



# School Based Outpatient Mental Health Services

Magellan Behavioral Health of Pennsylvania (Magellan) Performance Standards

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

## 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 PA HealthChoices Program must first be enrolled in the Pennsylvania Medical Assistance Program as the appropriate provider type. Providers must comply with all applicable Pennsylvania laws, including Title 55, Chapter 1101 General Provisions, and Chapters 1153 and 5200, as well as 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 email blasts:

<https://www.magellanofpa.com/for-providers/communications/provider-announcements/compliance-alerts/>

## Level of Care Description

Outpatient clinic services provided within the youth’s school setting.

## Scope of Services

The scope of School Based Outpatient Mental Health services includes:

- School aged youth
- Place of service to include main clinic or on-site at pre-approved and licensed school location
- Individual, family, and group therapy
- Psychiatric evaluations
- Evaluations/ Assessments (non-MD)
- Medication management
- Psychological and Neuropsychological testing

## Service Description

School Based Outpatient Mental Health Services provide on-site counseling services to youth identified by school personnel, themselves, or families as needing specialized mental health services to function within the school setting. To be eligible for PA HealthChoices reimbursement, the youth must have Pennsylvania Medical Assistance. Services should be directed toward helping youth remain integrated with their natural community and work to prevent the necessity of a more restrictive or intrusive service. The program serves as a partnership between the educational and behavioral health systems. Topic specific psycho-education groups may be provided on an as needed basis when recommended by clinical or school staff.

It is best clinical practice for individual, family and group outpatient therapy services to be provided by a mental health professional. Accordingly, school-based clinical services should be delivered by a licensed, certified, or master's prepared individual as per facility policy and the Pennsylvania Code. Mental health professionals should be supervised in their practice by a psychiatrist, senior clinician, or other appropriately trained clinicians. Per the regulations, services within a licensed outpatient clinic may also be provided by a mental health worker under the supervision of a mental health professional. Clinics are expected to have a policy and procedure outlining appropriate clinical supervision frequency as well as content and substance of the supervision. The clinic is expected to maintain ongoing training and supervision records for clinicians who are employed as outlined in the facility policy. Medication management could be provided in the school for high-risk youth or those who cannot attend the clinic. Medication management and medication administration may be provided only by a psychiatrist, physician, certified registered nurse practitioner, physician assistant, or registered nurse within the scope of practice under state law.

All clinicians who may have direct contact with children/adolescents aged 18 and under must have Act 33 (Pennsylvania Child Abuse History Clearance), Act 34 (Pennsylvania State Police Criminal Record Check), and FBI Background Check prior to the provision of services. The school-based outpatient provider must also have a policy in place that requires Act 33/34 clearances and FBI Background Check for employees working with children/adolescents ages 18 years and under. Child Protective Services law must be followed at hire and again every 5 years at a minimum.

Each school location is individually licensed, and the provider is credentialed, enrolled, and contracted for each school-based site by Magellan. It is required that all services rendered in the school setting should be reflected with the appropriate school service location address and should have a corresponding/unique NPI number which is used when submitting claims for school-based outpatient clinic services.

## Service Exclusions

It is considered duplicative for an individual to receive School Based Outpatient Mental Health services in conjunction with:

- Psychiatric Inpatient Services
- Substance Use Withdrawal Management
- Substance Use Residential
- Substance Use Partial Hospital Program
- Substance Use Intensive Outpatient Program
- Substance Use Outpatient
- Substance Use Case Management
- Residential Treatment Facility Services
- Residential Treatment Facility for Adults
- Community Residential Rehabilitative Host Home
- Family Based Services
- IBHS if receiving Mobile Therapy
- Multi-Systemic Therapy

- Functional Family Therapy
- Assertive Community Treatment
- Psych Rehab Site Based
- Psych Rehab Mobile
- Mental Health Partial Hospital Program

Outpatient services can occur at the provider’s outpatient clinic, school site-based clinic, or another school-based site in the district based on what is most conducive for the youth and family. If additional services are necessary in conjunction with School Based Outpatient Mental Health services, we encourage providers to contact a Magellan Care Manager.

## Referral Process

A strength-based recovery oriented comprehensive assessment should be completed, which should contain information provided by the youth, caregivers and school staff. The assessment should include the psychiatric, medical, psychological, social, vocational, and educational needs. Youth can be recommended for services by a variety of sources but would still need to go through the formal referral process agreed to by the school and the identified provider.

## Admission Process

A mental health professional or mental health worker under the supervision of a mental health professional determines that the person could benefit from School Based Outpatient if exhibiting emotional or behavioral problems, mental illness, or distressing symptoms that result in significant challenges in home or school that could impact school performance or school placement. Additionally, if the youth exhibits symptoms of a psychiatric illness associated with reduced levels of functioning and/or subjective distress or has a history of psychiatric illness and presents in remission or with residual state of psychiatric illness that without treatment there would be a significant potential for regression.

## Treatment or Service Plan

Per Chapters 1153 and 5200, a recovery oriented and strengths-based treatment plan should be developed, reviewed, approved, dated, and signed prior to the provision of any treatment services beyond the 30<sup>th</sup> day following intake with the youth. Treatment plans need to include input from caregivers, school, and those involved in the member’s treatment. The youth and caregivers should be included in developing the treatment goals, and the goals should be measurable and observable. Treatment plan updates are to occur at least every 180 days or when the youth’s goals change, goals are met and/or new goals are identified. Discharge criteria should also be documented in the treatment plan. All versions of the treatment plan must be signed. The youth and family should sign the treatment plan as evidence of collaboration and provided a copy. Any refusal should be documented in the medical record. The treatment plan shall also be signed and dated by the mental health professional, mental health worker under the supervision of the mental health professional, certified registered nurse

practitioner, or physician assistant providing treatment services to the individual. The treatment plan must also be reviewed on an annual basis by the psychiatrist or advanced practice professional (depending on whether the individual is receiving medication management services) throughout the course of treatment and the review documented in the individual record.

## Expectations of Service Delivery

School Based Outpatient Mental Health Services are provided at the licensed and contracted school site. Youth may also receive services at the main clinic as needed to account for routine medication management appointments or therapy sessions scheduled during times when school is not in session. Typically, youth receive individual services one time per week and family therapy a minimum of one time per month. Group services are provided in accordance with the group topic and membership. All services should be provided in relationship to the Treatment Plan which outlines the type and required frequency of services.

The school and the identified outpatient provider should clearly define roles and expectations prior to rendering services. The school and the provider should have a clear understanding of the provider's role in school-based crisis management for both enrolled and non-enrolled students. This should be documented through a Memorandum of Understanding (MOU) or other similar agreement and updated annually.

Youth and caregivers should be made aware of what the process is if there is a need for services outside of school hours as well as after business hours. After-hours coverage should include at minimum an answering service with emergency contact information for immediate services when necessary to evaluate or stabilize a potentially life-threatening situation. There should also be timely responses to contact made outside of normal operating times, within 24 business hours.

### *Documentation*

The documentation in the youth'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 youth'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 youth 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 treatment plan, must be entered in the record. Drugs prescribed as part of treatment, including quantities and dosages, must be entered in the record. If

- a prescription is telephoned to pharmacist, the prescriber's records require a notation to this effect.
- 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 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 addition to the above notations, providers must follow the applicable MA regulations for the services for which they are licensed and enrolled.

## Care Coordination

Services should continue to be offered to the youth during school holidays and summer vacation. It is expected that providers work with the school district on service offerings during holidays/summer vacation. If the youth will not be continuing with services during these times, it must be documented in the medical record and information must be provided informing the youth on how to get reconnected with services in the future. If the youth will not be continuing with School Based Outpatient services, they should be connected to other supports and resources.

Routine communication should occur between the school-based outpatient clinician and treatment team with the appropriate releases of information. The youth's family should also be engaged and attend family therapy sessions once per month at minimum.

With appropriate releases of information, school-based clinicians should be coordinating with the school personnel to ensure the youth's clinical needs are being met, supporting them in achieving educational goals.

Coordination needs to occur when the individual is receiving services from additional providers, as this is essential for the delivery of integrated quality care. The school-based outpatient provider is

expected to obtain the necessary releases and coordinate with the youth's primary care physician and other providers routinely and at significant points in treatment.

## Discharge Planning and Transition

There needs to be established discharge criteria and a clear discharge plan from the onset of treatment.

If the youth and/or family continues to need community supports and/or medication management, the School Based Outpatient Mental Health provider is to coordinate with the youth/caregivers and provide the date, time, and contact information of aftercare supports. Information about crisis services is to be given to the youth, caregivers and primary supports, as well as information about how to reengage with School Based Outpatient Mental Health services if needed in the future. The transition should be designed to allow the individual's treatment to continue without disruption whenever possible.

Discharge information should be shared with supports involved with the youth/caregivers as appropriate based on releases of information.

An alternate level of care should be considered if improvement is not seen within a clinically appropriate period of time or the youth's mental status declines to the point that the youth cannot be safely maintained in the School Based Outpatient Mental Health setting. If a youth is discharging from a higher level of care to School Based Outpatient Mental Health services, it is expected that the youth will be seen by the provider within seven days of discharge to support engagement in treatment and community tenure.

## Outcomes

It is expected that School Based Outpatient Mental Health service providers will identify an outcomes collection process to measure impact of services delivered. It is expected that your agency will review annually and make the appropriate adjustments to services as needed.

Potential outcomes for collection may include:

- Caregiver engagement
- Provider use of standardized outcomes tool
- Follow up within 7 days of Higher Levels of Care discharge
- Retention rates
- Hospital admissions/readmissions
- Member/Family satisfaction

### **Performance Outcomes Management System (POMS)**

POMS is a tool the Department of Human Services (DHS) established to continuously evaluate the effectiveness of the PA 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.

PA HealthChoices' providers are **mandated** by DHS to collect priority population data and submit POMS data on every PA 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 PA HealthChoices (the member may have seen you as a fee-for-service patient and subsequently converted to PA 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).
- 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 provider agreement Facility and Program Participation Agreement with Magellan regarding cooperation with appeal and grievance procedures (Section 2.2.1). 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 is sufficient enough 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 will 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.Magellanoftpa.com](http://www.Magellanoftpa.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, and Other.

[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.