agency, with contact information for all
- Linkage agreement with community treatment providers

C. ***Individual/Family Input and Inclusion:*** **no more than two (2) pages**

- Describe how you will solicit and respond to input from individuals and/or their families concerning your services.
- Describe any formal or informal structures to obtain such input.
- Describe how you will engage with families and natural supports to support treatment and discharge planning.
- Discuss how you will handle individual/family concerns about the quality and appropriateness of your services.
- Attach copies of brochures, policies, or any other materials that describe problem solving/complaint/grievance system.

D. ***Description of the Population to be Served:*** **no more than two (2) pages**

- Describe what you perceive to be the needs of the population to be served.
- Describe how you will address the specialized needs of any individual in the program, e.g. communication, physical accessibility; utilization of catheters and/or nasogastric intubation tubes etc.), sensory impairments.
- Describe the anticipated length of stay.
- Identify any behavioral or physical health issues your organization is not able to address.
- Describe how you will address the cultural diversity of the suburban Philadelphia area.

E. ***Program Content:*** **no more than ten (10) pages**

- Describe the pre-admission and admission assessment processes.
- Describe the process for individualized treatment plan development and review(s).

- Describe the clinical/therapeutic approaches to assist individuals in their recovery. Identify any evidence-based or promising practices that you intend to provide.
- Describe the plan for addressing aggressive or self-injurious behaviors in a trauma-informed culture.
- Describe the protocol for the use of medication in a recovery-oriented environment.
- Describe any specific health/wellness approaches you will use, such as smoking cessation, nutrition education, and exercise.
- Describe what integrated health approaches will be implemented to address both behavioral and physical health factors jointly throughout treatment planning as well as within discharge planning.
- Provide a sample schedule of the individual and group therapeutic activities provided to individuals.
- Describe the assistance provided by staff to individuals regarding tasks of daily living. Describe the proposed activities that foster social connections and inclusion with the community at large.
- Describe the general and specialty health services available to individuals while on the unit.
- Describe the process for assessing social determinant of health needs and activities related to engaging the appropriate community-based organizations.
- Describe the policies regarding the confidentiality of mental health records in the EAC, resident rights, grievance procedures, and access to advocates.

Attach copies of assessment tools, treatment plan formats, policies and procedures and any other documentation that will expand on the narrative.

Section 1.02

F. ***Discharge Planning/Community Transition:*** **no more than two (2) pages**

- Describe the process for formulating a comprehensive discharge plan, including the areas to be addressed in each plan and how the member and their input will be included in the planning process.
- State what interventions your agency/organization will put in place to have continual focus on community re-integration.
- As part of community reintegration, describe the process for transitional visits and/or therapeutic leave options, particularly when the plan is a step down to another 24-hour level of care such as LTSR or CRR placement.
- Describe how you will support members in connecting to social determinants of health resources, advocacy groups, and/or other personal supports.

- Describe how family and natural supports will be incorporated into community transition planning.
- Describe your process for crisis planning and ensuring the plan is shared with community supports.
- Describe how you will integrate/coordinate behavioral health services with physical health services during treatment and in preparation for discharge.
- Describe the expectations for arranging for physical health aftercare appointments post-discharge.
- Describe post discharge follow-up procedures.

G. *Quality Improvement:* no more than two (2) pages

Describe your quality management structure and your Quality Improvement Plan. Explain the standards used to ensure that services are provided in accordance with the program model.

- Describe the proposed outcomes that will be used to evaluate the effectiveness of the service and explain how information from such evaluations will be collected, analyzed, disseminated and used to enhance EAC program performance.
- Submit your agency's Corporate Compliance Plan and report any founded Fraud, Waste, and Abuse indications over the last 3 years.

H. *Site Description and Plan*: no more than two (2) pages

Describe how the EAC space will be organized to assure culturally competent, trauma informed stabilization and safety, promote recovery and resiliency and foster community inclusion.

Address the following issues in this section:

- Location
- Floor plan
- Living and sleeping quarters (furniture, facilities, single room accommodations, common areas, etc.)
- Housekeeping and maintenance procedures
- Laundry service
- Food service
- Outside area for resident use

VII. FINANCIAL PROPOSAL

GENERAL

An executive summary must be submitted, along with the seven-page budget, completed on the budget template provided.

Data should be prepared on an accrual basis and should be reported in accordance with Chapter 4300. County Mental Health and Intellectual Disability Fiscal Manual Regulations, at the following link:
http://www.pacodeandbulletin.gov/Display/pacode?file=/secure/pacode/data/055/chapter4300/chap4300toc.html

Applicants may mark certain portions of their responses as "Confidential." The Counties, however, are not bound by any such designation of confidentiality and may disregard such designation to the extent required to comply with the provisions of the Pennsylvania Right-To-Know Law.

EXECUTIVE SUMMARY

Provide a concise description of the project timeline and tasks, from the date of award/contracting through the end of the start-up year. Include a plan for how often members will be admitted once the facility is licensed and ready for admissions. How long will full start-up take? Will you be requesting Reinvestment funding to supplement your start-up plan? Also include a summary as to what your budget will look like in year two, once you are up to full capacity. What are you projecting in terms of Other Revenue payments (i.e. Medicare, Commercial etc.)? Identify the average daily rate you will need to support all 20 beds. Knowing that Medicare may pay a different rate, please also identify that rate separately.

FORMS A & B:

I. HEADING

a. Enter your agency name and address, as well as the estimated start date. Enter the program name as it appears in the RFP.

II. COLUMNS

a. Start-Up Year Budget **(If Reinvestment funds are requested, they should only be requested to support the first start-up year**): *Form A & Form B*

i. This column is used to report costs associated with the start-up of the EAC, including those which will only be incurred during the first year, as well as those which are not yet reimbursable under MA HealthChoices, Medicare, County Mental Health Base funding or other funding, beginning on the date upon which contracting for this project is completed, and continuing for 12 months. Costs in this category will include, but are not limited to property purchase/acquisition, staff development, renovation, equipment, furniture, fixed assets, motor vehicles, etc. This could also include salaries and wages, benefits, purchased personnel, operating and administrative expenses, not covered by other billable revenue.

b. 2nd year Budget (without Reinvestment funds): *Form A & Form B*

   i. This column is used to report any costs related to the second year of the of the EAC, which may be ongoing (i.e., salaries and wages, benefits, purchased personnel, operating and administrative expenses). This column represents the program revenue and expenses once the program is up to full capacity.

III. **ROWS**

a. Most of the line items listed under the Personnel Services, Operating Expenses, and Equipment and Other Fixed Assets categories are self-explanatory. Enter the expenditure amounts for each line item for which you incur an expense.

b. Add the line item amounts within each major category and enter the sub-total amount.

c. A roster of Personnel (*Form F* and *Form G*) must be completed as back-up for all salary and wages expenditures. The total from Column 6 on Form F and Form G should equal the amounts entered online A.1. in the Start-Up Year Budget and 2nd Year Budget columns of *Form A and Form B.*

d. In addition to Salary and Wages, line items A1, A2, A3 & A4 require further explanatory information when budgeting. This may be provided on *Form D* and *Form E*.

e. Employee Benefits – Each type and amount of benefit must be listed individually.

f. Purchased Personnel – Each category and amount must be listed individually. The rate and units being budgeted must be stated if appropriate.

g. Rent/Mortgage – Must show the amount of rent or mortgage involved.

h. Purchase of Equipment and Furnishings – Each item and cost must be listed individually.

i. Motor Vehicles – Each vehicle should be listed by the year and make and whether it is leased or owned.

j. Motor Vehicle Repair/Maintenance/Insurance – The repair and maintenance amounts may be shown in summary form and the insurance amount must be specified for each vehicle.

k. Depreciation – A schedule showing how the depreciation was calculated must be included.

l. Total Direct Cost of Service, is the sum of the subtotal amounts entered in each column for sections A, B, and C on *Form A and Form B.*

m. Administrative Costs should contain the budgeted administration costs for this service. Retained Earnings are allowed in the second year only and cannot include any Reinvestment funds. Retained earnings during the second year may be budgeted at a maximum of 3%. Program Sub-Administration refers to the fact that some providers have a level of administration, such as residential, below the main level of administration. This line may be used if you calculate a sub-level of administration. The Upper Level administration line is used to apply the agency overall administrative costs. It may also include a program administration if your agency does not separate these costs.

   i. In any event, a separate budget must be prepared for administrative costs appearing on either line E. 2 or E. 3, and may be described on *Form D* and *Form E*.

ii. An allocation schedule must also be developed which shows how total administrative costs are applied to each service.

n. Total Expenditures is the sum of line D plus the sub-total of Section E.

o. Revenue should agree with the amount reported for this service on *Form C.*

IV. ADDITIONAL INFORMATION

a. The number of clients and number of units of service must be completed for the period in question.

FORM C

I. GENERAL

a. This form is used to report all sources of revenue which the agency might receive which serve to offset eligible expenditures in determining the Bucks County request.

b. Provide a signature attestation that you will be in compliance with the 4300 regulations.

II. HEADING

a. Enter your provider name and the name of service description in the RFP. Enter the periods covered by this report.

III. REVENUE DESCRIPTION

a. Line 1: MA HealthChoices (CCBHO/Magellan) – This is estimated revenue to be received from MA HealthChoices through Magellan, for treatment.

b. Line items 1 & 6 require further explanatory information when budgeting. This may be provided on *Form D* and *Form E*.

c. Line 2: MH Base– This is estimated revenue to be received from BH/DP for treatment services provided to individuals not covered by MA HealthChoices.

d. Line 3: Grants/Donations – These are contributions or gifts from the general public.

e. Line 4: Reinvestment – These are funds provided through Reinvestment for the first year only, used for renovations to the facility, or clinical and operational expenses. This may also include expenses for individuals served during the start-up year until the facility has been licensed.

f. Line 5: Other – This is money the provider may wish to contribute to the cost of this service, for those expenses not covered or requested in the RFP.

g. Line 6: Third Party Liability – This is estimated revenue to be received from other insurances for treatment services provided to individuals who may also be MA/HealthChoices eligible.

h. Line 7: Medicare- this is the revenue to be received from Medicare for treatment services provided to individuals who are Medicare only or Dual Eligible for HealthChoices and Medicare Primary.

i. Line 19: Total – All of the different revenue lines should be summed and the total entered.

FORMS D & E

I. GENERAL

This form is used only when the provider must report supportive information which has been requested in other budget form instructions.

II. HEADING

Enter your provider name, period covered, and the service identified in the RFP.

III. DESCRIPTION

This section is used to identify the nature of the supplemental information which is being presented. This may involve an explanation, a listing of items or a cost formula.

IV. AMOUNT

Enter the amount of expense or revenue across from the appropriate item identified in the description section.

On forms D and E, please identify the average Per Diem Rate you require if all beds were Medicaid and or Mental Health Base funded only and also identify the Medicaid Rate required for the program when the Medicare Rate/Revenue and member mix of (35%) is considered.

FORMS F & G

I. GENERAL

a. This form is used for Budget purposes. It provides back-up data to the Salaries and Wages reported on the *Form A and Form B.*

b. This form should include information for all salaried employees who are directly charged to the service in question.

c. This form also serves as back-up when budgeting the agency administration costs.

d. An agency organization chart should be submitted which includes the position number of each funded position.

II. HEADING

a. Enter your agency name and the period covered by the report.

b. Enter the contract service description exactly as it appears in the RFP. This description should agree with the one on the budget forms for which this form is serving as back-up.

III. COLUMNS

a. NAME (COLUMN 1): In this column, list the names of all salaried personnel who will be charged to this service. If a position to be budgeted is currently unfilled, use the word vacant.

b. TITLE (COLUMN 2): Enter the position classification or functional description for each employee or vacant position that is listed in Column 1.

c. TOTAL AGENCY HOURS PER WEEK (COLUMN 3): Enter the total number of hours worked for the agency by each employee named in Column 1. These are the total hours on which the person's actual salary is based.

d. THIS PROGRAM HOURS PER WEEK (COLUMN 4): Enter the hours worked by each employee for this particular contract service.

e. TOTAL AGENCY ANNUAL SALARY (COLUMN 5): This should be the employee's total actual salary. It should correspond to the hours recorded in Column 3.

f. THIS PROGRAM ANNUAL SALARY (COLUMN 6): Enter the salary for each employee that applies to this particular service. This salary should correspond to the hours per week entered in Column 4.

g. TOTAL AGENCY ELIGIBLE ANNUAL SALARY (COLUMN 6 line I-32): Report in this space the total program salary and wages, as based on the program hours reported in Column 4 and the program salary as determined in Column 6. The total from this column is reported in Column 2, Line A.1. of *Form A and Form B* when budgeting.

INSTRUCTIONS FOR REPORTING ADMINISTRATIVE COSTS

I. Although administrative costs must be reported as a line item expense within each cost center or service, the agency must prepare an administrative budget and distribution schedule in support of the line item expenses. The forms to be used for this budget are *Forms A, B, C, D, E and G.*

a. Some providers may wish to separate administrative costs into two levels. They may have a "program" administration which is only distributed to a particular service level. This would be reported on Line E. 2. of *Form B* for the service to which the administration is being distributed. Then they also have the overall administration which is distributed to all services operated by the agency, and is reported on Line E. 3. of the same form.

b. Even if the agency has multi levels of administration, it may wish to budget them together and distribute them all at once if that is how the provider normally functions. If this is the case, then all administrative expenses when distributed, would be reported on Line E. 2. of *Forms B and D.*

c. The form of the administrative distribution schedule is left to agency discretion but must reflect the distribution of total administrative costs to the various service programs operated by the agency. Also, the method or basis used for distribution must be clearly stated, (e.g., total cost, personnel costs, number of clients, etc.

II. For the purpose of reporting, administration is defined as general managerial functions or activities which are supportive to but not an intrinsic part of the provision of direct services. These administrative functions or activities include executive supervision, personnel management, accounting, auditing, legal services, purchasing, billing, community board activities, activities associated with management information systems (does not include maintenance of individual client case records), and clerical activities which are supportive to these administrative functions.

a. Clerical activities which provide direct support to the program activity are to be reported as direct costs of the service program.

b. Clinical or program supervision associated with direct client care is to be considered a direct program expense. Staff time associated with such supervision should be allocated among and reported within service programs as a direct program expense. The method of allocation is at the discretion of the agency if it is verifiable and results in an equitable distribution among service programs.

VIII. APPENDICES

APPENDIX A

Introduction

Bucks, Chester, Delaware, Montgomery, and Philadelphia Counties have a long history of collaborative work that dates back over 25 years. These Southeast Region counties have closed and downsized three state hospitals; implemented Medicaid Managed Care through HealthChoices; developed an array of comprehensive community-based behavioral health services at both the individual county and regional level; and, developed a Regional Mental Health Services Coordination Office. The primary function of the Regional Office includes development and oversight of regional services; development of policies and procedures that provide a regional management structure for the operation of these services; and coordination of special projects that focus on work with a variety of systems of care.

The closure of three state hospitals has resulted in funding for significant enhancement of the community-based service infrastructure. Combined with reinvestment funds from the HealthChoices program, Southeast Region counties have individually and collectively developed a wide variety of housing, treatment, and rehabilitative resources for persons with serious mental illness.

Since 2015, several external events have had an impact on the continued service development in the Region. These events include: the American Civil Liberties Union (ACLU-PA) lawsuit filed against Department of Human Services (DHS) in 2015 and subsequent settlement agreements that occurred in 2016 and 2017; the announcement of the closure of the civil section of Norristown State Hospital (NSH) in 2017; the closure of civil admissions to NSH in 2018; the allocation of 30 civil beds at Wernersville State Hospital (WeSH) providing 6 beds for each Southeastern Region county; the development of NSH as a Regional Forensic Treatment Center (RFTC); and the land planning agreement between the PA Department of General Services (DGS) with the Municipality of Norristown requiring the development of a Southeast Region plan of action for relocation of individuals currently residing in NSH facilities scheduled for demolition and subsequent land conveyance to Norristown for local development.

In response to these external factors, the four suburban counties of Bucks, Chester, Delaware, and Montgomery have worked to combine resources and develop programs that expand their capacity to meet the needs of individuals with complex psychiatric needs. Philadelphia, as the largest population center in the Southeast Region, has undertaken the majority of its service development in a parallel process. Examples of suburban county development include a Long- term structured residence (LTSR) in 2007, an Extended Acute Care (EAC) program in 2014, and an Adult Residential Treatment Facility (RTF-A) in 2017.

Additionally, the suburban counties have created policies and procedures for the collaborative oversight of the referrals, admissions, and waiting lists for access to these regional programs as well as state hospital access at WeSH and the RFTC at NSH. The collaborative oversight, which also includes the Managed Care Companies (MCOs) and

Behavioral Health Organizations (BHOs) in the Region, has also led to the development of standardized processes for: authorization, comprehensive treatment planning, treatment team and incident reviews, structured bed-borrowing procedures, and coordinated discharge planning. These coordinated efforts are designed to assure that there is a flow in and out of these programs meeting both the treatment needs of the individuals receiving services as well as the fiscal viability of the agencies providing those services.

In summary, in the Southeast Region, the foundation for the development of an accessible, comprehensive, integrated, and effective community-based system of care has been built by collaborative efforts over many years. Strengths of the system include: a commitment to the development of services that place the need and satisfaction of the individual receiving service at the center of planning and decision making; a strong values-based approach to service that supports recovery; a well-established provider network that has experience and expertise in treating adults with serious mental illness; a commitment to the development of person- centered planning; a willingness to seek out new opportunities that support systems development and reorganization to meet the needs of the people that live in our communities.

Successful inter-county service development is a complex process requiring all counties and their MCO and BHO partners to collaborate in the planning, design, implementation, and monitoring of programs and services that meet the needs of the Southeast Region residents with mental health challenges. Continued collaborative success is dependent upon all stakeholders sharing: a common vision of recovery and resiliency, a commitment to developing evidence-based and best-practice models; the availability of adequate and flexible funding; and engagement in an organized planning process that allows for system change as needed over time.

The following Appendix B provides an overview of the policies and procedures that have been developed for an EAC level of care to achieve and support this vision of Regionally Coordinated Collaboration. These policies and procedures are currently implemented in the existing Regional Extended Acute Care program but have been modified as draft for future EAC level of care development. They include: (1) *Regional Extended Acute Care Protocols and Process - Comprehensive Plan of Care Form, (2) Regional Extended Acute Care Referral Review and Wait List Protocol, and (3) Regional Extended Acute Care Exception to Admission/Appeal Process.* These existing documents should be viewed as a regional procedural protocol “template” for future EAC providers.

APPENDIX B

Regional Extended Acute Care Protocol and Process

Instructions:

1. Eligibility criteria must be met before any person can be considered for referral to the Regional EAC level of care.

   Eligibility Criteria:

   A. General criteria

      i. Individual is at least 18 years of age or older

      ii. Resident of Bucks, Chester, Montgomery, or Delaware Counties, unless otherwise approved by the Counties and the MCO.

      iii. Referral from an acute psychiatric inpatient setting that recommends transfer to an EAC or referral based on a psychiatric evaluation that specifically recommends admission to an EAC with medical clearance for admission. HealthChoices, Medicare and/or Dual eligible (Medicare/Medicaid)

      iv. If uninsured, the County Administration pre-authorization of funding may be considered

      v. Meets medical necessity criteria (refer to DPW website & MCO)

   B. Treatment/Service History

      i. 45 days of accumulated inpatient psychiatric hospitalization during the last 12 months **AND/OR**

      ii. Including current commitment, at least two 303 commitments within the past 12 months **AND/OR**

      iii. The client must have a primary diagnosis that meets criteria for treatable serious mental illness as defined by Bulletin OMH 94-04 **AND/OR**

      iv. Documentation that the individual poses a significant risk of harm to self or others and/or is unable to take care of self; **AND/OR**

      v. The individual has psychiatric symptoms that are insufficiently resolved despite acute inpatient hospitalization and treatment; **AND** which cannot be provided in a less intensive level of care.

2. **Part I of the attached Comprehensive Plan of Care Form must be completed for any individual who is being considered for potential referral to a Regional EAC.**

3. **Comprehensive Plan of Care Process** – This process will include documentation, a Comprehensive Plan of Care Form (CPC Form) and a Comprehensive Plan of Care Meeting (CPC Meeting) to determine if the referral to the EAC is appropriate or if the individual's needs can be met at a less restrictive level of care.

A. Contact will be made by the treating provider to either the County or MCO to discuss consideration for EAC level of care and/or alternative service options. **NOTE: No direct contact should be made with the EAC unless a referral has been approved by the COUNTY and the MCO.**

B. Upon approval by the County and MCO, Part I of a Comprehensive Plan of Care Form (see attached) will be initiated by the treating provider containing the individual's demographic information, service and historical information, as well as information which identifies current challenges and service needs. Part II of the CPC Form will be completed in collaboration with all present during the CPC Meeting.

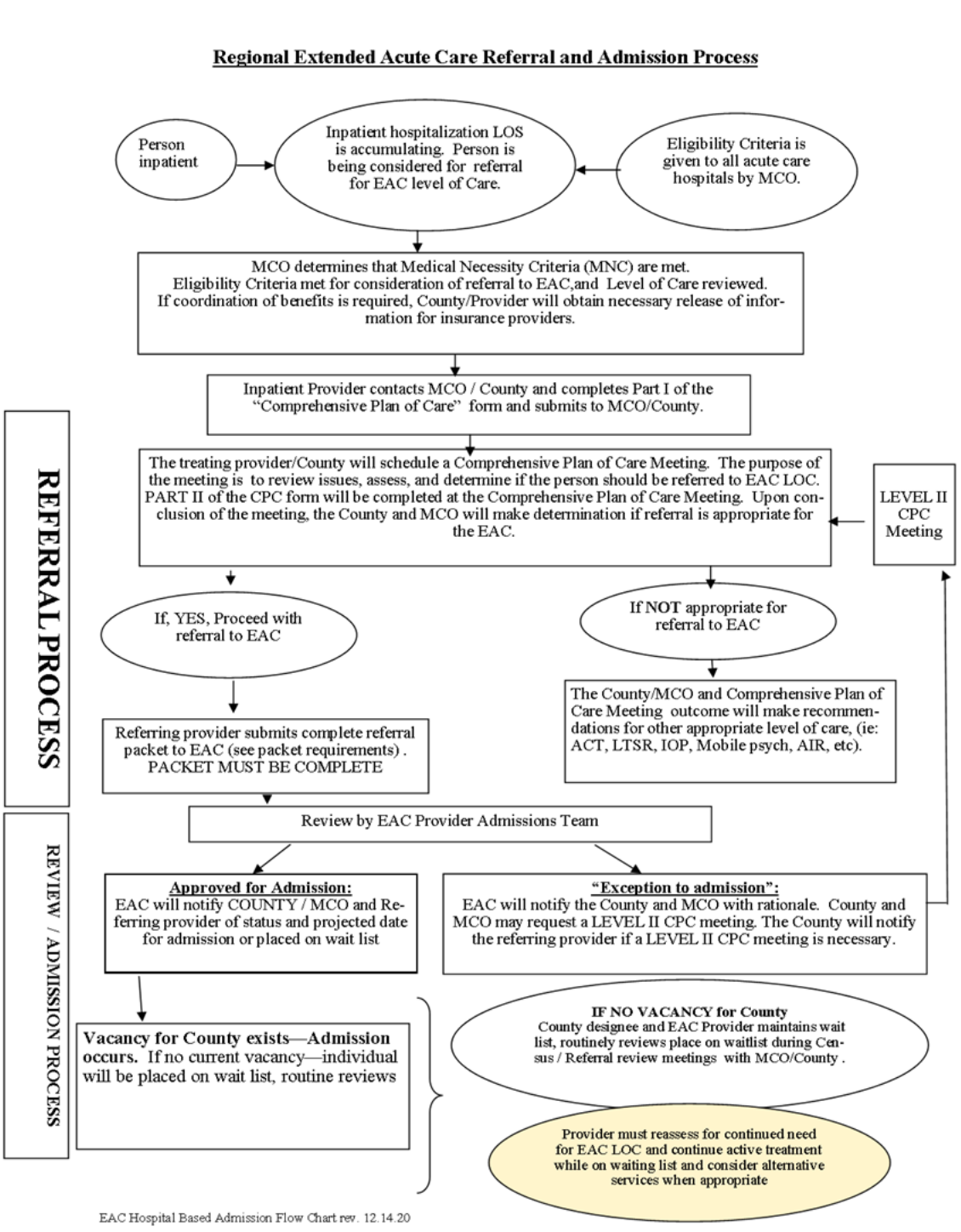
C. After submission and review of the CPC Form, the treating provider will convene a "Comprehensive Plan of Care Meeting" with all stakeholders including but not limited to: the individual being considered for potential referral to EAC, family/other support persons, the current treating provider, other ancillary and service support staff, County and MCO representatives, etc.

D. Upon conclusion of the Comprehensive Plan of Care Meeting, the County and MCO will make the determination if the referral is appropriate for the EAC level of care.

E. If referral is deemed appropriate for EAC level of care and the MCO has determined that Medical Necessity Criteria has been met, the referring provider should then complete the referral and submit to the EAC. (See Referral Packet requirements listed in Attachment B. Completed referrals sent to TBD EAC Provider.

F. The EAC will review the referral packet and notify the MCO and County as to the proposed disposition.

G. If there is an "Exception to Admission", the process for review and steps will be followed according to the Regional Exception/Appeal protocol. If the referral is identified as not appropriate for the EAC level of care, the County and MCO will revisit and provide assistance in accessing appropriate services/supports based on the individual's identified needs.


Regional Extended Acute Care Referral and Admission Process
Person inpatient
Inpatient hospitalization LOS is accumulating. Person is being considered for referral for EAC level of Care.
Eligibility Criteria is given to all acute care hospitals by MCO.
MCO determines that Medical Necessity Criteria (MNC) are met. Eligibility Criteria met for consideration of referral to EAC,and Level of Care reviewed. If coordination of benefits is required, County/Provider will obtain necessary release of information for insurance providers.
Inpatient Provider contacts MCO / County and completes Part I of the "Comprehensive Plan of Care" form and submits to MCO/County.
The treating provider/County will schedule a Comprehensive Plan of Care Meeting. The purpose of the meeting is to review issues, assess, and determine if the person should be referred to EAC LOC. PART II of the CPC form will be completed at the Comprehensive Plan of Care Meeting. Upon conclusion of the meeting, the County and MCO will make determination if referral is appropriate for the EAC.
LEVEL II CPC Meeting
REFERRAL PROCESS
If, YES, Proceed with referral to EAC
If NOT appropriate for referral to EAC
The County/MCO and Comprehensive Plan of Care Meeting outcome will make recommendations for other appropriate level of care, (ie: ACT, LTSR, IOP, Mobile psych, AIR, etc).
Referring provider submits complete referral packet to EAC (see packet requirements) . PACKET MUST BE COMPLETE
Review by EAC Provider Admissions Team
REVIEW / ADMISSION PROCESS
Approved for Admission:
EAC will notify COUNTY / MCO and Referring provider of status and projected date for admission or placed on wait list
"Exception to admission":
EAC will notify the County and MCO with rationale. County and MCO may request a LEVEL II CPC meeting. The County will notify the referring provider if a LEVEL II CPC meeting is necessary.
Vacancy for County exists—Admission occurs. If no current vacancy—individual will be placed on wait list, routine reviews
IF NO VACANCY for County
County designee and EAC Provider maintains wait list, routinely reviews place on waitlist during Census / Referral review meetings with MCO/County .
Provider must reassess for continued need for EAC LOC and continue active treatment while on waiting list and consider alternative services when appropriate
EAC Hospital Based Admission Flow Chart rev. 12.14.20

Appendix D

Regional Extended Acute Care Comprehensive Plan of Care (CPC) Form Part I

Instructions: Provider/Inpatient Facility will complete the information on the Comprehensive Plan of Care (CPC) Form and submit with request for Comprehensive Plan of Care Meeting to MCO and/or County. Part II of the CPC Form will be completed at the Comprehensive Plan of Care Meeting, which is designed to discuss strengths and concerns, assess need for services/supports, and develop a comprehensive plan with the individual to best meet his/her needs. Please send referral to EAC PROVIDER CONTACT:

Individual's name:_____
Last name, First Name, MI

Date of Birth (MM/DD/YYYY): _____

Social Security #:_____

County(circle): **BUCKS CHESTER DELAWARE MONTGOMERY**

Referral source: Hospital/Individual completing form:_____

Individual contact #:_____

Email:_____

Current Hospital Admission Date: _____

Current Commitment & Effective Date:_____

Previous Commitments within last 12 months (List dates and commitment type):
_____
_____

Insurance (circle all appropriate): Magellan Community Care Behavioral Health MA (FFS) MA Pending None Medicare Private/Commercial (list) Other
Insurance Policy Number:
_____
_____
_____

Does Individual pay any health insurance premiums for Medicare or Medicaid (MAWD)? Y/N

Income Amount:_____
Source: _____
Representative: _____

Payee if applicable: _____

Individual's Housing Status: Homeless: Y/N

If none, previous housing type:_____

Current Address: _____

Does individual have a Case Manager/Recovery Coach/ACT? Y / N

Name/agency/contact number: _____

Previous Hospitalizations & Substance Abuse Treatment in last 12 months:

Hospitalization	Dates of Admission/Discharge	Disposition

Does Individual have history of Substance Use? If yes, list type, frequency, and last use.

Type	Frequency	Last use

Current Legal Status Y/N (i.e.: Probation, Parole, pending charges, etc.

_____

Incarcerations / Legal encounters:

_____

List Formal and Informal Supports within the last year: Include all professional and other self-help supports, i.e. treatment services such as outpatient, case management, housing, peer supports, faith-based groups, family, etc.

Service/Support: (Agency/support Contact Name)	Frequency of Contact

Clinical Presentation:
Description/history of suicide attempts:

Behavioral Challenges:

Presenting Problem: Clinical Impression of current crisis, (based on current and past information about the individual), & why is it happening now:

Current Treatment Interventions/Plan:

Current/Past Medical Conditions:

Diagnosis/Medical Condition	Past Treatment Provider	Contact / if known	Comments

Current Medications:

Medication	Dose	Frequency	Reason

Previous medications (if known) and outcome/ failed trials:

Current Diagnosis:

Psychiatric: _____

Medical: _____

Social Stressors: _____

Comprehensive Plan of Care Form Part II

To be completed by provider during the Comprehensive Plan of Care Meeting in collaboration with all present at the meeting.

Date of Comprehensive Plan of Care Meeting: _____

Persons Attending:

Name	Agency/Role	Contact information (phone/email)

Presenting Problem/ Successes/Challenges: _____
_____
_____
_____
_____

How to best support this individual: _____
_____
_____
_____
_____

Barriers to continued support in the community: _____
_____
_____
_____
_____

Appendix E

CHECKLIST OF REQUIRED REFERRAL INFORMATION: (To be supplied by TBD EAC Provider)

Example checklist:

In addition to the completed **Comprehensive Plan of Care (CPC)** we are requesting the following documents from the referring Inpatient facility:

- Psychiatric evaluation
- Psychosocial evaluation including psychiatric treatment history
- Medical assessment including consults and or information related to the medical treatment being provided (Health & Physical)
- 30 days of progress notes (*additional notes may be requested*)
- Current medications/ PRN usage
- Existing lab work completed at referring facility
- PPD results or chest X-ray if PPD refused or positive
- Hepatitis screening/panel
- Information regarding legal issues
- Symptoms checklist
- Drug and alcohol assessment form if the individual has a Drug/Alcohol co-occurring disorder/diagnosis
- Discharge summaries from previous Inpatient Hospital at the current facility
- Copies of commitments (Voluntary or Involuntary)
- **Individual's insurance cards, ID cards**
- Family, significant other or emergency contacts
- **If applicable to individuals referred with medical conditions, please include:**
    - Urinalysis results
    - CBC and Comprehensive Metabolic Panel (CMP)
    - Lipid panel
    - EKG results
    - Applicable Medical Specialty Consultant reports/recommendations

REGIONAL EXTENDED ACUTE CARE REFERRAL REVIEW & WAIT LIST PROTOCOL

Background

EAC Beds are allocated among the four suburban counties with an additional 4 floater beds:

Regional EAC Bed Allocation Chart			
County	**# of Beds**	**MCO Contact for Referrals**	**County Contact Person for Referrals**
Bucks	4	Patricia Dryzga, Magellan	Wendy Flanigan
Chester	4	Beverly O'Sullivan / Kelly Doyle	Lindsey Dougherty
Delaware	4	Patricia Dryzga, Magellan	Tracy Halliday
Montgomery	4	Patricia Dryzga, Magellan	Thomas Costello
Floater Beds*	4	Magellan Behavioral Health or Community Care Behavioral Health or another MCO/Private Funder as applicable	

Referral Packet Review and Admission Process

The EAC provider's admission unit will review referral packets for completeness and compliance with the referral procedures. If the packet is not complete, the EAC provider's Admission Office will contact the referring provider to request missing information. Referral information will be passed on to the EAC when the referral is approved through the Comprehensive Plan of Care process and all required information has been received. Once all information has been received and a bed is available, the admission will occur.

If no is bed available, the individual will be placed on a Waiting List.

Waiting List

The EAC provider will maintain a waiting list by **Date of Referral** and **County of Referral**.

Each County and Managed Care Organization (MCO) will also maintain a waiting list for the EAC.

On a bi-weekly basis (every two weeks) there will be a conference call involving the EAC provider, the four counties, the Regional MH Services Director, and the BH-MCOs. The purpose of the call is to coordinate the identification of the next individual(s) to be admitted from the waiting list based upon the projected discharge date(s) of individuals currently in the unit. In compliance with HIPAA standards, only initials or first names of individuals will be used during these calls.

The bi-weekly conference call will have a standard agenda to include the following items:

1. Unit census - how many people from each county are currently on the unit
2. Status of county bed allocations – temporary transfers of beds from one county to another, if any
3. Census status - projected discharges in the next two weeks, by county
4. Status of the Waiting List – how many people, by county and date of referral; identification of priority(ies) for admission
5. Status of potential referrals, by county
6. Other items, as appropriate

Characteristics that will be considered in identifying the next admission(s) include:

- County(ies) of origin of the potential vacancy(ies)

- Length of time on the waiting list
- Gender of the potential vacancy(ies)
- Severity of illness/severity of clinical issues
- Any clinical or other issues with the current census

The EAC provider, the counties, and the MCOs will work together to balance the goals of:

- keeping the unit at full capacity,
- keeping the bed allocation among the four counties as originally planned,
- managing of floater beds, including allowing admissions from other counties as appropriate if there is no one on the wait list, see below
- maintaining a priority of admitting the individuals who have been waiting the longest and/or have the most urgent need for admission

Every effort will be made to have an admission scheduled for the same day or within five days of a discharge.

Allocation of Beds–Borrowing Beds for County Allocated Beds

Definitions:
County of Origin (COO)– the county where the vacancy occurs
County of Borrow (COB) – the county to which the bed is temporarily released
Primary Counties - Bucks, Chester, Delaware, Montgomery
Outside Counties – any County that the MCO contracts with that is outside the SE Region
Floater Beds – any one of 4 available beds noted in above "EAC bed allocation" chart

The Primary Counties (Bucks, Chester, Delaware and Montgomery) will retain rights to the sixteen (16) beds designated as "primary County beds" and also have access to the four (4) floater beds* upon referral and needs and will maintain rights of first refusal. The four (4) floater beds however could be accessed by other outside Counties with the MCO approval. See *Availability and Access to Floater Beds* section below.

If the County that projects a vacancy does not have an appropriate referral the bed may be released to another County. Appropriateness of referrals will be determined by the characteristics noted above.

If this occurs, the County of Origin (COO*)* and the County of Borrow (COB*)* shall agree to the following:

- The County of Origin has the right of first refusal on the next vacancy in the County of Borrow.
- The County of Origin and the County of Borrow will maintain their bed allocations as originally defined.
- The County of Borrow will attempt to prioritize discharge, as appropriate, so that the County of Origin has access to a bed as soon as needed.

In cases where beds have been borrowed, the EAC provider and the counties, will maintain a list of COO and COB beds.

In these cases, when the County of Borrow has a vacancy, but the County of Origin does not have a pending admission or wait listed referral, the next individual on the wait list may be considered. If a different County of Borrow is identified, the County of Origin will remain the same and will retain the right of first refusal of the next vacancy in the new County of Borrow.

REGIONAL EXTENDED ACUTE CARE REFERRAL REVIEW & WAIT LIST PROTOCOL

Availability and Access to "Floater" Beds*

The EAC provider will maintain 4 "floater" non-designated primary County beds on the unit. Depending on the clinical milieu on the unit and the clinical need of the individual being referred, these beds will be available to the primary Counties and/or other outside counties of the SE Region Counties as requested. If the primary Counties have a waiting list, excess demand for the EAC level of care, they will maintain rights of first refusal to the 4 floater beds.

The floater beds may also be accessed and temporarily utilized by other Counties outside the region or the EAC vendor may opt to utilize the beds for private pay or other MCOs funding if the beds are available and not in use and not immediately needed by the primary Counties. If the primary Counties relinquish the right of first refusal for a floater bed, it is then an "open available bed" and the EAC provider may advertise bed availability to Counties and funders outside the region. The primary Counties also may agree to loan their original designated beds as needed to other Counties outside the region. This is determined by the County and MCO as applicable.

Any County who utilizes an EAC bed, is expected to adhere to the Regional EAC Referral process, Admission process, and Census Referral review process. The EAC provider will maintain a listing of the Counties' bed utilization and the listing will be shared with Counties and funders during census review and wait list meetings during the bi-weekly conference calls.

Regional EAC Exception to Admission / Appeal Process

BACKGROUND:

The Regional Extended Acute Care program operated by TO BE DETERMINED EAC PROVIDER maintains 20 inpatient EAC level of care beds for the four suburban Southeast Counties in Pennsylvania (Bucks, Chester, Delaware, and Montgomery). Each County has a designated number of beds for utilization and the Counties and Managed Care Organizations (Community Care Behavioral Health and Magellan Behavioral Health) use a common referral, review, and determination process for admission to the EAC.

When individuals have been recommended for EAC level of care from an acute inpatient unit, a Comprehensive Plan of Care process is initiated, and information is reviewed by the County and MCO. It is the County and MCO who will make a determination that either the individual is appropriate and meets the level of care for extended acute care inpatient psychiatric treatment or the individual does not meet the need for EAC level of care. If the referral is appropriate to proceed for EAC, a completed EAC referral packet and completed CPC form will be forwarded to TBD EAC PROVIDER Admissions Office for review.

Admissions will be approved based on bed availability and medical necessity level of care needs. It should be noted that only the MCO will determine the Medical Necessity Criteria, (See attachment X). At times there may be exceptions to the admission process as described below.

See Regional EAC Flowchart for full referral and admission process.

REASONS FOR DENIAL/EXCEPTION TO ADMISSION CRITERIA:

All approved referrals will be reviewed by the EAC Admissions Office, EAC Director and EAC Medical Director for determination of admission. Occasionally, there may be reasons/ exceptions to approve a referral for admission to the EAC program. These exceptions will be identified with the EAC and County following the review. The following items are potential reasons for not accepting an individual into the EAC program:

1. Does not meet the Medical Necessity Criteria (see attachment B) for Inpatient psychiatric level of care
2. Open criminal charges requiring detention setting

PROCESS OF REVIEW / APPEAL:

Upon review of the completed referral packet, the EAC will make a preliminary decision regarding acceptance. If the decision is to accept, the EAC will notify the County Coordinator, the MCO and the referring provider. If the decision is to not approve of an admission, the EAC will notify the County Coordinator and MCO to discuss the reason(s) for preliminary exception of the admission. The EAC will notify and provide a written notice identifying the reasons for exception. The EAC will NOT contact the referring provider until the County and MCO have been contacted and the case discussed.

If there are extenuating circumstances or further information is needed to make a determination, the EAC will clearly document, what information is necessary or what additional circumstances are required in order render a final decision to admit the referred individual. This notification and written information will be shared with the County and MCO within 7 days of the referral review.

Regional EAC Exception to Admission / Appeal Process

Referrals where the decision to admit may require further information (i.e.: co-occurring medical conditions, serious clinical and/or behavioral concerns) and may require a more in-depth chart review and/or teleconference or face to face meeting with the EAC and referring provider, the EAC will notify the County and MCO and make determination within 10-14 days of the referral. Notification regarding the decisions to accept or pend the referral will be sent directly to the County Coordinator and MCO. The above process for providing written notice identifying the reasons for exception will also be followed.

Level II Comprehensive Plan of Care (CPC) Process

Upon an exception determination by EAC, the exception rationale will be presented to the County/MCO, who will then make the determination on whether to proceed forward in a Level II Comprehensive Plan of Care (CPC) meeting. The Level II CPC meeting will be arranged by the County/MCO, and will include at minimum; the referring provider, EAC staff, and any additional supports identified.

Following the Level II CPC meeting, the County, MCO and EAC will review the outcome of the meeting and determine if acceptance and admission to EAC will occur.

Following this review, if the individual is not accepted to the EAC for admission, the reasons will be clearly identified in writing within 10 business days and provided to County and MCO and referral source. The County and/or MCO may opt to "Pend" the referral of the individual, so that the referral may proceed at a later time, upon resolution of the circumstances as identified.

Grievance and Review based on MCO Criteria

Grievance and appeal processes exist with the Managed Care Organization. Each MCO has written guidelines which will be followed if there is discrepancy regarding a decision on eligibility to admit an individual to the EAC. For each MCO's process see links: Community Care Behavioral Health or Magellan Behavioral Health.

Note: For further information regarding ***HealthChoices Complaint***, Grievance and Fair Hearing process, refer to: http://www.healthchoices.pa.gov/cs/groups/webcontent/documents/document/c_276584.pdf

*For further information regarding **Community HealthChoices** Complaint, Grievance: http://www.healthchoices.pa.gov/cs/groups/webcontent/documents/document/c_277983.pdf*

Regional EAC Exception to Admission / Appeal Process

THIS PAGE LEFT
INTENTIONALLY
BLANK