Crisis Residential Services

Magellan Behavioral Health of Pennsylvania (Magellan) Performance Standards

Performance Standards are intended to give guidance for contracted services as part of the HealthChoices program, with a goal to promote the utilization and progress toward providing best practices performances, to increase the quality of services and to improve outcomes for members.

Current Version Information

Substantive changes in most recent update:

1. Use of Performance Standards section - Added requirement that providers comply with Proposed Rulemaking Crisis Intervention Services in addition to Pennsylvania Code Title 55, Chapter 1101 General Provisions and associated Medical Assistance (MA) Bulletins, licensing requirements and any contractual agreements made with Magellan in order to be eligible for payment of services.

Use of Performance Standards

Disclaimer: These Performance Standards should not be interpreted as regulations, but instead add to the foundation provided by current licensing guidelines and regulations. It is a Magellan Behavioral Health of Pennsylvania, Inc. (Magellan) expectation that providers apply these Performance Standards when developing internal quality and compliance monitoring activities. Magellan will use this document as a guide when conducting quality and compliance reviews; but also share with providers as needed to communicate expectations and best practices. Entities providing services as part of the HealthChoices program must first be enrolled in the Pennsylvania Medical Assistance program as the appropriate provider type and specialty. Providers must then comply with all applicable Pennsylvania regulations and requirements, including but not limited to The Pennsylvania Code Title 55, Chapter 1101 General Provisions and Proposed Rulemaking Crisis Intervention Services as well as all associated Medical Assistance (MA) Bulletins, licensing requirements and any contractual agreements made with Magellan in order to be eligible for payment for services.

Please routinely visit the link below to stay up to date on Compliance Alerts:
https://www.magellanofpa.com/for-providers/

Level of Care Description

Crisis Residential Services (also referred to as Residential Crisis Services) are provided in small facilities that provide residential accommodations and continuous supervision for individuals in crisis. The service provides a temporary place to stay for individuals who need to be removed from a stressful environment or who need a place in which to stay to stabilize or until other arrangements can be made.

Scope of Services

Crisis Residential Services are provided on a short-term basis in a community-based residential setting in order to prevent psychiatric inpatient admission. These services can be provided to both children and adults but cannot be provided to both age groups at the same facility. Individuals served in this setting must be diagnosed with a primary DSM-5 mental health disorder.

Service Description

Crisis Residential Services have staffing that consists of a multi-disciplinary team led by a full-time and dedicated supervisor. The supervisor, who shall meet criteria as either a mental health or a medical professional provides overall supervision of the crisis residential program and conducts individual supervision with the additional staff. The team may also include crisis workers, medical assistants, or service aides. At least two staff members shall be on duty at all times and at least one of these staff members must be a medical professional or mental health professional. Medications are administered by someone authorized to do so and a physician must be available as back up to authorize the administration of medications if needed. Treatment services required include an intake, examination and assessment (including a medical examination and diagnosis within 24 hours of admission), room and board, counseling and crisis stabilization, limited recreation activities, linkages and referrals to needed services, and administration of medications during the stay.

Staffing Requirements per the proposed Crisis Regulations:

To qualify as a mental health professional under this chapter, an individual shall have at least one of the following:
(1) A master's degree in social work, psychology, rehabilitation, activity therapies, counseling, education or related fields and 3 years of mental health direct care experience.
(2)A bachelor's degree in sociology, social work, psychology, gerontology, anthropology, political science, history, criminal justice, theology, counseling, education or a related field, or be a registered nurse; and 5 years of mental health direct care experience, 2 of which shall include supervisory experience,
(3) A bachelor's degree in nursing and 3 years of mental health direct care experience.
(4) A registered nurse license certified in psychology or psychiatry.

A Mental Health Crisis Intervention (MHCI) service medical professional is one of the following:
(1) A psychiatrist
(2) A physician with 1 year of mental health service experience in diagnosis, evaluation and treatment
(3) A certified registered nurse practitioner authorized in accordance with. 49 Pa., Code § 21.291 (relating to institutional~ health care facility committee; committee determination of standard policies and procedures) to diagnose mental illness.

MHCI service crisis workers who are not mental health professionals shall be supervised by a mental health professional and one, of the following:
(1) Have a bachelor's degree with major course work in sociology, social work, psychology, gerontology, anthropology, political science, history, criminal justice, theology, nursing, counseling, education or a related field.
(2) Be a registered nurse.

(3) Have a high school diploma or equivalency and 12 semester credit hours in sociology, social welfare, psychology, gerontology or other social science and 2 years of experience in public or private human services with 1 year of mental health direct care experience.
(4) Have a high school diploma or equivalency and 3 years of mental health direct care experience in public or private human services with employment as a mental health staff person prior to January 1, 1992.
(5) Be a consumer or a family member who has 1 year of experience as an advocate or leader in a consumer or family group and has a high school diploma or equivalency.

An MHCI service medical assistant is one of the following:
(1) A licensed practical nurse
(2) A certified paramedic
(3) A physician's assistant.

An MHCI service aide or mobile aide has the following:
(1) A high school diploma or equivalency.
(2) Completed the provider's approved training requirements.

Staff persons employed by a provider who has 5 years' experience as a supervisor, of mental health services in a mental health agency prior to January 1, 1992 are exempted from the staffing requirements.

OMHSAS Bulletin OMHSAS–02-01 The Use of Seclusion and Restraint in Mental Health Facilities and Programs:
https://www.dhs.pa.gov/docs/Publications/Documents/FORMS%20AND%20PUBS%20OMHSAS/d_005714.pdf

Service Exclusions

There are some instances in which use of Crisis Residential Services would be restricted. These would include admission and current treatment in any other 24 hour a day, 7 day a week level of care, such as Acute Inpatient Hospitalization, Extended Acute Care, Withdrawal Management, Hospital based and non-hospital-based Rehabilitation, and Residential Treatment Facilities for both adults and children. Crisis Residential Services also should not be utilized in situations in which a significant portion of the individual's day are spent in treatment, such as with both mental health and substance use Partial Hospitalization Program services, Intensive Outpatient Program services, and Site-based or Mobile Psychiatric Rehabilitation Services.

Referral Process

Magellan members have "voice and choice" when it comes to selecting a behavioral health treatment provider. Members are encouraged to review the provider search tool on www.magellanofpa.com.

If a member prefers one in-network Crisis Residential program over another, Magellan respects these preferences and has an expectation that referring providers act accordingly during the referral process.

While Magellan can assist in making referrals to Crisis Residential Programs (CRPs), referrals are made directly to Crisis Residential Programs from community sources, including, but not limited to, outpatient providers, case managers, Emergency Departments, inpatient hospitals, county crisis agencies, and probation officers. Individuals can also contact a Crisis Residential Program directly in order to refer themselves. To determine whether a Crisis Residential Program is needed, it is expected that an individual will be assessed within 24 hours of the referral/admission. The assessment does not need to be completed by a licensed clinician and can be completed by the accepting Crisis Residential Program in the case of self-referrals. The assessment does not need to be completed in person, but it must include information about current stressors and precipitating factors, current symptoms, risk of harm to self or others, and rationale for admission to Crisis Residential Services.

Referrals to out-of-network Crisis Residential Programs should not occur except in rare circumstances including those where there is no availability at an in-network program or there is an extenuating clinical need for such a referral. Geographic considerations may also necessitate a referral to an out-of-network Crisis Residential facility. Admissions to out-of-network Crisis Residential Programs require prior approval by Magellan. If a member is recommended for admission to a Crisis Residential Program, but there is no available bed, referral/admission to a higher level of care (i.e. Acute Inpatient Hospitalization) should be considered.

Admission Process

Crisis Residential Services are provided on a short-term basis to prevent a psychiatric inpatient admission. Admission to Crisis Residential is appropriate for individuals who have a primary DSM-5 diagnosis of a mental disorder, are at risk of hospitalization, have a need for immediate intervention because of exhibiting behaviors that are threatening to self or others, or are experiencing a rapid deterioration of functioning as a result of psychiatric symptoms. In addition, individuals admitted to Crisis Residential should be able to benefit from the intervention. Magellan's Supplemental Guidelines for Mental Health Utilization Management and Treatment Planning II-2 Residential Crisis can be found here: https://www.magellanofpa.com/documents/2021/07/mnc-full-mnc-guidelines.pdf/

Crisis Residential Programs are voluntary, and these facilities are not locked. Individuals admitted to Crisis Residential must be agreeable to the admission and must not be assessed as needing a secure facility to maintain safety of self or others.

Medical clearance is required prior to individuals being admitted to a Crisis Residential Program. Although medical clearance is typically determined by a face-to-face evaluation with a physician (or physician extender), a Crisis Residential facility can develop procedures for medical clearance using a nursing assessment and telephone consultation with the facility's physician to provide a verbal order for medical clearance and admission to the facility. Prior to admission, a nursing assessment shall be completed by the registered nurse on staff within their scope of practice. Upon completion of the nursing assessment, a telephone consultation with the facility physician for medical clearance must

occur. Upon receiving the verbal order for medical clearance, which must be documented in the record, the individual can be admitted to the CRP. The documentation of the verbal order for medical clearance must be signed by the physician within 24 hours of the admission to the CRP (OMHSAS Policy Clarification: #04-12).

A comprehensive member assessment including psychiatric consultation, psychological evaluation, nursing assessment, social evaluation, and other evaluations used to develop an individualized strengths-based treatment plan is to be completed within 24 hours of admission (Supplemental Guidelines for Mental Health Utilization Management and Treatment Planning II-2 Residential Crisis). Authorization to Use and Disclose (AUD) forms should be obtained as part of the admission process so that coordination can occur with natural supports (i.e. family, friends, etc.) and community service providers (i.e. Assertive Community Treatment, Intensive Case Management/Blended Case Management, Outpatient, Primary Care Provider, etc.) as appropriate.

Prior authorization is needed from Magellan for admission to Crisis Residential Programs. The prior authorization is to be completed telephonically with Magellan within 24 hours of admission by the referring party or by the admitting CRP in the case of self-referrals. This notification is made by calling the Magellan Provider Line. If the member has a commercial insurance, the referring party must contact the commercial insurance plan to obtain authorization from the commercial insurance plan prior to requesting prior authorization from Magellan. If a member's commercial insurance authorizes admission to a Crisis Residential Program, Magellan considers the admission as a Coordination of Benefits (COB). If the member's commercial insurance does not authorize admission to a Crisis Residential Program or if the member does not have a benefit for Crisis Residential Services, the referring party should take the steps necessary to obtain that information in writing so that it can be provided to the admitting Crisis Residential Program for billing purposes.

If additional time beyond the initially authorized days at Crisis Residential is requested, a continued stay review must be completed with the assigned Magellan Care Manager. Continued stay at CRP is appropriate for individuals in which clinical evidence indicates the persistence of the problem that necessitated Crisis Residential services, that diversion from inpatient hospitalization continues to appear possible, and whose current available living environment is not suitable for stabilizing the individual during the crisis (Supplemental Guidelines for Mental Health Utilization Management and Treatment Planning II-2 Residential Crisis).

The continued stay review should be completed on the last covered day of service. If the continued stay review cannot be completed on the last covered day of service, it must be completed on the first uncovered day. Continued stay reviews are completed by telephone. Continued stay reviews will include a discussion of presenting symptoms, current risk of harm to self or others, diagnostic changes, medication adjustments, member engagement in programming, progress toward identified treatment goals, coordination of care among community services/supports, housing plans, and aftercare plans. Information about barriers to progress as well as steps being taken to address those identified barriers will also be discussed.

Treatment or Service Plan

Crisis Residential services are provided on a short-term basis, and the treatment teams must have a targeted and focused approach to member care. A thorough diagnostic assessment and evaluation leads to an understanding of the presenting clinical needs. The treatment plan goals must match the diagnostic impression of the member. Treatment plans must be informed by a case formulation that answers the question "what is this all about?"

The clinical team at the CRP must develop a treatment plan that is individualized and focuses on the member's own goals for treatment. The member must be involved in the development of the treatment plan. Treatment plans must be strengths-based and grounded in recovery concepts. Treatment plans must be reasonable, measurable, and appropriate for the member's level of functioning and stage of change. Treatment plans developed by the Crisis Residential facility must adhere to all applicable ethical standards.

Magellan does not give approval to treatment plans but works in partnership with the CRP to ensure that the treatment plan is easily understood, updated to reflect progress and barriers, and provides a clear picture of the member. Treatment plan development must be an interactive and evolving process that includes input from the member and members of the clinical team. The initial treatment plan must be completed within 24 hours of admission.

Treatment plans must include all the treatment interventions including psychotropic medication, if applicable. When psychotropic medications are prescribed, the treatment plan must provide a rationale for each prescribed medication. The treatment plan must reflect member agreement with prescribed medication and what psychoeducation will be provided to the member about medication.

Treatment plans must address the precipitating factors and acute symptoms that lead to the need for Crisis Residential Services. Treatment plans must be culturally competent and must build on the inherent strengths of the member. Treatment plans must also include a crisis and/or safety plan, if appropriate.

The criteria for discharge from Crisis Residential Services must be identified in the treatment plan, and the treatment goals and interventions must be geared toward helping the member resolve the crisis situation and toward meeting the criteria needed for discharge. Discharge criteria must be individualized, measurable, and attainable.

Expectations of Service Delivery

Crisis Residential Services serve as an important part of a coordinated continuum of care and should not be viewed as a stand-alone resource. The short-term nature of the program necessitates that service delivery be focused on the current crisis and on stabilizing or reversing identified problem areas.

Crisis Residential facility treatment teams must work with established community service providers and identified natural supports in order to develop a comprehensive view of the current crisis and to identify additional community services and/or supports that need to be in place at discharge in order to assist the individual in maintaining stability that was attained while at the CRP.

The specific therapy services provided at Crisis Residential Programs vary based on individual needs and member risk. Typical therapy services include group and individual therapy, case management and care coordination, medication evaluation, and discharge planning. Family therapy should be offered and encouraged as clinically appropriate.

Interventions utilized at Crisis Residential Programs should be member-driven, recovery based, and least-restrictive. The use of mechanical and/or chemical restraints are not permitted in Crisis Residential facilities (OMHSAS-02-01).

Unstable or inadequate housing is often identified as a precipitating factor for individual's needing Crisis Residential Services. Also, unstable or inadequate housing can pose a barrier to discharge from a Crisis Residential facility once the individual's acute symptoms have stabilized. Crisis Residential facilities are not long-term housing placements and are not a substitute for an appropriate housing placement. The biopsychosocial assessment completed as part of the admission process must include information about the individuals housing situation and must identify housing issues that could become a barrier to the individual returning to the community once symptoms are stabilized or reversed. A discharge housing plan must be identified as soon as possible and completing tasks related to maintaining or attaining stable and adequate housing must be a focus of case management services provided by Crisis Residential staff.

Documentation

The documentation in the individual's behavioral health record allows mental health professionals to evaluate and plan for treatment, monitor health care over time, and facilitate communication and continuity of care among healthcare professionals involved in the individual's care. It ensures accurate and timely claims review and payment, promotes appropriate utilization review and quality of care evaluations, and can be used for research and education.

- The record must be legible throughout.
- The record must identify the individual on each page.
- Entries must be signed and dated by the responsible licensed provider. Care rendered by ancillary personnel must be counter-signed by responsible licensed provider.
- Alterations of the record must be signed and dated.
- The record must contain the results, including interpretations, of diagnostic tests and reports of consultations.
- The record must contain documentation of the medical necessity of a rendered, ordered, or prescribed service.

- The documentation of treatment or progress notes for all services, at a minimum, must include:
    - The specific services rendered;
    - The date the service was provided;
    - The name(s) of the individual(s) who rendered the services;
    - The place where the services were rendered;
    - The relationship of the services to the treatment plan – specifically, any goals, objectives and interventions.
    - Progress at each session, any change in diagnosis, changes in treatment and response to treatment;
    - The actual clock hours that services were rendered.

In compliance with the daily per diem rate that encompasses both Treatment plus Room and Board costs, it is Magellan's expectation that providers of 24-hour levels of care implement behavioral health interventions for each day of service billed, including all weekends and holidays. Staffing patterns must align with all Medical Assistance Regulations and Bulletins as well as OMHSAS Licensing Requirements to allow for meaningful treatment to be provided every day that the member is physically in the facility.

In accordance with this requirement that behavioral health interventions are provided on a **daily basis**, it is Magellan's expectation that **each date of service that is billed** have corresponding documentation in the member's record. This documentation should include any and all interventions, both formal and direct treatment (i.e. structured individual and group sessions) as well as those interventions that are less traditional. Please note that the intervention may be delivered by any level staff member and there is no minimum time requirement for the intervention as long as it is documented; however documenting medication dosing only is NOT considered sufficient substantiation of payment for a day of service. Providers must also provide all services and programming as outlined in their approved Service Descriptions.

Care Coordination

Coordination must occur with any other treatment providers that the individual is involved with, including any Assertive Community Treatment teams, Blended or Intensive Case Management, Peer Support, co-occurring disorder treatment, medication management services, outpatient treatment providers, and housing providers. With appropriate releases of information, communication must occur between the clinical staff and any involved providers regarding the individual's treatment, including treatment goals, progress, barriers, and discharge planning. In person and/or phone contact with these providers should be completed in order to maintain therapeutic rapport and collaboration on these treatment goals. Contact should occur between outside providers and the individual as well as staff members at the Crisis Residential placement. If any outside medical treatment appointments must be completed during admission, crisis residential staff and community providers should coordinate and develop an appropriate plan of action to accomplish these tasks.

If the individual prefers, any natural supports involved with the individual, including caregivers, family, or friends should also be included in treatment and appropriate releases of information must be obtained when needed to allow for this collaboration. These natural supports should also be involved in discharge planning and preparation to ensure a smooth transition back to the community.

If a member requires evaluation or placement in a higher level of care such as inpatient while being treated in a CRP, staff will obtain those necessary services and notify/collaborate with any involved treatment and natural supports so as to initiate continuity of care for the individual.

Discharge Planning and Transition

Discharge from Crisis Residential facilities is appropriate once the individual no longer requires supervision and active support to ensure the adequate, effective coping skills necessary to live safely in the community, participates in self-care and treatment, and manages the effects of their illness. Also, there is no significant current risk of hospitalization or harm to self or others. In addition, the individual's own resources and social support system are currently adequate to provide the level of support and supervision currently necessary for community re-entry. Finally, discharge from Residential Crisis is appropriate once arrangements for follow-up care have been made (Supplemental Guidelines for Mental Health Utilization Management and Treatment Planning II-2 Residential Crisis).

Discharge planning starts on the day of admission. The discharge plan must specify all psychiatric and behavioral health services and supports that the individual will have after discharge. Evidence of discharge planning must be included in progress notes and treatment plans. Barriers to discharge, progress toward discharge, and rationale for change in discharge plans should be clearly documented. Coordination between community service providers and must occur as part of the discharge planning process to help ensure that all psychiatric and behavioral health service needs are being addressed upon discharge. The progress notes must include evidence of the individual's active involvement in developing the discharge plan.

The Crisis Residential team must prepare a written aftercare plan with the individual. The aftercare plan must include the dates of all appointments including any appointments for physical health issues. The aftercare plan must include a crisis plan to use if something goes wrong. The crisis plan must include formal and informal supports and be based on the individual's strengths. The written aftercare plan must be provided to the individual in their preferred language.

The aftercare plan must provide clear, easy to understand information about all medications being prescribed to the individual. It must include the name of the medication, the dosage, the time(s) of day that it is taken, and the purpose of the medication.

In the event of an unplanned or an against medical advice (AMA) discharge, the Crisis Residential facility must make a reasonable effort to assist the individual in securing aftercare appointments and crisis resource information must be provided. All efforts to assist individuals in setting up aftercare for unplanned or AMA discharges must be clearly documented in progress notes.

Magellan must be notified of all discharge from a Crisis Residential facility within one business day. The notification is made by contacting the assigned Magellan care manager via telephone. The following information pertaining to the aftercare plan must be available at the time of the discharge review:

- Date, time, and provider information (name, address, and phone number) of the behavioral health follow-up appointment
- Date, time, and provider information (name, address, and phone number) of appointments with other providers/supports involved
- Safety Plan
- Discharge address and phone number of the individual

The behavioral health follow-up appointment must be scheduled within one week (7 calendar days or 5 business days) of the discharge. All attempts to secure follow-up appointments must be documented, as well as rationale for situations in which a follow-up appointment could not be secured within the required time. If an individual chooses to make their own follow-up appointment or declines a follow-up appointment, that information must also be clearly documented in the progress notes.

Outcomes

All providers of Crisis Residential Services should have policies and procedures in place to evaluate outcomes for the program. Some of the indicators that could be considered include:

- Inpatient diversion rates
- Member satisfaction
- Average length of stay
- Engagement with community-based supports (case management, ACT, etc.) during stay

Performance Outcome Management System (POMS) is a tool the Department of Human Services (DHS) established to continuously evaluate the effectiveness of the HealthChoices' program. POMS allows DHS to identify members with a serious illness or risk of illness; establishes a data baseline for member functioning at registration or entry into the HealthChoices' system; updates member data as the course of treatment evolves; and finalizes member data at closure of treatment.

HealthChoices' providers are ***mandated*** by DHS to collect priority population data and submit POMS data on every HealthChoices' member receiving mental health services at certain points during treatment. These include the following:

- When you are seeing the member for the first time (initial registration);
- When you are seeing the member for the first time under HealthChoices (the member may have seen you as a fee-for-service patient and subsequently converted to HealthChoices);
- When you are seeing the member for the last time (either termination from your care, if the member is moving to another provider; or closure, if the member is ending all mental health treatment); and
- Whenever there is a change in any POMS element.

Complaint Process

Magellan provides a formal mechanism for all members to express a complaint related to care or service, to have any complaints investigated and resolved, and to receive a timely and professional response to their complaint in compliance with the HealthChoices Program Standards and Requirements Appendix H. This Complaint process is managed by Magellan's Quality Improvement Team. Complaint information is integrated as a key indicator for informing patient safety, credentialing, quality improvement activities, and analyzed for trending and opportunities throughout the network.

When a member files a complaint directly with Magellan, Magellan partners with the provider to address the concern. A member's decision to file a complaint with Magellan should not compromise their care or services. Providers are expected to adhere to their Facility and Program Participation Agreement with Magellan regarding cooperation with appeal and grievance procedures. The identified provider will receive an acknowledgement letter summarizing the complaint items and requesting documentation to be submitted for the review. The response and documentation should be faxed to 888-656-2380 on or before the deadline listed in the letter. Additional information and follow up activities might be requested.

The information that is collected through Magellan's investigation is presented to a first level complaint review committee, which makes the first level complaint decision. HealthChoices standards and regulations, contractual standards, and generally accepted standards of care apply those standards to the issue at hand. Magellan is required to make a decision and send a letter to the member explaining the findings and the reasons for the decision within 30 calendar days of receipt of the Complaint.

Magellan uses information gained from member complaints to identify areas where opportunity for improvement may exist. Magellan may request corrective action of a provider in response to supported complaints and identified trends in complaints. If Magellan identifies a supported (substantiated) complaint involving an agency, Magellan staff will collaborate with providers to develop a Complaint Resolution Plan to address the concern. Please review the Provider Communication shared with network providers here about this important and collaborative process.

Viewing complaints from the member's perspective is critical. If the member feels the concern sufficiently to raise it, the matter should be taken seriously and treated accordingly. If the member is still active with provider's services, attempts to resolve the member's issue or concerns and an internal review of the concerns should occur. As opportunities for improvement are identified, corrective action(s) should be implemented in accordance with provider's internal policies, procedures, and protocols.

Service providers should also have internal written policies and procedures for filing and resolving complaints within their organization. These policies and procedures must comply with state and federal regulations, as well as applicable accreditation standards. Staff should be trained to listen effectively and manage a member's expectations and employ a proactive approach to customer service. Organizations should always try to resolve the member's concerns immediately and informally whenever possible. Complaints/concerns involving minor issues might not require a formal written response. However, even if the matter is addressed quickly and informally, documentation of the member's complaint/concern and actions taken to resolve it should be documented and recorded.

If the member (or their family members or representatives) feel that their concerns have not been addressed, the matter might require a more formal review involving designated staff within provider's organization. Because these reports might be received by a variety of staff, clear definitions, and clearly defined procedures for submission of verbal or written complaints/grievances are essential. The information must be forwarded promptly to the designated staff or department for investigation and follow up.

Persons receiving services should be provided with information explaining the agency's complaint/grievance policies and procedures. Programs often provide this information upon admission to the service; however, it should also be readily accessible throughout the duration of services. Physicians and staff should have adequate training on helping individuals as needed to report, address, and resolve a complaint or grievance.

Grievance Process

Magellan and the Pennsylvania HealthChoices Program Standards and Requirements defines a grievance as a request by a member, the member's representative or health care provider (with written consent of the member), to have Magellan or a utilization review entity reconsider a decision concerning the medical necessity and appropriateness of a covered service.

Magellan reviews requests from providers for behavioral health services to ensure that approved services are medically necessary and appropriate.

If a level-of-care request is not authorized at the level, frequency, or duration as requested, Magellan members are entitled to grieve a medical necessity denial. At the time of a denial, Magellan informs members of this right and how to proceed. Each medical necessity grievance is handled in a timely manner consistent with the clinical urgency of the situation and in compliance with the HealthChoices Program Standards and Requirements Appendix H.

If a level-of-care request is not authorized at the level, frequency or duration requested, it is the expectation that the behavioral health provider will meet with the member and the member's family, if appropriate, to discuss treatment changes and options. This discussion will include, but not be limited to, a review of the services that are authorized, a review and revision of the treatment plan

based on authorized services, a referral to additional and/or an alternative provider if indicated, other options available to the member, and a review of member grievance rights and procedures as outlined in the denial letter should the member choose to grieve the non-authorization decision.

Please see the Provider Handbook and Provider Handbook Supplement for HealthChoices' Program Providers for additional information including provider-initiated grievances and filing a provider complaint.

Quality Management

Quality care for members and their families is important. Magellan is committed to continuous quality improvement and outcomes management through its company-wide Quality Improvement Program that includes assessment, planning, measurement, and re-assessment of key aspects of care and services. Magellan has collaborated with Counties and providers to develop a Quality Improvement Program that strives to improve the delivery of services to HealthChoices' members.

Magellan's Quality Improvement Program's policies and procedures are structured to support compliance with the accreditation requirements of several organizations, including the National Committee for Quality Assurance (NCQA) and URAC. Assessment of compliance with these requirements is integrated into our quality improvement activities.

NCQA's accreditation standards for managed behavioral health care organizations (MBHOs) emphasize quality standards and activities in a number of areas. NCQA reviews the quality of care and service we deliver, as well as the direct care provided, particularly in the areas of access and availability to care, utilization management, and continuity of care across behavioral health programs. Magellan has developed a number of performance measurement and quality oversight activities to support these NCQA standards and HealthChoices' requirements.

Per Magellan's contractual agreement, providers must cooperate and participate with all quality improvement procedures and activities. Providers shall permit access to any and all portions of the medical record that resulted from member's admission or the services provided. Magellan's utilization review program and/or quality improvement program may include on site review of covered services and shall permit Magellan staff on site access.

In support of our Quality Improvement Program, providers are essential quality partners. It is important that providers are familiar with our guidelines and standards and apply them in clinical work with members in order to provide, safe, effective, patient-centered, timely, and equitable care in a culturally sensitive manner. Please refer to the Magellan National Provider Handbook and Provider Handbook Supplement for HealthChoices' Program Providers for additional information and guidelines.

In addition to adhering to state and federal regulations, providers are responsible to:

- Follow policies and procedures outlined in Magellan's Provider Handbook and Provider Handbook Supplement.
- Meet treatment record standards as outlined in the Treatment Record Review Tool found under Audit Tools in the Appendix of Magellan's Provider Handbook.
- Provide treatment records as requested for quality of care issues and adhere to clinical practice guidelines and HEDIS®-related measures.
- Participate as requested in treatment plan reviews, site visits and other quality improvement activities.
- Use evidence-based practices.
- Adhere to principles of member safety.
- Attend or log on to provider training and orientation sessions.
- Participate in the completion of a remediation plan if quality of care concern arises.
- Encourage use of member and clinician outcome tools including use of the PHQ-9 and other standardized tools at intake and established treatment intervals, and to review real-time reports together.
- Incorporate the use of secure technology into their practice to make accessing services more convenient for members, e.g., email communication, electronic appointment scheduling, appointment or prescription refill reminders, electronic referrals to other practitioners or programs, and online access to personal health record information.
- Assist in the investigation and timely response of member complaints.
- Assist in the investigation and timely response of adverse incidents.

Magellan supports a wide range of evidence-based and best practices. Magellan requests that contracted providers and practitioners keep inventory and fidelity of evidence-based or best practices that they offer and incorporate into treatment.

Magellan commits to a strong cultural competency program and believes that all people entering the behavioral health care system must receive equitable and effective treatment in a manner that is respectful of individual member preferences, needs and values and sensitive to residual stigma and discrimination. Magellan encourages providers to maintain practices that are deeply rooted in cultural competence as well, focusing on continual training and education to support staff. Cultural Competency and the LGBTQIA+ Tools are available on www.Magellanofpa.com to help with development of provider cultural competency programs.

There are instances where Members may benefit from oral interpretation, translation services, non-English languages, or alternative formats of materials or communication approaches. Providers are encouraged to maintain a process of accessibility and training for staff so that when opportunities present to support Members that may have language assistance needs, the team is prepared to fully respond to ensure the best possible treatment outcomes. Magellan offers language assistance service educational resources for network providers. These are located on Magellan's website.

Please note: Reporting requirements for Magellan remain consistent and in line with the PA DHS Bulletin, OMHSAS-15-01. A copy of all reportable incidents must be submitted to Magellan's Quality Management Department within 24 hours of an incident or upon notification of an incident. The types of incidents that are reported to Magellan include: Death, Attempted Suicide, Significant Medication Error, Need for Emergency Services, Abuse/Childline Report, Neglect, Injury/Illness, Missing Person, Seclusion, Restraint, Other (https://www.magellanprovider.com/media/29919/adverseincidentreporting.pdf).

Appendix A to the Pennsylvania HealthChoices Supplement to the Magellan National Provider Handbook offers an updated Incident Reporting Form, Provider Instructions and Definitions. Magellan also provides an electronic format for incident reporting for submission to ease provider paper burden.