Mental Health Case Management

Magellan Behavioral Health of Pennsylvania, Inc. (Magellan) Performance Standards

Performance Standards are intended to give guidance for contracted services as part of the PA 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. Documentation – information regarding encounter form requirements updated
2. Outcomes – POMs requirement removed
3. Quality management – incident reporting submission information updated

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 Magellan's 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. Entities providing services as part of the Pennsylvania (PA) HealthChoices Program must first be enrolled in the PA Medical Assistance Program as the appropriate provider type and specialty. Providers must then comply with all applicable Pennsylvania laws, including the Pennsylvania Code Title 55, General Provisions 1101, and Chapters 1247 and 5221 of the PA Code, 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 and look for the "Compliance Alerts" accordion to stay up to date on compliance email blasts: https://www.magellanofpa.com/for-providers

Level of Care Description

Mental Health Targeted Case Management includes Mental Health Intensive Case Management, Resource Coordination, and Blended Case Management and is a service to assist adults with serious mental illness and children with serious mental illness or emotional disorder in connecting with and navigating needed mental health, medical, social, educational, vocational, recreational, or other services. The intensity of services varies based on a needs assessment completed with each individual and may vary over time.

Scope of Services

Individuals must meet the eligibility criteria established by the Office of Mental Health and Substance Abuse Services (OMHSAS) for the program in which they are being enrolled.

Adult Eligibility

TCM

Mental Health Targeted Case Management (TCM) services are intended for adults diagnosed with a Serious Mental Illness (SMI). The definition of SMI for Adult TCM services is based on the broader

definition in the federal regulations, which states: “adults aged 18 and over, who currently or at any time during the past year, had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the DSM resulting in a functional impairment, which substantially interferes with or limits one or more major life activities. These disorders include any mental disorders (including those of biological etiology) listed in DSM with the exception of “V” Codes, Substance Use Disorders, and developmental disorders, which are excluded unless they co-occur with other diagnosable Serious Mental Illness. Functional Impairment is defined as difficulties that substantially interfere with or limit role functioning in one or more major life activities including basic daily life skills (e.g. eating, bathing, dressing); instrumental living skills (e.g. maintaining a household, managing money, getting around the community, taking prescribed medication); and functioning in social, family, and vocational/ educational contexts. Adults who would have met functional impairment criteria during the referenced year without benefit of treatment or other support services are considered to have serious mental illness.”

BCM

Any individual who qualified for Intensive Case Management or Resource Coordination level of case management, as specified in 55 PA Code Chapter 5221 or OMH-93-09 respectively, is eligible for Blended Case Management (BCM). Per MA Bulletin OMHSAS-10-03, adults eligible for BCM services are those who “have a serious mental illness as defined by meeting the criteria for Diagnosis, Treatment History, and Functioning Level” as follows:

1. **Diagnosis**: Diagnosis within DSM IV R (or succeeding revisions thereafter), excluding those with a principal diagnosis of intellectual disability, psychoactive substance abuse, organic brain syndrome, or a V-Code.
2. **Treatment History:** Shall be established when **one** of the following criteria is met:
    i. Six or more days of psychiatric inpatient treatment in the past twelve months.
    ii. Met standards for involuntary treatment within the past twelve months.
    iii. Currently receiving or in need of mental health services and receiving or in need of services from two or more human service agencies or public systems such as Drug and Alcohol, Vocational Rehabilitation, Criminal Justice, etc.
    iv. At least three missed community mental health service appointments, or two or more face-to-face encounters with crisis intervention/emergency services personnel within the past twelve months, or documentation that the consumer has not maintained his/her medication regimen for a period of at least 30 days.
3. **Functioning Level**: Global Assessment of Functioning (GAF) Scale* (as defined in DSM IV R or revisions thereafter) ratings of 60 and below.

- Adults who were receiving resource coordination, intensive case management, or blended case management services as children and were recommended by the provider and approved by the County Administrator or his/her designee, or the Behavior Health Managed Care Organization, as applicable, as needing blended case management services beyond the date of transition from child to adult are also eligible for the service.

Children and Adolescent Eligibility

TCM

Mental Health Targeted Case Management services are intended for children diagnosed with a serious emotional disorder. Per PA Code 55 Chapter 5221 Mental Health Intensive Case Management, children & adolescents are eligible for Case Management if they are "mentally ill or emotionally disturbed and who meet one of the criteria described as follows":

1. Children, 6 years of age or younger, who are enrolled in, or require, early intervention services under section 671 of the Education of the Handicapped Act (20 U.S.C.A. § 1400).
2. Children who, with their families, are receiving services from three or more publicly funded programs such as, Medical Assistance, Aid to Families with Dependent Children and Special Education.
3. Children who are returning from State mental hospitals, community inpatient units or other out-of-home placements, including foster homes and juvenile court placements.
4. Children who are recommended as needing mental health services by a local interagency team which shall include county agency representatives.

BCM

Under a Blended Case Management (BCM) model, per MA Bulletin OMHSAS-10-03, children & adolescents are eligible for BCM under the following criteria: "diagnosed mental illness or serious emotional disturbance as defined by meeting the criteria for Diagnosis, Treatment History & Functioning Level" as follows:

1. Diagnosis with DSM IV R (or succeeding revisions thereafter)
2. Treatment History
    i. Six or more days of psychiatric inpatient treatment in the past 12 months.
    ii. Without blended case management services would result in placement in a community inpatient unit, state mental hospital, or other out-of-home placement, including foster homes or juvenile court placements.
    iii. Currently receiving or in need of mental health services and receiving or in need of services from two or more human service agencies or public systems such as Education, Child Welfare, Juvenile Justice, etc.
3. Global Assessment of Functioning (GAF) Scale* (as defined in DSM IVR or revisions thereafter) ratings of 70 or below

Case Management Functions

Case Management activities include:

- Linking with services – Assisting the consumer in locating and obtaining services specified in the treatment or services plan, or both, including arranging for the consumer to be established with the appropriate service provider.
- Monitoring service delivery - There shall be an ongoing review and written record of the person's receipt of, and participation in, services. Contact with the member shall be made on a regular basis to determine his opinion on progress, satisfaction with the service or provider,

and needed revisions to the treatment plan. Contact with the member's therapist shall be made on a regular basis to determine if the person is progressing on issues identified in the treatment plan and if specific services continue to be needed and appropriate. A process shall be developed for resolution between staff members with levels of appeal to be pursued when there is clinical disagreement on the nature and extent of progress a particular member is making. Regular contacts shall be made with other public agencies serving the member and with parents, if the member is a child.

- Gaining access to services - Assertive and creative attempts are required to help the person gain resources and services identified in the treatment or service plan, or both. This may include home and community visits and other efforts as needed. It does not preclude the member's therapist from accompanying the case manager on these visits. Home and community shall be defined broadly to include field contacts which may take place on the street, at the person's residence or place of work, psychiatric treatment facilities, rehabilitation programs and other agencies where support or entitlements are available to the recipient.
- Assessment and service planning - A review of clinical assessment information and a general discussion with the member is required regarding unmet needs and plans for the future.
- Problem resolution - Active efforts to assist the person in gaining access to needed services and entitlements. Staff shall have easy access to communicate with the county administrator for the purpose of obtaining assistance in resolving issues which prevent a person from receiving needed treatment, rehabilitation, and support services. On a systems level, this may include providing information to help plan modifications to existing services or implement new services to meet identified needs and providing information to help plan modifications for accessing resources.
- Information support/network building - Contact with the consumer's family (not family counseling or therapy), and friends with consumer's permission and cooperation to build an informal support network.
- Use of community resources - Assistance to persons in identifying, accessing, and learning to use community resources to meet his daily living needs shall be provided as needed by making referrals to appropriate service providers.

While all members have unique needs and discharge decisions are made based on individual circumstances, Targeted Case Management services are intended to be time limited with average lengths of stay from 24-36 months. Discharge planning discussions should begin at the onset of care at the initial assessment and documented, at a minimum, with each service plan review.

Case Management services are **intended to be delivered in the setting in which the member resides** or needs service. Reasonable attempts shall be made to contact the member or the parents, if the member is a child, at least every 2 weeks. The contact or the attempt to contact shall be documented.

If contact with the member or a parent cannot be made, then attempts to locate another member of the family, a relative or a friend shall be documented. For members receiving Blended Case Management or Resource Coordination services, a **minimum of one face-to-face contact per month** is required (note that this is more than is required by regulation).

For members receiving Intensive Case Management services and those receiving Blended Case Management services with an Environmental Matrix score of 4.0 – 5.0, **a minimum of one face-to-face contact is required every 14 days**. These expectations are a *minimum* – it is anticipated that members may require more frequent contact based on individual strengths and needs. Services in excess of minimum requirements should be provided in accordance with member needs.

Services should be **offered at times that meet member needs**, which may include weekend and/or evening hours for those engaged in vocational or educational activities during daytime hours. Members receiving Blended or Intensive Case Management services are required to have access to the service 24-hours per day. 24-hour on-call services are highly recommended for members receiving Resource Coordination services.

**Please note that while the GAF is not included in the DSM 5, the current regulations/ bulletins still reference it, and therefore, it is included in these standards.*

Service Description

Staff Requirements

Mental Health Targeted Case Managers must meet one of the following criteria:

1. Bachelor's degree with major course work in sociology, social welfare, psychology, gerontology, anthropology, other related social sciences, criminal justice, theology, nursing, counseling, or education; OR
2. Registered nurse; OR
3. A high school diploma and 12 semester credit hours in sociology, social welfare, psychology, gerontology, or other social science and two years' experience in direct contact with mental health consumers; OR
4. A high school diploma and five years of mental health direct care experience in public or private human services with employment as a case management staff person prior to April 1, 1989.

*** Although not required by regulation, Magellan strongly recommends that all case managers meet either criteria 1 or 2 above and have at least six months mental health direct care experience, which may include volunteer work and/or college internships.

Supervisors of Mental Health Targeted and Blended Case Managers must meet one of the following criteria:

1. A master's degree in social work, psychology, rehabilitation, activity therapies, counseling or education and three years mental health direct care experience; OR
2. A bachelor's degree in sociology, social work, psychology, gerontology, anthropology, history, criminal justice, theology, counseling, education, or be a registered nurse, and five years mental health direct care experience, two of which shall include supervisor experience; OR
3. A bachelor's degree in nursing and three years mental health direct care experience.

Supervisors of Resource Coordination may meet one of the above or:

- A bachelor's degree in sociology, social work, psychology, gerontology, anthropology, nursing, other related social sciences, criminal justice, theology, counseling, or education, and have two years mental health direct care experience.

Mental health direct care experience is defined as working directly with mental health service consumers (adults, child or adolescents) providing services involving casework or case management, individual or group therapy, crisis intervention, early intervention, vocational training, residential care, or social rehabilitation in a mental health facility or in a facility or program that is publicly funded to provide services to mental health consumers, or in a nursing home, a juvenile justice agency, or a children and adolescent service agency.

Organization

Providers must adhere to maximum caseload size as described in the applicable regulations and MA bulletins. However, it may be necessary to have caseloads below the maximum allowable size based on the needs of each member.

- Intensive and Blended Case Managers shall maintain caseloads of no more than 30 members.
- Resource Coordinators shall maintain caseloads of 30 – 75 adult members or 20 – 24 child and adolescent members.
- Supervisors of Intensive Case Managers may supervise no more than seven case managers and must devote 1/7th of their available time each week to supervising each ICM.
- Supervisors of Blended Case Managers may supervise no more than nine case managers and must devote 1/9th of their available time each week to supervising each BCM.
- Supervisors of Resource Coordinators may supervise no more than 10 resource coordinators and must devote 1/10th of their available time each week to supervising each RC.
- All Mental Health Targeted Cased Managers must work full-time in the program unless an exception has been requested and approved by OMHSAS.

Expansion of Programs

Mental Health Case Management providers interested in expanding the number of case managers within their programs must first receive approval from Magellan. Providers interested in expansion should email mbhinterestedproviderapplication@magellanhealth.com to request Magellan's Interested Provider Form. Once the completed form has been submitted, all information will be reviewed and the provider will be notified whether the expansion is approved. This does not apply to filling vacant case manager positions that were previously staffed, only to expanding the total number of case managers beyond what the provider has previously offered.

Service Exclusions

Targeted Case Management services are not intended to be provided in conjunction with other programs that include a case management component.

This includes:

- Assertive Community Treatment
- Dual Diagnosis Treatment Team
- Family Based Services
- Extended Acute Care
- Residential Treatment Facilities
- SUD Case Management

If a member is receiving duplicative services, providers should coordinate with the member and the other provider entities to determine the most appropriate service and course of action based on the member's current needs. Members may only receive Blended Case Management, Intensive Case Management, or Resource Coordination from one agency at a time and, should a transfer be requested, must be discharged from the transferring agency. An **overlap of up to 30 days** is allowable as needed at the beginning and end of member stays in programs that contain a case management component for purposes of providing a seamless transition for members.

Per PA Code 55 Chapter 5221 Mental Health Intensive Case Management and OMHSAS-10-03 Blended Case Management, eligibility for Case Management **excludes** those with a **principal** diagnosis of Intellectual Disability, Substance Use Disorder, Organic Brain Injury or a "V"-Code. The diagnosis supporting TCM/ BCM eligibility should be indicated in the **first** position on all claims submissions to Magellan, while any co-occurring condition should also be indicated in the secondary (tertiary, etc.) position.

Per federal and state regulations, traveling to and from appointments, or **providing transportation to members, is not a directly reimbursable service**. Providers should offer assistance to members in identifying and using alternate forms of transportation as needed, including assisting members in learning to use public transportation.

Referral Process

Referrals to Mental Health Targeted Case Management should, at a minimum, include:

- Demographic information
- Member's diagnosis(es)
- Recent treatment history
- Member or parent/guardian signature

Some counties may require that specific referral forms be used. Refer to the applicable County Administrator or designee for this information.

Case management agencies must obtain documentation of member assessment, including diagnosis and treatment history, completed within the last 12 months. This evaluation does not need to specifically recommend case management services, however there must be the presence of an assessment completed by a Mental Health Professional level or higher within the prior year. Upon receipt of a completed referral, it should be reviewed to ensure the member meets eligibility criteria. The referring party should be notified the completed referral was received and whether the member meets eligibility criteria.

Members meeting eligibility criteria **should be offered a first appointment within seven calendar days** of receipt of completed referral (urgent and emergent referrals should be offered an initial appointment within one – two business days).

If an agency is unable to meet the expected timeline, they are to **inform the member that they can assist in referring the member** to another case management provider in the area. If the member chooses not to be referred to another provider, the agency shall complete an assessment (as needed) and begin services as soon as possible.

Admission Process

The initial appointment shall include the member, the parent/guardian (if applicable), and other family members or providers as identified by the member. At the initial appointment, the Environmental Matrix should be completed to determine the appropriate level of case management services.

If no case management services are indicated, **the member should be provided with alternative options to meet their needs**. In addition to the information received upon referral, case management programs should ensure that the following information is obtained, reviewed to determine any needed changes to services, and updated yearly within the member's record:

- Physical exam including medical history within the past 12 months
- Assessment of consumer's strengths, needs and interests
- Summary of out-of-home placements: hospitals, incarcerations, etc. (place and date of admission, reason for admission, length of stay and discharge plan)
- For children: IEP, school testing (psych eval, guidance counselor reports, etc.)
- A copy of a psychiatric or psychological evaluation, or other treatment records including diagnosis and treatment history, completed/updated within the last year

Treatment or Service Plan

Each member receiving Mental Health Targeted Case Management services must have a written Service Plan that meets the following requirements:

- All goals/objectives are to be specific and measurable. Plans should include responsible parties, time frames and case manager role in relation to goal as well as the member and any other parties involved.
- Document member strengths/assets as well as what the member believes would be supportive and helpful regarding personal needs and goals.
- The initial Service Plan shall be developed within 30 days of admission to services and updated at a minimum of every six months (for Resource Coordination, plans may be updated annually). Members are to drive input in the creation of the plan.
- Services are to occur where the member resides or would benefit from service delivery. Every effort should be made to have services occur in member's home and community context. If this is not possible due to environmental factors, office-based services can occur. Case managers should document why services are occurring in the provider's office rather than in the member's home and community, so that service delivery context can be understood.
- The Service Plan should include a Crisis Plan that is developed with the member and collateral input (as appropriate and with approved consent in place). Identified persons to call in a crisis must include current phone numbers and the relationship should be noted. Copies of the Crisis Plan should be provided to the member, collateral contacts, and other service providers, if agreed upon by member and available to case management staff for crisis resolution involvement.
- The Service Plan should include mention of other involved providers and ancillary services with whom member is involved.
- The Service Plan should be signed by the member, Case Manager, and Case Management Supervisor. If signatures cannot be obtained from the member (or guardian), the reason and attempts need to be documented. Signatures should continue to be pursued during future sessions.
- When possible, contingency plans to address noted patterns in member personal history can be included - (for example, known vulnerabilities, anniversaries, etc.).
- When goals are met, the expectation is that goal attainment is noted and the plan is updated regardless of "due date."
- If a member changes a goal or is no longer interested in addressing a goal on the Service Plan, this should also be documented.

If a member is experiencing difficulty or barriers meeting goals, a re-assessment of service delivery including frequency, location and type of contact should occur in conjunction with the member, natural supports and other professionals.

Expectations of Service Delivery

Ensuring correct level of service

The Environmental Matrix (EM) is critical in ensuring the correct level of service is provided. OMHSAS requires that the EM be completed every 6 months at a minimum and whenever there is a change in level of service. A change in the individual's level of care should be communicated to all relevant agencies/ providers involved in the member's care. In addition to the EM, it's expected that programs use additional tools/ methods to ensure the appropriate level of service is provided including consumer/ family input; crisis contacts; input from other involved providers; current or anticipated stressors; and use of a program specific monitoring tool.

Specialized programs

When appropriate, case managers should receive training in specialized forms of case management including Critical Time Intervention (CTI) and Transition to Independence Process (TIP) (see Appendices I and II). Decisions to implement specialized case management models must be made in conjunction with Magellan and County partners. Magellan encourages general case management programs to incorporate appropriate concepts from these models to enhance the services members are receiving.

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.
Magellan has established minimum record keeping requirements that align with Pennsylvania Medical Assistance regulations. Specifically:

- The record must be legible throughout.
- The record must identify the member on each page.
- Entries must be signed and dated by the responsible licensed provider. Care rendered by ancillary personnel must be count-signed by responsible licensed provider.
- Alterations of the record must be signed and dated.
- The record must contain a preliminary working diagnosis, as well as final diagnosis, and the elements of a history and physical examination upon which the diagnosis is based.
- Treatments, as well as a service plan, must be entered in the record.
- Drugs prescribed as part of treatment, including quantities and dosages, must be entered in the record.
- The record must indicate the progress at each session, change in diagnosis, change in treatment and response to treatment.

- The record must contain the results, including interpretations, of diagnostic tests and reports of consultations.
- The disposition of the case must be entered in the record.
- 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 service plan – specifically, any goals, objectives and interventions.
    - Progress at each session, any change in diagnosis, changes in treatment and response to treatment;
    - The actual time in clock hours that services were rendered.

As a result of Magellan's ongoing auditing practices and the continued expansion of fraud, waste, and abuse oversight responsibilities, we identified the need for consistent and comprehensive requirements in the attainment of signature verification for service encounters (i.e. Encounter Forms). Encounter Forms offer an extra check and balance for an agency to ensure that services delivered in the community are done so as documented. As such, this mechanism for oversight and control is best enforced by obtaining pertinent information which can verify the provision of services.

Encounter Forms

Encounter forms offer an extra check and balance for an agency to ensure that services delivered in the community are done so as documented. As such, this mechanism for oversight and control is best enforced by obtaining pertinent information which can verify the provision of services.

In accordance with Medical Assistance (MA) Bulletin 99-89-05, a recipient signature is required for MA services unless the service is signature exempt (please reference details in the bulletin). If a provider is unable to obtain a signature on the encounter form (including refusal), it must be documented why, and attempts should be made to obtain a signature the following session.

Per MA Bulletin 99-89-05, the following information must be recorded on the encounter form:

- Certification Statement: "I certify that the information shown is true, correct, and accurate. I understand that payment and satisfaction of this claim will be from federal and state funds, and that any false claims, statements or documents, or concealment of material facts may be prosecuted under applicable federal and state laws."
- Provider Name and MA ID
- Recipient Name and MA ID
- Date of service

- Member/ guardian signature

Magellan requires providers of community-based services (which includes MH Case Management) to obtain a signed Encounter Form for each face-to-face contact that results in a claim being submitted to Magellan. In addition to the requirements outlined in MA Bulletin 99-85-05, the start and end time of the session (the actual time in clock hours, not the duration, i.e. '2:00 PM-4:00 PM', not '2 hours') must be included on the encounter form for all face-to-face community-based services.

Although a requirement for in-person community-based/ mobile services, Magellan also considers the inclusion of start and end times on telehealth encounter forms to be a best practice. Per OMHSAS-22-02, signatures for telehealth service verification may include hand-written or electronic signatures, unless prohibited by other laws. Consistent with Act 69 of 1999 Electronic Transactions Act, an electronic signature is an electronic sound, symbol or process attached to or logically associated with a record and executed or adopted by a person with the intent to sign the record. Providers using electronic signatures must have systems in place to ensure that there is an audit trail that validates the signer's identity. Physical signatures may be obtained through a variety of different mechanisms including in-person with the member; US Mail; or e-mailed forms to a member who has the capability to print and return the hard copies; or print, scan and e-mail copies. Signatures can also include an audio recording of voice consent (i.e., the "sound") stored within a HIPAA-compliant telehealth platform. Recording means that the member's voice consent is stored within the medical record system. Signatures are to be obtained as soon as possible and no later than 90 days after the service.

Magellan does permit encounter signatures on multiple dates of service, for example, a weekly/ monthly encounter form for all services rendered during the prior week/ month, as long as the minimum requirements outlined above are met. Signed encounter forms should be available at the time of a Magellan audit or review. If a provider is unable to obtain a signature on the Encounter Form (including refusal), it must be documented why, and attempts should be made to obtain a signature the following session. The signed encounter forms also must match all other supporting documentation for the session (i.e., progress notes).

Care Coordination

It is the expectation that collaboration and communication with an individual's natural and professional supports is part of the treatment experience to enhance and reinforce recovery principles and processes. This should include monthly (or more frequent as appropriate) contact with the member's therapist to coordinate treatment and services.

Case management providers should build partnerships with community providers, including, but not limited to, other mental health service providers, primary care physicians, substance use service providers, psychiatric inpatient providers, and providers and community organizations that address social determinant of health needs, such as vocational rehabilitation and housing services. Regular coordination should occur with all other providers/services members are engaged with.

If a member is in crisis, Targeted Case Management should be involved, assessing the member to provide feedback, and offer diversion to a lower level of care if clinically appropriate. For example, if a member is in an emergency room seeking admission to an inpatient psychiatric hospital and TCM staff are notified and assess member as benefitting from an alternative crisis residence, advocacy can occur prior to an inpatient admission.

In instances where a case manager is notified that an involuntary commitment is being considered for a member, the case manager is required to be present on-site at the crisis center/ hospital to ensure appropriate alternatives are considered.

If a member is admitted to an inpatient psychiatric hospital, crisis residential program, or substance abuse treatment facility, it is also the expectation that the case manager document weekly contact (or attempts to make contact) with both the member and hospital staff and be involved in discharge/aftercare planning. The appropriate releases must be in place and updated in accordance with all confidentiality regulations and agency policies and procedures in order to support these coordination efforts.

All case management programs must have written agreements with mental health crisis intervention services to engage when the on-call case manager is contacted by a member or parent/guardian. It is also suggested that releases of information are obtained for frequently used local programs and agencies, including, local crisis agencies, inpatient facilities, primary care physicians/ specialists, and outpatient providers. Assessing, supporting, and assisting members as well as their providers with planning for re-integration into the community during a period of non-community tenure is fundamental to the principles of TCM services.

Magellan has a process in place to notify TCM providers when members are admitted to a Mental Health Acute Inpatient (AIP) Hospital. Providers who have given Magellan the necessary information (one shared email box per provider and locations that should be included), Magellan sends daily emails to notify of members who were admitted. In order to receive a notification for a member, Magellan must have a claim from one of the included services from the provider with the date of service within the 60 days prior to the inpatient admission. This claim must have been received by Magellan prior to the inpatient admission date.

AIP providers also receive notification emails (if enrolled) when members are admitted. Both outpatient/ community-based and AIP providers should work together to improve this communication and to coordinate member discharges from higher levels of care and referrals to services for new members.

Additionally, case managers are asked to encourage members to participate in Magellan's text messaging program in order to receive text reminders of aftercare appointments following inpatient discharges. The texting program allows members to received text reminders of appointments. For more details about the texting program go to: https://www.magellanofpa.com/for-members/ and see the "Release Forms and Member Access Portal Information" accordion.

Discharge Planning and Transition

Utilizing the Environmental Matrix is an important tool in ensuring the correct level of service is being provided to members. OMHSAS mandates this tool be used at a minimum of every six months or whenever a change in service level occurs. Areas to be explored that may warrant a change in TCM services include, but are not limited to, assessment of daily living skills, housing/shelter needs, access to resources including food, medical status, legal and forensic issues, access to transportation for wellness appointments or other needs, peer and family relationships, vocational and educational factors, behavioral health status, safety concerns and issues, childcare/family needs, substance abuse concerns, and cultural, religious, and spiritual considerations.

When a change does occur with TCM services, this should be clearly communicated to the member and all providers and agencies involved in the member's care whereby permission has been given.

When considering a change in service, other factors to be considered other than the Environmental Matrix are member and family input on the member's status, recent clinical history and presentations, including crisis contacts, admissions to higher levels of care, known or anticipated stressors, and any other evidence-based tools utilized by the provider to assess clinical dimensions.

Targeted Case Management Services may be terminated for any of the following reasons:

- Member decides services are no longer needed or desired. Assertive efforts are made in collaboration with the member to develop an aftercare plan.
- Provider determines the member is no longer meeting criteria for TCM services.
- Member moves out of geographical jurisdiction of provider. In this case, the goal is to link the member to comparable and appropriate services and resources in new area of residence.

Members who are being transferred to a more intensive level of care (ex: ACT, Family Based, etc.) due to increased needs should be transitioned to these services over a period not to exceed 30 days.

If a member declines or refuses services, it should be clearly documented that assertive outreach attempts have been made over a period-of-time to both the member and those that are involved with the individual with appropriate consents in place. Discharge from TCM services should not be automatic as there are numerous circumstances potentially impacting the member and their current level of engagement in services.

Providers should have internal standards for what would necessitate discharge from TCM services, but as noted previously, assertive outreach attempts are the standard and all members are to have a documented aftercare plan established. When discharge from services does occur, a copy of the discharge summary and aftercare plan should be made available to the member. Note that individual counties may have expectations above what has been described in this section. In those cases, the more stringent expectations must be followed.

All discharge plans should be clearly documented in progress notes and service plans, with emphasis on preliminary discharge plans, barriers to planning, progress of discharge planning, and any rationale for change in discharge plans. Additionally, a discharge summary including the following information must be included in the member record and should include the following information:

- Reason for admission to case management
- Services provided
- Goals attained
- Goals not completed and why
- Reason for closure
- Follow up appointment with behavioral health provider – provider name, date, and time
- Follow up appointments with other providers/supports involved
- Safety plan
- Member (or parent/guardian) signature, if obtainable
- Signature of the county administrator/designee (as applicable)

Outcomes

Magellan has developed an outcomes tool, the ICM Perception of Outcomes, for use by case management providers. The use of this tool is required by all case management providers participating in Magellan's Value Based Purchasing program. The outcomes tool is a short survey to be completed with the member upon admission to case management services, 3 months after starting services, 6 months after starting services, and every 6 months thereafter. The results are compiled into an outcomes dashboard that is shared with providers on a quarterly basis and used for discussion in regularly scheduled provider meetings.

Additionally, all providers of Mental Health Targeted Case Management should have policies and procedures in place to evaluate outcomes for the program. Some of the indicators that could be considered include:

- Decreased hospitalization rates
- Increased involvement with service providers
- Increased stability in housing
- Active involvement in vocational and academic goals
- High levels of participant's satisfaction
- Decreased involvement of legal forces
- Increased community tenure
- Increased ability to manage own care
- Increased participant's ability to communicate openly with service providers
- Decreased number of service providers across levels of care
- Increased community linkages
- Frequency of contact with members

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.

Magellan uses information gained from member complaints to identify areas where opportunity for improvement may exist. 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.

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.

Complaint and Grievance Information and Resources

Network providers are required to display information at their offices about how to file a Complaint or a Grievance, the Complaint and Grievance process, and notice that Members will not incur a fee for filing Complaints or Grievances at any level of the process.

For additional information about Complaints and Grievances, including provider-initiated grievances and filing a provider complaint, please visit the Complaint and Grievance page of the Magellan of Pennsylvania website at https://www.magellanofpa.com/for-providers/services-programs/complaints-grievances/ and the Provider Handbook and Provider Handbook Supplement for HealthChoices' Program Providers.

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). Assessment of compliance with these requirements is integrated into our quality improvement activities.

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 commits to a strong cultural competency program and believes that all people entering the behavioral health care system must receive equitable and effective that respects individual member preferences, needs and values, and is sensitive to residual stigma and discrimination. Magellan encourages providers to maintain practices deeply rooted in cultural competence and prioritize health equity and inclusion. These practices include focusing on continual training and education to support staff. Cultural Competence and Diversity, Equity, and Inclusion (DEI) resources are available on www.Magellanofpa.com to help develop provider cultural competency programs.

There are instances where Members may benefit from oral interpretation, translation services, and materials/communication approaches in non-English languages or alternative formats. Providers are encouraged to maintain staff training to support Members with language assistance needs and ensure that their team is prepared to respond to provide the best possible treatment outcomes. For practitioners, Magellan makes in-person, video or telephonic interpretation services available, as needed. 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).

Magellan requires an electronic submission process. This can be accessed at magellanofpa.com.

Appendix I – Transition to Independence Process (TIP)

The Transition to Independence Process (TIP) model is an evidence-supported practice developed for youth and young adults (ages 16-26) with emotional/behavioral challenges. TIP programs are staffed by transition facilitators and a transition program supervisor. Some TIP programs have an embedded Peer Support. Due to the intensive nature of TIP services, caseloads for TIP works should be capped at 15 members.

TIP staff work with members, their families, and other information supports, across Transition Domains including:

- Employment/career
- Education
- Living situation
- Personal effectiveness/wellbeing
- Community-life functioning

TIP staff employ seven guidelines and core practices in engaging youth and families in futures planning, provide services and supports, and preparing for and facilitating movement toward self-sufficiency and goal achievement.

TIP Model Guidelines

1. Engage young people through relationship development, person-centered planning, and a focus on their futures.
2. Tailor services and supports to be accessible, coordinated, appealing, non-stigmatizing, and developmentally-appropriate -- and building on strengths to enable the young people to pursue their goals across relevant transition domains.
3. Acknowledge and develop personal choice and social responsibility with young people.
4. Ensure a safety net of support by involving a young person's parents, family members, and other informal and formal key players.
5. Enhance young persons' competencies to assist them in achieving greater self-sufficiency and confidence.
6. Maintain an outcome focus in the TIP system at the young person, program, and community levels.
7. Involve young people, parents, and other community partners in the TIP system at the practice, program, and community levels.

TIP Model Practice Competencies:

- Strength Discovery and Needs Assessment
- Futures Planning
- Rationales
- In vivo Teaching

- Social-Problem Solving (SODAS)
- Prevention Planning on High-Risk Behaviors and Situations (WHAT'S UP?)
- Mediation with Young People and Other Key Players (SCORA)

Because the TIP model was designed specifically for working with youth and young adults, TIP staff are trained in assisting members in working through the challenges that arise during the time that they are transitioning to adulthood. TIP Model training is an intensive training required for facilitators and supervisors and includes trainings on the TIP Model Practice Competencies. Staff should complete the initial TIP training within the first 3 months of employment and all competencies within the first year.

All TIP programs are required to gather and report TAPIS outcomes data to Magellan at TIP admission and discharge, at a minimum.

As TIP addresses the same domains traditional Targeted Case Management services address, TIP and TCM services are considered duplicative and cannot be provided during the same timeframe, with the exception of a brief (less than 30 days) overlap and the beginning and/or end of TIP services.

Implementation of TIP requires prior approval from Magellan and the applicable county/counties.

Further information regarding TIP can be found by utilizing the following resources: The California Evidence-Based Clearinghouse for Child Welfare (2020). *Transition to Independence (TIP) Model*. Retrieved December 28, 2020 from http://cebc4cw.org.

https://www.starstrainingacademy.com/tip-model-institute/

Appendix II – Critical Time Intervention (CTI)

Critical Time Intervention (CTI) is an evidence-based program designed to address and prevent recurrence of homelessness in individuals with severe mental illness and other vulnerable populations. CTI is a time limited program that requires specialized training for workers to implement the model. CTI employs a phased approach delivered over a nine-month period. The phases are as follows:

- Phase 1
  - Weekly contact with the member (may vary based on individual needs)
  - Complete assessments
  - Establish contact with existing supports and introduce new supports
  - Provide support and advice
- Phase 2
  - Bi-weekly contact with the member (may vary based on individual needs)
  - Observe and modify support network as needed
  - Conflict mediation between members and caregivers
- Phase 3
  - Monthly contact with the member (may vary based on individual needs)
  - Develop plan for long-term goals
  - Review progress made
  - Meet with member and supports to transfer care

Due to the intensive nature of CTI services, caseloads for CTI works should be capped at 15 members. CTI workers must hold a minimum of a bachelor's degree, complete required training, and be supervised by a mental health professional.

Implementation of CTI requires prior approval from Magellan and the applicable county/counties.

Further information regarding CTI can be found by utilizing the below resources:

Social Programs that Work (2017). *Critical Time Intervention*. Retrieved December 28, 2020 from http://evidencebasedprograms.org.

Center for the Advancement of Critical Time Intervention (n.d.). *CTI Model*. Retrieved December 28, 2020 from http://criticaltime.org.